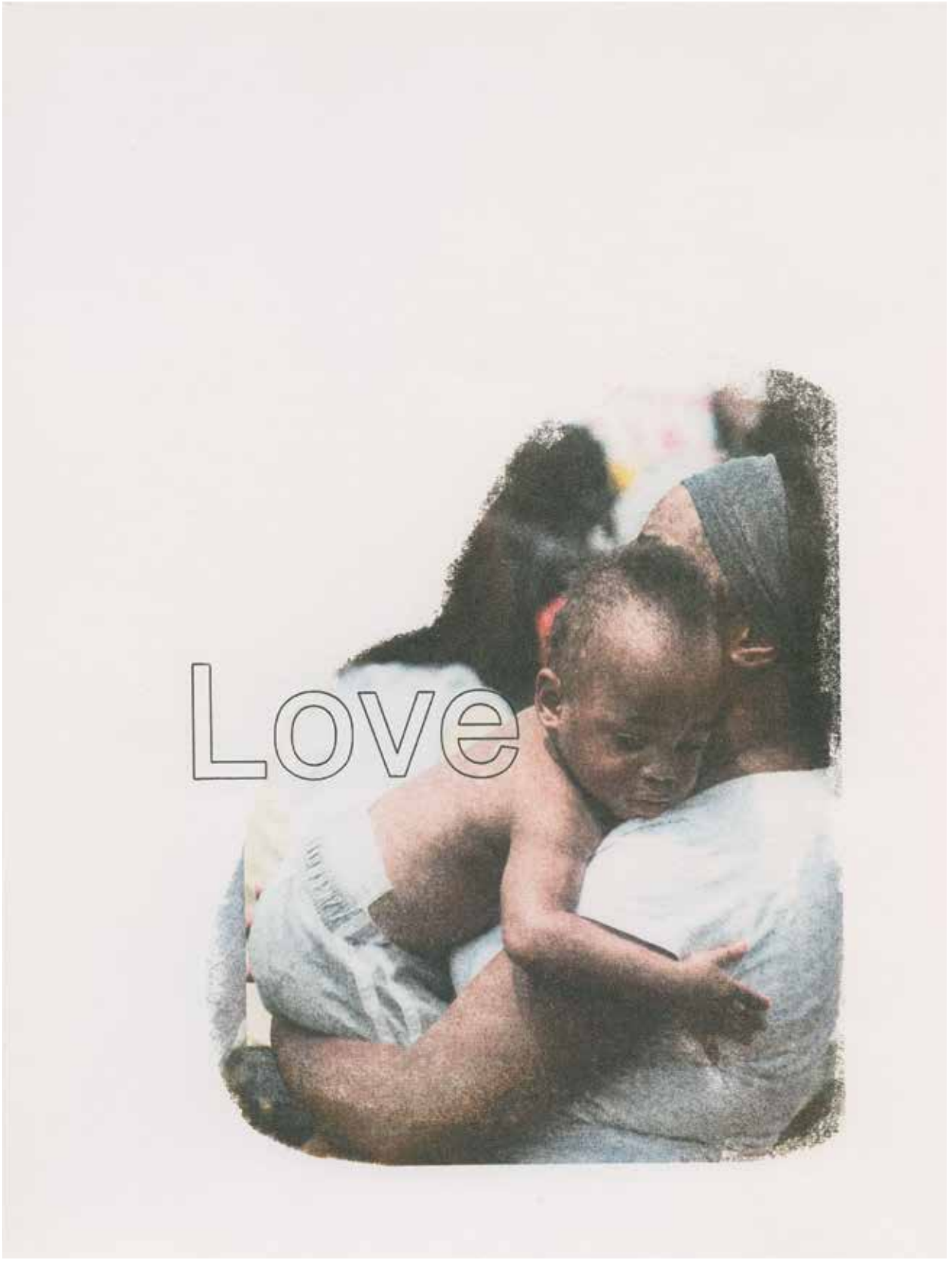

Jen Everett

ACA Insurance Expansion Shows Signs of Reducing Racial Disparities

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The national consciousness and conversation are now focused on racial disparities across all aspects of society: employment, law enforcement, education and certainly health. Over the course of the pandemic, COVID-19 has imposed disproportionate burdens of severe illness and death on Black and Latino Americans. These disparities are in fact part of a long-standing feature of the U.S. health system.

Racial and ethnic disparities in health care access, quality and in services provided affect a massive swath of the U.S. population — as of 2018, approximately 40% individuals living in the United States were people of color.[1] Because insurance coverage, or the absence of it, contributes to many of the disparities and their severity, the 2010 Patient Protection and Affordable Care Act has resulted in significant reduction in disparities, particularly for women and children of color, as millions more people in the United States have become insured due to the law.

Racial and ethnic health care disparities affect people in profound ways. Imagine two women, both of whom are pregnant. One is Black and one is white. Both are joyful at the news. They will receive care in the United States, where maternal health has a good track record, even if it is not as good as in many other rich countries.[2] Nevertheless, a number of factors make it more likely that the white mother and her fetus will receive recommended prenatal care, visit a provider who is trained in advising women on healthy pregnancies, and deliver in a clean, safe, well-staffed facility able to respond to the health care needs that may arise for the mother or her newborn. The Black mother is three times as likely to die from complications occurring after her child is born.[3] This is true even if both women are college educated.

HOW DISPARITIES AFFECT CHILDREN

After birth, the disparities continue and widen. When newborns grow to be children ages 1 to 4, a Black child is twice as likely to die generally than a non-Hispanic white child, and even more likely to die if diagnosed with cancer, congenital heart disease or if that child has complications from surgery.[4] A Black child visits doctors less and has higher odds of going one year or longer from the last physician visit, a higher rate of emergency department visits, greater likelihood of medically unnecessary Emergency Medical Services transports, fewer calls to physicians' offices from the child's guardians, and lower odds of well-child care and diagnosis and treatment for various pediatric conditions.[5]

If suffering from asthma, the Black child is

4-5 times more likely than a non-Hispanic white child to be hospitalized for it.[6] His or her teeth will fare worse as well. Black and Latino children are almost twice as likely as white children to have untreated tooth decay in primary teeth.[7]

RACIAL GAPS PERSIST FOR ADULTS

As children become adults, the disparities continue. Black and Hispanic workers, especially men, are more likely to be injured in the workplace. Ensuing injuries are therefore more likely to cause long-term disability and related susceptibility to illness. Minorities also lack access to preventive care that catches disease early and lessens its toll. Rates of screening for colorectal cancer among minority patients lagged rates among white patients in 2009: 43% of patients of color who were candidates for screening completed it versus 69% of white patients.[8] Black adults are 30% more likely to die from heart disease, twice as likely to have a stroke, and suffer higher rates of heart failure.[9]

Even where disparities do not result in death, the economic damage is massive. A 2011 study estimates that the economic costs of health disparities due to race for African Americans, Asian Americans and Latinos from 2003 through 2006 was a little over $229 billion.[10]

THE REASONS FOR DISPARITIES

Of course, the reasons for these disparities are manifold and include outright discrimination in how health care services are provided, the poverty magnification effects of race and ethnicity (African Americans and Hispanic populations are more likely to be poor than their white counterparts), and differences in neighborhood environments (since these populations tend to live in or near urban centers). While by no means exhaustive, a patient who is a person of color might be discriminated against with a longer wait time to see a provider or having a provider spending less time with a patient and misdiagnosing as a result. Neighborhood environments can make a difference because persons in some urban areas have less access to nutritious food or may live in neighborhoods where there is more violence.

Yet what is abundantly clear is that insurance status is tightly linked with racial and ethnic status, and having insurance plays a significant role in addressing those disparities. A literature review conducted for the Kaiser Family Foundation concluded that health insurance was the single most significant factor explaining racial disparities in having a usual source of care.[11] "As might be expected, health insurance coverage indeed explains substantial proportions of disparities, and remains the focal point of policymakers for eliminating disparities."[12]

Historically, up to and including the present, most Americans obtain their health insurance through their employer. Three fifths (60%) of the population under the age of 65 receive coverage through employers. However, minorities are less likely than whites to be have jobs where health insurance is a benefit. Nearly 70% of nonelderly whites receive employer-based insurance while only 40% of Hispanics receive such coverage. Only 48% of Black adults receive health insurance through their employer.[13]

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ACA PROVIDES PART OF THE SOLUTION

The Affordable Care Act of 2010 was committed to expanding coverage, improving quality and reducing costs (including reductions in fraud and abuse). While each of these objectives was likely to address long-standing racial and ethnic disparities in health outcomes, the law was also explicitly committed to acknowledging and addressing those disparities head-on. The Affordable Care Act established individual Offices of Minority Health within the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the Food and Drug Administration, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration. It also established the National Institute on Minority Health and Disparities, or NIMHD, within the National Institutes of Health.

The law expanded access to insurance through

three principal mechanisms: the establishment of exchanges that offered a choice in insurance options modeled on what federal employees had long enjoyed; mandates on individuals and employers to purchase and provide insurance, respectively; and, the expansion of Medicaid, the joint state-federal health care program for the indigent. Before 2010, it was not sufficient to be poor for purposes of Medicaid eligibility. A recipient had to be poor and "something else" — pregnant, disabled, a child, etc.

The law's effect on disparities was immediate. The proportion of nonelderly adults lacking health insurance fell from 20.5% in 2013 to 12.3% in 2017, a decline of 40%.

All U.S. racial and ethnic groups saw comparable, proportionate declines in uninsured rates. However, because uninsured rates started off much higher among Hispanic and Black non-Hispanic adults than among white non-Hispanic adults, the coverage gap between Blacks and whites declined from 11.0 percentage points in 2013 to 5.3 percentage points in 2017.[14] The biggest absolute reductions in uninsured rates occurred among Hispanic, Black, and lower-income, nonelderly adults in Medicaid expansion states. Because of this, while disparities in coverage shrank in both nonexpansion and expansion states, the reduction in disparities was greater in the expansion states. From 2013 to 2017, the coverage gap between Blacks and whites in expansion states had dropped from 9.8 percentage points to 3.2 percentage points, and the corresponding gap between Blacks and whites in nonexpansion states declined from 11.4 points to 6.2 points.[14]

While there is an enormous amount of research under way, the declining disparities in coverage appear to be translating to decreasing disparities in important health outcomes. A retrospective analysis, published in *JAMA Oncology*, found that there was a large difference in breast cancer stage among racial/ethnic minorities that had insurance and access to care. Non-white women covered by insurance or Medicaid were more likely to have their breast cancer caught early.[15]

Similarly, the likelihood that an infant would be born into a household with health insurance was approximately two times greater in states that expanded Medicaid than in states that did not.[16] The finding is important because access to Medicaid improves health outcomes, and infants' household environment has long-term implications for their educational achievement, positive developmental trajectories and transitions to productive adult roles.[17]

In Oregon, the expansion of Medicaid did not have a preliminary effect on diagnosis or treatment for hypertension or high cholesterol, but it did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression and reduce financial strain.[18] A 2015 study comparing health care utilization between two expansion states (Arkansas and Kentucky) and one non-expansion state (Texas) found a 22.7 percentage-point reduction in the uninsured rate, significantly increased access to primary care, fewer skipped medications due to cost, reduced out-of-pocket spending, reduced likelihood of emergency department visits and increased outpatient visits.[19] Screening for diabetes, glucose testing among patients with diabetes, and regular care for chronic conditions all increased significantly after expansion. Quality of care ratings improved significantly, as did the share of adults reporting excellent health.

MORE TO BE DONE

Despite coverage gains, changes adopted by the federal government after 2016 appear to have caused expansion rates to dip. For example, the Trump administration allowed states to impose work requirements for Medicaid, elimination of the individual mandate, de-funding enrollment outreach through healthcare.gov, and ending subsidies to insurance companies that provide individual policies.

Increasing insurance coverage through the Affordable Care Act, Medicaid expansion, or other policies — like tax subsidies to employers to provide health insurance or high-risk pools for people with specific conditions — remains a priority to address racial disparities in health outcomes. Indeed, even in 2017, nearly half a million new mothers remained uninsured.[20] There appears to be significant evidence that mothers and children have benefited most from the expansion of insurance in the U.S. Moreover, there appears to be popular support. In Idaho, Nebraska and Utah, where state governments refused to expand Medicaid, the voters did so through referendum. Jonathan Schleifer, executive director of The Fairness Project, a health care advocacy organization, argued that those elections stood for something fundamental to Americans' views.

"Expanding access to health care isn't a blue state value or a red state value; it's an American value."[21]

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NOTES

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