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HED
Health Emergency Declaration

National Black Church Initiative Affordable Care Act Institute (NBCIACAI)

The purpose of the National Black Church Initiative's Affordable Care Act Institute (**NBCIACA I)** is to track the health statistics of all eligible Black and Latino citizens who are, and who are not yet, enrolled into the ACA program nationwide. We hope to create a continuous comparative analysis of the uninsured, those eligible for coverage under the ACA, those who are ineligible, those who are enrolled and those who are not and why. The overall purpose is to highlight any and all obstacles to care – both under the old health care model and under ACA.

We hope to identify all of the barriers impacting health care access in addition to discovering ways those barriers can be eliminated in the early stages of the rollout. Most importantly, we hope to identify comparative efficiencies of the old and new models of health care coverage in the U.S., as the ACA's intent is to lower cost, expand access and introduce innovation that will deliver a superior quality of care to all who want it, and especially to those who need it.

NBCI intends to ask the difficult questions. For example - if the ACA was created on the theory of prevention and early diagnosis, why do access problems still exist? What is HHS doing to correct them?

NBCI will post minority health statistics on our main website and other online portals for easily accessible information surrounding the ACA**.** These statistics will serve as benchmarks and points of discussion for policy makers, researchers, providers, insurers and other key stakeholders. There are so many competing forces, each with a narrow agenda and singular goal in mind. NBCIACAI plans to cut through these agendas and deliver real facts on care delivery to minority communities across the country,

NBCIACAI falls under NBCI's Health Emergency Declaration Program (HED). We plan to develop best practices and share our analysis with affinity organizations and the

entire health community, with the ultimate goal of eliminating health disparities. ACA's mandates and goals can only be realized if everyone is pushing in the same direction.

NBCIACAI will continue to advocate for access and common sense approaches to eliminating barriers to access to care and encouraging best health care practices. We will be calling for national standards of care.

NBCIACAI will call for comprehensive cultural competency educational training for all health care workers to assure provider non-discrimination across demographics and cultures. Culture is often described as the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements, including personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups. For the provider of health information or health care, these elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services. The concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients.

Cultural competency is critical to reducing health disparities and improving access to high-quality health care, health care that is respectful of and responsive to the needs of diverse patients. When developed and implemented as a framework, cultural competence enables systems, agencies, and groups of professionals to function effectively to understand the needs of groups accessing health information and health care—or participating in research-in an inclusive partnership where the provider and the user of the information meet on common ground.

NBCIACAI is adding its voice in calling for national standards in the areas of access to care and cultural competency.

We are proposing a mini-demonstration project utilizing the BCHCIS approach of a five question survey though NBCIACAI with the participation of 50 -75 NBCI churches. We hope to survey up to 10,000 to 30,000 NBCI congregants to solicit the views on the rollout of the ACA and its individual impacts. We will utilize fresh data for a comparative analysis of the ACA's early impact and experiences during the rollout. We will also glean lessons learned from the data. The findings will be presented at the forthcoming October Health Disparities Conference.

Black Church Health Consumer Index Survey Project (BCHCIS)

The National Black Church Initiative's (NBCI) Black Church Health Consumer Index Survey (BCHCIS) is an innovative tool to track and analyze up-to-date data covering our membership's interactions with the health care system. BCHCIS enables NBCI to better understand the behaviors and patterns corresponding to a wide array of issues across our 34,000 churches and 15.7 million members. The Black church's demographics span the entirety of the Black community – across age, ethnicity, geography, sex, gender, political persuasions and the like. Our surveys, dating back to the late 1990s, make NBCI a leader in African American consumer information and analytics. Our methodology is simple and culturally relevant – we use five focused and pointed questions to get at the heart of how our congregants perceive and use the health care system. PhD students help us analyze responses in way that allows NBCI to understand disparities that exist between mainstream America and minority communities. Additional queries that arise from our initial surveys are addressed through additional questions that clarify data analyses. NBCI is excited about BCHCIS' potential, especially its ability to help the health care industry understand the nuances of African American patients and researchers. BCHCIS will provide the health care community with new and improved statistical data for educational and marketing purposes. BCHCIS hopes to impact two promising areas: 1) African American participation in clinical trials; and 2) Unlocking questions about African American drug therapy compliance. These are two critical areas that dramatically impact African American health outcomes. The success of BCHCIS lies squarely in the ethical teachings of their faith leaders. NBCI through BCHCIS has broken through miscommunication and mistrust barriers affecting the African Americans vis-à-vis the health care and health research industries. Many researchers seek to find answers to health problems plaguing minority communities only to run into mistrust and a lack of communications. BCHCIS will address this foundational mistrust and help reveal answers on how to overcome major psychological barriers that had, and are still having, devastating effects on African American population health.

Sample Survey Questionnaire - First Set

1. What is your overall impression of how the Affordable Care Act (ACA) program was rolled out:
   (a) Chaotic
   (b) Orderly
   (c) Sporadic
2. Did you receive any literature on the ACA directly?
   (a) Yes
   (b) No
3. Where did you receive your information on the ACA?
   (a) From your employer
   (b) From the media
   (c) From your friends
   (d) From your church
   (e) From a government office
4. Did you or any of your family try to enroll via healthcare.gov
   (a) Yes
   (b) No
5. Were you successful in enrolling into the ACA program?
   (a) Yes
   (b) No

Second Set

1. If you were successful in enrolling did you have the money to pay for the insurance premium?
   (a) Yes
   (b) No
   (c) Does not apply
2. Have you used your healthcare that was obtained through the Affordable Care Act?
   (a) Yes
   (b) No
   (c) Does not apply
3. If you answered “yes” to 2, did your healthcare provider(s) seem like they understood the system?
   (a) Yes
   (b) No
   (c) Does not apply

4. Have you experienced problems getting to medical care through your ACA coverage?
   (a) Yes
   (b) No
   (c) Does not apply
5. How do you feel about getting care through ACA?
   (a) It is easy
   (b) It is about right
   (c) It is too hard
   (d) Does not apply

Third Set

1. Do you feel that the new ACA system is good for African Americans?
   (a) Yes
   (b) No
   (c) Does not apply
2. Do you feel that the new ACA system will be helpful to low income African Americans?
   (a) Yes
   (b) No
   (c) Does not apply
3. Is this your first time having health insurance?
   (a) Yes
   (b) No
   (c) Does not apply
4. Do you believe that the President made a mistake in changing the healthcare system?
   (a) Yes
   (b) No
   (c) Does not apply
5. How do you feel the new health system under ACA will impact African Americans compared to the old system
   (a) It will continue to provide less care
   (b) It will improve health for African Americans slightly
   (c) It will help to end health care disparities and improve health significantly.
   (d) Does not apply

NBCI 60-Question Health Survey

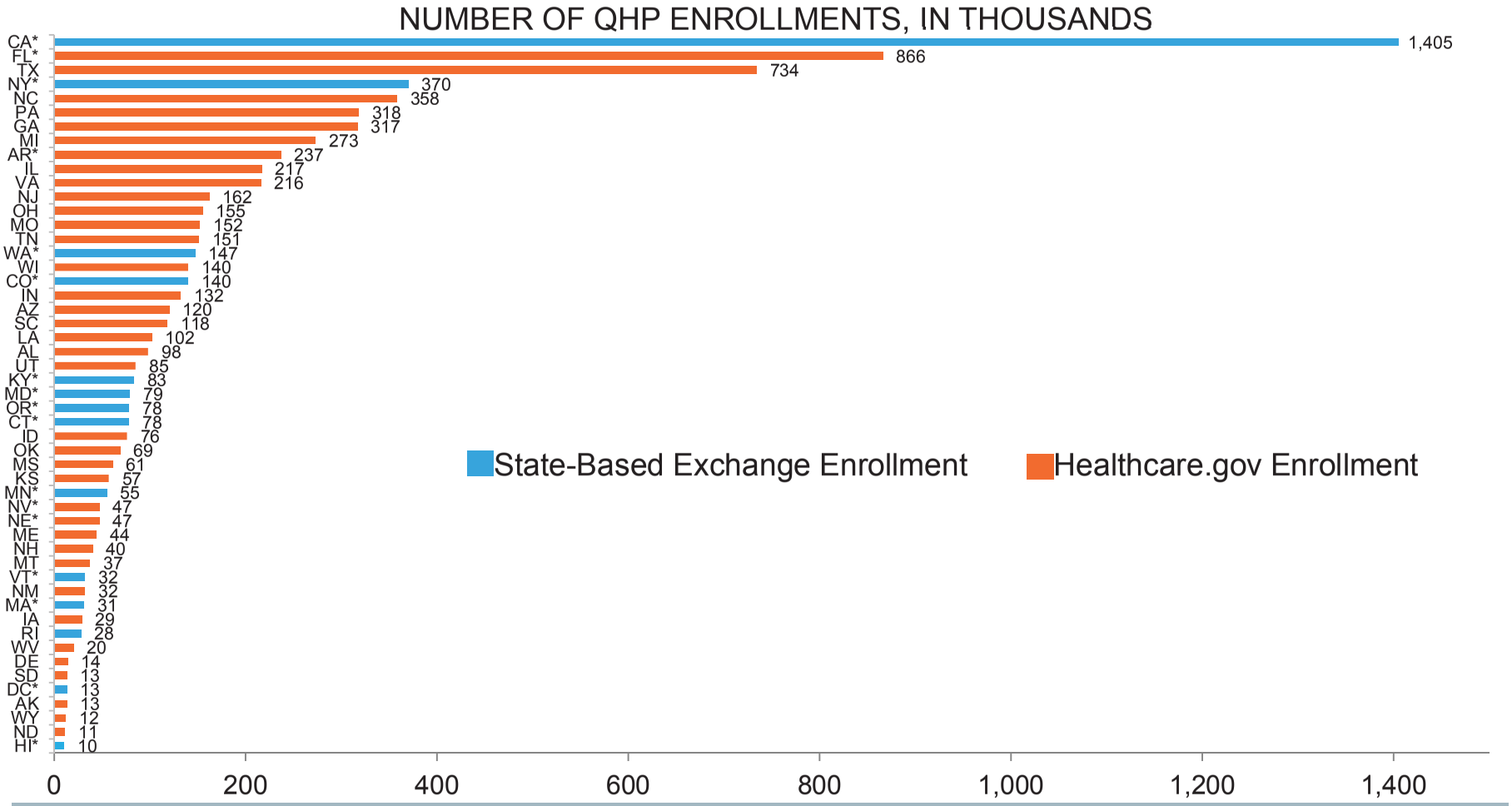
Credible, reliable and up-to-date demographic information on African American population health is virtually nonexistent in the United States. NBCI is turning the tide on this crisis by instituting a 60 question health survey to be administered through our 34,000 churches and 15.7 million members. These questions were based upon frequently asked questions concerning black health by scholars, researchers, marketers and the corporate community.

However, two compelling issues keep this survey from being administered. First is the issue of credibility. NBCI is not a research organization. It is a faith-based organization. Many in the scientific and research community will question the purpose and research validity of such an expansive health questionnaire. In response, NBCI has recruited 60 leading African American organizations in administering our health survey. We are now in the process of working out the protocol for administering such an expansive statistical survey. We do believe that the questions raised earlier on the issue of qualification and credibility will inevitably be raised again for whatever reasons those in the scientific and research community deems as scholarly necessary.

Second, NBCI faces issues of cost and the ability to attract corporate health sponsors. NBCI is taking a comprehensive look at this initiative and hopes to redesign it in such a manner that would help dispel the issues surrounding qualifications and credibility by recruiting a nationally known partner that is recognized in the health research field. We also hope to expand and attract key corporate and academic sponsors to provide the necessary resources to build a stronger national committee of stakeholders.

The first slide captures Exchange enrollment by state and the second slide aptures new Medicaid enrollment by state. At the close of open enrollment, about 8M individuals were reported as having selected an Exchange health plan. However, you may have heard that just recently CMS Administrator Marilyn Tavenner testified to Congress that there are currently 7.3M people enrolled in an Exchange plan. Unfortunately, no details on the attrition or remaining enrollees were provided. As such, our slide does not match the 7.3M enrollment number, but rather reflects the latest state-specific reports on enrollment to date. The Medicaid enrollment slide is based on the latest Medicaid and CHIP Enrollment report from CMS, released September 22.

Enrollment Varies Substantially by State, with CA, FL, and TX Capturing Nearly 40% of Total Sign Ups



Since October 1, SBEs have enrolled 2.6 million individuals, while the FFE has enrolled 5.4 million.

Updated: Avalere *State Reform Insights*, September 15, 2014
These numbers are based on the latest information available from HHS, marketplace press releases, interviews, and news articles. The numbers reflect the most recent enrollment stats from October 1 through August 8. In general, enrollments reflect individuals who have selected a plan.
*States with more recent enrollment data than that available from HHS' report on enrollment through April 19.
ID will operate a SBE, but will rely on HHS for eligibility and enrollment.
FFE= Federally-Facilitated Exchange
SBE= State-Based Exchanges
QHP= Qualified Health Plan

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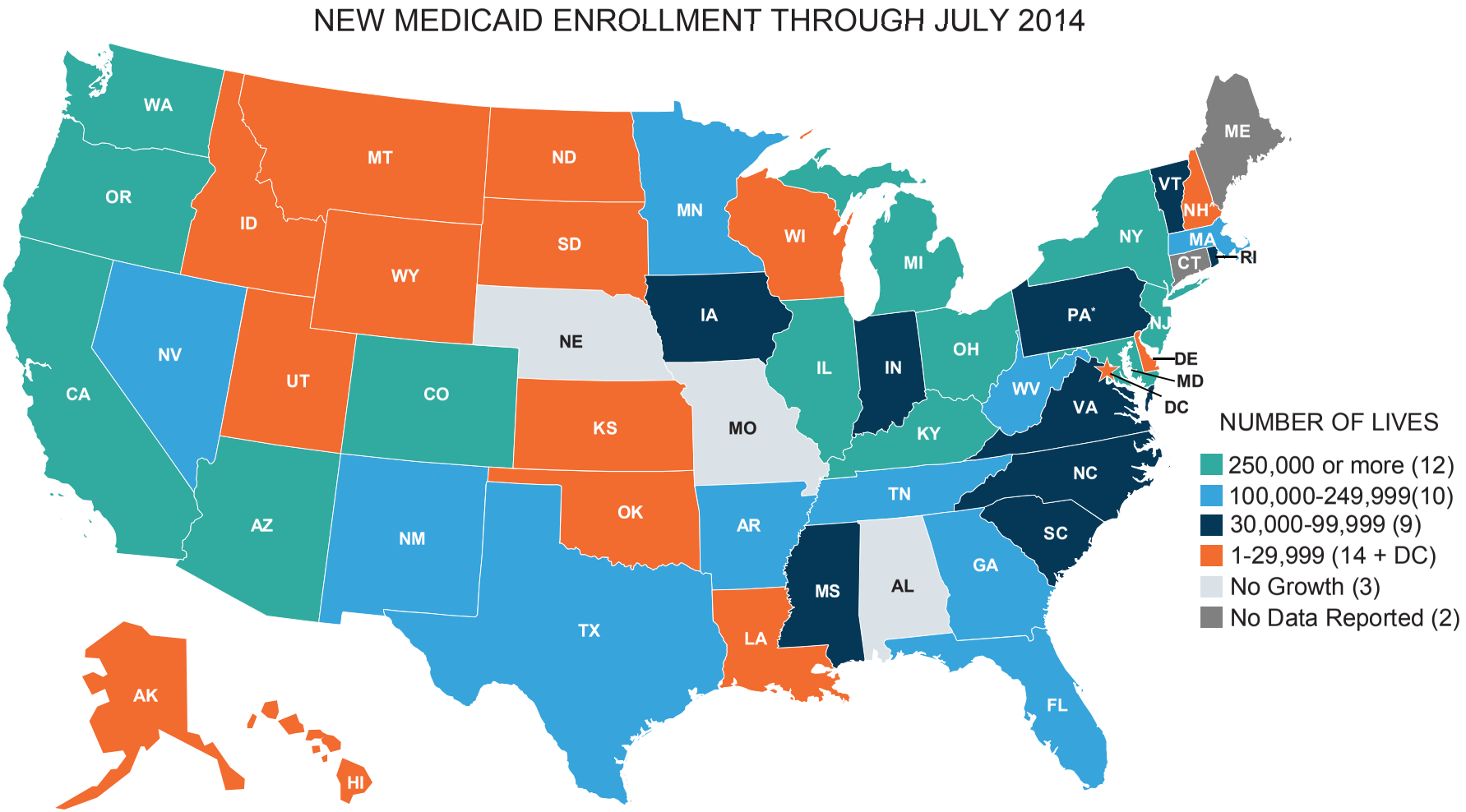
CMS Data Finds 7.9 Million Individuals Newly Enrolled in Medicaid Through July



Note: This analysis compares monthly Medicaid enrollment reported through July 31, 2014 to the monthly enrollment reported from the July-September 2013 time period.
^The New Hampshire Health Protection Program (NH's expansion) began accepting applications on July 1, 2014, and individuals in NH began to receive benefits under the expansion on August 15, 2014.
*Pennsylvania's requested effective date for implementing the expansion is January 1, 2015.
Sources: CMS Medicaid & CHIP: July 2014 Monthly Applications, Eligibility Determinations and Enrollment Report, released September 22, 2014. New enrollment in non-expansion states is largely expected to be due to the woodwork effect, but data reporting errors could distort these figures.
CHIP = Children's Health Insurance Program

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Medicaid and the Uninsured

FACT SHEET

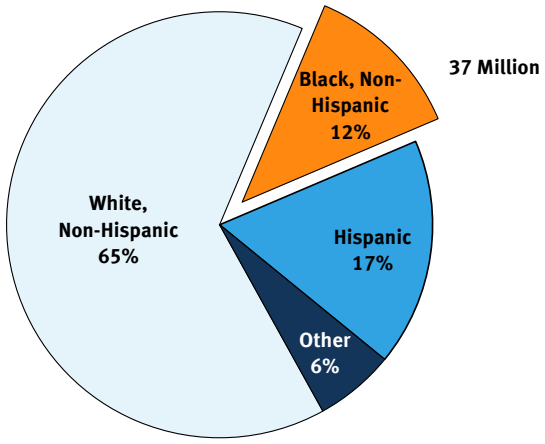
Health Coverage for the Black Population Today and Under the Affordable Care Act

July 2013

As of 2011, 37 million individuals living in the United States identified as Black or African American. Blacks currently comprise the third largest racial or ethnic group in the United States after non-Hispanic Whites and Hispanics (Figure 1). While it is projected that the nation will become increasingly diverse and the Black population will grow over the next few decades, Blacks are anticipated to maintain a consistent share of the population. The Affordable Care Act (ACA) has important implications for Blacks as they face longstanding and persistent disparities in health and health care.

Figure 1

Blacks as a Share of the Total U.S. Population, 2011



Total U.S. Population: 307.9 Million

NOTE: Other includes Asian/Pacific Islander, American Indian/Alaska Native, and two or more races.
SOURCE: Urban Institute and KCMU estimates based on the Census Bureau's March 2012 Current Population Survey Annual Social and Economic Supplement.

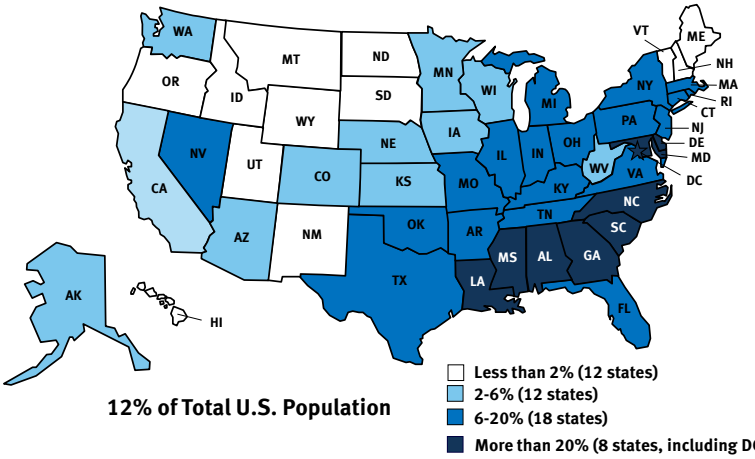
One of the key goals of the ACA is to reduce the number of uninsured through an expansion of Medicaid and the creation of new health insurance exchange marketplaces with tax credits to help moderate-income individuals purchase coverage. Many uninsured Blacks could benefit from these new pathways to coverage, which would help increase their access to care and promote greater equity in health care. This brief provides an overview of the Black population in the U.S., their health coverage today, and how their coverage may be affected by the ACA coverage expansions.

Overview of the Black Population

The 37 million Blacks residing in the United States make up more than a tenth of the total population. In eight states, largely concentrated in the South, and the District of Columbia, Blacks comprise at least 20% of the total population, whereas they comprise a very small share of the population in many states in the Northwest and Midwest (Figure 2). Over half of all Blacks live in just eight states, including Texas, Florida, Georgia, New York, California, North Carolina, Illinois, and Maryland.

Figure 2

Black Population, by State, 2010-2011



NOTE: Percent of Total State Population
SOURCE: KCMU/Urban Institute analysis of March 2011 Current Population Survey, Annual Social and Economic Supplement

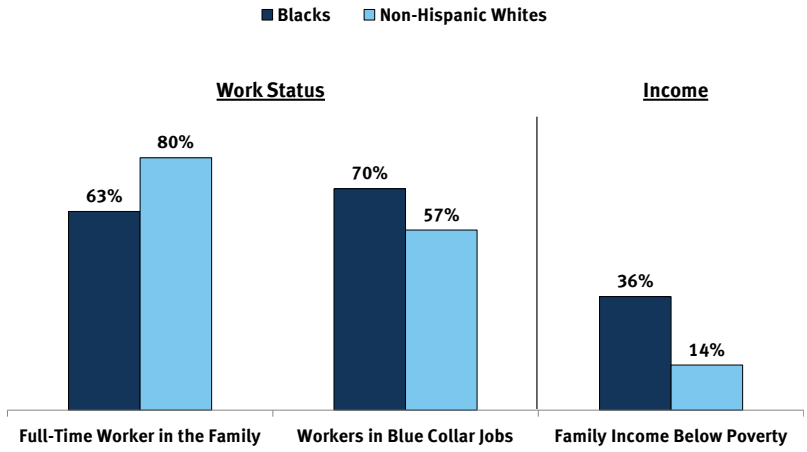
There is diversity within the Black population. The population includes individuals of varying ethnicities and immigration statuses. For example, while some African American families have been in the United States for many generations, others are more recent immigrants from places such as Africa, the Caribbean, or the West Indies. However, the vast majority of Blacks are U.S.-born citizens (92%). In addition, there is diversity in educational attainment, socioeconomic status, and other characteristics. Aggregate data can obscure many of these socio-demographic differences within the Black population.

Compared to non-Hispanic Whites, the Black population is notably younger. Overall, 40 percent of all Blacks are under the age 26, compared to 30 percent of non-Hispanic Whites and 35 percent of all U.S. residents. Blacks are also nearly half as likely as Whites to be over the age of 65. In 2011, 10 percent of Blacks were elderly adults, compared to 17 percent of Whites.

While the majority of nonelderly Blacks are in working families, they are significantly more likely than Whites to be poor. Overall, nearly two-thirds of nonelderly Blacks have a full-time worker in the family. However, the large majority of Black workers (70%) are employed in blue-collar jobs that typically provide low wages and are less likely than white collar jobs to offer health insurance coverage. Reflecting both lower full-time employment rates and higher concentrations of Black workers in blue-collar jobs, African Americans are two and half times more likely than Whites to have family income below the poverty level (Figure 3).

Figure 3

Income and Work Status for Nonelderly Blacks, 2011



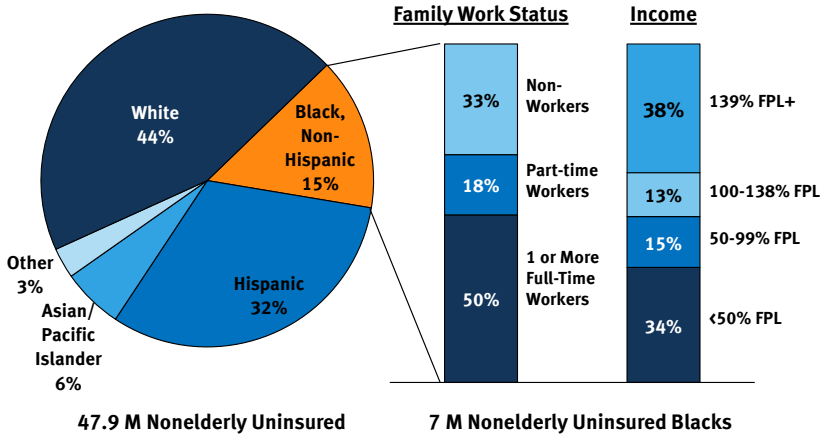
Includes nonelderly individuals 0-64.
SOURCE: KCMU/ Urban Institute analysis of 2012 ASEC Supplement to the CPS.

Health Coverage of Nonelderly Blacks Today

As of 2011, there are over 7 million uninsured nonelderly Blacks, who make up about 15% of the total nonelderly uninsured population (Figure 4). Over five in six (84%) uninsured Blacks are adults, while the remaining one million are children age 18 or younger. More than two-thirds are in a working family, including half who have at least one full-time worker in the family. However, the majority have low incomes (below 138% of poverty), including over a third who have very low-incomes below half the poverty level.

Figure 4

Characteristics of Nonelderly Uninsured Blacks, 2011

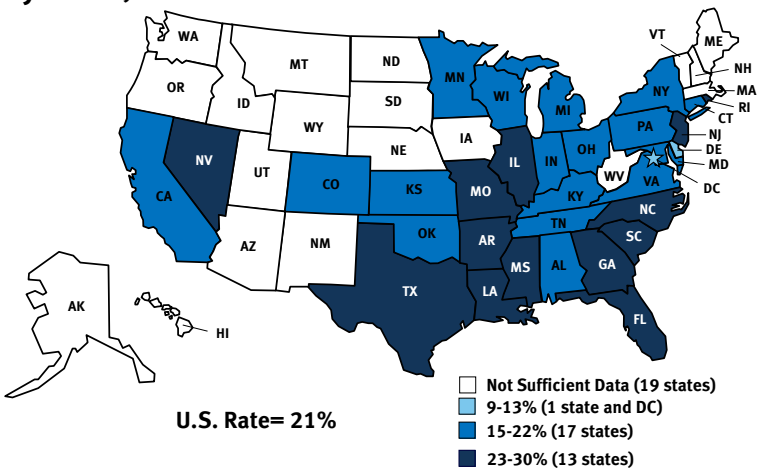


NOTE: Includes nonelderly individuals 0-64. Other includes American Indian/Alaska Native, and two or more races. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

Nationwide, just over one in five (21%) of Blacks do not have health insurance. However, the likelihood of being uninsured varies widely across states, ranging from 9 percent of Blacks in Delaware to 30 percent in Louisiana. Uninsured rates for nonelderly Blacks are particularly high in the South (Figure 5). The largest uninsured nonelderly Black populations reside in Florida (718,800), Texas (613,100), and Georgia (594,600). In addition, Blacks comprise a large share of the uninsured population in the District of Columbia (52%), Mississippi (48%), and Louisiana (42%).

Figure 5

Uninsured Rates for Nonelderly Blacks, by State, 2010-2011



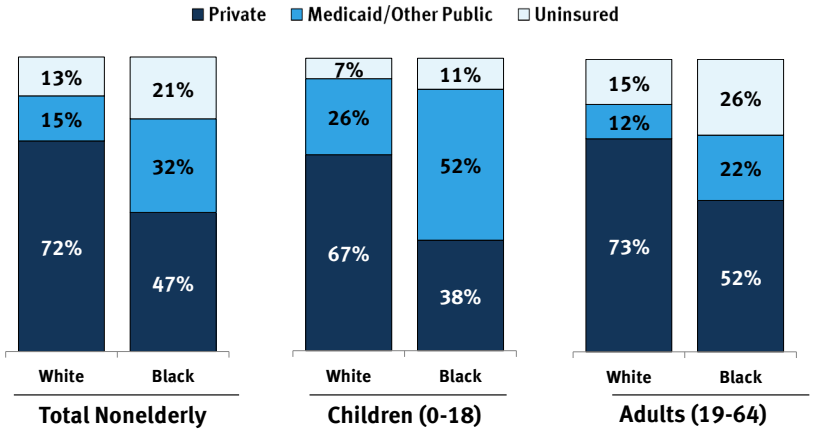
NOTE: Percent of Total State Population
SOURCE: KCMU/Urban Institute analysis of March 2011 Current Population Survey, Annual Social and Economic Supplement

Blacks are significantly more likely than Whites to be uninsured. Reflecting their limited access to employer-sponsored insurance, less than half of nonelderly Blacks have private coverage compared to over seven in ten non-Hispanic Whites (Figure 6). Medicaid coverage helps fill some of the gap in private health insurance, covering nearly one in three of all nonelderly Blacks (32%). However, Medicaid does not fully offset the difference leaving more than one in five (21%) nonelderly Blacks uninsured, compared to 13% their White counterparts.

Medicaid covers over half of Black children (51%), helping to substantially fill their gap in private coverage. Medicaid plays a much more limited role for Black adults, leaving more than a quarter uninsured (26%). These coverage patterns reflect the fact that states have significantly expanded children's eligibility for Medicaid and CHIP, while Medicaid eligibility for adults remains very limited in most states.

Figure 6

Health Insurance Coverage for Nonelderly Blacks Compared to Non-Hispanic Whites by Age, 2011



NOTE: Includes individuals 0-64. Whites includes only non-Hispanic Whites. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

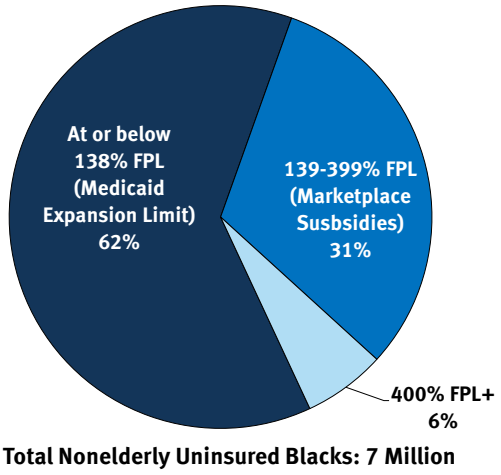
Coverage for Blacks Under the ACA Coverage Expansions

As noted, one of the key goals of the ACA is to reduce the number of uninsured. Beginning in 2014, Medicaid eligibility will expand to adults with incomes up to 138% of poverty ($26,951 for family of three in 2013), in states that implement the ACA's Medicaid expansion. In addition, beginning in 2014, new health insurance marketplaces will become available through which individuals will be able to purchase coverage, and premium tax credit subsidies will be available to help moderate income individuals without access to affordable employer coverage pay for coverage offered through these marketplaces.

Given the low incomes of uninsured Blacks, nearly all (94%) would be in the income range to qualify for the Medicaid expansion or premium tax credits. Nearly two thirds (62%) of uninsured Blacks have incomes at or below the Medicaid expansion limit of 138% FPL, while an additional 31% would be income-eligible for tax subsidies to help cover the cost of buying health insurance through the exchange marketplaces (Figure 7).

Figure 7

Income of Nonelderly Uninsured Blacks, 2011



Total Nonelderly Uninsured Blacks: 7 Million

NOTE: Data may not total 100% due to rounding. The federal poverty level was $18,530 for a family of three in 2011.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

Uninsured Blacks have high stakes in state decisions to expand Medicaid. While the ACA intended for the Medicaid expansion to occur nationwide, the June 2012 Supreme Court decision on the ACA effectively made this expansion a state option. Given that the majority of uninsured Blacks have incomes below the Medicaid

expansion limit, they will be significantly impacted by state decisions to expand Medicaid. In the absence of the expansion, poor uninsured adults will not gain a new coverage option and likely remain uninsured. Other analysis finds that Blacks are at highest risk of continuing to face coverage gaps due to state decisions not to expand at this time, with nearly six in ten (59%) uninsured Blacks with incomes below the Medicaid expansion limit residing in states that were not planning to expand Medicaid as of late June 2013.[1]

Implications

Today, Blacks remain significantly more likely to be uninsured compared to Whites. This disparity, in large part, reflects that many Blacks do not have access to employer-sponsored insurance and cannot afford to purchase private coverage on the individual market due to their low incomes. Given limited access to private coverage and low incomes, Medicaid is an important source of coverage for 9.4 million Blacks, many of whom would otherwise go uninsured. However, Medicaid eligibility levels for adults remain limited in most states today, particularly in the South, where Blacks are more likely to live. As such, over 7 million Blacks remain uninsured, the majority of whom are adults.

The ACA coverage expansions provide an important opportunity to increase health coverage and access to care for uninsured Blacks. Given that most uninsured Blacks are in low-income families, the majority would be in the income range to qualify for the ACA coverage expansions, particularly the Medicaid expansion. As such, state decisions to implement the ACA Medicaid expansion have particularly important implications for Blacks. If a state does not implement the expansion, poor uninsured adults will not gain a new coverage option and will likely remain uninsured. Currently, Blacks are at the highest risk of continuing to face coverage gaps due to state expansion decisions. Even with the coverage expansions, targeted outreach and enrollment assistance will be important for ensuring eligible individuals enroll in coverage. The ACA will help address many historical procedural barriers to enrollment through new streamlined, data-driven enrollment processes that will go in place in 2014. However, targeted outreach and one-on-one application assistance from trusted individuals within the community will remain key for facilitating enrollment of eligible individuals.

Increasing health insurance coverage may significantly reduce disparities in access to care and health outcomes for Blacks. Widespread research shows that uninsured individuals experience worse access to care and poorer health outcomes.[2] Moreover, evidence suggests that Blacks face wide and persistent disparities in health[3] and health care.[4] For example, infant mortality rates are significantly higher for Black infants and Black males of all ages have the shortest life expectancy compared to all other groups.[5] Several chronic conditions affect a greater percentage of Blacks compared to non-Hispanic Whites, including diabetes and obesity.[6] In addition, Blacks are less likely to have a usual source of care, compared to Whites.[7] Increasing health coverage rates among Blacks could significantly increase access to care and eventually contribute to improved health outcomes as well as greater equity in health and health care. Conversely, coverage gaps, especially in states that do not move forward with the Medicaid expansion, may lead to widening disparities in coverage and care over time.

TABLE 1
PERCENT AND DISTRIBUTION OF NONELDERLY BLACKS BY STATE, 2010-2011

State	Nonelderly Blacks	Percent of Nonelderly State Population	Distribution of Nonelderly Blacks by State	Uninsured Rate Among Nonelderly Blacks
United States	**33,369,663**	**12.5%**	**100.0%**	**21%**
Alabama	1,112,510	27.2%	3.3%	20%
Alaska	15,630	2.5%	0.0%	--
Arizona	232,321	4.1%	0.7%	--
Arkansas	387,555	15.9%	1.2%	25%
California	1,822,148	5.5%	5.5%	18%
Colorado	187,365	4.3%	0.6%	21%
Connecticut	280,261	9.2%	0.8%	16%
Delaware	167,574	22.0%	0.5%	9%
District of Columbia	253,489	47.3%	0.8%	13%
Florida	2,546,896	16.4%	7.6%	28%
Georgia	2,573,938	29.8%	7.7%	23%
Hawaii	--	--	--	--
Idaho	--	--	--	--
Illinois	1,601,103	14.4%	4.8%	23%
Indiana	525,455	9.6%	1.6%	17%
Iowa	81,578	3.1%	0.2%	--
Kansas	143,432	6.0%	0.4%	17%
Kentucky	295,708	7.9%	0.9%	22%
Louisiana	1,275,521	32.9%	3.8%	30%
Maine	16,036	1.5%	0.0%	--
Maryland	1,458,048	28.8%	4.4%	17%
Massachusetts	355,956	6.4%	1.1%	--
Michigan	1,199,486	14.4%	3.6%	17%
Minnesota	263,500	5.8%	0.8%	15%
Mississippi	980,607	38.7%	2.9%	26%
Missouri	612,346	12.0%	1.8%	25%
Montana	--	--	--	--
Nebraska	75,129	4.8%	0.2%	--
Nevada	194,742	8.3%	0.6%	29%
New Hampshire	12,702	1.1%	0.0%	--
New Jersey	986,956	13.1%	3.0%	24%
New Mexico	--	--	--	--
New York	2,418,781	14.5%	7.2%	19%
North Carolina	1,815,666	22.3%	5.4%	23%
North Dakota	7,195	1.3%	0.0%	--
Ohio	1,209,558	12.4%	3.6%	21%
Oklahoma	245,319	7.7%	0.7%	15%
Oregon	54,264	1.7%	0.2%	--
Pennsylvania	1,170,564	11.0%	3.5%	17%
Rhode Island	55,278	6.3%	0.2%	25%
South Carolina	1,158,943	29.5%	3.5%	24%
South Dakota	8,931	1.3%	0.0%	--
Tennessee	955,200	17.5%	2.9%	19%
Texas	2,721,905	12.0%	8.2%	23%
Utah	22,183	0.9%	0.1%	--
Vermont	6,185	1.2%	0.0%	--
Virginia	1,309,191	19.2%	3.9%	20%
Washington	178,061	3.1%	0.5%	--
West Virginia	49,867	3.2%	0.1%	--
Wisconsin	275,963	5.7%	0.8%	22%
Wyoming	--	--	--	--

"--" = Sample size is not sufficient for a reliable estimate.

SOURCE: KCMU/Urban Institute analysis of 2011 and 2012 ASEC Supplements to the CPS.

Endnotes

[1] Kaiser Family Foundation. "The Impact of Current State Medicaid Expansion Decisions on Coverage by Race and Ethnicity." June 2013. Available at http://www.kff.org/disparities-policy/issue-brief/the-impact-of-current-state-medicaid-expansion-decisions-on-coverage-by-race-and-ethnicity/.

[2] KCMU. "The Uninsured: A Primer. Key Facts About Americans Without Health Insurance." October 2012. Available at http://www.kff.org/uninsured/issue-brief/the-uninsured-a-primer/.

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This publication (#8460) is available on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION

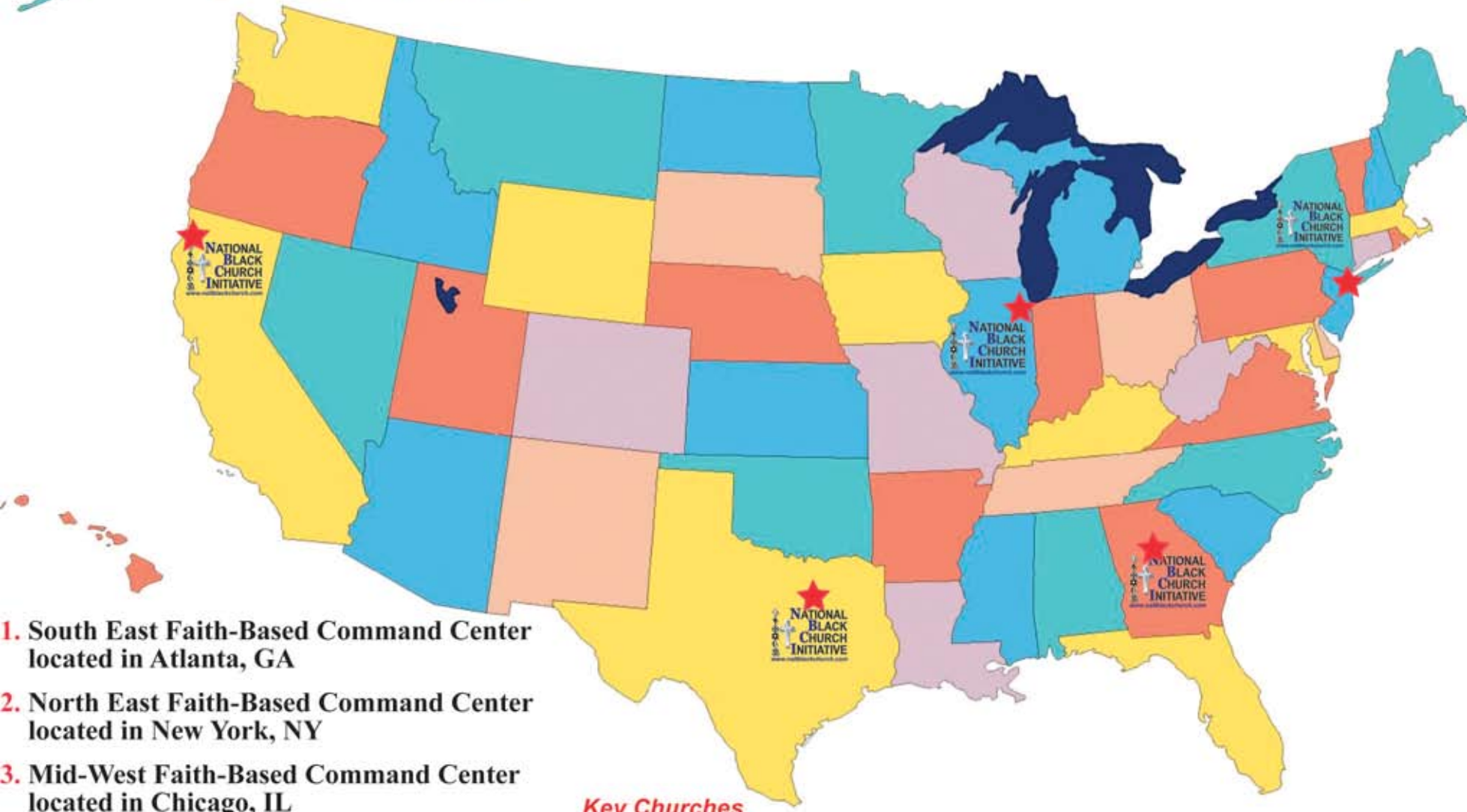
THE KAISER COMMISSION ON
Medicaid and the Uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

NATIONAL BLACK CHURCH INITIATIVE
www.naltblackchurch.com

How NBCI Is Organized?

NBCI is organized by dividing the country into five geographic areas.



1. South East Faith-Based Command Center located in Atlanta, GA
2. North East Faith-Based Command Center located in New York, NY
3. Mid-West Faith-Based Command Center located in Chicago, IL
4. Western Faith-Based Command Center located in Oakland, CA
5. South West Faith-Based Command Center located in Dallas, TX

Key Churches

- We divide every metropolitan city and rural area into key churches. These churches are placed strategically to cover all geographic areas.
- The number of key churches that we designate for any given area depends upon the size of the population of the state or the city.

NBCI Faith Communities Demographics and Statistical Composition

NBCI has created a statistical analysis of its churches, locations and demographics

The South East Faith Command	16,830 Churches
The West Faith Command	8,502 Churches
The Mid-West Faith Command	3,047 Churches
South West Faith Command	3,265 Churches
Western Faith Command	2,356 Churches

THE NATIONAL BLACK CHURCH INITIATIVE DEMOGRAPHIC AND STATISTICAL COMPOSITION

Faith Command	No. of Churches	Age Range	Gender %		Race %	
			Male	Female	Black	Hispanic
SOUTHEAST FAITH COMMAND ***Atlanta, GA*** ***A***						
Florida						
Tallahassee	268	30-75	36%	64%	100	
Miami	280	42-80	35	65	100	
West Palm Beach	12	34-80	39	61	100	
Fort Lauderdale	58	45-80	35	65	100	
Georgia						
Atlanta	2,560	28-85	45	55	100	
Savannah	99	39-85	34	66	100	
B						
Louisiana						
Baton Rouge	600	45-85	34	66	100	
New Orleans	356	46-85	35	65	100	
Alabama						
Birmingham	780	28-85	45	55	100	
Montgomery	656	32-85	45	55	100	
C						
Arkansas						
Little Rock	86	35-85	40	60	100	
Tennessee						
Memphis	860	28-85	45	55	100	
Nashville	906	28-85	45	55	100	
Chattanooga	458	28-85	45	55	100	
D						
Kentucky						
Louisville	362	33-85	38	62	100	
Lexington	198	35-85	38	62	100	
Mississippi						
Jackson	1,807	24-85	41	59	100	

Faith Command	No. of Churches	Age Range	Gender %		Race %	
			Male	Female	Black	Hispanic
E						
North Carolina						
Charlotte	450	25-85	45	55	100	
Winston Salem	346	25-85	45	55	100	
Raleigh	462	25-85	45	55	100	
Durham	241	25-85	45	55	100	
Greensboro	250	25-85	45	55	100	
South Carolina						
Columbia	838	29-85	40	60	100	
Charleston	682	29-85	40	60	100	
F						
Washington, DC	1,609	45-85	40	60	100	
Virginia						
Richmond	606	35-85	45	55	100	
Northern-Virginia	1,000	35-85	33	67	100	
NORTHEAST FAITH COMMAND						
New York						
A						
New York						
New York City	2,680	47-85	32	68	99	1
Albany	156	38-85	50	50	100	
New Jersey						
Newark	680	45-85	31	69	100	
Trenton	692	45-85	31	69	100	
B						
Pennsylvania						
Philadelphia	1,001	38-85	35	65	100	
Pittsburgh	500	43-85	35	65	100	
C						

16,830

Faith Command	No. of Churches	Age Range	Gender %		Race %	
			Male	Female	Black	Hispanic
Maryland						
Baltimore	1,008	28-85	45	55	100	
Prince George's County	985	28-85	45	55	100	
D						
Massachusetts						
Boston	400	47-85	32	68	100	
Connecticut						
Hartford	200	38-85	38	62	100	
New Haven	200	38-85	38	62	100	
MIDWEST FAITH COMMAND						
Chicago						
A						
Ohio						
Columbus	162	47-85	32	68	100	
Cleveland	289	47-85	32	68	100	
Dayton	316	47-85	32	68	100	
Cincinnati	186	47-85	32	68	100	
B						
Illinois						
Chicago	800	27-85	40	60	100	
C						
Kansas						
Kansas City	89	38-85	38	62	100	
Topeka	69	38-85	38	62	100	
Wisconsin						
Milwaukee	58	38-85	38	62	100	
D						
Michigan						
Detroit	969	38-85	38	62	100	
E						

8,502

Faith Command	No. of Churches	Age Range	Gender %		Race %		
			Male	Female	Black	Hispanic	
Indiana							
Indianapolis	109	38-85	38	62	100		3,047
SOUTHWEST FAITH COMMAND							
Dallas							
A							
Texas							
Dallas	956	26-85	48	52	96	4	
Houston	1,206	26-85	48	52	96	4	
B							
Forth Worth	603	26-85	48	52	98	2	
San Antonio	500	26-85	48	52	95	5	3,265
WEST FAITH COMMAND							
Oakland							
A							
California							
Oakland	1,356	41-85	33	67	100		
Los Angeles	700	41-85	33	67	94	6	
San Francisco	300	48-85	32	68	94	6	2,356

34,000

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