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Access to Healthcare for the Poor: Will the Affordable Care Act Address Income-Related Health Disparities in the United States?

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ABSTRACT *Background:* Low-income populations live shorter and less healthy lives in the United States due to a complexity of social, environmental and behavioral factors.

These populations also face significant barriers in accessing health services. In 2010, the Patient Protection and Affordable Care Act (PPACA) passed, marking the first major reform of the American healthcare system since the 1960s. This paper evaluates its potential to address health disparities through changes to medical care delivery. *Methodology:* Results were compiled from government documents, reports from research institutes, journal articles, and an expert interview. A section-analysis was also performed, evaluating the strengths and weaknesses of the Affordable Care Act in addressing the needs of low income populations. *Findings:* The PPACA includes extensive provisions to amend income-related barriers to care. These include expanded access to federal insurance coverage, subsidized cost-sharing for low-income brackets, elimination of payments for specific preventive services, and investment in infrastructure. Weaknesses not addressed include the high cost of medical care, disparities in quality and availability of care between the federally and privately insured, and access to care for immigrants. *Conclusion:* The PPACA will expand access to and reduce the cost of preventive care. However, these improvements do not address structural deficiencies of the US healthcare system that are root causes of income-related health disparities. True reform requires integration of the multiple-payer model to ensure equitable availability and quality of basic care, tougher measures to control costs, and coverage that includes migrants.

Keywords health reform, disparities, poverty, income, United States

I.INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA) of 2010 signaled the first significant healthcare reform of the American healthcare system since the establishment of Medicare and Medicaid in 1965 (Gostin, Jacobson, Record, & Hardcastle, 2011, p. 1779). Disagreements over its provisions reduced town halls to raucous quarrels and elicited wholesale dismissals of the legislation as “socialized medicine.” Even after its passage, its opponents work to repeal the act at the state level and challenge its constitutionality in the Supreme Court (Brown, 2012). Partisan politics obscure the more critical truth at stake, namely the potential of reform to achieve its stated goal: ensuring that “all Americans have access to quality, affordable health care” (Democratic Policy and Communications Center, p. 1).

In a country with the most costly medical care in the world, the American poor survive precariously between untreated illness and medical bankruptcy. Whether measuring poverty by income, education or occupation, the poor bear a disproportionate burden of disease. This phenomenon is due to health behaviors such as nutrition and tobacco use, environmental exposures such as living and working conditions, and access to health services (Adler & Newman, 2002, p. 60; Stiehm, 2001). Addressing income-related health disparities requires a multidimensional policy approach that understands the social determinants of health and is impossible without a health system that delivers services based on need rather than ability to pay (Brown, 2012). A review of studies on access, health outcomes and socioeconomic status by Andrulis (1998) concludes that despite the host of social, economic and environmental factors that breed health disparities, "elimination of financially based differences in access is central to any effort to create equity in outcomes across socioeconomic groups" (p. 412)

American healthcare is unaffordable to the poor unless subsidized or provided at no cost through government-sponsored programs. The United States ranks number one for percentage of GDP spent on healthcare at 16% (Kreier & Zweifel, 2010, p. 101), allocating significant sums for federally funded insurance programs intended to deliver care to those who can't afford it. Yet the American poor live shorter and less healthy lives than the wealthy, many succumbing to diseases that are easily preventable by modern health standards. Prior to the full implementation of the PPACA in 2014 more than one in six Americans remains without health coverage, the majority of which live at or close to poverty (The Uninsured: A Primer, 2011). Government-sponsored programs are designed to serve as safety-nets, yet large contingents of the low-income population are ineligible for these programs. For those enrolled, cost-sharing and limited availability of services continue to pose significant barriers to access (Ahmed, Lemkau, Nealeigh, & Mann, 2001).

Primary objectives of the PPACA include decreasing cost, improving quality and increasing accessibility of healthcare in the United States. The act includes a universal mandate requiring all individuals to obtain health care coverage, making the U.S. the last industrialized nation to join the ranks of countries with universal coverage (Brown,

2012). In addition, it expands access to federally funded insurance programs, requires all insurance plans to cover preventive care, subsidizes cost-sharing for low-income brackets, eliminates payments for specific preventive services, and invests in infrastructure in underserved communities (Patient Protection and Affordable Care Act, 2010).

While its's objectives and provisions target the primary concerns of low-income individuals seeking health care, questions remain about the PPACA's ability to effectively reduce socioeconomic disparities in health on the ground: to what extent will it achieve coverage of the US's low-income population? Recognizing that coverage does not guarantee access to care, to what extent will the new law ensure that delivery of services is determined by need rather than the ability to pay? Healthcare reform cannot be considered effective from a public health perspective unless it is designed to maximize health outcomes for the impoverished. What follows is an analysis of the PPACA's ability to catch and care for those that need healthcare most.

II.METHODOLOGY

Background and results for this research were accessed primarily through the electronic database of the author's home institution, with the exception of data from research institutions, which were identified using a general Google search. Sources included government documents, reports from research institutes, peer-reviewed journal articles, and an expert interview. Different sources produced dissimilar health and insurance statistics for the United States. While these results were roughly in agreement, the author relied on data from the US-based Commonwealth Fund in the event of discrepancies.

A primary source was the 900 pages of the Patient Protection and Affordable Care Act of 2010 which served as the foundation of section-analysis of the health reform. Summaries of the legislation were integral to understanding the strengths, weaknesses, and important aspects of the legislation with respect to income-related heath disparities. Policy perspectives found within journal articles provided additional insight in drawing conclusions about the PPAC.

Many attempts were made to contact relevant experts in Switzerland. While this did not produce many responses, the author did have the opportunity to interview Philippe Wanner, a professor at the University of Geneva. His expertise in demography provided a critical framework for understanding the relationship between health systems and health disparities. Pr. Wanner also had critical advice for the US health system to address these disparities.

The author would also like to acknowledge the academic directors of Switzerland's School for International Training (SIT), Dr. Christian Viladent and Dr. Maribel Fehlmann, both of whom were so generous with their time and knowledge. Finally, the author would like to thank Dr. Astrid Stuckelberger who served as this project's adviser. Dr. Stuckelberger was a tireless source of contacts, relevant articles, and most importantly, very good advice in the planning, researching and sculpting of this work. Without her high expectations and expert assistance this research would not have delved as deep, nor shot as high.

III. RESULTS

Defining Poverty

Poverty Guidelines - The US Department of Health and Human Services (DHHS) uses measures of absolute poverty to determine eligibility for government-funded health programs such as Medicaid. Absolute poverty is defined "in terms of basic physical needs. A person is poor according to this concept when her access to essential goods like food, clothing, housing or health care is restricted to those quantities required for bare survival" (Leu & Burri, 1999, p. 304). The DHHS "poverty guidelines" determine a threshold income below which an individual or family is considered to be poor, called the "Federal Poverty Line" (FPL) (U.S. Department of Health and Human Services, 2012). The FPL is calculated to be $11,170 for an individual and $23,050 for a family of 4. (See *Appendix A* for a complete table indexing the DHHS's Poverty Guidelines.) Those living below 100% of the FPL are deemed "poor" by the DHHS, and those living below 200% of the FPL are deemed "near poor."

The DHHS quantifies absolute poverty in the US based on assumptions of patterns of family expenditure from the 1960s. According to research by the National Center for Children in Poverty, "across the country, families typically need an income of

at least twice the official poverty level to meet basic needs" (Fass, 2009). Based on these findings, poverty is conceptualized to include those with incomes up to 200% of the FPL for the purpose of this work.

Health of the American Poor

Disparities in Medical Expenditure - In 2004, Chen and Escarce (2004) conducted a study to quantify income-related disparities in healthcare delivery in the United States (US). Using multivariate regression analysis of previously compiled data, the authors found "income-related inequality in need-adjusted medical care expenditures among Americans of all ages" that favored the wealthy. This inequality was the second highest among developed countries.

Disparities in Health - Braveman, Cubbin, Egerter Williams & Pamuk (2010) looked at a variety of health indicators related to lifestyle, health status and mortality in people of all ages with respect to income. Their findings revealed significant disparities within these indicators such as activity limitation, diabetes, obesity, heart disease, and life expectancy (p. 189). The Gallup-Healthways Well-Being Index Data is comprised of data from telephone poll interviews and showed similar results: "those making less than $24,000 per year suffer from much lower emotional and physical health, have poorer health habits, and have significantly less access to medical care" than their wealthier counterparts (Mendes, 2010). With regards to chronic health issues, 32% of low-income respondents were obese compared with 21.7% of high-income respondents; 36.4% suffered from diabetes compared to 12.8% of high-income respondents; and 29% suffered from depression compared with 18.7%. Overall, individuals making less than $24K per year reported a well-being index score of 57.2, 17.1 points below those making $90K or more per year. Disparities were distributed incrementally across the income spectrum, with health improving at equitable intervals with each income bracket and the poorest experiencing the worst health (Braveman et al., 2010; Mendes, 2010).

Access for the Poor: Before Reform

IN PUBLIC POLICY

Providers - Healthcare in the US is primarily provided by private physicians, and hospitals may be non-profit, for-profit or public (The Commonwealth Fund, 2010, p. 55).

Payers - With the exception of non-group private insurance, third-party payers (e.g. the government, employers) are responsible for controlling the cost of services. This is achieved through incentives to patients and providers for efficient treatment and through price negotiations with providers (Brown, 2012; King, 2011).

Health Insurance Status - Health insurance status is a key determinant of whether or not an individual has access to health services (The Uninsured: A Primer, 2011). Health insurance in the U.S. is provided through a multiple-payer model weighted towards private coverage. Alternatives to private insurance for the elderly and those who can't afford health insurance premiums include Medicare, Medicaid, State Children's Health Insurance Program (CHIP), the Department of Veterans Affairs (DVA), and Indian Health Services (Riedal, 2009, p. 440). Sources of insurance and rates of the uninsured are summarized below:

Figure 1: Sources of Insurance and Rates of Uninsured in the US 2009

All Income Brackets

Privately Insured: 60%		Federally Insured: 24%			Uninsured: 15% 46 million people
Employer-Sponsored	Non-Group	Medicaid	Medicare	DVA	
55%	5%	10%	13%	1%	

Of those living below the FPL

18%	46%	36%

(The Commonwealth Fund, 2010; The Uninsured: A Primer, 2011)

The availability of insurance for low-income individuals varies by age-group. Of those living below the FPL, 28% are 18 or younger, 19% are between the ages of 19 and 64,

and 14% are 65 or older (The Henry J. Kaiser Family Foundation, 2010). Access to coverage under the pre-existing healthcare system can be broken down by age:

18 Years and Younger - Children are eligible for coverage through their parents' employer-sponsored plans up to age 18. For those without access to employer-sponsored insurance (ESI), all children with family incomes below 133% are eligible for enrollment in Medicaid. CHIP supplements Medicaid by providing coverage to children with family incomes too high to qualify for Medicaid. This threshold varies by state but most cover children with family incomes up to 200% of the FPL; as a result two-thirds of low-income children were covered by one of the two state-sponsored programs in 2010 (The Uninsured: A Primer, 2011).

Between 19 and 64 Years - Health insurance in the US is heavily weighted towards employer-sponsored group plans. Should these individuals lose their jobs, they simultaneously lose their coverage. This issue was targeted by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which allows individuals and their families to continue with the same insurer for 18 months and up to 36 months in the event of divorce from or death of the employee (The Uninsured: A Primer, 2011, p. 16).

Medicaid is intended to cover four groups of low-income individuals. In addition to having an income below 133% of the FPL, enrollees must fall into one of 4 categories: children, their families, pregnant women, and the disabled. Undocumented migrants and documented migrants living in the United States less than five years are ineligible for any government-sponsored health insurance. According to the Kaiser Commission on Medicaid and the Uninsured, 40% of the "poor" and 24% of the "near poor" in America rely on Medicaid coverage.

65 years and older - All adults over 65 years of age and some disabled individuals are eligible for Medicare coverage, leaving just over one percent of the elderly uninsured (Stiehm, 2001).

The Uninsured - A mix of safety-net providers such as public hospitals and community clinics offer essential health services to those without health insurance (The Uninsured: A Primer, 2011, p. 12; Fiscella, 2011).

ON THE GROUND

Consider how legislation intended to deliver services to low-income individuals manifests in terms of access to care on the ground, looking first at the availability of coverage:

*18 Years and Younge*r - Almost half of the 10% of American children that were uninsured lived below the FPL in 2010, meaning that they are eligible for Medicaid, and another 28% were living below 200% of the FPL, meaning they were eligible for CHIP((The Kaiser Commission on Medicaid and the Uninsured, 2011, p. 1; Clemans-Cope, Kenney, Pantell, & Perry, 2007). These children are not enrolled in these programs for various reasons. Their families may not be aware of the child's eligibility, cost-sharing may continue to pose an obstacle, or the complexity of enrollment requirements may limit uptake of available coverage (The Uninsured: A Primer, 2011, p. 20).

Between 19 and 64 Years - Serving 18% of nonelderly adults below the FPL in 2009, employer-sponsored insurance is largely inaccessible to low-income individuals because it is supplied primarily by high-wage firms. Premiums also pose a barrier. In 2005, 39.8% of those below the FPL were offered insurance by their employers, compared with 89.6% of individuals above 400% of FPL. 63.5% of the poor offered insurance by their employers remained uninsured in 2005 (Clemans-Cope et al., 2007). While COBRA is intended to temporarily extend insurance for the newly unemployed, these individuals and their families often find themselves unable to afford premiums that their employers once subsidized (The Uninsured: A Primer, 2011, p. 16; Clemans-Cope et al., 2007).

For those below 133% of the FPL without ESI, Medicaid eligibility depends on the aforementioned categorical criteria and other income conditions. For example, low-income adults with dependent children must fall below their state's July 1996 eligibility

level, an amount that is often below 50% of the in FPL. Over half of the 49 million nonelderly that were uninsured in 2010 lived below 133% of the FPL (The Uninsured: A Primer, 2011, p. 22).

Also ineligible for federal coverage are undocumented migrants and naturalized immigrants who had lived for less than 5 years in the U.S. Migrants are three times more likely to be uninsured than native residents (The Uninsured: A Primer, 2011, p. 7).

65 Years and Older - As noted, Medicare has achieved almost universal coverage of the American elderly population. Many enrolless purchase supplementary coverage for basic services not covered under Medicare. 35% of the low-income elderly do not have complementary coverage for these required services.

Medicaid does cover the elderly that reach impoverishment, imposing the aforementioned cateogrical income criteria (Stiehm, 2001, p. 295). Chen and Escarce (2004) found the greatest discrepancies in expenditure on medical care between the wealthy and poor for those over 65 years. The authors attributed this to poor populations' inability to afford supplemental insurance for services not covered by Medicare, the heavy burden of cost-sharing that prevented the elderly from using their insurance, and the greater susceptibility to disease that comes with age.

The Uninsured - The "patchwork" system of charity clinics to cover the uninsured is insufficient to guarantee access to providers (The Uninsured: A Primer, 2011, p. 12). With the exception of emergency rooms, private providers may turn away those that can't afford to pay.

The uninsured are far less likely to receive preventative care, e.g. screenings to detect cancer, diabetes or hypertension. Lacking timely screening, the uninsured tend to be diagnosed later and die earlier. They are also less likely to follow through with recommended post-care treatments. For example, these individuals may not fill a prescription in anticipation of the cost of the medication. The uninsured have higher rates of hospitalization for preventable illnesses, are less likely to receive appropriate diagnosis and treatment once hospitalized, and have higher mortality rates inside and outside the hospital than the insured.

Without insurance, poor health can lead to bankruptcy. “After [uninsured] households’ debts are subtracted from assets, the median net worth of uninsured households drops to zero – leaving many of the uninsured with no financial reserves to pay unexpected medical bills” (p. 15). The uninsured are also more likely to receive inferior care when hospitalized for an injury (Andrulis, 1998, p. 414).

Disparities in access to health care between the insured and uninsured have continued to rise in the last fifteen years with the greatest differences and growth in disparities occurring in access to primary and preventative care (The Uninsured: A Primer, 2011).

Cost-sharing – The U.S. spends more per-capita on healthcare than any other country, reflecting the higher cost of care rather than higher utilization of services (Anderson, Reinhardt, Hussey, & Petrosyan, 2003). Furthermore, the rate at which healthcare costs are increasing outstrips the rate at which national income is growing (The Commonwealth Fund, 2010, p. 56).

Premiums limit uptake of both government and employer-sponsored programs. Co-payments prevent the poor from utilizing necessary services, preventive care in particular (Georgetown University Health Policy Institute, 2009; Stiehm, 2001). Ahmed et. al.’s study of perceived barriers to care in a low-income population indicated that 93% of respondents were enrolled in either Medicare or Medicaid, yet 61% reported inability to pay for health services as a perceived barrier to healthcare (2001, p. 447).

Availability of Services - There are limitations on coverage under federal health insurance: Medicare does not cover “routine physical checkups, eyeglasses, routine dental care, long-term nursing home care, prescription drugs and medications taken at home” (Stiehm, 2001, p. 294). For its part, Medicaid reimburses private providers at a lower rate than either Medicare or private insurers, requires lengthy claims processes that delay compensation, and limits the physicians whom beneficiaries are permitted to visit. All these factors deter participation of providers, creating an artificial shortage of physicians for those on federally-funded programs (Stiehm, 2001, p. 286).

The National Healthcare Quality Report of 2010 found disparities in care between the publically and privately insured. For example, the publically insured were less likely to have a regular source of care, less likely to receive necessary information regarding treatment follow-up, and more likely to face delays in getting necessary medical care, dental care, or medications. Similar disparities were found between Medicare patients with supplementary private insurance and those with supplementary public insurance or without any supplementary insurance (Agency for Healthcare Research and Quality, 2011). Newacheck et al. (1998) found that children on Medicaid are more likely than privately insured, non-poor children to have "unmet health needs" and less likely to have consistent healthcare. Finally, those enrolled in federally-funded programs experience worse health outcomes: Medicaid beneficiaries are 75% more likely to be hospitalized for preventable illnesses than for the privately insured (Stiehm, 2001, pp. 298-99).

Access for the Poor under the PPACA

IN PUBLIC POLICY

The PPACA is estimated to reduce the number of uninsured by half by extending insurance coverage to 33 million people, including 16 million more people enrolled in Medicaid and CHIP and 19 million receiving subsidies in the newly formed Health Insurance Exchange. What follows is a summary of selected sections of the PPACA deemed particularly pertinent to access to healthcare for the poor.

Improved Access to Coverage - The PPACA stipulates that all taxpayers maintain minimum essential coverage. Individuals exempt from this "individual mandate" include "those who cannot afford coverage" (Sec 1501) – that is, if the cost of the lowest possible coverage exceeds 8% of income for the month – as well as undocumented immigrants and "lawfully abiding" migrants living in the U.S. less than 5 years. Corresponding efforts to increase knowledge of available healthcare to consumers include a "Health Benefit Exchange" where consumers can shop for standardized health plans and an internet portal cataloguing coverage options and market prices for services.

The PPACA extends federal coverage by removing the categorical qualifications for Medicaid eligibility for those living below 133% of the FPL, covering foster-care children up to age 26 who have aged out of the system, and increasing CHIP funding Accompanying these measures are outreach efforts aimed at enrolling eligible children. Section 1101 creates a temporary "high-risk pool" that offers immediate coverage to individuals with pre-existing conditions that have gone without coverage for at least 6 months. The act also allocates 5 billion dollars to subsidize employer-sponsored insurance for early retirees between 55 and 65, including their spouses and dependents.

The PPACA expands private employer-sponsored coverage by fining firms with 50 or more employees that fail to offer group plans. The PPACA also requires all health insurance plans to cover a minimum essential benefits package, and to extend coverage to dependents up to age 26. Of note, this requirement does not apply to "grandfathered" plans, e.g. those plans taken up prior to 2010. Additional regulations restrict insurers from denying or rescinding coverage and forbid variation in premiums based on health status.

Reduce Cost-Sharing - The PPACA offers refundable tax credits to subsidize premiums for individuals with incomes up to 400% of the FPL and limits out-of-pocket payments for low-income individuals. The percentage of benefits covered by for an average individual, known as the "actuarial value," is adjusted with respect to these subsidies. The subsidies are summarized in Figure 2.

Figure 2: Reduction of Cost-Sharing through Subsidies of Premiums and Caps on Out-of-Pocket Expenses

Income (% of FPL)	Premium subsidy (premium as maximum % of income)	Reduction of out-of-pocket payments[1]	Out-of-pocket individual maximum[2]	Out-of-pocket family maximum	Adjusted Actuarial Value
>133%	2.0%	Medicaid	Medicaid	Medicaid	94%
133-150%	3.0-4.0%	2/3 reduction	$2,167	$4,033	94%

[1]Percentage reduction of out-of-pocket caps for "silver" insurance plans, adjusted annually by the Health Savings Account (HSA) (California Health Benefit Advisers, 2012)
[2]Based on HSA values for 2012 (California Health Benefit Advisers, 2012)

150-200%	4.0-6.3%	2/3 reduction	$2,167	$4,033	87%
200-250%	6.3-8.05%	½ reduction	$3,250	$6,050	73%
250-300%	8.05-9.5%	½ reduction	$3,250	$6,050	70%
300-350%	9.5%	1/3 reduction	$4,333	$8,067	70%
400%	9.5%	1/3 reduction	$4,333	$8,067	70%

Assistance is given to those covered by employer-sponsored plans in the event that such a plan does not cover at least 60% of healthcare costs or if the employee's share of the premium exceeds 9.5% of their income.

The PPACA also eliminates cost-sharing for many preventive services including preventive services encompassed by the Essential Benefits Package: services deemed of moderate benefit (B-rated) or significant benefit (A-rated) by the U.S. Preventive Services Task Force (USPSTF), immunizations recommended by the Health Resources and Services Administration (HRSA), evidence-based screening and testing for children, and USPSTF-recommended screening and testing for women.

The legislation also allocates state-based grants that incentivize Medicaid enrollees to participate in health-behavior change programs such as those encouraging weight loss and smoking cessation. This program will end in 2015.

Increase Availability of Services - $50 million is provided for the development of School Based Health Clinics with preference given to clinics serving larger contingents of children enrolled in Medicaid and a total of $12.5 billion is allocated toward building and improving community-based health centers. Funding for these programs ends in 2013 and 2015, respectively. To increase human health personnel as well, grants are established to improve the community-health workforce in underserved areas (ending in 2014), as well as to train graduate medical residents in preventive medicine specialties, with favor given to those practicing in underserved communities (ending in 2015).

Figure 3: Analysis of PPACA Sections Targeting Healthcare Access for the Poor

Section		Summery	Strengths	Weaknesses
1001	Amendments to the Public Health Service Act	Bans lifetime or "unreasonable" dollar limits on coverage; prohibits rescission of coverage; extends coverage of dependents to age 26	Increases access to coverage at vulnerable point in life course	
1002	Health insurance consumer information	Creates program to collect, analyze and disseminate health insurance consumer information	Lowers information barriers to accessing insurance	
1101	Immediate access to insurance for uninsured individuals with a preexisting condition	Creates a temporary "high-risk health insurance pool program" granting immediate coverage to individuals with pre-existing conditions	Immediate access; the poor are more prone to chronic disease	Ends January 1, 2014
1102	Reinsurance for early retirees	$5 billion to subsidize ESI for early retirees who are not yet eligible for Medicare, as well as their spouses and dependents	Increases access to coverage at vulnerable point in life course	Ends January 1, 2014 or when $5 billion runs out; $90K limitation on claims
1201	Amendment to the Public Health Service Act	Forbids insurers from refusing to cover individuals or varying premiums based on health-status	The poor are more prone to chronic conditions	
1302	Essential health benefits requirements	Requires all health plans include an "Essential Benefits Package"	Increases coverage of preventive services	Does not apply to grandfathered plans
1311	Affordable choices of health benefit plans	Establishes "Health Benefits Exchanges," marketplaces intended to facilitate consumers in purchase of a qualified health plan	Lowers information barriers to accessing insurance	
1401	Refundable tax credit providing premium assistance	Establishes a refundable tax credit to subsidize premiums for individuals and households with incomes up to 400% of the FPL (See *Figure 1)*	Reduces cost-sharing for low-income brackets	Benefit is limited by high cost of healthcare
1402	Reduced cost-sharing for individuals enrolling in qualified health plans	Caps out-of-pocket payments for individuals and households with incomes up to 400% of the FPL (See *Figure 1*)	Reduces cost-sharing, targeting the poor	Does not apply to grandfathered plans
1413	Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs	Ensures that anyone applying for insurance through the Exchange who is determined to be eligible for Medicaid or CHIP will subsequently be enrolled	Increases ease of access to coverage, targeting the poor	
1501	Requirement to maintain minimum essential coverage	Requires all taxpayers to obtain "minimal essential coverage" or face an annual penalty tax; Specific categories of individuals are exempt	Could reduce healthcare costs by eliminating "free riders"	Does not apply to "individuals who cannot afford coverage" or immigrants
1513	Shared responsibility for employers	Imposes a $2,000 tax penalty on any firm employing more than 50 employees that does not offer ESI	Increases availability of coverage	Negative effect of tying health insurance to employment
2001	Medicaid coverage for the lowest income population	Extends Medicaid coverage to all individuals living below 133% of the FPL	Extends coverage to 54% of the uninsured; targets access for the poor	Excludes undocumented migrants; doesn't address disparities between private and federal coverage
2003	Requirement to offer premium assistance for employer-sponsored insurance	Premium assistance for those with ESI that does not have a minimum actuarial value of 60%, or if the employee's share of the premium exceeds 9.5% of their income	Reduces cost-sharing, targeting the poor	Negative effect of tying health insurance to employment
2004	Medicaid coverage for former foster care children	Extend Medicaid coverage to foster children up to age 26 who have aged out of the Medicaid system	Increases access to coverage; targets access for the poor	Does not address disparities between private and federal coverage

2101	Additional federal financial participation for CHIP	Establishes the continuation of CHIP through 2019, providing funding through 2015 with a 23% increase in funding; expands outreach to enroll more children	Targets access for the poor	Does not address disparities between private and federal coverage
4101	School-based health centers	Provides $50 million per year for the development of School Based Health Clinics, with preference given to clinics serving larger contingents of children enrolled in Medicaid	Targets preventive care for low-income communities	Temporary: expires in 2013
4103	Medicare coverage of annual wellness visit providing a personalized prevention plan	Covers an annual wellness exam for Medicare enrollees to include a personalized prevention plan	Targets preventive care for the poor	
4104	Removal of barriers to preventive services in Medicare	Eliminates cost-sharing for Medicare enrollees for specified preventive services included in the Essential Benefits Package	Targets preventive care for the poor	
4106	Improving access to preventive services for eligible adults in Medicaid	Increases federal funding to states that eliminate cost-sharing specified preventive services	Targets preventive care for the poor	
4107	Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid	Eliminates cost-sharing for tobacco-cessation programs for pregnant enrolled in Medicaid	Targets preventive care of the poor	
4108	Incentives for prevention of chronic diseases in Medicaid	Establishes 5-year state-based grants for incentivizing Medicaid enrollees to participate in health behavior programs	Targets preventive care of the poor	Temporary: expires in 2015
5313	Grants to promote the community health workforce	Supplies grants to improve the community-health workforce in underserved communities	Targets preventive care for low-income communities	Temporary: expires in 2014
10501	Preventive medicine and public health training grant program	Provides grants to train graduate medical residents in preventive medicine specialties, with favor given to those practicing in underserved communities	Targets preventive care for low-income communities	Temporary: expires in 2015
10503	Community Health Centers and the National Health Service Corps	Allocates $12.5 billion towards investment in community health clinic infrastructure	Targets availability of services for the poor	Temporary: expires in 2015

IV.DISCUSSION

The poor bear an inequitable burden disease due to a range of socioeconomic factors including access to health services, which is significantly impacted by income-related barriers to care. The discrepancy between the poor's greater burden of disease and lesser access to health services is well-documented among experts and is termed "inverse care" by the World Health Organization. "People with the most means – whose needs for healthcare are often less – consume the most care, whereas those with the least means and greatest health problems consume the least" (2008, p. xiv).

Reform under the Affordable Care Act focuses on insurance as the key to accessing care (King, 2011), a strategy to meet the high cost of care in the U.S. that renders services unaffordable for the poor. Despite the establishment of federally-funded programs to insure those living at or below the FPL, 78% of the uninsured in 2010 were either poor or "near-poor," indicating that the pre-existing system fell far short of providing this preliminary key to access. Employer-sponsored insurance is the primary source of coverage for nonelderly adults in the U.S. but remains unavailable or unaffordable to the majority of low-income workers. The working poor may find themselves employed but without access to healthcare as their low-wage job does not offer health insurance while their limited income disqualifies their families and themselves from Medicaid eligibility (Stiehm, 2001, p. 285).

Eligibility for Medicaid is similarly restricted due to strict categorical criteria applicable no-matter an individual's degree of financial destitution. Minors and the elderly have significantly higher rates of coverage than nonelderly adults due to Medicare and CHIP. Nonetheless, an insurance card does not guarantee access to care. As W.L. Steihm notes, "other factors that must be considered include the type of coverage provided by the plan, the amount the insured must pay in the form of copayments and deductibles, and whether the payments made on behalf of the insured are adequate to ensure participation by a sufficient number of providers" (2001, pp. 283-4). Evidence shows that insurance premiums, co-insurances and co-payments continue to limit uptake of coverage, as well as use of health services. The poor, facing substantial income-related barriers to healthcare, tend to postpone care. This is especially true of preventive treatment, a phenomenon leading to exacerbated health problems that can only to be resolved in the emergency room. Emergency care is a solution that leads to worse health outcomes and a greater financial burden for the individual, further shouldering the system with redistributed cost. The alternative is for these individuals to seek preventative treatment. Considering that healthcare costs in the U.S. are the highest in the world, this can easily lead to bankruptcy.

Federal coverage may improve access to care but does not achieve the levels of access enjoyed by the privately insured (Andrulis, 1998). Those enrolled in federally funded programs, the majority of the insured below the FPL, often find that these

programs fail to cover essential services. Even if the necessary services are covered, those who are federally insured confront additional barriers not faced by the privately insured, including longer wait times and lack of a consistent primary-care provider. Such disparities can be found between the publically and privately insured, as well as between Medicare enrollees with supplementary private coverage and those without.

These disparities expose fundamental differences between public and private insurance. In the case of Medicare, many essential services such as routine physical checkups are not covered. Medicaid, on the other hand, reimburses providers at lower rates than either Medicare or the privately insured, limiting the number of providers willing to treat those enrolled.

To address income-related health disparities, utilization of health services should be determined by an individual's need rather than their ability to pay. From a public health perspective, this should be the intent of healthcare reform: to increase equity and ease of access to healthcare for those with the greatest health needs. In this context the U.S.'s hard-fought battle for health reform is successful only if it amends the primary barriers to access that the poor confront, including lack of healthcare coverage, prohibitive cost-sharing, and lack of available health services.

The PPACA has the potential to greatly increase healthcare coverage for low-income individuals by expanding eligibility for Medicaid. This provision will extend coverage to the 54% of the uninsured who have incomes below 133% of the FPL. Similarly, prohibiting discriminatory underwriting based on health status will grant the poor greater access to private insurance plans as they bear a greater burden of chronic disease. Note also, in 2001, those ages 18 to 24 composed the largest contingent of uninsured at 30% (Stiehm, 2001, p. 286). This group, made vulnerable by the fact that they are tend to work low-income jobs that are less likely to offer coverage, will continue to be covered up to age 26 provided that their parents have health insurance. At the other end of the life-course, early retirees 55 and older as well as their spouses and dependents will be eligible for a re-insurance program to tide them over until they reach 65.This is an important provision given that income-related disparities in health expenditure rise as an individual ages. The PPACA also provides immediate coverage

to those with pre-existing health conditions, though this “high risk pool” lasts only until 2014.

The PPACA also mandates that all insurers must cover use of specified preventive services without any cost to the patient. The poor are much more likely to delay preventive services due to barriers such as lack of insurance or prohibitive costs. Chronic diseases such as heart disease and obesity that inequitably burden the poor can be reduced through proper preventive care and according to Gostin et al. (2011), one should expect to see “increased utilization of screenings for HIV, blood pressure, cholesterol, cancer, and blood sugar, as well as vaccinations, annual exams for infants and children, prenatal care, and smoking cessation or weight reduction counseling” (p. 1807) under the PPACA.

Finally, upwards of $11 billion is allocated towards incentivizing physicians to practice primary care in underserved communities, and the expansion of community health centers, including the implementation of health behavior programs (Koh, 1813) with funding favoring low-income communities. By increasing the availability of human and structural infrastructure alike in underserved communities, these initiatives have the potential to strengthen one of the main primary-care safety-nets for the uninsured and to reduce provider shortages for the federally insured.

All together these provisions indicate a reorientation of the healthcare system away from curative towards preventive medicine. Pr. Wanner (2012) states that the system’s capacity to deliver preventive care is the fundamental determinant of a its ability to close health disparities. Indeed, preventive care has the greatest potential of all services to improve health outcomes and reduce medical costs for the individual and for the system as a whole. Yet this resource is most likely to be underutilized by the poor.

It remains unanswered if a reorientation towards preventive care will translate into improved delivery for the poorest Americans. Even after the full implementation of the legislation in 2019, a projected 23 million people – undocumented immigrants and those to whom care poses a financial hardship among them – will remain uninsured (Fiscella, 2011; The Uninsured: A Primer, 2011). These individuals are arguably the most affected by the inverse care phenomenon. Overall, the poorest are impacted most by socioeconomic determinants of health (Braveman et al., 2010, p. 189). Migrants,

particularly those undocumented, work disproportionately in sectors with low wages and high risks of environmental exposure. Pr. Wanner notes that the health of migrants working in low-wage industries quickly disintegrates following their arrival to the US. Under the PPACA, the 5-year waiting period will remain for "lawfully abiding" migrants seeking federal coverage unless states chose to lift it and undocumented migrants will continue to be excluded (The Uninsured: A Primer, 2011, p. 7). Wanner also explains that immigration will be the primary cause of changing demographics in the future, changes that remain impossible to predict given the multitudinous factors that push and pull immigration. This uncertainty poses a significant challenge to a healthcare system that still fails to provide a safety net for migrants after reform. This is one indication of the fact that, despite its provisions to expand coverage for the poor, reform fails to address deeper-rooted incongruities in the system.

The legislation proposes to fine large employers that don't offer group plans for their employees and to offer premium subsidies for those with incomes up to 400% FPL. The author argues, however, that while this may expand access to coverage, it ignores deficiencies associated with linking insurance to employment. Linking health insurance to employment speeds the process by which determinants of poverty accumulate to break down economic resilience, a reality only weakly mitigated by COBRA.

Another weakness of the healthcare system not properly addressed under the Affordable Care Act is the high cost of care, exemplified by an unprecedented 9% increase in premiums in 2011 (Abelson, 2011). Consider for example that Ahmed, et al. (2001) found cost-sharing posed a barrier to care for 61% of low-income respondents that participated in their study despite the fact that 98% were Medicaid beneficiaries. Such statistics indicate significant structural deformities in delivering affordable care to poor populations under federal programs. The PPACA attempts to offset costs with subsidies targeted at low income brackets, but this strategy will carry little weight if healthcare prices aren't deflated (Brown, 2012).

Some argue that patients should bear *greater* responsibility for healthcare costs in order to stimulate cost-conscious shopping for procedures and providers and to stem the use of extravagant treatments, allowing consumer choice to curtail the price of care (King, 2011). Certainly, cost-sharing is a necessary alternative to managed care.

Without this measure, what will guide patients towards cost-effective treatment, or prevent them from seeking a second, third, or even fourth physician's opinion? (Brown, 2012; Stiehm, 2001). A significant problem arises when cost-sharing stands in the way of preventive care, as often occurs for low-income individuals. Those prevented from accessing screening, testing, or preliminary treatment will face exacerbated health problems down the line, eventually requiring more costly procedures. When the poor are unable to pay their medical bills, costs fall to the provider, further inflating healthcare prices.

This dilemma highlights the necessity of controlling the cost of care in the United States. While the individual mandate will increase the effectiveness of cost-shifting by eliminating "free-riders" that don't take up insurance until they become ill (Stiehm, 2001), the structure of the system itself contributes its inability to control costs. Experts note that the process by which multiple payers negotiate different rates with different providers leads to inconsistent and unregulated rates for services and undermines federal attempts to keep prices down (Kreier & Zweifel, 2010; Stiehm, 2001). Discordance between employers negotiating on behalf of group-plans, the plethora of government programs negotiating on behalf of the federally insured, and individuals paying their own prices out-of-pocket causes waste, hikes administrative fees, and limits efforts to control cost. This phenomenon has the greatest impact on the smallest payers: small employers, those not offered coverage by their employers, and the uninsured (Kreier & Zweifel, 2010, p. 109).

This same fragmentation results in a tiered system of healthcare, as exemplified by the substandard access experienced by Medicaid beneficiaries (Andrulis, 1998). Quality and availability of care is not standardized between payers at the level of basic coverage, but rather is stratified based on income. Certain services and providers remain inaccessible to low-income individuals without private coverage. The result is a pattern of worse health outcomes for the federally insured as documented by the National Healthcare Quality Report.

An instructive example is Medicare, a program once extoled as a model for the U.S. health system as a whole (Gitterman & Scott, 2011). Medicare is designed to ensure coverage to a population highly vulnerable to poor health, and its low-income

contingent cannot sustain the financial burden of healthcare without federal subsidies. Significant disparities in coverage exist between those with supplementary private coverage and between those with either supplementary public coverage or no supplementary coverage whatsoever. At the end of an individual's life course, when disease takes its greatest toll and income-related disparities in heath expenditure are the widest, the privately insured enjoy higher quality and easier access when it comes to basic preventive care. Ultimately those wealthy enough to purchase private insurance enjoy better health outcomes.

The government's ability to sustain current levels of coverage is highly uncertain as the Medicare fund heads swiftly towards bankruptcy (Obama, 2011). Nonetheless the Affordable Care Act proposes funding for Medicaid by reimbursing Medicare providers including "hospitals, long-term care hospitals, rehabilitation facilities, psychiatric hospitals, home health agencies, skilled nursing facilities, hospices, and other nonphysician providers" at a lower rate (Gitterman & Scott, 2011, p. 558). This will do to Medicare what has long produced provider shortages for Medicaid. With changing demographics and rising healthcare prices confronting all federally subsidized healthcare programs, current limitations on access to care will increase if health reform isn't robust enough to meet these changes.

V.CONCLUSION

According to Or, Cases, Lisac, Vrangbaek, Winblad, & Bevan (2010), "the principal objectives of the health care system in all countries are to maximize health outcomes, quality of care, ease and equity of access, while at the same time containing costs" (p. 3). Given the current system's impotency in delivering care to its low-income population, the American healthcare system demands reform. The Affordable Care Act aims at the objectives cited by Or et al. Despite facing virulent partisan opposition, this act targets income-related barriers to care under the previous system by expanding access to federally funded insurance programs, subsidizing cost-sharing for low-income brackets, eliminating payments for specific preventive services, and investing in infrastructure in underserved communities. The legislation's strength lies first and

foremost with provisions intended to make preventive care affordable and available under all health insurance plans.

With the focus on expanding federal coverage and subsidizing employer-sponsored insurance, however, this legislation does not address structural deficiencies of the US healthcare system which perpetuate income-related health disparities. The multiple-payer model remains fragmented under the Affordable Care Act, the discordance of which renders it ineffective at controlling costs and delivering on-par services to the federally insured. Two-tiered healthcare systems under which government-financed care offers basic health coverage and those with higher incomes can purchase supplemental insurance are common and can be found in nations such as France, Canada and Switzerland (The Commonwealth Fund, 2010), nations lauded for accessibility and equity of care. Yet without standardizing reimbursement rates, quality of care, or availability of providers, stratification in access persists between payers, perpetuating income-related health disparities for the insured and uninsured alike.

By expanding federal coverage and increasing the availability of preventive care the PPACA takes essential steps towards better access for the poor. Nonetheless the American healthcare system will continue to face limitations on its ability to address income-related health disparities so long as structurally-rooted deficiencies are not addressed. These deficiencies will only become more pronounced as the country confronts changing demographics run dry. True reform requires integration between payers to effectively control costs, achieve more widespread coverage of neglected populations, and to ensure equitable availability and quality of basic care.

Appendix

APPENDIX A:
2012 Poverty Guidelines Used to Calculate the Federal Poverty Level

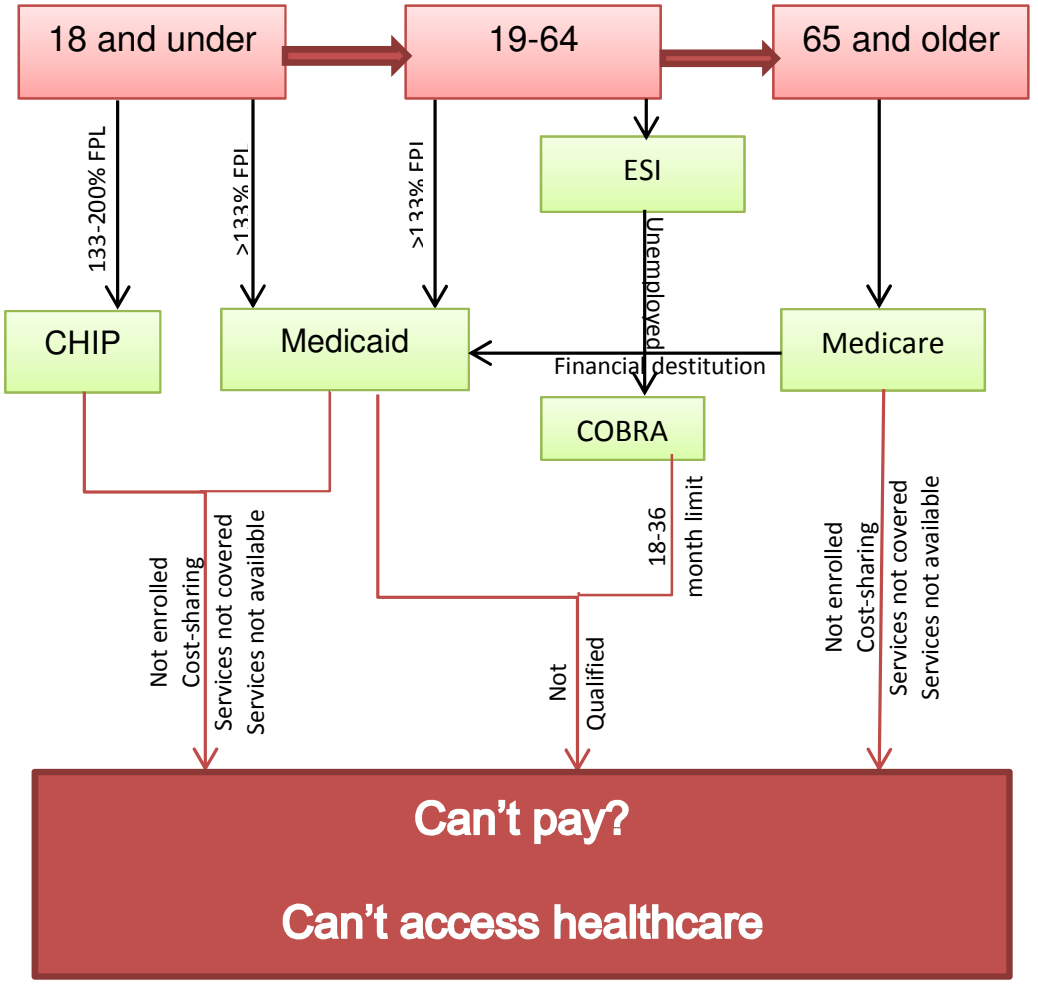
2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family/household	**Poverty guideline**
1	$11,170
2	15,130
3	19,090
4	23,050
5	27,010
6	30,970
7	34,930
8	38,890

For families/households with more than 8 persons,
add $3,960 for each additional person.

Source: U.S. Department of Health and Human Services. (2012, February 9). *2012 HHS Poverty Guidelines: One Version of the [U.S.] Federal Poverty Measure.* Retrieved from ASPE.HHS.org: http://aspe.hhs.gov/poverty/12poverty.shtml

APENDIX B:

Before the PPACA: Gaps in Coverage for the Poor in the U.S. Healthcare System



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Annex: ISP Work Journal

Date	Work Journal
Jan 30	*Meeting: Dr. Christian Viladent, Ecole-Club Migros, Nyon, Switzerland* I've begun the Independent Study Project (ISP) process meeting with SIT director Dr. Viladent, to discuss potential research topics. My two proposed topics of interest include cycles of health and poverty, and harm reduction in Switzerland.
Feb 10	*Finalizing research topic, Ecole-Club Migros, Nyon, Switzerland* I've been reflecting on the topic for my ISP. Specifically, I am interested in how medical bills can lead to bankruptcy and how poverty can lead to disease.
Feb 13	*Contact, Dr. Astrid Stuckelberger, Centre Medical Universitaire* After sitting in today on Dr. Astrid Stuckelberger's lecture on Mapping Healthcare Systems, I was inspired to consider the role a healthcare system plays in delivering equitable care, regardless of income. I spoke briefly with Dr. Stuckelberger, gerontologist and professor at the University of Geneva, about pursuing this topic. She remains a promising resource for information, and could potentially serve as my adviser.
15 Feb	*Preliminary research, Centre Medical Universitaire, Geneva, Switzerland* Upon reflecting I've finalized my research topic. I intend to compare between the Swiss and American healthcare systems in terms of eliminating financial barriers to access to healthcare for the poor. I began collecting resources using my home institution's database.
Feb 17	*ISP Subject Proposal and Justification, Centre Medical Universitaire, Geneva, Switzerland* I've completed my ISP Subject Proposal and Justification. Background research has helped me formulate a research question: **Given the current American health care system, to what extent do barriers to healthcare perpetuate socioeconomic health disparities in the U.S. and what can the U.S. learn from the Swiss system to address these disparities?**

	I am interested in the circuit between health and socioeconomic resources – how lack of means translates into poor health, and how poor health translates into lack of means.
20 Feb	*Meeting: Dr. Christian Viladent, Ecole-Club Migros, Nyon, Switzerland* I met a second time with Dr. Viladent to discuss my ISP Proposal. As a helpful resource he suggested Dr. Alberto Holly, professor of political economy at the University of Lausanne. I intend to contact Holly after I return from Morocco on 11 March, to request that he serve as my ISP adviser.
Feb 21-22	*Literature Review, Centre Medical Universitaire, Geneva, Switzerland* I worked at the med school library on my literature review. I'm more and more interested in systemic barriers to access to care for the impoverished in comparison to their wealthier counterparts.
Feb 25	*Literature Review, Centre Medical Universitaire, Geneva, Switzerland* I've completed my literature review, and as I continue researching I'm seeing significant disparities between private and public health insurance in the United States, which has directed me to look at inequalities in <u>quality</u> of care as well as <u>access</u> to care. Universal health coverage does not guarantee quality care for the impoverished. I emailed Dr. Holly today, requesting an interview.
March 19	I emailed Dr. Stuckelberger requesting an interview.
March 22	*Meeting, Dr. Stuckelberger, World Health Organization, Geneva, Switzerland* Following a lecture at the WHO, I met with Dr. Stuckelberger to discuss my project. I was deeply impressed with her skill at advising, and decided to ask her to serve as my advisor as well. Dr. Stuckelberger gave me guidance on how to approach my research and which organizations and experts to contact for interviews, and offered to open the door to these contacts for me. At Dr. Stuckelberger's suggestion, I plan to look at how socioeconomic disparities in health are addressed at two levels: first, how the legislation of the healthcare systems in Switzerland and the U.S. is designed to address these disparities, and secondly, the actual experience of the poor of access to and quality of healthcare. This will require that A) I look closely at the 2012 American

	Affordable Care Act (ACA) and Switzerland's Federal Health Insurance Act of 1994 and B) I research scholarly analyses and interview experts on the actual experience of the poor. For my research on Switzerland, I will be able to contact organizations such as the Salvation Army and UMSCO who can provide insight. I'll begin by defining "poverty," which I anticipate will be difficult, given that I am considering two very different countries, where federal definitions and societal conceptions of what it means to be poor are different.
March 26	*ISP Outline, Ecole-Club Migros, Nyon, Switzerland* I completed my outline and emailed it to Dr. Stuckelberger. Stuckelberger has offered to send an introductory email to these contacts to "open the door" to an interview. My hope is that this will make them more likely to respond to my request.
March 27	I received Dr. Stuckelberger's comments on my outline. She provided me with many contact names that seem highly useful. I continue my research and set up interviews after I return from vacation on April 5. Contacts: - Major Sylvette Huguenin, director of hospitality at the Salvation Army in Geneva. (sylvette_huguenin@swi.salvationarmy.org) - Dr. Philippe Wanner, professor of demography at the University of Lausanne. (Philippe.Wanner@unige.ch) - Dr. Hans Wolff, director at UMSCO (hans.wolff@hcuge.ch)
April 5	*Contacting Experts, Homestay, Prangins, Switzerland* I contacted the experts suggested by Dr. Stuckelberger, including - Pr. Phillippe Wanner, Universite de Geneve. – I heard back immediately. Interview set for Wednesday, April 18, in Nyon. - Dr. Hans Wolff, director at UMSCO – no reply yet - Major Sylvette Huguenin – director of hospitality at the Salvation Army
April 6-11	*Research, Homestay, Prangins, Switzerland* I've been working long days filling in the body of my ISP outline. Research has been productive and rewarding. The largest challenge has been analyzing the

	Affordable Care Act (PPACA), which is over 900 pages long and very hard to navigate.
April 12	*Research and Writing, Homestay, Prangins, Switzerland* I've found, particularly in my analysis of the PPACA, that I have great deal of content and a lot more work to do on the U.S. system. I am interested in focusing in the US healthcare system, doing as detailed an analysis as possible, and not looking at the Swiss system. My research question has become: **To what degree does the Patient Protection and Affordable Care Act address income-related health disparities in the United States?** I proposed this to Dr. Stuckelberger by email, and she gave it her approval. I have an interview with Major Huguenin set for 2PM on 16 April at Hôtel Bel'Espérance, in Geneva.
April 13-15	*Writing and Editing, SIT Office, Nyon, Switzerland* I finished a preliminary draft of my paper and sent it to Dr. Stuckelberger for review. In the meantime, I am working on editing.
April 16	*Interview, Major Sylvette Huguenin, Hôtel Bel'Espérance, Geneva, Switzerland* It quickly became apparent that Major Huguenin's area of expertise doesn't overlap with my research. Furthermore, the Salvation Army does not provide health services as I'd been told. Thus the interview was interesting, but not pertinent to my research.
April 17	*Editing and Oral Presentaiton, SIT Office, Nyon, Switzerland* I've begun putting together the slides for my Oral Presentation on 1 May. I am also brushing up the final draft for my paper.
April 18	*Interview, Dr. Philippe Wanner, Confisserie-tea room, Nyon, Switzerland, 4pm* In our interview, Dr. Wanner emphasized the importance of preventive care in addressing socioeconomic health disparities, noting that preventive care is both less expensive and more expensive than curative care. Other insights included: the significance of health disparities between migrants and non-migrants; and that immigration will be the most significant source of changing demographics in the future, though what exactly this change will look like is unsure. I'm now integrating these thoughts into my paper and completing my final edits.

April 30	*Oral Presentation, Ecole-Club Migros, Nyon, Switzerland* Presented my research to the academic directors and colleagues of the SIT: Switzerland program.