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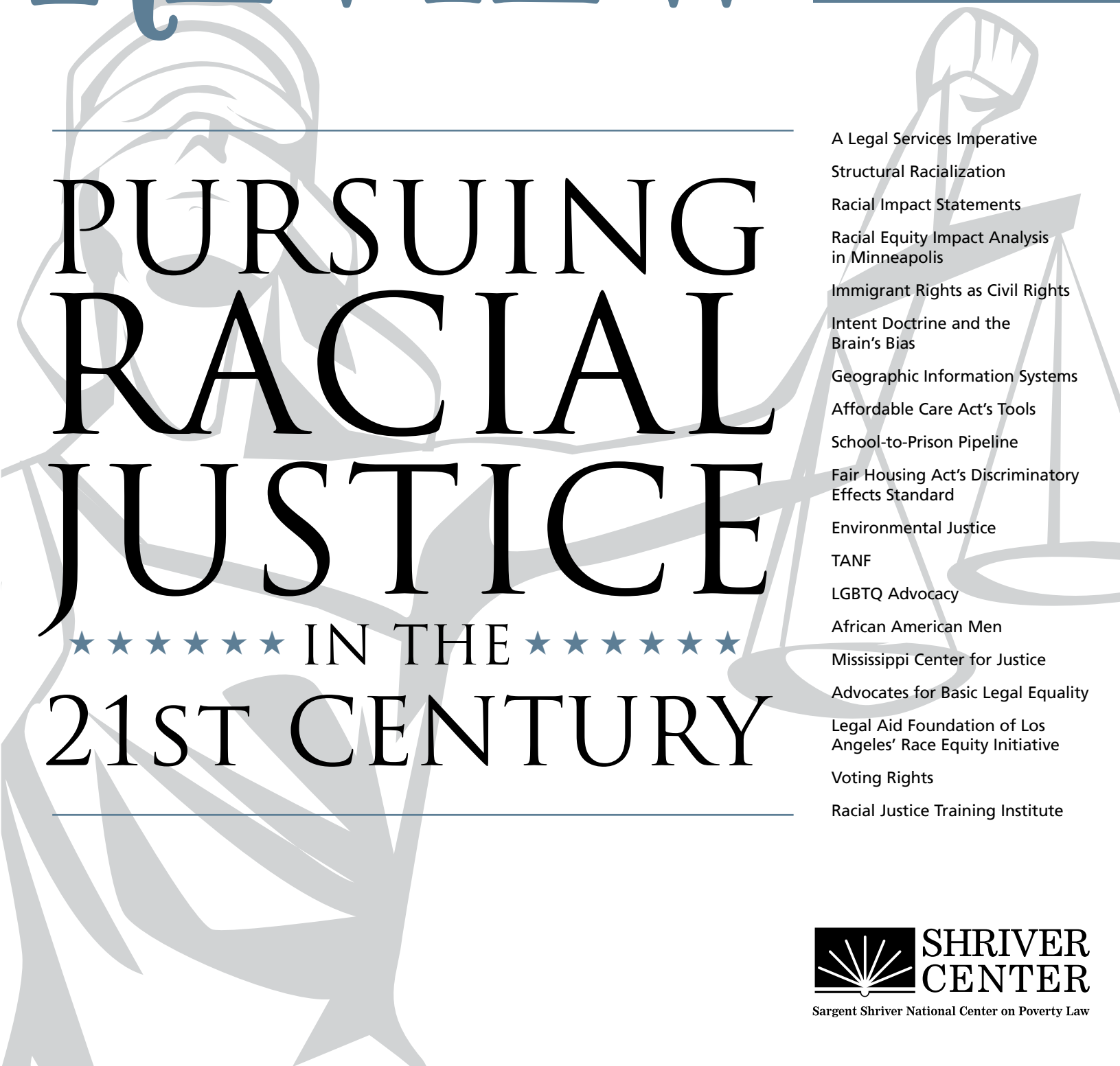
PURSUING RACIAL JUSTICE IN THE 21ST CENTURY



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The Affordable Care Act's Tools for Attacking Racial Health Disparities

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In the United States health care is a commodity for purchase on a market, and this means that those who do not have the resources to purchase care do not have equal access to the market. This flaw in the health care market has been "corrected" by public insurance or subsidy programs, notably the Medicare and Medicaid coverage for seniors and people with disabilities and the Medicaid and Children's Health Insurance Program coverage for the lowest-income children and parents. Medicaid, however, has been so severely underfunded in most states that the coverage does not always translate into quality care. Moreover, a large segment of the lowest-income population, no matter how penniless, never was eligible for Medicaid. The market system and the patchwork government-operated "corrective" programs leave huge holes and quality issues. Unsurprisingly in a country with our history, the people falling through the gaps in our health care system are disproportionately people of color.

Significant racial health disparities have long been entrenched in our country's health care landscape.[1] People of color face greater barriers to access and receive lower-quality care than whites even when factors such as socioeconomic status and clinical conditions are taken into account.[2] People of color have shorter life expectancies than whites due to factors such as disproportionate burdens of chronic disease and lack of access to health care.[3] Racial and ethnic minorities receive poorer-quality health care and face more barriers in accessing that care.[4]

The Patient Protection and Affordable Care Act of 2010 contains tools that, if used aggressively by the states, have the potential to decrease the disparity in life expectancy, health status, and outcomes for people of color in the United States.[5] Most

[1]See Office of Minority Health and Health Disparities, Centers for Disease Control and Prevention, About Minority Health (n.d.), http://1.usa.gov/1c0g62t.

[2]See Richard Allen Williams, *Historical Perspectives of Healthcare Disparities*, in Eliminating Healthcare Disparities in America 3, 16–17 (Richard Allen Williams ed., 2007) (tracing history of documenting health care disparities).

[3]See Lara J. Akinbami et al., *Asthma Prevalence, Health Care Use, and Mortality: United States, 2005–2009*, National Health Statistics Reports, Jan. 12, 2011, at 3, http://1.usa.gov/14DSrn7; Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report—United States, 2011*, Morbidity and Mortality Weekly Report, Jan. 14, 2011, at 1, http://1.usa.gov/11c8J3N; Melonie Heron et al., Centers for Disease Control and Prevention, *Deaths: Final Data for 2006*, National Vital Statistics Reports, April 17, 2009, at 2, http://1.usa.gov/19g82v0.

[4]Agency for Healthcare Research and Quality, 2012 National Healthcare Disparities Report 2 (May 2013), http://1.usa.gov/1bdrMRB.

[5]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

notably, the Act offers health insurance coverage expansions, which, if implemented nationally, could cover millions more Americans, 60 percent of whom are people of color.[6] The Act's provisions on data collection, prevention of chronic illness, workforce development, and quality improvement can improve the health status of people of color.[7] Here we summarize the Act's main provisions that can be deployed in the fight to equalize health care.

Coverage Expansion to Remedy Racial Health Disparities

Overall, people of color are more likely than whites to be uninsured and low-income since they are more likely to work in low-wage jobs that do not offer employer-sponsored insurance, and people of color often have difficulty affording coverage when it is offered.[8] In 2010, compared to 11.7 percent of whites, 20.8 percent of African Americans and 30.7 percent of Latinos did not have insurance.[9] According to the Institute of Medicine, lack of insurance hurts the quality of care that people of color receive more than any other factor and thus is a major contributor to disparities in health care.[10] Poor health outcomes and premature death caused by cancer, diabetes, asthma, and heart disease, among others, are more difficult to avert when the disease is not identified early and treated accordingly.[11] The Affordable Care Act confronts this inequity through several new pathways for health insurance coverage.

Health Insurance Marketplaces. The Affordable Care Act authorizes new health insurance marketplaces, which will give states a one-stop shop for individuals seeking access to qualified private insurance plans as well as a new application pathway for Medicaid.[12] The marketplaces will offer a range of private health insurance plans for purchase by individuals who are unable to obtain insurance through their employers or who are ineligible for Medicaid.[13] All qualified health plans available on the marketplace will be required to cover a set of ten essential health benefits, which include preventive care, maternity care, and mental health and substance use disorder services (behavioral health treatment among them).[14] The Act prescribes advance premium tax credits for individuals with incomes between 100 percent and 400 percent of the federal poverty level (between about $11,490 and $45,960 for an individual in 2013). These tax credits will function as "real time" monthly cash subsidies to

[6]This percentage is based on data finding that out of the 25.4 million nonelderly uninsured people living at or below 138 percent of the federal poverty level (the Medicaid expansion limit), 15.1 million are people of color (Kaiser Commission on Medicaid and the Uninsured, The Impact of Current State Medicaid Expansion Decisions on Coverage by Race and Ethnicity 7 (July 2013), http://bit.ly/12gq3qV).

[7]Many of these provisions authorize funding in the amount of "such sums as may be necessary." Accordingly, although these provisions were included in the Act, some may not become funded unless they are included in the appropriations process (see C. Stephen Redhead et al., Congressional Research Service, R41390, Discretionary Funding in the Patient Protection and Affordable Care Act (PPACA) 1 (Sept. 2, 2010), http://bit.ly/132CLIt; see, e.g., Affordable Care Act §§ 4101(b) (codified at 42 U.S.C. § 280h-4) (school-based health centers), 4102(a) (codified at 42 U.S.C. § 280k-2) (oral health education campaign), 4202(a) (codified at 42 U.S.C. § 300u-14) (community wellness pilot program), 5401 (codified at 42 U.S.C. § 293) (recruitment and retention of underrepresented minorities in health professions), 10501(m)(2) (codified at 42 U.S.C. § 295e(a)) (Public Health Workforce Programs)).

[8]Samantha Artiga, Kaiser Commission on Medicaid and the Uninsured, Health Coverage by Race and Ethnicity: The Potential Impact of the Affordable Care Act 1 (March 2013), http://bit.ly/1alSuht.

[9]Carmen DeNavas-Walt et al., U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2010, at 24 (Sept. 2011), http://1.usa.gov/13aDu5w.

[10]Denise Osborn et al., Healthcare Cost and Utilization Project, Reducing Racial and Ethnic Disparities Through Health Care Reform: State Experience 1 (Aug. 26, 2011), http://bit.ly/16ZShCo.

[11]See Sinsi Hernández-Cancio et al., Families USA, Medicaid: A Lifeline for Blacks and Latinos with Serious Health Care Needs 12 (Oct. 2011), http://bit.ly/18D4rI2.

[12]Affordable Care Act § 1311 (codified at 42 U.S.C. § 18031). See *id.* §§ 1301–1302 (codified at 42 U.S.C. §§ 18021–22) (requirements for "qualified health plans").

[13]*Id.* § 1302 (creating guidelines for essential health benefits packages and establishing levels of coverage for silver, bronze, gold, and platinum plans).

[14]*Id.* § 1302(a)–(b) (codified at 42 U.S.C. § 18022(a)–(b)).

make health coverage premiums affordable, and they will be available when the person enrolls in a plan.[15] Communities of color represent almost half of the sixteen million adults who have no insurance and have incomes between 150 percent and 399 percent of the federal poverty level.[16]

Filling the Historic Medicaid Eligibility Gap. Before the Affordable Care Act, not everyone in poverty was eligible for Medicaid.[17] Income eligibility levels for parents are quite low in most states, below the poverty level in thirty-three of them, and this excludes many parents from Medicaid even if their children qualify.[18] Furthermore, in all but nine states, an able-bodied, nonelderly adult with no cohabiting dependent children can be penniless and not qualify for Medicaid.[19]

Medicaid is critical to health coverage for people of color. Medicaid covers many more white people, but, because African Americans and Latinos tend to have lower incomes than whites, they are more than twice as likely to rely on Medicaid for health coverage.[20]

The Affordable Care Act offers states the option to close the historic gaps in Medicaid.[21] Beginning in 2014, states that take up the option can cover all people with incomes at or below 138 percent of the federal poverty level ($15,856 for an individual in 2013), whether or not they have dependent children, as long as they are citizens or have been legally present in the United States for five years or more.[22] For the first three years, the federal government will pay for all of the costs for those who are newly eligible for Medicaid. The federal share will gradually decline in 2019 to 90 percent, where it will remain indefinitely for future years.[23] The expansion is an excellent financial deal and a tremendous opportunity for the states to solve racial health disparities.

The Medicaid expansion will significantly increase health coverage for low-income people of color across states. In 2011 about one in four nonelderly people of color was uninsured. More than half (59 percent) of uninsured people of color would qualify for Medicaid based on the expansion's income limit of 138 percent of the federal poverty level. Of the total 25.4 million nonelderly uninsured with income at or below 138 percent of the federal poverty

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[15]See Consumers Union, Help Consumers Learn About the New Premium Tax Credit (n.d.), http://bit.ly/17DGmfS.

[16]Dennis P. Andrulis et al., Joint Center for Political and Economic Studies, Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations 9 (July 2010), http://bit.ly/1alZCKM.

[17]Samantha Artiga & Jessica Stephens, Kaiser Commission on Medicaid and the Uninsured, Impact of the Medicaid Expansion for Low-Income Communities of Color Across States 1 (April 2013), http://bit.ly/12jqpx0.

[18]Kaiser Commission on Medicaid and the Uninsured, Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults 2 (March 2013), http://bit.ly/144SBO6.

[19]*Id.*

[20]DeNavas-Walt et al., *supra* note 9, at 78–81. Median income for African Americans is $32,100 and for Latinos, $37,800, compared to $54,600 for whites (*id.* at 8). In both African American and Latino communities, a little more than one in four people rely on Medicaid for health care; in contrast, Medicaid covers fewer than one in eight whites (*id.* at 78–81).

[21]While the Affordable Care Act intended the Medicaid expansion to be implemented in all states, implementation is now effectively a state option as a result of the June 2012 U.S. Supreme Court ruling on the Act (see *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012)). If a state does not expand Medicaid, poor uninsured adults in that state will not gain a new coverage option and will likely remain uninsured and continue to face barriers to accessing care. As of July 1, 2013, thirty states had indicated their support for implementing the Medicaid expansion (Henry J. Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Decision, as of September 3, 2013 (n.d.), http://bit.ly/17DQ5ml).

[22]Affordable Care Act § 2001 (codified as amended at 42 U.S.C. §§ 1396a, 1396b, 1396d, 1396r-1, 1396u-7). Under the Affordable Care Act, individuals with a modified adjusted gross income that is at or below 133 percent of the federal poverty level will be eligible for Medicaid. Adjusted gross income is based on the Internal Revenue Code definition, modified to disregard 5 percent of income; this essentially increases income eligibility to 138 percent of the federal poverty level.

[23]Affordable Care Act § 2001(a)(3) (codified as amended at 42 U.S.C. § 1396d).

level, people of color made up 60 percent of this eligible population.[24]

Full implementation of the Medicaid expansion would increase minority access to medical services by increasing minority enrollment in Medicaid.[25] Lessons learned from past Medicaid and Children's Health Insurance Program enrollment efforts indicate that specialized outreach and enrollment tactics will be critical to enrolling people in communities of color. These tactics include using trusted community members who understand the language and cultural needs and preferences of the community in assisting individuals directly.[26]

Consumer Operated and Oriented Plans. Implementation of Consumer Operated and Oriented Plans can increase availability of affordable private insurance to people of color and thus contribute to improving their health outcomes.[27] The Affordable Care Act authorized $6 billion to establish these plans by July 1, 2013, to foster the creation of a nonprofit, member-operated health insurance plan in each state and the District of Columbia to compete for business in the state marketplace with for-profit companies.[28] Consumer Operated and Oriented Plans can be a possible marketplace for low-income people of color seeking affordable options and coverage, provided that the plans can build a presence with sufficient bargaining influence, ensure that risk is spread widely, and offer health benefits at minimal out-of-pocket cost.[29] Importantly, individuals who are undocumented may purchase health insurance coverage from such a plan if membership is offered outside the marketplace or by their employers.[30]

Employer-Based Health Insurance Coverage Reforms. In 2005 nearly three-quarters of working-age whites had employer-based health insurance, compared to only one-third of working-age Latinos and half of working-age African Americans.[31] The Affordable Care Act requires employers with fifty 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 coverage through exchanges.[32] Employers with two hundred or more employees must automatically enroll employees into their health insurance plans.[33] Employers with twenty-five or fewer employees and average annual wages of less than $50,000 will receive a tax credit, implemented in two stages, with the first phase (2010–2013) giving a credit of up to 35 percent of the employer's contribution toward employee health insurance and the second phase (2014 and following years) giving a credit

[24]Artiga & Stephens, *supra* note 17, at 1–2. Of note, over half (54 percent) of uninsured people of color with incomes below the Medicaid expansion limit live in five states: California (20 percent), Texas (16 percent), Florida (9 percent), New York (5 percent), and Georgia (5 percent) (*id.* at 2).

[25]Lisa Clemons-Cope et al., *The Affordable Care Act's Coverage Expansions Will Reduce Differences in Uninsurance Rates by Race and Ethnicity*, 31 Health Affairs 920, 924–25 (2012). Assuming full implementation of the Medicaid expansion, African Americans would have disproportionately large gains in coverage compared to other racial and ethnic groups (*id.* at 924). The share of African Americans covered by Medicaid or the Children's Health Insurance Program would increase by 8.4 percent, compared to a more modest 5.7 percent gain for whites (*id.*).

[26]Artiga & Stephens, *supra* note 17, at 6.

[27]Affordable Care Act § 1322 (codified at 42 U.S.C. § 18042).

[28]However, Congress decreased these funds, and only twenty-four states were funded for a cooperative (see Centers for Medicare and Medicaid Services, Section 644: Consumer Operated and Oriented Plan Program Contingency Fund (n.d.), http://go.cms.gov/12j7f89).

[29]Andrulis et al., *supra* note 16, at 9.

[30]Steven P. Wallace et al., UCLA Center for Health Policy Research, Undocumented and Uninsured: Barriers to Affordable Care for Immigrant Populations 14 (Aug. 2013), http://bit.ly/19mLNkA.

[31]Andrulis et al., *supra* note 16, at 8.

[32]Affordable Care Act § 1513 (codified as amended at 26 U.S.C. § 4980H). The Obama administration has delayed implementation of the employer mandate until 2015 (Mark J. Mazur, U.S. Department of the Treasury, Continuing to Implement the ACA in a Careful, Thoughtful Manner (July 2, 2013), http://1.usa.gov/19khddU).

[33]Affordable Care Act § 1513.

of up to 50 percent.[34] This policy could expand coverage for a sizable low-income population of color, especially since over 90 percent of minority-owned firms have fewer than twenty-five employees, and diverse populations are more likely to be employed by a small firm that does not offer health coverage. Data suggest that, among nonelderly workers in small firms, about 57 percent of Latinos, 40 percent of African Americans, and 36 percent of Asians do not have insurance. Whites have the lowest percentage of people who are uninsured at 24 percent.[35]

Other Provisions to Lessen Racial Health Disparities

The Affordable Care Act contains provisions that can reduce racial health disparities. Note, however, that some of these provisions depend on discretionary federal spending that is annually threatened in the federal budget process.

Data Collection. Data can give critical information for advocates and policymakers about which populations are suffering the most from poor health outcomes and how resources can be strategically used.[36] With pertinent information, health care providers are made aware of disparities and the need and duty to offer culturally and linguistically appropriate services.[37] The data also reinforce the need for increased opportunities for clinical training on the cultural and health needs of underserved communities.[38]

The Affordable Care Act requires the U.S. Department of Health and Human Services (HHS) to collect and report data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants in any federally conducted or supported health care or public health program, activity, or survey.[39] HHS must identify and monitor health inequities and collect demographic data relevant to the disparities.[40]

The information and reporting required by the Affordable Care Act can help identify racial and ethnic health disparities and trends for purposes of potential civil rights claims on behalf of the underserved populations.[41] Such information and reporting can help advocates and policymakers identify policies and investments that can remedy these disparities.

Clinics and Participating Doctors. About fifty-six million Americans are believed to be "medically disenfranchised" or do not have sufficient access to a primary care doctor, whether or not they have insurance.[42] In response, the Affordable Care Act funds community health centers to expand their services and facilities and build new sites because such health centers heavily serve low-income and minority patients and are the only source of primary care for undocumented patients.[43] The Act supports growing the number of primary care doctors by increasing funding for

[34]*Id.* § 1421 (codified as amended at 26 U.S.C. §§ 38, 45R, 196, 280C).

[35]Andrulis et al., *supra* note 16, at 8.

[36]Osborn et al., *supra* note 10, at 1.

[37]See, e.g., Jenni Lovegrove, Office of Minority Health and Health Equity, Nebraska Department of Health and Human Services, Cultural Competency Assessment of Health Care Providers Across Nebraska: A Survey of Limited English Proficient (LEP) Individuals (April 2009), http://1.usa.gov/15MWZEu.

[38]See, e.g., Jeff Krehely, Center for American Progress, How to Close the LGBT Health Disparities Gap (Dec. 21, 2009), http://bit.ly/14MkyAI.

[39]Affordable Care Act § 4302 (codified at 42 U.S.C. § 300kk). See Mara Youdelman, National Health Law Program, The ACA and Language Access 7 (Jan. 2011), http://bit.ly/17FR2KW (recognizing problem of tasking U.S. Department of Health and Human Services with multiple responsibilities for data collection without appropriated funding to do so).

[40]Affordable Care Act § 4302.

[41]See Affordable Care Act § 1557 (codified at 42 U.S.C. § 18116) (prohibiting discrimination in health care programs on basis of race, color, national origin, sex, sex stereotypes, gender identity, age, or disability).

[42]Andrulis et al., *supra* note 16, at 10.

[43]*Id.* at 9.

the National Health Service Corps.[44] The Act expands training to graduate medical residents in preventive medicine specialties.[45] To attract doctors to participate in Medicaid, the Act funds increases in payments to physicians for primary care to 100 percent of the Medicare payment rates for 2013 and 2014.[46]

Community Health Education and Medical Homes. The Affordable Care Act expands health promotion, prevention, and education activities that take advantage of community assets and go beyond traditional medical settings and practices.[47] Private health plans must cover a range of preventive services (including regular checkups, cancer screenings, and immunizations) and may not charge any copayments, deductibles, or coinsurance to patients receiving these services.[48] Community Health Teams are a promising step toward improving coordination and continuity of care. They assist primary care providers in creating patient-centered medical homes, which promote trust and understanding among diverse communities and increase healthy habits and preventive practices. Collectively these initiatives are critical to supporting low-income people of color who may not otherwise seek care. More than half of Latinos (54 percent) and Asians (52 percent), as well as just under half of African Americans (44 percent), report that they often postpone or skip routine and preventive care.[49]

Prevention. Besides eliminating out-of-pocket costs for preventive services in all forms of health insurance, the Affordable Care Act emphasizes preventive care in other ways. For example, the Act funds a National Diabetes Prevention Program, which establishes community-based lifestyle intervention strategies for populations at risk of diabetes.[50] The sixth leading cause of death in the United States, diabetes has a heavily disproportionate impact on people of color.[51]

The Act offers competitive community grants to state and local governments and community-based organizations to implement and evaluate community prevention programs that target healthier school environments, wellness programs, and social and geographic determinants of health and drivers of disparities.[52]

Health Care Workforce. As the United States has become more diverse, the nation's health care workforce has not kept pace.[53] Having more diverse providers reflecting the racial and ethnic composition of the patient population is essential to building rapport and trust with patients and to improving communication and coordination of care with patients, families, and other providers. Physicians of color are more likely to treat patients of color and practice in poor and underserved areas.[54]

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[44]Affordable Care Act § 5207 (codified at 42 U.S.C. § 254q).

[45]*Id.* § 10501(m)(2).

[46]Health Care and Education Reconciliation Act § 1202 (codified at 42 U.S.C. § 1396a(a)(13)(C)).

[47]See, e.g., Affordable Care Act §§ 2703 (codified at 42 U.S.C. § 1396w-4) (medical home option for Medicaid enrollees with chronic conditions), 3502 (codified at 42 U.S.C. § 256a-1) (Community Health Teams to support medical homes for patients), 4101(b) (codified at 42 U.S.C. § 280h-5) (school-based health centers), 5208 (codified at 42 U.S.C. § 254c-1a) (nurse-managed health clinics).

[48]Affordable Care Act § 1001 (codified at 42 U.S.C. § 300gg-13).

[49]Andrulis et al., *supra* note 16, at 10.

[50]Affordable Care Act § 10501(g) (codified at 42 U.S.C. § 280g-14).

[51]Agency for Healthcare Research and Quality, Diabetes Disparities Among Racial and Ethnic Minorities 1 (Nov. 2001), http://1.usa.gov/1c6tvWT.

[52]Affordable Care Act § 4201 (codified at 42 U.S.C. § 300u-13). See National Health Law Program, Analysis of the Health Care Reform Law: PPACA and the Reconciliation Act 27 (n.d.), http://bit.ly/18BQYwX.

[53]Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Healthcare Workforce, Institute of Medicine of the National Academies, In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce 23 (Brian D. Smeadley et al. eds., 2004), http://bit.ly/15NuExZ.

[54]American Public Health Association, Public Health Services Act Title VII and Title VIII: Why Are These Programs So Important? (May 2009), http://bit.ly/172IBqP.

The Affordable Care Act establishes the National Health Care Workforce Commission, charged with reviewing the health care workforce and projected workforce needs and recommending national health care workforce priorities, including concerns of special groups, such as medically underserved populations.[55] The Act includes many initiatives for education and training programs for health professionals and others, particularly for those who are willing to work with populations with health disparities.[56]

Quality Improvement. The Affordable Care Act seeks to improve the quality of health services by developing a national strategy and an interagency working group and by focusing on ways to measure quality. The Act funds the creation of national quality measures that assess factors such as patient outcomes, efficiency of care, equity of services across health disparity populations and geographic areas, and patient satisfaction.[57] Provider performance on quality measures must be made public.[58]

■ ■ ■

The current health system in the United States is fraught with racial and ethnic imbalance, starting with the impact of racial and ethnic income and poverty disadvantages that automatically cause problems with access to health care in the country's market-based health system. The government-based "corrections" on the market system, mostly Medicare and Medicaid, have been incomplete and underfunded. The Affordable Care Act confronts these issues head-on, starting with massive expansions of access to health coverage and including a wide variety of race-conscious solutions. The tools are ready for those states wanting to tackle their shameful racial health disparities.

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[55]Affordable Care Act §§ 5001, 5101 (codified at 42 U.S.C. § 294q). The National Health Care Workforce Commission can recommend creating or revising national loan repayment programs and scholarship programs to low-income, medical students of color to serve in their home communities if designated as medically underserved communities (*id.* § 5101).

[56]See, e.g., Affordable Care Act §§ 5101–5102 (codified at 42 U.S.C. § 294r) (workforce development grants), 5301 (codified at 42 U.S.C. § 293k) (training grants for primary care providers, general internists, and pediatricians), 5303 (codified at 42 U.S.C. § 293k-2) (general, pediatric, and public health dentists), 5306 (codified at 42 U.S.C. § 294e-1) (grants for culturally sensitive mental and behavioral health training), 5307(a)–(b) (codified at 42 U.S.C. §§ 293e, 296e-1) (cultural competency, prevention, and public health), 5313 (codified at 42 U.S.C. § 280g-11) (grants to promote positive health behavior and outcomes in underserved communities), 5403(b) (codified at 42 U.S.C. § 294b) (continuing educational support for health professionals serving in underserved communities).

[57]*Id.* § 3013 (codified at 42 U.S.C. § 299b-31).

[58]*Id.* § 3015 (codified at 42 U.S.C. §§ 280j-1, 280j-2).

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