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Ailing Federal Investments
In Latino Health Priorities

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INTRODUCTION

Access to quality, affordable health care is a major policy priority for the burgeoning Latino community.† Latinos will account for 60% of the nation's population growth between 2005 and 2050. New immigrants (those arriving from 2005 to 2050) and their descendents account for the projected 74% growth in the Latino population for the same time period.[1] Yet much of the Latino community is disconnected from health care access, which jeopardizes the well-being and productivity of a group that will compose such a substantial part of the nation. Today more than one-third (34%) of Latinos lack health insurance and Latino children make up almost 40% of the estimated 8.6 million children in the Untied States who lack health coverage.

Until recently, policy debates have been unsuccessful in addressing Latinos' barriers to health coverage. In 2007, the State Children's Health Insurance Program (SCHIP) was extended through 2009 after two other compromised reauthorization bills were vetoed by President Bush. The extension maintained funding at levels that could sustain current participation but offered no additional resources to provide millions of uninsured children with a pathway to health care. An especially critical provision for Latinos, the Legal Immigrant Children's Health Improvement Act (ICHIA, S. 764, H.R. 1308), was not included in either vetoed bill or the extension. Passing of this legislation in 2009 will give states the option to restore federal Medicaid and SCHIP benefits to legal immigrant children and pregnant women. An estimated 400,000 legal immigrant children will benefit from this new funding stream.

The inadequacy of health care in the U.S., paired with rising health care costs, is a significant policy issue. A recent poll by the Kaiser Family Foundation found that Americans count rising health care costs among their top economic concerns.[2] Health care, which increased in importance for Latino voters in 2008, requires a decisive stance from the Obama Administration. President Obama's health care plan has a vision to control health care costs by broadly focusing on prevention, technology, and market competition. However, the success of such a plan also hinges on investments in current programs that help to sustain healthy families as the health care system is streamlined. The condition of the federal budget is also critical in efforts to strengthen or modify the health care system. Federal health care programs can lower the barriers that many Latinos face in accessing health care. Underfunding programs targeting

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† The terms "Hispanic" and "Latino" are used interchangeably by the U.S. Census Bureau and throughout this document to refer to persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, Spanish, and other Hispanic descent; they may be of any race.

low-income populations and the working poor, two groups that are composed of a significant number of Latinos, would continue a legacy of harmful policy choices.

Adding to the larger issue of health care financing, everyday necessities are further out of reach for many in the U.S. Millions of Latinos and other low-income Americans are already in very fragile financial positions, worsened by rising food, energy, and health care costs and the housing crisis. In 2008, Congress responded to the public's fears of recession by passing the Recovery Rebates and Economic Stimulus for the American People Act of 2008 (P.L. 110-185). Now in 2009, Congress is again passing legislation to tackle the economic crisis. Without meaningful investments in federal programs serving the unique needs of the Latino population, measures like the stimulus package will do little to keep Latino families from falling into extreme levels of poverty.

This paper will document issues and trends in federal investments in health care programs affecting Latinos in the United States. It will highlight policy measures that would assist in connecting the millions of uninsured Latinos living in the U.S. with quality, affordable health care.

BACKGROUND

In 2006, more than one in three 34% Latinos in the United States did not have health insurance, despite the fact that many uninsured Latinos work.[3] Although employer-based health care is a traditional source of coverage in the U.S., Latinos are less likely than non-Hispanics to have health care offered through their employer.[4] Given that there are more than 20 million Latinos in the workforce, health disparities are a national priority.

These gaps exist while the U.S. Latino population is projected to grow substantially in number over the next few decades. According to Pew Hispanic Center estimates, the Hispanic population will grow to 128 million by 2050 and will constitute 29% of the total U.S. population.[5] If the overall share of uninsured Latinos remained the same, about 42.6 million Hispanics would be without health insurance by 2050, which is roughly equivalent to the entire estimated 2005 U.S. Latino population.[6] By 2050, Latino children will make up 35% of all children in the U.S.[7] Federal investments can reduce the health care challenges that Latinos face and could go a long way to improve the health and well-being of all Americans in the long run.

INCREASES IN FEDEAL HEALTH CARE SPENDING

The general trend in health care over the last three decades has been an increase in spending from various contributors. The largest contributors to national spending on health care are federal, state, and local governments, households, and private businesses.[8] National health care spending includes personal health care, physician and clinical services, hospital costs, dental services, nursing home care, and prescription drug spending, among other associated expenditures.[9] In 1975, total national health care expenditures composed 8% of the Gross Domestic Product (GDP).[10] By 2006, it was 16% of the GDP.[11] The federal government's contribution to national health expenditures was 10% in 1965,[12] when Medicare and Medicaid were enacted; in 2006, the federal government's contribution was 33.5%.[13]

The Congressional Budget Office has identified factors such as general inflation, population growth, and changes in the age distribution of the population as contributors to the growth in governmental health care spending.[14] While Americans have longer life spans, there is greater prevalence of chronic illnesses that require long-term care.[15]

Federal health spending for discretionary and mandatory programs has been the subject of policy debates for decades. The pressure that federal and state governments are under to control spending overall, and on health care specifically, is not new. However, simply slashing program funds can jeopardize the well-being of people. Congress has a history of targeting programs that serve low-income

populations when looking for federal cost savings. For example, the 1996 welfare and immigration reform bills were part of an effort to balance the budget and achieve $60 billion in savings.[16] The result of the reform was tougher criteria for receiving welfare in the U.S. Under the law, no person could receive welfare payments for more than five years, consecutive or nonconsecutive. States were also prohibited from providing federally-funded means-tested benefits to post-enactment qualified immigrants for their first five years of lawful residency.[17] This law created significant restrictions to these programs and did not necessarily provide for the tools or resources to ensure that welfare participants could gain future economic stability.

When the economy becomes weak, one consequence is that expenses for means-tested programs tend to rise because need and program participation generally increase during these periods. The most recent budget proposal from President Bush for fiscal year (FY) 2009 would cut Medicaid spending by more than $17 billion during the next five years by reducing the federal match rate for certain services and various other Medicaid administrative functions.[18] In 2008, the Administration proposed regulatory changes to Medicaid that would reduce federal spending on the program by more than $10 billion.[19]

MEDICAID AND AND SCHIP: THE OUTLOOK

The "big three" entitlement programs, Medicaid, Medicare, and Social Security, constitute the bulk of mandatory federal spending. Arguably, the most critical mandatory health care spending on Latinos is on Medicaid and SCHIP. Medicaid is the nation's major public health coverage program for low-income and medically-needy Americans. Many of the low-income individuals and families who are enrolled in Medicaid lack access to private health insurance or the resources to pay for it outside of employment. In FY 2004, more than 12 million Latinos were eligible for coverage through Medicaid or SCHIP, and approximately ten million were enrolled in these programs.[20] SCHIP beneficiaries are the children of low- and moderate-income families who lack the financial resources to purchase private health care coverage. This program shows great potential to be a means of ensuring that Latino children have health coverage. Based on studies conducted by the Kaiser Commission on Medicaid and the Uninsured, about 82% of all uninsured Latino children are income-eligible for SCHIP enrollment.[21]

However, as concerns for health care costs have surfaced, the pressure to reduce federal investments in health care programs has increased. Despite its importance to and growing need in the Latino community, the Medicaid program has been drastically scaled back in recent years. The Deficit Reduction Act of 2005 (DRA) reduced expected Medicaid funding by $11.5 billion between 2006 and 2010 and by $43.2 billion between 2006 and 2015.[22] In practice, these changes to the program can increase the out-of-pocket costs for beneficiaries accessing health care, as well as reduce funding of key benefits under the programs. In subsequent years, the president's proposed budgets reflected growth in Medicaid spending, but the federal outlays for the program actually decreased. According to the Bush Administration's proposed FY 2006 budget, estimated Medicaid spending would total approximately $197 billion. Actual Medicaid spending for FY 2006 was $180 billion. Similarly, the FY 2007 budget from the White House estimated federal Medicaid expenditures to total $199 billion; actual spending was $196 billion.

The Bush Administration has continued to promote reductions in Medicaid spending. President Bush's FY 2009 budget plan proposed to cut $17 billion more from Medicaid through legislative proposals from FY 2009 to FY 2013, with a bulk of the reductions ($10 billion) achieved by reducing federal match rates for certain services (e.g., reimbursing all Medicaid administrative activities, offering family planning and case management at a reduced match rate). Several of the proposals were

included in the president's FY 2008 budget proposal, but they were not implemented or adopted by Congress.[23]

Many states are currently facing budgetary restraints. Medicaid and SCHIP cost shifts may force states to impose further reductions in services within the programs or push those costs onto participants (e.g., increasing co-pays). In addition, a reduction at the federal level often translates to reduced funding or elimination of important state-funded programs. This could adversely affect low-income participants. Reductions in federal Medicaid spending have the potential to put at risk the long-term ability of these programs to reach Latinos and other low-income individuals and families. Furthermore, for those families already enrolled in the program, it could shift the burden of cost to those who can least afford it, the beneficiaries.

SHRINKING DISCRETIONARY HEALTH SPENDING IMPLICATIONS

In recent years, overall federal discretionary spending has shrunk as both a part of the federal budget and the economy.[24] According to analysis conducted by the Center for Budget and Policy Priorities, from FY 2001 to FY 2008 funding for domestic discretionary programs has been more constrained than any other area of the federal budget.[25] Federal discretionary spending supports many of the programs that have proven successful in serving the unique needs of Latinos. These programs are designed to assist low-income populations, which have the most difficulty accessing important health information and shouldering the costs of health care expenses.

For example, one program that has been affected by the federal reduction in spending is the Patient Navigator program. Enacted as part of the Patient Navigator Outreach and Chronic Disease Prevention Act of 2005 (P.L. 109-18), this program was a pilot project that received funding in only one of its four years of existence. Among other provisions contained in the act, patient navigators with direct knowledge of communities conduct ongoing outreach to needy populations. In 2002, one-fifth of Spanish-speaking Latinos reported not seeking out medical attention due to language barriers.[26] From 2003 to 2004, 30% of Hispanic adults did not have a regular source of health care.[27] The Patient Navigator program created a means for connecting Latinos with the health care services available to them in their communities, preventing future need for costly emergency care. After three years of existence, the Patient Navigator program was funded for the first time in FY 2008 with $2.9 million, falling short by millions of dollars that were authorized to ensure effective implementation of the program.

Another example is the consistent decrease in federal support for the Centers of Excellence (COEs) and Health Careers Opportunity Programs (HCOPs). In 2002, a congressionally mandated report by the Institute of Medicine found that racial and ethnic minorities received a lower quality of health care than nonminorities, even when factors such as income status and insurance were controlled. One recommendation to alleviate this problem was to increase the proportion of underrepresented racial and ethnic minorities among health professionals.[28] According to the American Medical Association, Blacks and Hispanics make up only 3.2% of doctors in the United States.[29] HCOPs and COEs are the only targeted federal programs that encourage diversity in the physician workforce. These programs are funded through the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services (HHS). Grants to these programs strengthen the national capacity to train students from minority groups to help build a more diverse health care workforce. Funding for these programs has been whittled down from the HHS budget over the past few years, virtually eliminating dedicated support for Latino students pursuing this field. Most recent budgets, including the FY 2009 budget request from President Bush, have zeroed the programs out entirely from HHS funding.

The immediate impacts of these cuts are felt by the millions of low- and moderate-income families that would benefit from such services. These are programs that, when properly funded, can address the current disparities existing for Latinos in the health care system. Programs that provide effective outreach and lower the language barrier can help connect Latinos with essential health care services that could prevent them from developing serious chronic health conditions later in life. Underfunding them will continue to disconnect this growing population from the health care system and jeopardize their future well-being. The implications of this situation will be felt in the overall health of the nation and its future labor force for years to come.

BUDGET OUTLOOK AND FISCAL CHALLENGES

Since 2000, the national debt has grown from $5.6 trillion to $9.4 trillion.[30] The Bush Administration entered the White House in early 2001 with a budget surplus of $128 billion. By 2002, the surplus was gone and there was instead a budget deficit of $158 billion;[31] by 2004, it reached $422 billion.[32] This deficit growth affects the overall health of the economy and can influence policymakers in deciding how federal dollars are spent.

According to the Congressional Budget Office, tax cuts have been the single largest contributor to the reemergence of substantial budget deficits in recent years. The tax cuts introduced by the Jobs and Growth Tax Relief Reconciliation Act of 2003, which also served to accelerate tax changes from the Economic Growth and Tax Relief Reconciliation Act of 2001, are two policies widely believed to have increased the overall federal budget deficit.[33] Despite this, many policymakers continue to push to make these tax cuts permanent.

Furthermore, the alternative minimum tax (AMT) is a measure that was enacted to prevent higher-income earners from evading tax liability. The AMT is not adjusted for inflation, and because other tax cuts reduce regular income liability, this has increased the amount of people subject to the AMT, including many middle-class families. There has been more political pressure on lawmakers to "fix" the AMT and each year Congress has passed a short-term patch. According to analysis by the Center for Budget and Policy Priorities, "repealing the AMT altogether would cost an estimated $800 billion over the next decade (2008-2017), but could reach $1.5 trillion, depending on whether the 2001 and 2003 tax cuts are extended (according to estimates by the Urban Institute-Brookings Institution Tax Policy Center)."[34] Policymakers do not agree on what method should be used to fix it, but many agree that some kind of AMT reform is needed.

Both mandatory and discretionary programs continue to compete for funds in this climate of what some could call "fiscal instability." Long-term budget forecasts will be influenced by funding for the war and resolving these and other tax policy issues. Defense spending remains a growing share of the federal budget. The rise in appropriations for defense and security-related programs since 2001 has outpaced domestic discretionary program spending.[35] Defense is still the fastest-growing area of the federal budget even when wars in Iraq and Afghanistan are excluded, suggesting that investment in nondefense domestic discretionary programs is threatened.[36]

ISSUES

Some categories of legal immigrants are barred from accessing federally funded health services. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) restricted eligibility for Medicaid, and later SCHIP, for many legal immigrants. It divided immigrants into eligibility categories based on their arrival before or after the law's enactment on August 22, 1996. The exclusion of legal immigrants from Medicaid and SCHIP benefits stands out as a significant setback for Latinos. As previously mentioned, SCHIP was extended in 2007 amidst a political climate that was charged with anti-immigrant sentiment. ICHIA would have restored Medicaid and SCHIP

coverage to a population that had its eligibility for the programs taken away in 1996. If SCHIP is reauthorized in 2009, it will include this provision in the final bill. ICHIA has support from hundreds of organizations representing the interests of women and children, as well as the medical community. Research shows that people who have this access are more likely to receive preventive care and avoid developing serious medical conditions that would cause them to visit an emergency room.[37] The exclusion of this provision ensures that the most vulnerable populations in this country, including large numbers of legal immigrants and Latinos, are discouraged from accessing preventive and timely health care.

Verification requirements present barriers to eligible citizen recipients. The Deficit Reduction Act of 2005 contained a citizenship provision advanced on false accusations of federally funded health care. It required U.S. citizen applicants or participants in Medicaid to prove their citizenship by submitting a birth certificate or passport (or a limited set of similar documents) or go without Medicaid coverage. The bill placed significant administrative burden on states and has caused eligible beneficiaries to be denied access to the program. For instance, the Centers for Medicare & Medicaid Services (CMS) advised states to include an additional five minutes per Medicaid application to process the DRA proof of citizenship and identity documents. This five-minute estimate formed the basis for a supplemental budget appropriation in Colorado to carry the additional costs of the new paperwork requirement. After the DRA went into effect, the Colorado Health Institute conducted a survey of county eligibility technicians (ETs) who assist families with Medicaid eligibility. The ETs in this study reported "spending 20 additional minutes per application because of the DRA–four times the CMS estimate."[38] Findings from the survey also revealed that: Medicaid populations that were not subject to the DRA were being asked to provide citizenship and identification documents; ETs were able to process fewer cases since the DRA took effect; DRA processes were not being uniformly implemented; and DRA-related factors made Medicaid enrollment more difficult and provided barriers to enrollment.[39] State Medicaid directors generally agree that the citizenship requirements in the DRA have contributed to fewer Medicaid applicants in FY 2007 and FY 2008. On average throughout all states, total Medicaid enrollment dropped by 0.5% in FY 2007.[40] State Medicaid directors report that it is difficult for many eligible citizens to obtain and provide the required documentation necessary to gain coverage.[41] Again, in this SCHIP debate, some members of Congress attempted to advance more verification requirements.

Immigrant use of federal benefits is misreported. A study by the RAND Corporation found that foreign-born residents (including undocumented immigrants) accounted for only 8.5% of national medical spending.[42] RAND estimated that undocumented immigrants alone accounted for a mere 1.5% of total medical spending. This study found that in Los Angeles, which has the largest concentration of immigrants in the nation, foreign-born residents tended not to have any contact with a formal health care system.[43] This finding counters the claims often made by anti-immigrant factions that immigrants disproportionately use public services. This argument has continued to resurface within nearly every policy debate during the past few months. Inflated figures are used to paint a negative picture of the economic effects of immigration and alleged abuse of the federal medical system by undocumented Latino immigrants. The public perception of immigrant use of public services, and especially of Latinos, is colored by anti-immigrant propaganda. A rash of amendments targeting immigrants has risen, with very few positive measures to counter them.

The influence of this negative stream of misinformation played out in Congress in the drop in support for ICHIA. Many believed that inclusion of ICHIA in SCHIP reauthorization would have granted undocumented immigrants unrestricted access to public benefits.

Meanwhile, the provision would have restored access to health care to legally residing immigrants, including large numbers of Latino mothers and children. ICHIA was approved by the House and the Senate during different Congresses. Around this time, there was a series of immigration hearings held in the House. ICHIA was added to the House version of SCHIP reauthorization, though it was excluded from the final conference report approved by House and Senate negotiators in late 2007. Ironically, the purpose of SCHIP was to expand health care coverage to more children; in its final form, this bill prevented hundreds of thousands of legally residing children from accessing it, awaiting passage in 2009.

The need for health care coverage is rising. The rising cost of health care can contribute to an increase in the demand for coverage under federal- and state-supported health care programs. Rising health care costs have affected employer-sponsored insurance coverage rates, which have been decreasing in recent years.[44] A report from the Kaiser Commission on Medicaid and the Uninsured found that employer-sponsored insurance is sensitive to changes in health insurance premiums, which have risen over the past few years. Since 2001, family premiums for employer-sponsored insurance have increased by 78% while wages have risen by 19% and inflation by 17%.[45] Workers are now paying $1,400 more in premiums annually for family coverage than they did in 2000.[46] As discussed previously, Hispanics are less likely than non-Hispanics to have health coverage offered through their employer. But an overall increase in the number of people dependent on federal health care programs due to a loss of insurance coverage means that available resources will be strained if funding does not keep pace with demand. When adults lose employer-sponsored insurance, it also affects the coverage of their dependents, which accounts for an increase in the amount of uninsured children. Enrollment in Medicaid alone grew by 14% from 1999 to 2004.[47]

POLICY RECOMMENDATIONS

Restore access to federal health care programs to legal immigrants. While just under half of all states (plus the District of Columbia) have used their own funds to provide some benefits to immigrants who do not qualify for Medicaid,[48] policies vary from state to state. Furthermore, when states face deficits, as is expected to occur in the next fiscal year, these state-only programs are put at risk, as seen in Massachusetts, Washington, California, and the myriad of states that have faced funding shortages during the past decade. Restoring access to Medicaid and SCHIP to all legal immigrants will help connect millions of legal residents with access to health care they need and are entitled to. The federal government is better equipped than individual states to address this critical situation.

Revoke citizenship requirements from safety-net programs. The barriers presented by citizenship requirements contained in means-tested programs keep vulnerable children and families from accessing needed federal assistance. Lawfully residing Latino immigrants have been shut out of these programs in an attempt to keep undocumented immigrants from accessing these benefits. Before these requirements were introduced in 1996 and again in 2005, undocumented immigrants already did not have access to federal health programs. Inconsistent implementation of the citizenship eligibility requirements and a lack of understanding of which populations they impact have presented challenges to the health care professionals in charge of complying with the provisions. Revoking them would not result in an influx of undocumented immigrants accessing these benefits; rather, it would help to ensure that legal immigrants and other low-income children and families are not hindered from the federal assistance they are entitled to.

Discourage spillover effects of the immigration debate from influencing other policy decisions. The stream of misinformation surrounding undocumented immigrants has affected decisions in various policy areas, including health care, that are not appropriate arenas in which to address immigration policies. Policymakers must make an effort to evaluate the effects of past decisions that have been made in this environment and that have resulted in unintended, harmful consequences to populations such as legally residing immigrants and low-income U.S. citizens. Engaging groups that represent these populations in thoughtful discussions would help to ensure that this does not continue to happen.

Improve funding of affordable health care and complementary services. Economic downturns tend to increase the number of people qualifying for need-based programs like Medicaid and SCHIP. The Kaiser Commission on Medicaid and the Uninsured reports that a 1% rise in the nation's unemployment rate is projected to increase the number of uninsured by 1.1 million and result in an additional one million (600,000 children and 400,000 adults) enrolling in Medicaid.[49] The unemployment rate for Hispanics in the U.S. rose to 6.5% in the first quarter of 2008, which is higher than the 4.7% rate for all non-Hispanics.[50] For Hispanic immigrants, the unemployment rate rose to 7.5% in the first quarter.[51] The 27 states facing budget deficits in FY 2009 are likely to scale back services in Medicaid programs in order to meet budget-balancing requirements, just as the need for them increases.[52] Assistance from the federal government in the form of increased funds for these programs can prevent these services from being cut off to the vulnerable population relying on them. States in fiscal trouble should not implement policies like increased cost-sharing to Medicaid recipients, who are among low- and moderate-income individuals and families and are more likely to trade off needed medical care for other necessities. Giving states more funds for these programs could prevent this scenario from happening.

The discretionary programs highlighted in the Appendix are important to serving Latino health care needs. The Administration proposed allocating $68.5 billion to HHS in FY 2009, which represents a $2.2 billion decrease in discretionary spending from what was enacted in FY 2008. The table in the Appendix illustrates appropriation level differences in FY 2001, FY 2008, and FY 2009.

CONCLUSION

In order for the nation's health care policies to be effectively realized, they must be designed to meet the needs of Latinos, who make up a large and increasing number of the working poor in the U.S. This is a group that traditionally faces challenges in accessing health care. The trade-offs typically made between budget savings and health care programs serving the nation's poorest populations will only result in hindering their ability to enjoy optimal health, putting their long-term ability to achieve financial security at risk.

APPENDIX

A List of Government Discretionary Programs:

Community Health Centers (CHC) are community-based preventive and primary health care providers serving low-income populations. This is an important source of health care for Latinos in particular, who constitute almost 40% of all CHC patients.[53]

Health Resources and Services Administration (HRSA) provides national leadership, program resources, and services needed to improve access to health care. It can also give funds to programs to ensure that the quality of care Latinos receive improves.

Minority HIV/AIDS Initiative provides funds to help address the HIV/AIDS epidemic within minority populations in a culturally and linguistically relevant way. Many Latinos at risk of infection are ignored by HIV prevention efforts targeting only those groups that have been historically perceived as high risk.[54]

National Center on Minority Health and Health Disparities (NCMHD) promotes minority health and leads, coordinates, supports, and assesses the National Institutes of Health's (NIH) efforts to reduce and ultimately eliminate health disparities.

Office for Civil Rights (OCR) promotes and ensures that people have equal access to HHS services and the opportunity to participate in all HHS programs without facing unlawful discrimination. It plays an important role in reducing health care access disparities for Latinos.

Preventive Health and Health Services (PHHS) Block Grant gives states the autonomy and flexibility to tailor prevention and health promotion programs to their particular needs. Among other provisions, the PHHS Block Grant is used to support clinical services and preventive screenings. This can be critical for Latino health, especially in the area of diabetes, which disproportionately affects minorities.

Racial and Ethnic Approaches to Community Health (REACH) establishes community-based programs and culturally-appropriate interventions to eliminate health disparities among African Americans, American Indians, Latinos, Asian Americans, Alaska Natives, and Pacific Islanders.

FEDERAL FUNDING FOR SELECTED LATINO-SERVING HEALTH PROGRAMS[55]

	FY 2001 Appropriations	President's FY 2008 Request	FY 2008 Enacted (after 1.747% rescission*)	Nominal Difference (between President's FY 2008 Request and FY 2008 Enacted)	President's FY 2009 Request
CHC	$1,179 million	$2,020 million	$1,985 million	-$35 million	$2,048 million
OCR	$30 million	$34 million	$34.38 million	$0.38 million	$40 million
NCMHD	$132 million	$200 million	$199.45 million	-$0.55 million	$200 million
HRSA (program level)	$6,229 million	$6,916 million	$6,779 million	-$137 million	$5,921 million
PHHS Block Grant	$135 million	$0	$97.270 million	$97.27 million	$0
REACH	$38 million	$34 million	$33.8 million	-$0.244 million	$33.7 million
Minority HIV/AIDS	$88 million	$52 million	$50.98 million	-$1.01 million	$52 million

* FY 2008 figures are calculated after a 1.747% cut across the board to the Labor/HHS budget authority under the Consolidated Appropriations Act (P.L. 110-161).

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