Adepoju, O. E., Preston, M. A., & Gonzales, G. (2015). Health care disparities in the post--Affordable Care Act era. *American Journal of Public Health, 5*(105), S665–S667.

Health Care Disparities in the Post–Affordable Care Act Era

Disparities in health care have been targeted for elimination by federal agencies and professional organizations, including the American Public Health Association. Although the Affordable Care Act (ACA) provides a valuable first step in reducing the disparities gap, progress is contingent upon whether opportunities in the ACA help or hinder populations at risk for impaired health and limited access to medical care. (*Am J Public Health.* 2015;105: S665–S667. doi:10.2105/AJPH.2015.302611)

Omolola E. Adepoju, PhD, MPH, Michael A. Preston, PhD, MPH, and Gilbert Gonzales, MHA

DISPARITIES IN HEALTH CARE have been targeted for elimination by federal agencies and professional organizations, including the American Public Health Association. The Affordable Care Act[1] (ACA) offers the promise of reducing disparities in health and medicine by promoting access to equitable and more efficient health care. However, nearly 5 years after the ACA was signed into law, researchers are still finding a wide chasm in health care access, quality, and outcomes. An expert panel organized by the Disparities Interest Group at the 2014 AcademyHealth Annual Research Meeting, provided areas of interest to consider when addressing disparities. Our policy brief builds on some of the topic areas presented at the interest group meeting. We discuss the role of (1) differential access to health insurance, (2) medical homes and accountable care organizations (ACOs), (3) preventive medicine, and (4) cultural competency on health care disparities in the post-ACA era. Although the ACA provides a valuable first step in reducing the disparities gap, progress is contingent upon whether opportunities in the ACA help or hinder populations at risk for impaired health and limited access to medical care.

DIFFERENTIAL ACCESS TO HEALTH INSURANCE

Estimates from the Congressional Budget Office suggest that the ACA will expand health insurance coverage to an additional 26 million people by 2024. Following the first open enrollment period, more than 8 million people purchased private health plans through federal and state-based marketplaces, and an additional 6.7 million people enrolled in Medicaid, the publicly funded insurance program for low-income families and children.[2] However, only 27 states and the District of Columbia have decided to expand their Medicaid programs—a decision that leaves up to 4 million low-income adults without health insurance in the nonexpansion states.[3]

Strikingly, the states not expanding Medicaid are home to the highest uninsured and poverty rates across the country. In Texas and Florida alone, nearly 3 million low-income adults will remain uninsured as a result of their state's decision not to expand Medicaid.[4] In addition, although 1 in 5 residents in Mississippi and Louisiana are living in poverty,[5] state leaders are reluctant to expand Medicaid or consider customized approaches to expansion. Some states (Alaska, Montana, Indiana, Tennessee, Utah, Virginia, and Wyoming) are considering alternative solutions to fill the coverage gap through customized Medicaid expansions.[6] Until all states implement the coverage components of the ACA or have customized approaches for expanding Medicaid, disparities in health insurance coverage will widen between those states that expand and those that do not expand Medicaid. This differential access to health insurance may impede progress toward eliminating insurance disparities. In addition, racial/ethnic groups living in states that have not expanded Medicaid may continue to fall behind as the country moves forward with health reform. However, even when every state fully implements the ACA, public health policymakers should take action to ensure that new Medicaid enrollees do not receive inferior care. Medicaid reimbursements should match Medicare payment rates to encourage primary care providers to accept Medicaid patients, and Medicaid benefits must meet minimum federal requirements to ensure that Medicaid patients receive important and necessary health services.

MEDICAL HOMES AND ACCOUNTABLE CARE ORGANIZATIONS

The emphasis of the ACA on integrated service delivery models such as Medical Homes and ACOs has been identified as a key component of innovative health system transformation. Stemming from pediatric medicine as a model for addressing the complex needs of children with multiple health conditions, medical homes emphasize team-based, continuous, and holistic care across the care continuum. The medical home model has been greatly applauded by national policymakers and primary care medical societies as fundamental toward promoting health care equity and improving access to care while lowering health care

costs. However, evidence on the effects of medical homes has been mixed.

Racial/ethnic minority children, for instance, are less likely to have a patient-centered medical home (PCMH). Even when minority children have a PCMH, data from the National Survey of Children's Health indicate that PCMH services do not always narrow the quality gap between minority and White children.[7] Although White children with a PCMH are more likely to receive preventive services than their peers without a PCMH, the same is not true for African American and Hispanic children.[7] In another study among a cohort of adults with diabetes, African American patients in an internal medicine PCMH were less likely to receive hemoglobin A_{1C} testing and influenza vaccinations, and less likely to achieve cholesterol management compared with their White peers in the same PCMH.[8]

By contrast, ACOs encourage doctors, hospitals, and allied health care providers to form networks and coordinate patient care, spearheading the move from acute, episodic volume-based care delivery to coordinated care delivery models that reduce waste and improve quality. These networks become eligible to participate in shared savings when they successfully reduce the total cost of care and improve clinical quality for the lives served. Although ACOs are traditionally within the Medicare program, there are now fledgling ACO-like arrangements within Medicaid and private health insurance sectors. Since the passage of the ACA, the number of ACO arrangements has increased from a few dozen in 2010 to more than 600 networks and 22 million covered lives in 2014.[9] Like medical homes, preliminary evidence on the impact of ACOs in reducing disparities is in question. A recent study found differences in quality outcomes among Medicare ACO beneficiaries, such that participation in an ACO-like organization had no advantage on reducing disparities in preventable hospitalizations and select process quality measures.[10]

The future of ACOs in mitigating disparities will require deliberate tailoring of ACO quality metrics and incentives to the disparities performance gap. As medical homes and ACOs advance, providers should continue to address the social contexts that disrupt treatment adherence in vulnerable patients—or the social determinants of health.[11] Screening for and addressing adverse life events at home or in the workplace during clinical visits may lead to better health outcomes for adults at the greatest risk of poor physical and mental health.

PREVENTIVE HEALTH SERVICES

Underutilization of effective preventive health services and early detection interventions remains a persistent barrier to reducing the chronic disease burden. Health services research consistently demonstrates that cost is a significant barrier to health care utilization, particularly for preventive services.[12] Although cost is a particularly overwhelming barrier for low-income populations, even individuals from wealthier families underuse preventive services when out-of-pocket spending is required. Under the ACA, private health plans are required to cover preventive health services recommended by the US Preventive Services Task Force at no cost to the patient. Lowering out-of-pocket costs is one approach that may increase screenings and preventive care among low-income populations, but take-up of preventive health services is conditional upon patient awareness of insurance benefits under the ACA. Some newly insured populations may not know the full array of health services available to them. Other patients may be misinformed on the effectiveness of screenings, immunizations, and other forms of preventive medicine.

Addressing these knowledge gaps is paramount for eliminating disparities in preventive health services utilization, and providers will play a critical role toward achieving the goal that all patients receive age-appropriate preventive health services. For example, the use of community health workers and peer counselors has been suggested as practical methods to educate communities about the importance and availability of preventive services.[13]

CULTURAL COMPETENCY

Although the ACA creates opportunities to establish demonstration projects to expand health professional training in cultural competency, creating a culturally competent workforce is an immediate and necessary component to eliminating health disparities. To keep up with growing diversity of the American population, the Office of Minority Health in the Department of Health and Human Services published the revised National Standards for Culturally and Linguistically Appropriate Services (CLAS). The standards emphasize leadership, language assistance, and continuous evaluation throughout health care organizations to achieve

> effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.[14(p199)]

Language assistance and health literacy is an important challenge for the ACA, especially considering that previous studies have indicated low health literacy predicts the likelihood of being uninsured.[15] Approximately 9% of the American population have limited English proficiency (LEP).[16] As more LEP populations gain coverage, more patients with LEP may prefer to receive health care services in languages other than English. Providing interpretation services to LEP patients is required by the Civil Rights Act of 1964 and improves satisfaction, health outcomes, and quality of care among LEP population. However, health care jargon can be difficult for English speakers, making health insurance literacy an important new issue to address. More than half of US adults cannot accurately identify 1 of 3 terms commonly used in health care: premiums, co-pays, and deductibles.[17] Not fully understanding what health care services cost can prevent patients from receiving necessary medical care, but implementing CLAS standards throughout the health care system can maximize ACA access provisions, improve patient engagement, and reduce disparities in patient experiences.

CONCLUSIONS

To make further progress on reducing and eliminating health disparities in the post-ACA era, the next steps in health reform should eliminate differential access to care, consider underlying social elements that make medical

homes and ACOs robust, close knowledge gaps in preventive health services utilization, and incorporate the CLAS models in best practices for improving care in priority populations. Physicians and providers should continue to advocate for a stronger safety net and resources to provide patient-centered care, including communication across health systems and language services for patients. ■

About the Authors

Omolola E. Adepoju is with the Accountable Care/Health Homes Programs, United Health Group, Sugar Land, TX. Michael A. Preston is with the University of Arkansas for Medical Sciences, National Coordinating Center for Public Health Services & Systems Research, Little Rock. Gilbert Gonzales is with the Department of Health Policy & Management, University of Minnesota, Minneapolis.

Correspondence should be sent to Omolola E. Adepoju, PhD, MPH, Accountable Care/Health Homes Programs, United Health Group, 21714 Parsley Mist Lane, Richmond, TX 77469 (e-mail: lola.adepoju@hotmail.com). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This article was accepted January 24, 2015.

Contributors

O. E. Adepoju conceptualized the study. O. E. Adepoju, M. A. Preston, and G. Gonzales contributed to the initial draft and revised several versions of the article.

Acknowledgments

We gratefully acknowledge the editors and reviewers who provided comments on this timely topic. O. E. Adepoju is employed with United Health Group and serves on the Disparities Interest Group Advisory Committee at AcademyHealth.

Note. The contents of this article are solely the responsibility of the authors and do not necessarily reflect the views of employers, clients, or affiliated institutions. The authors acknowledge the AcademyHealth Disparities Interest Group; however, this work does not necessarily represent the official standpoint of the Interest Group or AcademyHealth.

Human Participant Protection

Institutional review board approval was not needed for this study because no human participants were involved.

References

1. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 855 (March 2010).

2. Department of Health and Human Services. Health insurance marketplace: summary enrollment report for the initial annual open enrollment period. Available at: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf. Accessed January 22, 2015.

3. Kaiser Family Foundation. The coverage gap: uninsured poor adults in states that do not expand Medicaid–an update. 2014. Available at: http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update. Accessed January 19, 2015.

4. Kaiser Family Foundation. The impact of the coverage gap in states not expanding Medicaid by race and ethnicity. Available at: http://kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity. Accessed January 22, 2015.

5. US Census Bureau. 2012 and 2013 American Community Surveys and 2012 and 2013 Puerto Rico Community Surveys. Available at: http://www.census.gov/content/dam/Census/library/publications/2014/acs/acsbr13-01.pdf. Accessed January 22, 2015.

6. Kaiser Family Foundation. Status of state action on the Medicaid expansion decision. 2014. Available at: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act. Accessed January 19, 2015.

7. Aysola J, Bitton A, Zaslavsky AM, Ayanian JZ. Quality and equity of primary care with patient-centered medical homes: results from a national survey. *Med Care.* 2013;51(1):68–77.

8. Simonetti JA, Fine MJ, Chen YF, Simak D, Hess R. Racial comparisons of diabetes care and intermediate outcomes in a patient-centered medical home. *Diabetes Care.* 2014;37(4):993–1001.

9. Muhlestein D. Health Affairs Blog. Accountable care growth in 2014: a look ahead. Available at: http://healthaffairs.org/blog/2014/01/29/accountable-care-growth-in-2014-a-look-ahead. Accessed January 7, 2015.

10. Anderson RE, Ayanian JZ, Zaslavsky AM, McWilliams JM. Quality of care and racial disparities in Medicare among potential ACOs. *J Gen Intern Med.* 2014;29(9):1296–1304.

11. Garg A, Jack B, Zuckerman B. Addressing the social determinants of health within the patient-centered medical home. *JAMA.* 2013;309(19):2001–2002.

12. Jones RM, Devers KJ, Kuzel AJ, Woolf SH. Patient-reported barriers to colorectal cancer screening: a mixed methods analysis. *Am J Prev Med.* 2010;38(5):508–516.

13. Martinez J, Ro M, Villa NW, Powell W, Knickman JR. Transforming the delivery of care in the post-health reform era: what role will community health workers play? *Am J Public Health.* 2011;101(12):e1–e5.

14. Koh HK, Gracia JN, Alvarez ME. Culturally and linguistically appropriate services—advancing health with CLAS. *N Engl J Med.* 2014;371(3):198–201.

15. Sentell T. Implications for reform: survey of California adults suggests low health literacy predicts likelihood of being uninsured. *Health Aff (Millwood).* 2012;31(5):1039–1048.

16. Kaiser Family Foundation. Overview of health coverage for individuals with limited English proficiency. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8343.pdf. Accessed January 20, 2015.

17. American Institute of CPAs. Half of US adults fail "Health Insurance 101," misidentify common financial terms in plans. 2013. Available at: http://www.aicpa.org/press/pressreleases/2013/pages/us-adults-fail-health-insurance-101-aicpa-survey.aspx. Accessed August 29, 2014.