Health Reform at the Crossroads: Will the Affordable Care Act Help Eliminate Health Inequities?

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This week marks the second anniversary of the passage of the Patient Protection and Affordable Care Act (ACA). It's also the week that oral arguments begin before the U.S. Supreme Court to consider the constitutionality of the law. At minimum, the court will consider whether the law's requirement that individuals who can afford health insurance coverage should carry it exceeds federal authority to regulate interstate commerce, and whether the law's provisions to expand the Medicaid program are "coercive" to states. Years of effort to create legislation that will expand insurance coverage, contain health care costs, and improve the quality of health care hang in the balance, and all Americans will ultimately be affected by how the high court rules.

Racial and ethnic minority Americans have an enormous stake in the law and Supreme Court's deliberations. Not only do many minorities face higher rates of disease, disability, and premature death than whites, they also face greater barriers to accessing high-quality health care. These problems, however, should trouble all Americans: given the nation's significant demographic shifts (over half of all babies currently born in the U.S. are non-white, and by 2042 1 of every 2 people living in the U.S. will be a person of color), the health of minorities increasingly defines the health of the nation.

This policy brief reviews the health status of minority Americans, and briefly reviews the complex factors that are associated with health inequities among majority and minority groups. Drawing upon research and policy analysis that the Joint Center conducted shortly after the law's passage (*Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*, http://www.jointcenter.org/research/patient-protection-and-affordable-care-act-of-2010-advancing-health-equity-for-racially-and), it reviews the potential of the ACA to address health inequities. We find that the law has tremendous potential to significantly narrow health inequities, a goal that is squarely in the national interest. Dozens of the provisions within the law address long-standing health and health care needs, going well beyond the controversial individual responsibility requirement and Medicaid expansion. The Supreme Court, as well as national policymakers and their constituents, should carefully consider these issues as they weigh the ACA's merits.

Racial and Ethnic Health Inequities

Racial and ethnic health inequities persist from the cradle to the grave. Some U.S. racial and ethnic minorities experience a disproportionate burden of poor health across a host of health measures, ranging from infant mortality to life expectancy as well as most chronic and infectious diseases. African Americans, American Indians, and Pacific Islanders face some of the most persistent and

pervasive inequities relative to whites.[1] For example, while the life expectancy gap between African Americans and whites has narrowed slightly,[2] African Americans still can expect to live 6-10 fewer years than whites and face higher rates of illness and mortality.[3]

In terms of lives, this gap is staggering: An analysis of 1991 to 2000 mortality data concluded that had mortality rates of African Americans been equivalent to that of whites in this time period, over 880,000 deaths would have been averted.[4] And while some racial and ethnic groups, such as some Hispanics and Asian Americans, have better overall health status than national averages, they suffer disproportionately from some diseases, such as diabetes, cancer, and liver disease, and tend to experience poorer health outcomes the longer they and their descendents live in the United States.[5]

The causes of racial and ethnic health inequities are complex and multifactoral. Socioeconomic differences are the most significant factor, given the strong correlation between socioeconomic status and health. People at every ascending step in the socioeconomic gradient generally have better health than those even a step below.[6] Given the disproportionate representation of many racial and ethnic minorities in lower socioeconomic tiers, socioeconomic inequality is a major factor contributing to health inequalities. Health behaviors also certainly play a role – some racial and ethnic minorities, for example, report being less physically active than whites – but these health behaviors are often shaped by neighborhood context.

Many public health researchers believe that the fundamental mechanism underlying these inequities is residential segregation, which powerfully shapes health resources, risks, and life opportunities. Racial and ethnic minorities are more likely than whites to live in segregated, high-poverty communities, communities that have historically suffered from a lack of health care investment. Many of these communities also face a host of health hazards—such as high levels of air, water and soil pollution, and a glut of fast food restaurants and liquor stores—and have relatively few health-enhancing resources, such as grocery stores where fresh fruits and vegetables can be purchased, or safe parks and recreational facilities where residents can exercise or play.

The Potential of the ACA to Help Eliminate Health Inequities

Several aspects of the ACA directly address healthcare inequities, such as provisions to improve the diversity and distribution of the healthcare workforce. Other provisions, such as health insurance coverage expansions and insurance reforms, disproportionately benefit communities of color because of the large racial and ethnic inequity that currently exists in access to health care. But the law's greatest impact on health inequities can be found in its potential to improve community conditions for health, given the growing body of evidence suggesting that a person's zip code is more important that his or her genetic code in determining health.

Provisions that Directly Address Health Inequities

Data collection. Many patients of color experience geographic, financial, cultural, and/or linguistic barriers to accessing health care. Importantly, these barriers persist even when minorities possess the same health insurance and incomes as white patients. Tracking data on health care access, quality, and outcomes for minorities relative to white patients is important because inequities might constitute violations of the Civil Rights Act of 1964. In addition, quality improvement and

disparities reduction efforts cannot be adequately assessed unless evaluators know when and under what circumstances health care inequities persist. The ACA contains several provisions to improve data collection and reporting procedures, with the explicit intention of tracking and reducing health care inequities.

Workforce distribution and diversity. Many U.S. communities—disproportionately those with lower incomes and a higher percentage of minorities –face severe shortages of health service providers. They also tend to have greater health care needs. This mal-distribution of healthcare resources relative to community need leads to inefficiency in healthcare delivery—if received at all—and higher healthcare costs. Research demonstrates that the providers most likely to make a difference in addressing these gaps are U.S. racial and ethnic minorities, who are more likely than white healthcare workers to seek to work in underserved communities and focus their careers on eliminating healthcare inequities. However, many U.S. racial and ethnic minorities—specifically, African Americans, Latinos, Pacific Islanders, American Indians, and Alaska Natives—are vastly underrepresented among the nation's physicians, nurses, dentists, psychologists, and other health professions. The ACA reauthorizes and expands programs to improve diversity in fields such as primary care, long-term care, and dentistry, and increases scholarships and loan forgiveness opportunities for health care providers who agree to work in communities that have a high need for health professionals.

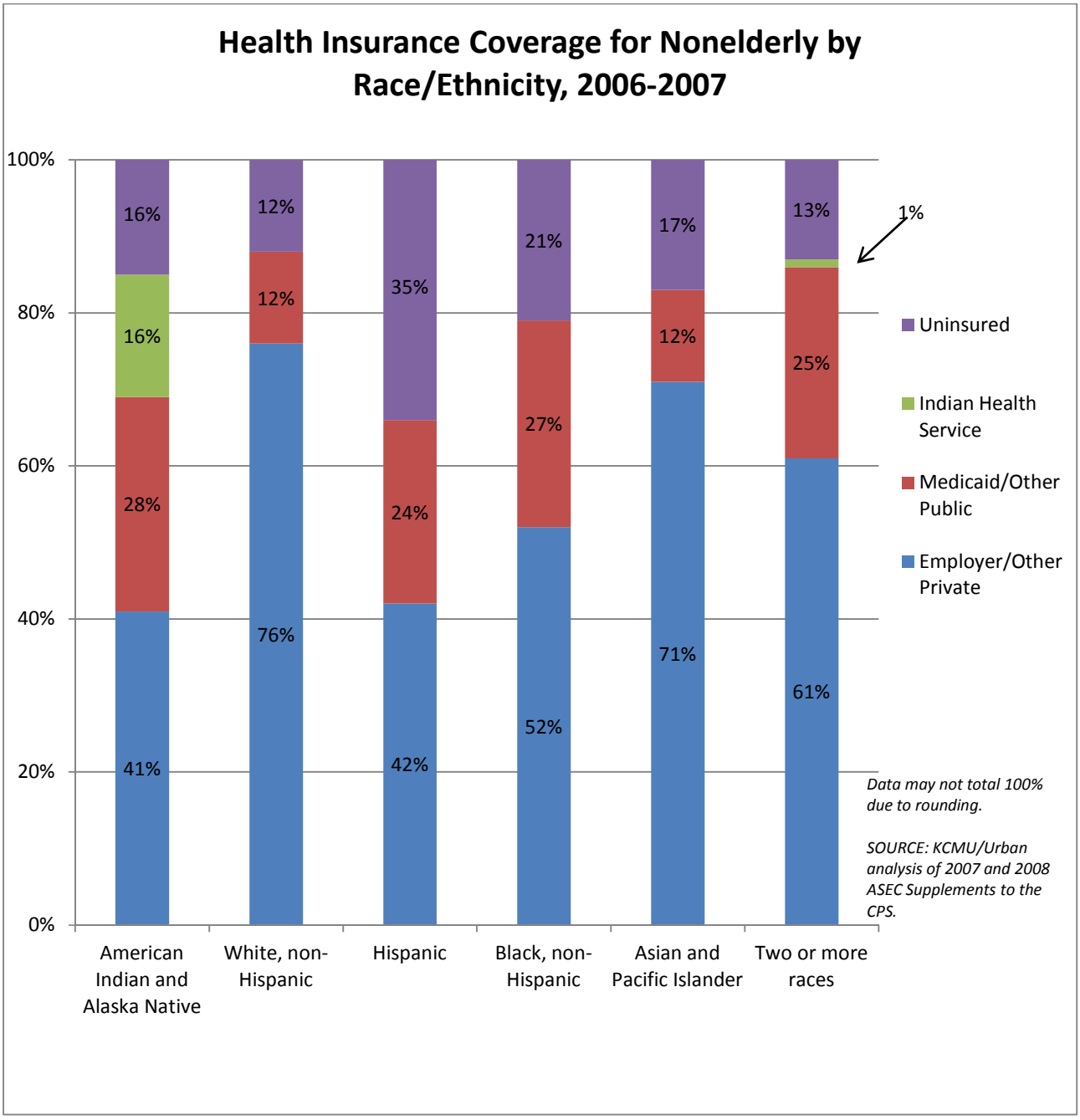
Cultural Competence Education. People of color are more likely than whites to report experiencing poorer quality patient-provider interactions, an inequity which is particularly pronounced among individuals whose primary language is other than English.[7] Cultural competence training and education, as well as language support for health professionals has gained credibility as a strategy for improving the quality of care delivered to culturally and linguistically diverse patients.[8,9] The ACA authorizes five years of support to aid the development and dissemination of model cultural competence training and education curricula, and offers support for loan repayment options with preference to individuals with experience in cultural competence training.

Health Inequities Research. Research on health inequities has historically received insufficient federal funding and attention. The ACA promotes the National Center on Minority Health and Health Disparities at the National Institutes of Health to *Institute* status, granting it the authority to plan, coordinate, and evaluate disparity-related research within NIH. Increases in funding to Centers of Excellence are also made available to support health disparities research. The law also creates a Patient-Centered Outcomes Research Institute, part of whose mission is to carry out comparative effectiveness research and to examine differences in healthcare service outcomes among persons of color.

General Provisions with Significant Implications for Communities of Color

Expanding Access to Health Insurance. About half of the 50 million U.S. residents who lack health insurance are racial and ethnic minorities. The problem of uninsurance persists in communities of color despite the fact that the majority of the uninsured are in full-time, working families, as minorities are disproportionately employed in jobs that do not offer health insurance benefits. For example, 71 percent of working-age whites had health insurance through their workplace in 2005, but only one-third of working-age Hispanics and half of working-age African Americans had employer-sponsored coverage.[10]

All U.S. racial and ethnic minority groups have higher rates of uninsurance that white Americans, and higher participation in public insurance programs (see figure below). Importantly, however, insurance coverage expansions under the ACA will dramatically reduce uninsurance rates among all groups.



The ACA requires employers with 50 or more employees to offer coverage to employees or pay a penalty for any full-time employee who receives a premium tax credit for purchasing their own coverage through exchanges. Large employers are mandated to automatically enroll employees into their health insurance plans, and small employers will be provided a tax credit for purchase of health benefits. These policies have the potential to expand coverage for a sizeable share of people of color, especially given that over 90 percent of minority-owned firms have fewer than 25

employees and people of color are more likely to be employed by a small firm that does not offer health coverage.[11]

The law will also expand Medicaid to include working families and adults who make barely above-poverty wages; this will disproportionately help people of color, particularly in states where minorities have faced the brunt of lack of insurance. For example, in Texas, 33 percent of all non-elderly adults are uninsured, and fully 74 percent of the uninsured are nonwhite.

Insurance Reforms. Nearly half of all African-American adults suffer from a chronic condition or disability.[12] The ACA will improve their ability to purchase and retain health insurance in that it prohibits health insurers from "cherry-picking" enrollees (e.g., denying coverage because of pre-existing conditions), dropping coverage when people become ill, and imposing annual and/or lifetime caps on benefits.

Improving Access to Health Care. Access to timely and needed healthcare is a major challenge for many racial and ethnic minorities. Even after adjusting for age, insurance and income, people of color are less likely than their white counterparts to have a usual source of care. More than half of Hispanic adults report not having a regular doctor, even when insured—a rate that is 2.5 times greater than the proportion of whites. Furthermore, compared to whites (77 percent), Hispanics and African Americans are less likely to receive care in a private doctor's office (44 and 62 percent, respectively) and are more likely to seek care in emergency departments.

The ACA contains several provisions designed to improve geographic access to primary, dental, and behavioral health services for underserved populations. For example, the ACA expands funding for community health centers (CHCs), which have successfully provided high-quality, culturally competent health care to diverse U.S populations.[13] In addition, the ACA expands funding for the National Health Service Corps, which provides loan repayment and other incentives to encourage providers to work in medically underserved communities.

Public Health and Prevention. Some of the greatest gains in the effort to eliminate health inequities are likely to be realized by the ACA's prevention programs. The Prevention and Public Health Fund, for example, was authorized to improve the nation's public health infrastructure, expand community-based and clinical prevention programs, and increase the public health workforce. Similarly, the ACA's Community Transformation Grants were authorized to address neighborhood conditions that shape health, such as the quality of the retail food environment, the availability of parks and recreational facilities, and the presence of environmental degradation and pollution.

Going Beyond the ACA

Government at all levels can improve health opportunities by stimulating public and private investment to help make all communities healthier. It can do so by creating incentives to improve neighborhood food options, by aggressively addressing environmental degradation, and by de-concentrating poverty from inner-cities and rural areas through smart housing and transportation policy. Many of these strategies are highly cost-effective. A study conducted by the Prevention Institute and Trust for America's Health, for example, found that for every $10 per person invested over five years in community-based primary prevention efforts—such as those focused on reducing

tobacco consumption, improving nutrition, and increasing physical activity—results in a return on investment within two years and an estimated annual savings of over $15 billion nationally within five years.

Conversely, failing to take action to address health inequities is costly. A study commissioned by the Joint Center found that the direct medical costs associated with health inequities—in other words, additional costs of health care incurred because of the higher burden of disease and illness experienced by minorities—was nearly $230 billion in the four years between 2003 and 2006. Adding the indirect costs associated with health inequities, such as lost wages and productivity and lost tax revenue, the total costs of health inequities for the nation was $1.24 trillion in the same time span.

The federal government recently announced national health goals in *Healthy People 2020*, which called for not only the elimination of health inequities, but also improved conditions for health for all. The nation has failed to achieve the *Healthy People 2010* health disparities objectives. Fully funding and implementing the ACA will ensure that the nation has a fighting chance to meet the new *Healthy People* goals – an objective that is clearly in the national interest.

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