

2017

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Recommended Citation

Imam, Nimrah H., "The Limits of Accessibility Under the Affordable Care Act" (2017). *Scripps Senior Theses*. 916.
http://scholarship.claremont.edu/scripps_theses/916

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THE LIMITS OF ACCESSIBILITY UNDER THE AFFORDABLE CARE ACT

by

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**SUBMITTED TO SCRIPPS COLLEGE IN PARTIAL FULFILLMENT OF THE
DEGREE OF BACHELOR OF ARTS**

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DECEMBER 14th, 2016

The Patient Protection and Affordable Care Act (ACA) served as a momentous step for President Obama and his Administration towards his commitment to uphold the value of health care as a human right. The policy's primary premise strived to ensure accessibility to medical resources such as hospitals, professionals, and treatments, regardless of socioeconomic status by reducing health insurance costs (H.R 3590 2009). Through the expansion of Medicaid, a publically funded program for low-income Americans that pays for health insurance coverage, an individual mandate, and other provisions, the government attempted to pave the road to increased health equity (H.R. 6675 1965; Davis et al. 2011). However, the implicit assumption that obtaining insurance would directly lead to better health outcomes and greater accessibility resulted in a number of unintended consequences.

The ACA, framed by its advocates as a means for those previously uninsured to access health resources, sparked a debate about how to improve affordability, accessibility, and quality of health care (Obama 2016). Policymakers asserted that that if individuals had the opportunity, obligation, and incentive to buy health insurance coverage, then more people could equally utilize health resources. Certainly, the passage of the ACA reformed our system and expanded health coverage to millions of Americans (Uberoi et al. 2016).

Enacted in 2010, the ACA included major provisions such as the individual mandate, employer mandate, expansion of Medicaid, and state/federal insurance exchanges. The individual mandate states that people who do not have coverage must purchase insurance or otherwise face a penalty. Employers with 50 or more employees must also offer insurance or pay a fine. Employees can buy a plan directly from the

Health Insurance Marketplace if an employer does not offer insurance. Multiple insurance program options exist, including Medicaid, Medicare, employer-based health insurance, the Veterans Administration, and plans on the individual market (H.R. 3590 2009).

Today, proponents of the ACA cite the 22 million Americans who acquired health insurance as a marker for the success of the policy (Hall 2015). Jonathan Gruber, an economics professor and key architect in drafting the 2006 Massachusetts Plan for which the ACA modeled off of, claims that “any objective analysis of the ACA will find that it vastly improved the lives of millions of Americans who could not previously rely on the security of employer or government” (Gruber 2016). Certainly, the increase in the number of insured individuals supports his statement. Health insurance in the U.S. stands as an institutional barrier for many low-income populations. Previous research shows that the uninsured have overall worse health outcomes than the insured (Institute of Medicine 2009). According to data from the CDC, since ACA coverage provisions in 2014 took place, uninsured rates for the nonelderly fell from 16.6% to 10.5% from 2013 to early 2016. Among the poor, Blacks, Hispanics, and Asians, uninsured rates declined sharply. Yet despite this progress, these minority populations still remain more likely to not have insurance in comparison to Whites and those with higher income (Cohen et al. 2016).

The creation of Medicaid expanded medical assistance to the poor. As a part of the Social Security Amendments of 1965, Medicaid serves as a program funded by the federal and state government. States can administer their own Medicaid programs that fall within broader federal regulations (H.R. 6675 1965). The ACA expanded eligibility requirements for Medicaid. Those at or below 133% of the federal poverty level may

qualify for Medicaid. States who expand receive all aid from the federal government for the first three years and then phase to 90% of federal funding the subsequent years (H.R. 3590 2009).

A 2012 Supreme Court ruling on the case, *National Federation of Independent Business v. Sebelius*, upheld the ACA as constitutional. However, states can opt-out of expanding Medicaid (National 2012). Since states voluntarily participate in the marketplace, discrepancies among states exist for coverage of healthcare plans. As of October 2016, 31 states and the District of Columbia adopted Medicaid expansions (Current 2016). Six years after the passage of the ACA, however, gains in equal accessibility have not reached expectations, especially for low-income communities, the main population targeted by the ACA (Adepoju et al. 2015). So why did health insurance coverage not equate to better access to healthcare?

Opponents of the ACA, a majority of whom represent the Republican base, staunchly refused to support the policy primarily due to political party differences. Polarized opinions aside, numerous studies point to data that shows Medicaid patients hold worse health outcomes than the privately insured, both prior to and after the 2014 Medicaid expansion (Dayaratna 2012). A 2010 study found that even after adjusting for factors like age, gender, etc., Medicaid patients faced significantly higher in-hospital mortality rates (Hasan et al. 2010).

Proponents of ACA set up the health reform as the gateway for a better quality of life for those who could not previously afford insurance, but we see that disparities in health accessibility still exist. If health insurance represented the key to better accessibility, how come Medicaid patients show significantly worse health outcomes?

John Ammon, a renowned physician, concisely asserted that, “ObamaCare was advertised to the American people as a fix for two problems: Reining in the runaway cost of healthcare and extending health insurance to the uninsured” (Ammon 2016). This thesis seeks to focus on the extension of health insurance coverage and what factors limit low-income minorities in accessing health resources.

The evidence and discourse surrounding health accessibility calls into question why, despite the growth of insured Americans, has the increase in health insurance coverage under the ACA not lead to greater accessibility for low-income minorities? For this project, I aim to answer this research question by examining causes of health disparities and identifying factors for limiting health accessibility. “Health care costs affect the economy, the federal budget, and virtually every American family’s financial well-being. Health insurance enables children to excel at school, adults to work more productively, and Americans of all ages to live longer, healthier lives,” (Obama 2016, 526). Low-income minorities have historically faced institutional barriers, such as health insurance, in attempts to gain access to high quality, affordable health care. This thesis highlights factors that continue to bar poorer populations from health resources, despite the progress and passage of the ACA.

Literature Review

Accessibility stands as a marker for a path towards a better quality of life. Access to health care refers to the ability to receive services when needed, and includes the ability to pay and the availability of health care personnel and facilities close to where people live, accessible by transportation, providing care in an appropriate manner, and culturally acceptable (Bodenheimer 2016). The number of doctor visits, patient

satisfaction, cultural competency, and location and number of physicians per patient and community exemplify just some of the metrics of access care.

The Obama Administration aimed to increase accessibility, but this goal met expectations for only certain groups. One part of the ACA allows young adults to remain on their parents' plan for up to an additional seven years, until age twenty-six (H.R 3590 2009). This provision increased the number of young adults insured, yet questions still remain about the improvement of access and which adults were most likely to gain coverage. More adults with coverage represent a positive effect of the Act, but different subgroups saw varying degrees of this impact. Experts found that broad access gains benefited young men, nonstudents, and single people under the age of 26. However, they also qualify that their study stands as one of the first to display that the dependence provision of the ACA lead to increased access to care among younger individuals (Sommers et al. 2013). Health outcomes as a result of insurance coverage for younger, healthier individuals could serve as more difficult to determine if not examined over a long period of time.

One of the problems with allowing younger people to stay on their parents' health plan, is that fewer individuals add to the risk pool that a national health insurance plan of this scale requires. Historically, young adults have disrupted their coverage when they "age out" of their parents' plan. This provision operated as a way to close that gap and incentivize young adults to obtain their own insurance by age twenty-six. As a result, both men and women aged 19-25 experienced gains in insurance coverage. Since 2013, men had a net increase of 8.2% and women saw a 4.9 increase in coverage, though the difference between the two was not found to be significant (Sommers et al. 2013). The

recession of 2008 certainly played a role in allowing younger adults to stay on their parents' plans. As unemployment rates increased, college students faced the uncertainty of getting a job after graduation. Many employees obtain health insurance through their employers, so younger individuals were less likely to hold coverage if they also did not have a job. The Obama administration addressed this issue through this provision, and as a result, health insurance rates and accessibility increased for young adults.

The ACA also opened doors toward greater accessibility for the employed. The employer mandate outlines the requirements for large businesses with 50 or more employees to offer health benefits to their workers, or otherwise face penalties (H.R 3590 2009). So those who work for businesses benefit from this provision. Yet it makes it more difficult for the unemployed to gain health accessibility. The United States stands as one of the few developed nations where such a large percentage of health insurance ties to employers. Medicine in the U.S operates in a for profit system, thus difficulties arise in attempting to balance efficiency and cost with quality of care (Single 2016).

Accessibility to different health professionals leads to questions of what types of services become more accessible for patients under the ACA. Although free clinics and community health centers offer primary care to the underserved, low-income populations often face denial of specialty services. Primary care physicians may attend to the overall well-being of patients, but if a patient suffers from a condition pertaining to a specific part of the body, he or she must be referred to an expert in that area. Difficulties arise among low-income individuals and families who rely on Medicaid for services. Medicaid patients often have higher costs for physicians and specialists largely congregate in more

profitable areas where those of a lower socioeconomic status do not reside (Cook et al. 2007).

The ACA assumed that if individuals gained resources to care, they would then have the means to utilize it. Greater accessibility assumed to follow the push for the extension of insurance. Yet these results only hold true for specific populations, like the young and employed. There exists little to no evidence that supports greater accessibility for low-income minorities, and studies suggest disparities still exist (Adepoju et al. 2015). The obtaining of health coverage for millions of Americans with little increase in accessibility or health outcomes for minorities constructs a policy paradox surrounding the ACA.

Prior researchers have attempted to answer my research question through examining the role of health insurance. Increasing the number of Americans holding health insurance stood as one of the central aims of the ACA. Over the past couple years, the decline in the uninsured rate, or the proportion of the uninsured population, represents significant progress towards this goal (Finegold et al. 2015). However, questions in the past arose pertaining to the role of health insurance in leading to overall better health. Researchers at the RAND Institute, funded by the U.S Department of Health and Human Services, attempted to investigate this relationship. While they conducted the study over three decades ago, the experiment remains the only long-term study of insurance cost sharing and its effectiveness on health done at such a large scale.

In their study, they asked, “does free medical care lead to better health than insurance plans that require the patient to shoulder part of the cost?” (Brook et al. 1984). The experiment, a randomized control trial that ran from 1974 to 1982 in six cities,

enrolled about 4,000 people aged 14 to 61 in one of several fee-for service health insurance plans. One plan provided free health care while the other three required enrollees to pay a share of the bill, either 95%, 50% or 25% of all health bills each year. A fifth plan resembled a nonprofit, HMO style cooperative (Brook et al. 1984).

The RAND study found no evidence of better health outcomes in any group. People who received free care did not exhibit any effect on health habits associated with issues like cardiovascular disease and cancer, despite the underlying habits, like smoking, resulted from behavior changes. Those who obtained free care, however, did increase their hospital and doctor visits. Thus, this study found that cheaper health insurance plans do not lead to better quality of life or care (Brook et al. 1984). The vast political implications of this study contradict many policy proposals associated with health reform, including the ACA, as adjusting health insurance eligibilities through decreasing costs would not solve the problem of health disparities among poorer individuals (Brook et al. 2006).

Another recent randomized controlled study shed light on the role of insurance in leading to better health outcomes. Researchers in Oregon ran an experiment beginning in 2008 where they conducted a lottery to allow low-income adults to apply for Medicaid and followed participants for 6 years. In the first year, they found a statistically significant difference in the utilization of health care, including preventative and primary care. Surveys also indicated a significant increased self-reported access to care and perceived quality of care. During the year following the random assignment, the treatment group saw only a 25 percent increase in likelihood to continue obtain insurance than the control group (Finkelstein et al. 2012). The researchers also found higher costs

associated for the state government (Finkelstein et al. 2015). Similar to the RAND experiment, no evidence indicated better physical measurable health outcomes for the treatment group.

Limitations for both the RAND and Oregon study do exist. Years have passed since the RAND study and a new long term study for health outcomes would shed more light onto recent effects of the ACA. On the other hand, the Oregon study centered around a non-generalizable sample, and the heterogeneity of Medicaid programs across state lines may not mirror that of Oregon. Additionally, a majority of the participants in the Oregon study comprised of Whites, who do not represent the general uninsured population (Finkelstein et al. 2012). Yet both studies set up research surrounding accessibility and health insurance. Advocates of the ACA thought that increased coverage would lead to the empowerment of healthier individuals, however, evidence from both studies question this assertion.

While expansion of Medicaid served as a component of the ACA, past studies have not equated Medicaid insurance with better health outcomes. Researchers at the Journal of the American Medical Association investigated whether Medicaid or uninsured patients in Massachusetts and Maryland exhibit higher occurrences of avoidable hospitalizations compared to privately insured patients. A panel of physicians identified 12 avoidable hospital conditions and found that patients who have Medicaid or are uninsured have higher hospitalization rates for conditions with preventative treatments (Weissman et al. 1992). This study suggests that Medicaid patients do not have access to higher quality care, even with health insurance.

Thus, the extent to which coverage translates to care for low-income minorities remains questionable. The ACA contains a provision pertaining to preventative care and many studies inferred to the imperative nature of preventative health measures. I aim to explore the role of preventative care and the accessibility of those services. Additionally, emergency room visits serve as an indicator for dire health situations. Do ERs serve as a kind of space can minorities access and navigate easily? Finally, issues with primary care providers lead me to call into question what kinds of physicians can best assist Medicaid patients.

Hypothesis

The aforementioned studies expose gaps in the ideas that formed the ACA, but also point to themes and factors that may prevent minorities from better accessing health resources. I propose that disparities in preventive care measures, emergency room visits, and primary care provider services stand as barriers for low-income minorities to access health care, and answer why increased insurance coverage for low-income minorities does not equate to greater accessibility.

Disparities

A discussion of health disparities will build the foundation for my argument and how they operate within the ACA and our health system as a whole. Why must we understand health disparities? Race and ethnicity, for instance, have historically perpetuated discrimination in housing, education, and income; factors that define our health and the way we live (Ver et al. 2004). Underdeveloped infrastructure, where poorer people of color are more likely to live, releases a great deal of hazardous and potentially toxic chemicals. Increased pollution disproportionately affects these areas,

which leads to irreversible damages to well-being. A lack of knowledge of health issues partly results in delayed action on behalf of the patient. Race and ethnicity even play a role in how a doctor interacts with his or her patient (Cooper et al. 2003). These few examples show that our social, political, and economic identities intersect to play a vital role in our health and health care system overall.

Disparities may arise through policy, historical, or scientific advances regardless of intentionality or conscious discrimination. They influence issues with accessibility and indicate the “differences in health and health care, where *health* refers to the status of an individual's condition...and *health care* refers to the process of treating an illness or injury” (Ver et al. 2004, 30). Race, ethnicity, socioeconomic position, and acculturation signify four dimensions of health disparities. In 2013, over half the uninsured consisted of people of color, most of whom comprise of adults. Even today, while the majority of communities of color have full time workers in their families, that worker likely holds a low-income job that provides very limited access to health insurance sponsored by an employer. Expansion increased coverage for people and families of color, but health disparities still persist (Ver et al. 2004; Health 2013).

Prior literature has extensively researched and documented various disparities that persist in health and social science disciplines in the United States, particularly related to race and ethnicity. Many of these issues have existed for generations, or at least since data was recorded to measure them. For instance, data pertaining to Asian American health remains scarce and arose in studies where the investigators grouped large subgroups together, such as South Asians, Chinese, Korean, etc. These types of studies not only mask disparities that persist among these large groups, but also homogenize

entire populations by ignoring their self-identities (Holland et al. 2012). While the causes of these disparities cannot be attributed to a single factor, differences in economic conditions across ethnic and racial minorities contribute to inequalities in health care. These populations not only face less accessibility to health resources and an inability to afford better quality care, but also a greater exposure to detrimental environmental and occupational factors, along with differences in education influence health-related behaviors. Furthermore, intrinsic biases fueled by institutional discrimination perpetuated the barriers that disproportionately affect communities of color (Ver et al. 2004).

Socioeconomic status serves as one factor leading to disparities. Those with greater economic resources have better health and knowledge of navigating health care system. Socioeconomic status comprises elements such as social capital, position in society, wealth, education, and occupation. Certainly these elements evolve over the course of a lifetime, but lower socioeconomic status directly links to a deprivation of resources pertaining to poor health such as nutrition, the environment, or mental illness (Ver et al. 2004). Expansion of the Medicaid in only half of the states leaves out a majority of those families and individuals in rural areas who would greatly benefit from these resources, especially in smaller areas plagued by unemployment.

Education level comprises a huge component of socioeconomic status. It embodies the ability to process information and make intellectual decisions on complicated health and medical decisions. Social networks can translate to better quality of care by engaging with health professionals. Higher education leads to a greater understanding of the importance of an active lifestyle and dietary requirements. Many of these activities require a gym membership or expensive organic foods that serve as

inaccessible cost wise (Ver et al. 2004). Thus, costs along with unequal access to health resources that exist outside of the typical system must be acknowledged and addressed when forming health policies. These disparities do not exist in an independent sphere, in fact they all intersect. Socioeconomic status relates to race and ethnicity, with minorities more likely to earn lower incomes.

Acculturation and language proficiency serve as another disparity that must be understood when addressing health equity. Acculturation, or the process whereby a group or person raised in another culture, usually immigrants, come in contact with another culture and resulting in subsequent behavioral changes, consists of many layers. The degree to which individuals maintain ties to cultures from the country of origin, particularly with respect to health, form norms and expectations that mold the lifestyle they hold. Language use in the United States demands proficiency in English speaking, reading, and writing. Factors such as generation status, place of birth, and time in the U.S. represent a few indicators of acculturation (Ver et al. 2004).

In America, acculturation affects health outcomes as well as interactions in the health system. Thomas Kuhn introduced the idea of how our medical system operates in a biomedical paradigm that differentiates from alternative medical practices. Science, along with medicine, exists in this framework that implements a Western-centric view towards the creation of ideas we hold as normative. The very language and tools of measurement we utilize produce restrictions on discussions of disparities, such as the prior example of the lack of disaggregation of data for Asian Americans (Kuhn 1970). Such a paradigm allows the framework of policies such as the ACA to dictate who can

and cannot benefit from systems in our government. Those in power essentially decide what levels of accessibility minorities may receive.

So how does accessibility to health care carry significance? “If the ultimate goal is to eliminate disparities in health and health care, then it is essential to understand the mechanisms that cause them. Measuring social variables such as race, ethnicity, SEP, language use, and acculturation and the extent to which these contribute...is key to that understanding” (Ver et al. 2004, 39). The ACA operated under the basic assumption that insurance would lead to accessibility and an overall improvement in health outcomes. Having a health insurance as a resource would open the doors to a better quality of life. This concept underlies Iris Marion Young’s argument of the distributive paradigm, which “defines social justice as the morally proper distribution of social benefits and burdens among society's members” (Young 1990, 16).

The distributive paradigm asserts that if resources were allocated equally, then the same outcome would result for each person. This idea has cemented much of the framework of capitalism that so heavily relies on the power of the free market to “fairly” reward consumers with products they deserve. If you work hard enough, you can achieve success measured by monetary and professional gains. This ideology neglects the adversities faced by historically disenfranchised groups and the privileges given to those in power, or those who fit the norm. Similarly, the development of nations serves as another example of this idea. Nations may follow a path towards modernization and development. Despite the fact that first world countries neglect and exploit underdeveloped nations, a country simply has to govern in an effective manner or else continue to suffer. Never mind the generational negative impacts of imperialism that

communities in underdeveloped countries to endure. Expressing the need for achieving the outcome of equality overlooks the outside power dynamics that produce inequality in the first place.

Young criticizes the distributive paradigm by arguing that conceptions of justice must begin with concepts of oppression and domination, rather than a focus on distribution. So often, we assume normative evaluations must analyze institutional structures. Young exposes the tendency of political theories to homogenize individuals and actors and value sameness over differences. Contemporary theories of justice generally restrict defining social justice to proper distribution of burdens and benefits. Society holds a moral obligation to evenly take responsibility for costs of all kind. The distributive paradigm extends beyond material goods, to cover goods like power, opportunity, and self-respect. Young quips that “while distributive issues are crucial to a satisfactory conception of justice, it is a mistake to reduce social justice to distribution” (Young 1990, 15). The ACA attempted to address issues of distribution of health resources through insurance, but ignored the social factors that influence how much ability individuals have to utilize such resources.

An equal distribution of material goods does not result in health equity. For instance, the individual mandate serves as one of the main provisions heavily criticized in the ACA. Its idea, as originated in the Massachusetts Plan, essentially served to spread the risk with the idea of balancing burdens. Healthy people had to pay into the pool in order to alleviate most of the costs from the elderly and sick (Bodenheimer 2016). The push by the Obama Administration for more people to buy health insurance ignores that

even if we equalize the burden of cost under our healthcare system, we obscure the social and institutional structures that help determine distributive patterns.

In conclusion, first, we must understand race, ethnicity, socioeconomic status, and acculturation in order to mitigate health disparities that still exist despite passage of the ACA. These disparities act as barriers for low-income minorities to access health resources. Second, Young's critique of the distributive paradigm theory offer insight into why the policy hoped to increase accessibility for the uninsured, but saw only minimal progression towards this goal. The question I initially posed asked why the increase in health insurance coverage under the ACA did not lead to greater accessibility for low-income minorities. Throughout the literature, I identified three main issues that may answer my question: preventative care, emergency room visits, and provider services.

Preventative Care

Good health outcomes arise not only from receiving medical care, but also from preventing diseases before they begin. The CDC recognizes the importance of prevention and the benefits of weaving it into all aspects of our lives to. Focusing on wellness and prevention creates an overall healthier nation, and greatly reduces the risk of patients getting sick and racking up health care bills (National 2014).

Title I and IV of the ACA elaborate upon coverage of preventative health services. Section 2713 requires insurance plans to cover preventive services along with immunizations mandated by the CDC and the U.S Preventive Services Task Force. Section 4003 expands upon clinical and community preventive services, such as cancer screenings or prescription of aspirin to prevent heart disorders. Furthermore, Subtitle B established tangible ways to increase access to preventive services, like funding for the

development of school-based health clinics and increases educational outreach to medically underserved families and children (H.R 3590 2009; Summary 2016).

The increased life expectancy in this century and the spread of baby boomers emphasize the importance of preventative health measures. Our lifestyles and daily actions influence so much of our health. Our diet, levels of activity, and the environment we reside in represent only a few of the many factors that comprise health. While the provision for preventive care in the ACA serve as an overdue measure to edge closer to equity, benefits for low-income minorities may not arise. The aging population of the baby boom generation face uncertain prospects of health. Vulnerable populations, like low-income minorities in the United States, face an increasing number of barriers towards a better quality of life (Johnson 2010).

Low-income populations suffer from the underutilization of effective services pertaining to preventative health services and early detection (Adepoju et al. 2015). The lives for a typical individual who barely survives from one paycheck to another offer insight into the underutilization. Poor individuals cannot afford to take time off of work to go into the hospital where preventive services like screenings and vaccinations take place. In a capitalistic society where time equates to money, these individuals must weigh working to earn wages or obtaining a vaccine that will serve as a positive externality. Certainly some employers offer paid time off, but even then, a majority of poor communities would rather choose the former to earn more money for themselves and their families. Furthermore, increased awareness of public health measures requires that these individuals take the time to educate his or her self about precautions and avenues to lead a healthy life. This relates back to educational disparities ingrained in our

institutions. Perhaps the increased outreach in the ACA may curtail some of these barriers.

Diet and exercise can act as a measure to prevent disorders to arise. Many disorders such as diabetes, cardiovascular disease, and obesity can benefit from certain foods and increased exercise. Yet organic and foods deemed healthy usually carry a large price tag that poorer people cannot afford. The spread of fast food chains disproportionately impacts lower income communities. Junk food solves the problem of limited time held by these populations and offers a cheaper alternative than the more expensive products in the grocery stores. Thus, the likelihood of poorer individuals consuming junk food increases. Even prioritizing exercise for lower income populations seems difficult to do after a long, tiring day at work. Additionally, gyms generally assist greatly in working out to maintain a healthy lifestyle. Membership also comes with a hefty price tag unaffordable for most in the lower class. How can poorer individuals reap benefits from preventative activities when constructed biases avert the attainment of better health? As a result, lower income minorities still face worse health outcomes that do not relate to insurance coverage.

The environment may stand as the greatest public health threat to lower income minorities. The effects of climate change disproportionately create negative consequences for these populations as well. So much of preventive care hinges on lifestyle, and the environment represents a large manifestation of that. The air we breathe, the water we drink, and the infrastructure of our communities. Greater concentrations of polluted air exist in poor communities. Issues of infrastructure including schools and homes exacerbate the risk of exposure to irreversible and damaging toxic chemicals. Since these

dangers persist over time, the emphasis on preventive care leans toward irrelevance if these communities have little power to change the outside factors that harm their bodies.

Therefore, while the ACA recognized the importance of preventative care measures, low-income minorities still cannot fully access those resources. Changes to work and lifestyle must come in order to mitigate health disparities for disenfranchised populations to more equally reap the benefits of preventative services.

Emergency Room

If low-income minorities are not benefiting as much from increased preventive services under the ACA, they would be more likely to require emergency room care for more severe illnesses. The emergency department serves as the place where the doctors and nurses attempt to mitigate the most life threatening events. They also represent a social environment where low-income minorities face barriers to accessibility.

The Oregon health experiment saw no effect on emergency room visits for Medicaid patients (Finkelstein et al. 2012). However, a recent poll from the American College of Emergency Physicians finds that physicians across the U.S report a greater number of patients visiting the ER since implementation of the ACA. 47% percent reported that the volume of emergency patients increased slightly, and 28% reported the volume increased greatly (2015). This increase suggests an increased utilization of the services provided by health insurance, but presents questions about the level of accessibility for emergency department resources.

Cultural competency, or the capability of health organizations and providers to meet the cultural, linguistic, and social needs of the patient. serves as one issue that impacts health accessibility. Under stressful emergencies, doctors and nurses must

heighten mindfulness of cultural competency surrounding their patients. For example, great variations in ideas about care exist, particularly pertaining to end of life care. Cultural competency provides a positive effect in care because it promotes providers to deliver services that respect the health beliefs and practices of a diverse patient population. The NIH has taken steps, outside of influence from the ACA, to push for culturally appropriate standards among health professionals (Cultural 2016). In an emergency room environment, having health professionals aware of the cultural and language barriers faced by low-income minorities allows patient to access the space more easily. While the ACA does create opportunity to establish a more culturally competent workforce needed to eliminate health disparities, more actions of enforcement, such as creating a diverse workforce, can create an environment easily accessible to those of a lower socioeconomic status (Adepoju et al. 2015).

In the United States, the prevalence and utilization of English creates a disadvantage for minorities who speak another language. If emergency rooms lack translation resources, non-English speaking patients cannot access an understanding for health issues. Non-English speakers more often do not feel satisfied with their care in the emergency department, and feel less willing to come back to the same ED in the future. Strategies to improve language barriers have taken place throughout the years, but this barrier continues to lead to health disparities today (Carrasquillo 1999). Thus, addressing the emergency room environment can increase accessibility for low-income minorities.

Provider Services

Perhaps the most direct form of health delivery rests between the physician and patient. The practice of Western medicine since its inception thrived as the interaction

between two individuals. The ACA certainly extended primary care services to Medicaid patients. However, a study from the Department of Health and Human Services reports that primary care providers were less likely to offer an appointment to these than specialists. Furthermore, specialists tended to have longer wait times (U.S Department 2014).

The requirement for a referral to a specialist by a primary care physician may serve as a possible explanation for the ease of appointment creations for specialties. Medicaid generally pays physicians 56 percent compared to the amount paid by private insurers. Due to these low reimbursement rates, a greater number of doctors refuse to accept Medicaid. Thus, finding physicians, both primary care and specialists, presents difficulties for lower income minorities to access (Dayaratna 2012). To provide context for limited access to doctors, research shows fewer doctors per capita compared to other wealthy nations, supporting the shortage of physicians Medicaid patients can access in the US (Assessing 2014). Perhaps as a result, patients most commonly report increased difficulty for arranging a follow up with either primary care or specialty physicians (2015).

However, we cannot overlook the value of increased access to primary care physicians under the ACA. The policy made expansion of community health centers a central part of its strategy to insure underserved populations. Low-income minorities benefit a great deal from these centers which they would not have access to in the past. In 11 states and the District of Columbia, community health centers serve over 30% of those with low income. More funding allocated towards community health centers can sustain accessibility for patients to health resources. At the same time, however, the Kaiser

Family Foundation reports the uninsured rate among community health center patient to remain high. Continuing to grow access to primary care providers while also extending specialty care will best allow low-income minorities to work towards a better quality of life (Shin 2015).

Conclusions and Future Prospects

The ACA largely ignored the social constructions and institutions that influence the usefulness of resources. Medicine, while largely influenced by a variety of social and political factors, at its core centers around providing the most accessible care for patients, and extends to the involvement of insurance companies and pharmaceuticals in power who dictate prices for drugs. Politics centers on the study of the distribution of power and wealth, and so an understanding of forces, agents, and policies that shape our health can better solutions of justice. Discussion of health reform primarily revolves around inequalities of wealth and the extent to which the government can mitigate suffering for the poor, as exemplified with the ACA (Young 1990). The Obama administration hoped to provide an economic solution to the rising costs associated with healthcare and by doing so, faced an opportunity cost. By formulating such a huge plan with numerous provisions, they lost the opportunity to include tangible steps to address the discussed disparities faced by minorities. We see that policymakers hinge onto the idea of spreading health insurance coverage assuming that those previously uninsured may take advantage of those resources.

Furthermore, the distributive paradigm focuses heavily on pattern orientation and assumes a sort of static conception of society. It evaluates justice by the outcome and end-state pattern or persons and goods. Therefore, if all or most individuals can obtain

health insurance and get covered, justice has prevailed. We see this prevalent among analysis of the ACA that all point to statistics about the insurance rate. Even the allocation of social funds and who pays for which part of the insurance still operates in this distributive paradigm framework. Different social interests compete for the ability to have less burden placed upon his or herself, such as younger people not buying health insurance because they are already healthy (Young 1990). When we discuss accessibility under the context of the ACA, it becomes evident that accessibility, then, does not equal care.

Why, then, was the assumption that health coverage equates to care made in the ACA? It relates back to the distributive paradigm. In a world where vast differences in wealth and material goods exist for millions of individuals across every country, where men, women, and children starve and others can eat plentiful, any idea pertaining to justice must aim for the reallocation of goods. The framework of capitalism further bolsters these cycles of oppression. Society functions in a lifestyle rooted in the notion of goods and services. It centers around the idea that justice equates to distribution. The market acts as a pendulum, always returning to a stable state even after times of extreme imbalance. Capitalism ignores the faces of oppression that are embedded in our institutions and policies at large (Young 1990). Theoretically, if all individuals had the same resources, we would reach the same outcome; a better quality of life. However, we do not see this.

The impacts of the ACA and what each provision entails leads to questions of accessibility that impede quality of life. As health reform lands on the radar of citizens and stakeholders in power, we must discuss the social and political institutions that

largely dictate the mechanisms of actions. Agencies and institutions have taken steps to better access to preventive care, the emergency department, and primary care services by addressing the imperative nature of things like cultural competency and language resources. However, low-income minorities continue to face these barriers.

Limitations do exist with any current analysis of the ACA. The relatively short duration of its implementation leave room for future progress to be made. Perhaps a few more years will allow us to fully break down the impacts on minorities and people of color. Health care issues and reform will continue to represent an imperative agenda item in the future that allow us to extend our quantity of active years and increase the quality of that time.

In my project, I asked why the increase in health insurance coverage under the ACA did not lead to greater accessibility for low-income minorities. After an examination of the literature and discussing the importance of health disparities, I identified that barriers in preventive care, emergency room visits, and health provider services result in limited accessibility for that population. Future implications of my thesis include pushing policymakers to increase awareness of continued health disparities facing minorities. Increased educational outreach in these communities by politicians and even health professionals can lead to greater health accessibility for low-income minorities and ultimately, the ability to lead a healthier life.

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