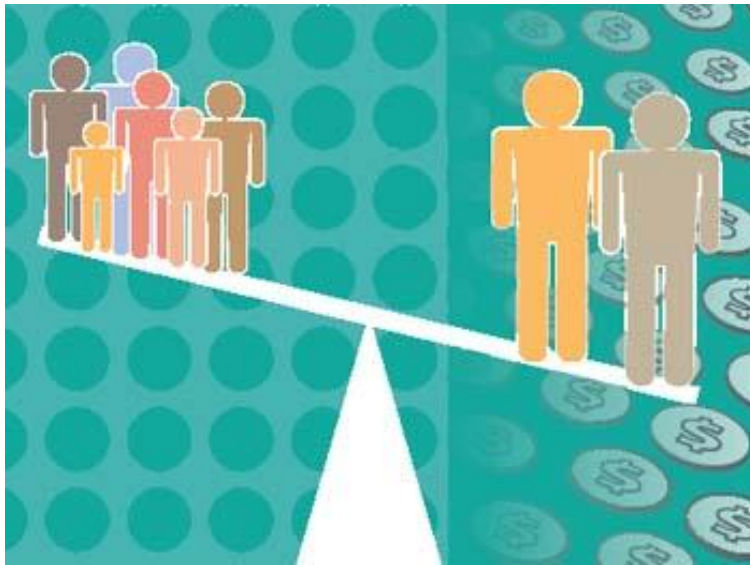


The Role Of Health Insurance In Addressing Health Inequity?



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Abstract

The purpose of this paper is to identify the ecosocial pathways that generate and perpetrate the inequitable distribution of health insurance in the United States and highlight the effective means of intervening on these processes. The paper examines the disparity in health insurance status by three primary levels: social economic status, race/ethnicity, and geographical location. Employing literature from disciplines of public health, social science, history, anthropology, and health policy, the author traces the multidimensional ecosocial pathways that relate social economic status, race/ethnicity, and location to adverse access to health insurance. The implications of the Patient Protection and Affordable Care Act (ACA) are then evaluated to determine the degree to which the law's provisions intervene on the established ecosocial pathways. The author then proposes recommendations on how the health insurance paradigm may further be modified to better reach and serve the marginalized population. Finally, the author appeals to public health professionals to advocate in favor of the ecosocial model by supporting the full and equitable implementation of the ACA in the United States.

Introduction

Since the turn of the 21st century public health professionals have begun exploring a new approach to understanding the etiology of health disparities. Rather than perceiving health disparities to be the result of individual health decisions, growing evidence suggests that the more macro-level social inequalities lead to health inequity. This shift in the public health paradigm marked the beginning of a "critical reengagement" that incorporates the fields of epidemiology and social sciences into what is called the "ecosocial" approach (Krieger 2000; Krieger 2008). The ecosocial model seeks to identify social, political, and economical levels,

pathways and powers that perpetrate health disparities. The model describes how socially-constructed factors, like class and race, lead to adverse health and wellness outcomes. The etiological pathways described by the ecosocial model are multi-dimensional as each social determinant is dependent upon some upstream set of factors, ultimately creating a “web” of causation (Krieger 2008). One factor that is frequently interwoven into the ecosocial web and, yet, is commonly overlooked is health insurance.

As a factor that has significant implications on access to and utilization of health care services, health insurance has a profound effect on health outcomes. Continuous health insurance coverage is associated with an increase in access to public health education materials, routine screenings, and medical care (Schoen and DesRoches 2000). With respect to the utilization of medical care, health insurance coverage makes a difference in whether and when health care services are sought, a factor that is more significant in cases of cancer and other conditions that demand specialized care (Newacheck 2007; Rowland and Shartzler 2008). Furthermore, evidence from observational studies suggest that health insurance affects the quality of care received and the ultimate health outcome, citing the uninsured as having an estimated 25% greater chance of dying compared to the privately insured (Institute of Medicine (IOM) 2002). Recent analysis from rigorous quasi-experimental designs have identified this association to be “real” and suggest that the data favors a reevaluation on current health care policies to address the disparity seen in health insurance coverage (Michael McWilliams 2009). While it is well documented that lack of health insurance coverage contributes to the development of adverse health outcomes, current literature lacks a description of the social determinants that inequitably distribute health insurance.

The imbalance of health insurance attainment, and the policies that regulate both private and public health insurance, extend across all four social levels defined by public health specialists Schulz and Northridge: 1) Fundamental (Macro Level), 2) Intermediate (Meso/Community Level), 3) Proximate (Micro/Interpersonal Level), and 4) Health and Well-Being (Individual or Population Levels) (Schulz and Northridge 2004). On a macro level, the United States lacks a universal health insurance system that guarantees access to quality medical care. While entitlement programs provide health insurance to a select group of individuals that fulfill specific age, income, or disability requirements, 62% of nonelderly individuals obtain health insurance either from their employers or individually, leaving 19% of the nonelderly population uninsured (Kaiser Commission on Medicaid and the Uninsured and the Urban Institute 2010). This neo-liberal approach to health care today creates inequity among groups defined by age, sex, race, income, educational attainment, employment status, disability status, location, citizenship status, household type and health status (Kaiser Commission on Medicaid and the Uninsured and the Urban Institute 2010). On the community level health insurance is not equitably distributed due to the lack of available, acceptable or affordable health insurance plans. Discriminatory interpersonal relationships mediate this effect (LaVeist, Rolley et al. 2003; Pager and Karafin 2009). Finally, these collective societal factors limit the individual's capacity to obtain health insurance and, in turn, increase his or her risk of morbidity and mortality (Institute of Medicine 2002; Chandler 2006).

The purpose of this paper is to apply the ecosocial model to transverse the four social levels to depict the etiological pathway that generates and perpetrates the disparate distribution of health insurance and identify effective methods for intervening on these

pathways. First, the magnitude of the disparity by three social determinants - social economic status, race, and geographical location - is depicted in a profile of the uninsured population. Literature from the disciplines of public health, social science, anthropology, and policy are then applied to illustrate the various pathways by which these determinants lead to adverse access to health insurance. The perceived impact of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA) is then assessed to determine the degree to which the law effectively intervenes on the ecosocial processes. To supplement the law's impact on the ecosocial model, supplemental health insurance components are recommended. Finally public health advocacy efforts are introduced as a method to ensure that the ACA is fully and equitably implemented as a means to promote the ecosocial model and dissolve the health insurance disparity.

Profile of the Uninsured

Health insurance status varies due to a number of different circumstances. The 2010 Current Population Survey (CPS) data highlight disparities in health insurance by age, sex, race, income, educational attainment, employment status, disability status, location, citizenship status, household type and health status (Kaiser Commission on Medicaid and the Uninsured and the Urban Institute 2010). For the purpose of this analysis the social determinants associated with social economic status (SES), race/ethnicity, and geographical location will be explored. However, given the multidimensional nature of the ecosocial model, many of the other disparate measures will be referenced or incorporated into the analysis of the three targeted measures.

SES

In general, individuals that do not have health insurance earn lower incomes. This trend leads many to site annual income as the primary predictor of health insurance status (McLaughlin 2004; DeNavas-Walt, Proctor et al. 2010). Recent statistics from 2009 indicate that 27% of people in households with annual incomes less than \$25,000 had no health insurance coverage; 21% of households earning between \$25,000 and \$49,999 were uninsured, and only 16% of people in households earning from \$50,000 to \$74,999 were without health insurance (Appendix A) (DeNavas-Walt, Proctor et al. 2010). The significance of this trend has progressed over the past years in parallel with the income gap since World War II (Budrys 2003). From 2004 to 2008 the uninsured rates for the “poor” (those living at or below the federal poverty level) and the “near poor” (those earning less than three times the federal poverty level) were significantly ($p < 0.001$) greater than the “non-poor” (Moonesinghe, Zhu et al. 2011). This pattern is indicative of the neo-liberal health insurance system currently in place in the United States.

In addition to income, the corresponding social economic variables of employment status, occupation, and education attainment, are profound health insurance indicators (Rowland and Shartzler 2008; Fronstin 2010; Moonesinghe, Zhu et al. 2011). Given that a majority of Americans receive their health insurance as a result of employer-based benefits, the 2010 Employee Benefit Research Institute (EBRI) report, a report based on the 2010 CPS statistics, claims employment status is the most significant determinant of health insurance (Fronstin 2010). The report cites that approximately 70% of workers have employment-based health benefits compared to 34.6% of non-workers. However, models predict that the uninsured rate for adult workers may be significantly higher than these statistics suggest due to the impact of the current economic recession on employment (DeNavas-Walt, Proctor et al.

2010). Insurance rates also differ by the type of position held. Approximately 73% of individuals in families headed by full-time employees receive health benefits compared to 34% among those in families headed by part-time employees receiving health benefits and 18% of individuals from families headed by non-workers (Fronstin 2010). Health insurance is also distributed to jobs with greater control over one's work. Individuals with a professional or managerial position, for example, are twice as likely to receive employment-based health benefits than service occupations (Fronstin 2010). Similarly, educational attainment is highly correlated with health insurance status and the type of health insurance held (Appendix B). According to the available National Health Interview Survey results from 2008, individuals without a college degree had significantly higher uninsured rates (81.5%) compared to college graduates (8.1%) ($p < 0.001$) (Moonesinghe, Zhu et al. 2011). Furthermore, 2010 CPS statistics indicate that 63% of nonelderly uninsured adults have no education beyond high school (Kaiser Commission on Medicaid and the Uninsured and the Urban Institute 2010). Being highly correlated with educational attainment, literacy, specifically health literacy, determines one's health insurance status with low health literate individuals being more likely to be uninsured (Kutner, Greenberg et al. 2006).

Race/Ethnicity

Given that income and poverty are inequitably distributed across racial groups in the United States (for reasons that will be discussed in the subsequent section), differences in health insurance by race/ethnicity are frequently documented and highlighted (Thomasson 2006; Moonesinghe, Zhu et al. 2011). On all national surveys that record health insurance and race, Hispanics represent a vast majority of the uninsured. According to the 2010 CPS data,

approximately 34% of Hispanics are uninsured compared to only 14% of the White, non-Hispanic population (Kaiser Commission on Medicaid and the Uninsured and the Urban Institute 2010). The American Indian/Alaska Native population is the second racial group disproportionately uninsured with 28% of the population lacking health insurance. However, these statistics are problematic given complications and confusion over the health benefits that come from enrollment in the Indian Health Service entitlement program. African Americans are the third largest uninsured racial group with an uninsured rate of 23% (Appendix C). In summary, racial minority groups endure significantly lower health insurance rates.

Location

The final disparity that will be addressed in the uninsured profile is the geographical distribution of the underinsured. State-specific 2009 BRFSS data indicate that the top 12 states with the highest uninsured rate are in the south, with the exception of Idaho and Nevada (Office of Surveillance 2009). This distribution is paralleled by the 2009 CPS statistics (Appendix D). The geographical distribution of the uninsured is also indicative of regions that endure the greatest limitations in accessing high quality and affordable health care (Garcia, Pagán et al. 2010). Reasons why we see this varying geographical spread of uninsured rates will be explored in the subsequent sections.

The aforementioned variables serve as the primary objective measures that outline the key differences between the insured and uninsured. A number of qualitative or subjective variables like literacy, acculturation, and immigration status are also relevant characteristics to be explored given their ties to SES and race (Leclere, Jensen et al. 1994; Fronstin 2005; Paasche-Orlow 2007; DeNavas-Walt, Proctor et al. 2010). These factors, however, are not measured

with respect to health insurance status and even less frequently reported in the literature on health insurance disparity. Therefore, these types of variables and their impact in the etiological pathways will be incorporated into the analysis rather than addressed as independent social determinants.

Ecosocial Pathways

While the key differences between the insured and uninsured are commonly cited in the literature, few studies have attempted to understand the etiological pathways that lead to health insurance status, and, in turn, lead to unequal health outcomes. This is largely due to the fact that access to health insurance is perceived to be entirely dependent on one's economic opportunity. When, in reality, there are countless proximal determinants at play. The complexity of the determinants and the challenge of disentangling the social factors serves as an additional barrier to depict the etiology of the health insurance disparity (Cunningham and Ginsburg 2001; Kronenfeld 2002; Budrys 2003; Krieger 2008; American College of Physicians 2010). Despite the complexity of the network, it is relevant to piece together the etiological pathways in order to identify areas where interventions may be most effective in breaking the ecosocial cascade and dissolving the health insurance disparity as a means to promote health equity (Jones 2010). In the following section interdisciplinary research findings will be applied to create a map of the various factors and pathways that develop and sustain adverse access to health insurance.

The two primary variables addressed in the uninsured profile are SES and race. In the United States there is a correlation between SES and race given that resources are inequitably distributed across races (Jones 2000). According to 2009 statistics, African Americans and

Hispanics suffer the highest poverty rates (25.8% and 25.3% respectively), and the income gap between these races and the White population continues to climb (DeNavas-Walt, Proctor et al. 2010). These statistics overlap with the fact that African Americans and Hispanics have the highest uninsured rates. To some degree race disparities may be explained by their underlying inequalities in SES, however this correlation varies widely depending on the population and does not explain the entirety of racial disparities in health insurance. Both race and SES are independent predictors of having coverage (LaVeist 2005), and therefore will be analyzed independently, yet their correlation will frequently be referenced.

SES

The association between SES and health insurance coverage is clear. Individuals earning high incomes are more likely to work higher paying jobs and receive employment-based health benefits that provide health insurance or supply the financial means for an individual to purchase private health insurance independently (Fronstin 2010). In other words, health insurance is not afforded by low-income workers. Therefore, to identify the cause of the disparity in SES, and subsequently health insurance, the author focuses on the upstream social factors that determine an individual's opportunity to hold a job that provides employer-based health benefits or the financial means to purchase health insurance independently.

One important social determinant of inequitable income opportunities is citizenship status. It is well reported that undocumented immigrants are disproportionately employed in low-income jobs that do not offer health insurance benefits (Fronstin 2005; Ponce, Cochran et al. 2008). Accordingly, "bad jobs" are found to be allocated to individuals based on citizenship status more so than race or sex (Hudson 2007). A study executed by Ponce et al. in California

found that undocumented immigrants, a group that represents 40% of California's low-income workers, endure the lowest rates of health insurance (Ponce, Cochran et al. 2008). The upstream factors that allow employers to capitalize by employing undocumented immigrants are grounded in the country's broken immigration system (Chavez, Flores et al. 1992; Ponce, Cochran et al. 2008). Currently undocumented immigrants in the United States do not have rights or protections to afford them the opportunity to obtain health insurance. As recent national news has depicted, attending a U.S. school alone is considered risky for an undocumented immigrant. Therefore, one way to address the disparity endured by the lower socio-economic class as well as the racial health insurance disparity, given that a majority of undocumented citizens are Latinos, is to provide undocumented workers and their families with the legal means of accessing health insurance, an approach that may also serve to be economically beneficial.

In parallel to the discrimination due to citizenship status, the allocation of well-paying jobs with health benefits is subject to racism. In the United States, racial minority groups are subject to hold jobs with less prestige and lower wages than their white counterpart, even after controlling for extraneous variables (Jones 2000; Mintz and Krymkowski 2010). The chances of holding a job alone are reduced for racial minorities. Employers in the United States today have a strong preference for White (or undocumented Latino) workers rather than Black workers (Pager and Karafin 2009). A recent study conducted in New York depicted the severity of this injustice by proving that Blacks with a clean criminal record had the same chance of being called back for an interview as White candidates that identified as having a criminal history (Pager, Western et al. 2009). In addition, the job market is explicitly driven to favor Whites over

racial minorities for jobs that provide employer-based health benefits (Ku and Waidmann 2003). Currently 68% of Whites have employer-based benefits compared to 47% of Blacks and 37% Latinos (Fronstin 2010). These trends are confirmed even after controlling for poverty status. Employment opportunities are also inequitably distributed in more affluent communities versus low-income neighborhoods inhabited primarily by racial minorities (Stoll, Holzer et al. 2000).

These findings suggest there is a need to dismantle institutional racism in the job market to allow racial minorities an equal opportunity to obtain and keep a job that either provides employer-based health benefits or the income necessary to purchase health insurance independently (Griffith, Mason et al. 2007). In addition, improved zoning laws and providing real-estate incentives may serve to further promote employment equity in marginalized communities.

Education attainment is another determinant of health insurance given that higher paying jobs that provide employer-based health benefits require a certain level of educational attainment from their employees. Educational attainment is primarily attributed to a low standard of living of which is dependent upon three factors: material poverty, lack of access to early education and educational success at the secondary level, and lack of health insurance coverage (Hernandez, Denton et al. 2010). As is illustrated in the 2010 film documentary *Waiting for "Superman"* (Guggenheim 2010), access to a high quality primary and secondary education is determined by geographical location, family income, and sheer luck. As previously addressed, racial minorities endure hardship in seeking out these resources. This is depicted in the 2008 educational attainment statistics where 66.8% of all Associate's Degrees were earned

by Whites, while only 12.8% and 12.2% were earned by Blacks and Latinos (U.S. Department of Education 2010). The disparity deepens with the increase in the number of years in school, ending with 71.6% of Professional Degrees earned by Whites, 7.0% earned by Blacks, and only 5.3% earned by Latinos (U.S. Department of Education 2010). Methods of addressing this disparity is primarily addressed by holding teachers and schools accountable to the academic achievement of their students, an approach that requires massive reform of our current public education system and the teachers' unions (Guggenheim 2010).

With lack of health insurance being an independent determinant of having a low standard of living, a feedback loop is created to continue the pattern of low socio-economic opportunity. According to a recent report, the primary means of breaking this cycle is to implement public policies that ensure all children and adults “have access to critical resources reflected in the associated rights” (i.e. the right to an “adequate standard of living”; the right to an education directed toward the development of the child’s “fullest potential”; the right to the “highest attainable standard of health”; and the right to “his or her own cultural identity, language, and values”) (Hernandez, Denton et al. 2010). Only then are individuals provided with the equitable opportunity of achieving education attainment that improves their opportunity to obtain a job that provides employer-based health benefits or the means to purchase private insurance independently.

Educational attainment is also an upstream determinant of health literacy, an additional SES measure that is highly correlated with insurance status. While health literacy is deemed to be the product of educational attainment (Desjardins 2003), growing evidence suggests that health literacy may serve as a basis upon which current health insurance providers discriminate

(Kutner, Greenberg et al. 2006). Health insurance plans are increasingly complicated and convoluted making it difficult for any person, much less an individual with a lower literacy capacity, to fully understand what services and procedures are covered in a health insurance plan (Paasche-Orlow 2007). Moreover, information about the patient's financial responsibility is often disclosed in a manner that is not well understood. Health insurance terms like "deductible," "premium," "co-pay," and "out-of-pocket expenses" are commonly used without defining them in layman's terms. With health insurance options growing in number and complexity, there is much confusion among health care consumers about what benefits a health insurance plan provides and at what cost to them (Kapp 2007; American Medical Association 2010). This challenge is further convoluted if the individual has limited proficiency in English. The ability to calculate an employee's share of health insurance costs for a year, for example, is today recognized as requiring a "proficient" skill level that only 12% of Americans attain (Kutner, Greenberg et al. 2006). Moreover, the National Center for the Study of Adult Learning and Literacy claims a literacy level of 3 (from a range of five proficiency levels) is needed on the National Assessment of Adult Literacy (NAAL) to be able to navigate the American health care system (Comings, Reder et al. 2001).

While this evidence is convincing that limited health literacy serves as a barrier to obtaining health insurance, studies examining the relationship between health literacy and health insurance are scarce. According to the 2004 Literacy and Health Outcomes report issued by the Department of Health and Human Services health insurance is rarely taken into consideration when studying the effects of literacy on health outcomes, and when it is documented it is only controlled for in multivariate analysis. The report highlights the fact that

the correlation between reading ability and lack of health insurance is ill defined (Berkman, Dewalt et al. 2004). Nonetheless an individual struggling with low literacy or limited English proficiency is faced with an additional barrier to obtain health insurance and therefore, health literacy, as a component of SES, has a meaningful perceived impact on health insurance attainment and utilization.

Race

The racial disparities in health insurance are strongly associated with the SES etiological pathway given that income and economic assets are inequitably distributed across racial groups. In fact many researchers claim the high uninsured rates of minority groups are a direct result of the aforementioned SES factors (Lillie-Blanton and Laveist 1996; Brown 2000). To address the causes of health disparities by race, it is, therefore, relevant to identify the processes that lead to the unequal distribution of educational attainment, employment, and income by race. It is important to note, however, that race is a “rough proxy” of SES and should not be perceived as a directly correlate with SES (Jones 2000; LaVeist 2005) given evidence that racial disparities in health insurance have historically persisted after controlling for SES factors (Thomasson 2006). In this instance ethnographic, anthropological and historical literature is employed to identify the means by which racism and cultural incompetency independently influence the racial and ethnic disparity in health insurance.

Dr. Camara Jones, an expert in race and health, claims racial groups suffer from poor access to health care (i.e. lack of health insurance) and adverse health outcomes due to three levels of racism - institutionalized, personally mediated, and internalized racism - of which, collectively, outline the ecosocial framework in which racism acts. Institutionalized racism is the

“differential access to goods, services, and opportunities of society by race” (Jones 2000). It is a macro-level process that is imbedded in American customs, practices, and law. For example the disproportionate allocation of poor employment opportunities and inadequate public schools to low-income racial minority communities is a result of institutionalized racism. These and other “racialized policies,” lead to disparities in access to health insurance (Becker 2004). According to Dr. Jones the magnitude of institutionalized racism, alone, may explain the association between race and SES. Personally mediated racism, defined as the inter-personal infliction of prejudice and discrimination, also contributes to the low-SES of minority groups (Jones 2000). An example of how personally mediated racism impacts SES is best depicted by the discrimination against Blacks in the job market. Finally, internalized racism is the “acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth” (Jones 2000). It manifests through the embracing of “whiteness,” self-devaluation, and resignation, helplessness, and hopelessness. Suppose an African American man seeking employment is repeatedly turned down by employers. This repeated insult increases his chances of developing a negative perception of his capabilities and his self-worth, which, in turn, leads him to become disempowered to move up on the social economic ladder to improve his access to health care. This is a common phenomenon that may explain the profound health disparity endured by racial minorities today.

The historical and current effects of the three levels of racism have led minority racial groups to mistrust the health care system as a whole, contributing to the increase in the uninsured rates for Blacks and Latinos. Ever since the establishment of the Emergency Medical Treatment and Active Labor Act in 1986, uninsured Blacks and Latinos are significantly more

likely than Whites to use the “safety net” of hospital’s emergency department for their health care needs (Lewin and Altman 2000). Reportedly, experiences at these facilities are frequently negative, with patients citing long waiting times, administrative complications, and discrimination by medical staff due to insurance status, race, and language barriers (Becker 2004). In fact reports of perceived racism that result in psychological harm (i.e. anger, frustration, belittlement, and loss of relationship and trust in one’s clinician) are frequently documented in the health care delivery system (LaVeist, Rolley et al. 2003; Kuzel, Woolf et al. 2004). This injustice endured by racial minorities, predominantly uninsured individuals, in the health care delivery system collectively leads racial minorities to distrust the American health care system as a whole (Gamble 1997; LaVeist, Nickerson et al. 2000; Boulware, Cooper et al. 2003). In turn, uninsured Blacks and Latinos avoid the American health care system as a whole unless their health status worsens to the degree to which immediate medical attention is needed (Becker 2004; Maclean 2004; LaVeist, Isaac et al. 2009). Tragically, this resistance to the discriminatory American health care system serves as a disincentive to obtain health insurance.

Ethnicity

The etiological pathway that limits access to health insurance for minority groups is grounded in the fact that society responds differently to individuals based on their visual appearance. Given that health insurers do not meet with their clients in person, race is commonly not reported or documented by insurance companies, making it difficult to identify any trends in racism that develop on behalf of health insurers (Boulware, Cooper et al. 2003). In fact it is thought that the lack of face-to-face contact alone accounts for why Blacks have greater trust in their health insurance providers compared to their physicians (Boulware,

Cooper et al. 2003). Nonetheless, insurance companies are proven to discriminate against racial and ethnic groups by favoring individuals with higher incomes, greater literacy capacities, and higher rates of acculturation (Paasche-Orlow 2007). This discrimination, as a product of both racism and cultural incompetency, further excludes racial/ethnic minority groups from obtaining health insurance benefits.

Lack of acculturation and familiarity with the capitalist American system serves as a key barrier to health insurance for ethnic minorities. In the United States health care consumers must be pro-active in seeking health care coverage in order to overcome the complex, burdensome and challenging nature of health insurance programs as well as the industry's demand for documentation (Weiss and Grossmann 2011). Health care consumers must educate themselves about their opportunities and make a number of robust decisions in order to enroll in a health insurance plan and utilize its benefits (McLaughlin 1999). Unfortunately, ethnic minority groups are disempowered to take this assertive approach given their lack of acculturation and, perhaps, their adverse experiences in the health care system (LaVeist 1992).

Associated with acculturation, immigration status is likely to influence the inequitable distribution of health insurance across racial groups. Immigrants, specifically immigrants from less developed countries, lack the capacity to overcome the complications they face in obtaining health insurance. A recent study that evaluates the effects of immigration on health care access confirmed that both African and Latino immigrants are less likely to have Medicare and other health insurance coverage than native-born elderly people (Lum and Vanderaa 2010). This trend is attributed to the fact that immigrants are more likely to have limited English proficiency, more likely to have a lower level of educational attainment and less acculturated to

the capitalist American health care system (Pavlish, Noor et al. 2010). Furthermore, recent immigrants have a less established lifestyle that further complicates the process of obtaining and maintaining insurance coverage. For example, many Latino immigrants rely on migrant work that leads to fluctuations in their income and residence, both lifestyle choices that are not accommodated by health insurance providers (Flores, Fuentes-Afflick et al. 2002). Racism further widens the ethnic health insurance disparity.

Very few studies to date have explored the degree to which complications with literacy, acculturation, and immigration status serve as a barrier for minority racial groups to become insured. A majority of the studies that have evaluated these “complicated and dehumanizing” components of health insurance are mainly focused on public entitlement programs (Baker, Gazmararian et al. 2004; LÓPez 2005; Davidoff, Stuart et al. 2010). No reports were found to document the discriminatory practices of private health insurance providers. Nonetheless, the uninsured statistics, federal reports as well as anecdotal information from patients indicate that these practices exist and contribute greatly to the disparity.

Location

As discussed previously the south and southwestern regions of the United States (herein characterized as “the South”) are disproportionately plagued with the higher uninsured rates. This evidence suggests that the aforementioned pathways that lead to the health insurance disparity by SES and race may be more concentrated in this region. When examining the economical, social, political and cultural environments of the South as well as the demographics of the region, this reasoning is proven to be valid.

The South is characterized as being poorer compare to other areas of the United States. Only one of the 12 states with lowest household income in 2009 were not considered to be “southern states” (U.S. Census Bureau 2009). With limited revenues and a conservative ideology, the South endures the greatest socio-economic inequality in the nation, with disparities in both income and education (Snead and Cockerham 2002). This situation adversely impacts racial minorities more than Whites given the historical discrimination and prejudices cast upon racial minorities in the South (Quadagno 2005). The political climate of the south and the region’s resistance to losing state rights or being regulated by the federal government further contribute to the disparity by depriving residents from mandated welfare and social programs that benefit individuals with low SES and provide them with the means to move up the socioeconomic ladder (Manza 2000; Quadagno 2005).

In addition to the economic and political distinctions, the South is characterized as having a culture that resists change. A 1980 study led by Roebuck and Neff validates this finding by identifying that white, working class Southerners maintain hostility towards “cosmopolitan” lifestyles and outsiders who adopt these modern lifestyles (Roebuck and Neff 1980). According to Snead and Cockerham this cultural ideology causes Southerners to reject modern health lifestyles or pressure from the outside sector to adopt certain health practices, like health insurance. This belief is best exemplified by the conservatives’ objection to the Patient Protection and Affordable Care Act. This cultural ideology contributes to the disproportionate uninsured rate in the South and, perhaps, provides insight into why low income Southerners, including racial minorities, continue to reside in the southern region of the country.

Results from a 2006 study suggests that regions with higher uninsured rates also have a weaker local health care delivery system, which, in turn, further increases the uninsured rate (Pagan and Pauly 2006). This feedback loop suggests that the uninsured rates in the South are the result of an inadequate health care delivery system, of which may be a product of lower state revenues and the inequitable allocation of funding to health care facilities.

Interventions: Implications of the ACA

With the ecosocial web of causation established we are able to better understand the etiological pathways of health insurance disparities. Health insurance disparity attributed to SES is a result of the unequal distribution of well-paying jobs or jobs that provide employer-based health benefits, the inequitable opportunity to receive a high quality education, and the insurance industry's discrimination against the low literate population. These same pathways are applied to the disproportionate uninsured rates by race given the correlation between SES and race. In addition, institutional, personally-mediated, and internalized racism contributed to the disparity endured by racial minorities. Ethnic minorities are further excluded from obtaining health insured due to their lack of acculturation and the cultural incompetency of health insurance providers. Finally the geographic disparity is attributed to the economical, social, political, historical, and cultural differences that differentiate the South from other regions of the United States.

With these pathways established it is crucial that we explore methods by which we may intervene on these processes in order to effectively dissolve health insurance inequity. One of the most comprehensive and most relevant interventions to explore with respect to addressing the health insurance disparity is the Patient Protection and Affordable Care Act (herein referred

to as the Affordable Care Act or ACA). This law is multidimensional in its approach to dissolving the unequal distribution of health insurance and as such will be evaluated on its efficacy for intervening on the etiological pathways that generate and perpetrate the disproportionate distribution of health insurance.

The ACA, signed into law on March 23, 2010 by President Barak Obama, seeks to expand coverage, control health care costs, and improve the health care delivery system. Portions of the law have been enacted over the past year; however, the provisions that relate to the more dynamic reforms in health insurance will not be enacted until January 2014. Therefore, the evaluation of the law will be made on projections of the law's provisions as they were written in the law at the time of its signing (Patient Protection and Affordable Care Act (P.L. 111-148) 2010).

SES

As is implied in the title of the law, one of the key provisions in the law is the expansion of coverage to the socially and economically disadvantaged population. This is done first by expanding Medicaid to all citizens under age 65 with incomes up to 133% of the federal poverty level. In addition low income families earning between 133-400% of the federal poverty level will be eligible to receive refundable and advanceable premium credits to assist them with purchasing a basic health plan through new state-based American Health Benefits Exchanges (AHBEs), a "public option" for health insurance. In turn employers will receive tax credits as an incentive to provide health insurance to their employees, allowing all small businesses with 25 employees or less to make health insurance available to their employees. The AHBEs in addition to the Small Business Health Options Programs (SHOPs) will make health insurance more

affordable and accessible by providing health insurance plans individually and through employers that offer certain benefit tiers that cover 90, 80, 70, or 60% of the benefit costs and are held to limitations of out-of-pocket expenses. In addition, the law mandates that the private insurance companies report medical loss ratios and justify their premium increases as a means to ensure their plans are affordable. Additional benefits include new insurance market rules that prohibit limits on the amount paid by insurance providers for a beneficiary's medical expenditures. Finally the law requires all insurance companies, public and private, to simplify their administrative procedures as a means to cut operational expenses and enforce cost containment which in turn may reduce the cost of premiums. In addition to executing means to promote transparency and accountability, these collective efforts serve to make health insurance more affordable for low SES groups.

In addition to addressing the health insurance disparity, these provisions are put in place to ensure that health insurance is made affordable by January 2014, when it becomes a federal mandate to obtain health insurance. If in violation of these mandates citizens will be fined a nominal fee. However a number of protections are put in place to further assist low economic families if the ACA measures still do not make health insurance affordable. Families enduring financial hardship are exempt from paying the fees and individuals for whom the lowest cost plan is more than 8% of their income and those with incomes below the tax filing threshold also are granted exemption.

While these efforts prove to make health insurance more affordable, the law does little to address the upstream determinants of income inequality, i.e. employment status and

educational attainment. It does, however, provide a training program and “workforce diversity grants” to help low income racial minority students receive the education and training they need to serve in the health care workforce. And by funneling funds into community and school health clinics, Consumer Assistance Programs (CAPs), and the development of the AHBEs and SHOPS the law serves to open up job opportunities that are equitably distributed across the nation to ensure socioeconomically deprived neighborhoods have access to community health care services. The ACA, however, primarily focuses on making health insurance affordable at the point at which health insurance is obtained.

Recognizing the potential impact that health literacy has on health insurance attainment, the ACA has successfully included provisions to ensure that the low literate and low health literate are accommodated in the enrollment process. Section 2715 of the law specifies the “development and utilization of uniform explanation of coverage documents and standardized definitions” to accommodate those with limited literacy capabilities and English proficiency. The law also mandates that the AHBEs and SHOPS provide high quality customer services through a toll-free telephone hotline and website and establish an “Enrollee Satisfaction System” to evaluate their efforts to accommodate individuals with all literacy levels. The enrollment process for the AHBEs and SHOPS is also to be simplified. In addition, the law specifies that all federally-qualified health centers must have a translator to accommodate the non-English speaking community in order to receive funding. These initiatives make considerable strides in closing the gap in health insurance that is associated with poor literacy. However, given the complexity of the American health care system the capacity for the low

literate population to obtain, understand, and process health insurance information remains limited.

Race and Ethnicity

In addition to implementing provisions that address the health insurance disparity by SES and, by association, race, the law establishes a means to improve the credibility of the health care system as a whole by improving the quality of care received by groups previously discriminated against due to their SES or race. First, provisions are put in place to prevent health insurance providers from turning down an applicant due to his or her health history. Secondly, a number of provisions are applied to improve services to beneficiaries of both Medicare and Medicaid. Third, the National Strategy for Quality Improvement in Health Care committee will be established to improve the health care system performance as a means to “reduce health disparities across health disparity populations and geographical areas.” Fourth, the National Prevention, Health Promotion and Public Health Council will be responsible for implementing federal prevention, wellness, and public health activities. Fifth, improvements will be made to long-term care, trauma care, community health centers and school-based health centers, most of which serve as the primary source of health care services for racial minorities. Finally, the law initiates the “Understanding Health Disparities: Data Collection and Analysis” provision to enhance “collection and reporting on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.” Collectively, these improvements and others not addressed here serve to protect citizens from maltreatment to increase the credibility of the health care system and motivate racial minorities to obtain and utilize health insurance.

A fallback of the ACA's efforts to address health insurance disparity among racial minorities is evident in the fact that the benefits of the ACA are strictly reserved for American citizens or legal residents. Undocumented citizens do not have access to any of the ACA's services or benefits. Given the large number of undocumented citizens in the United States, this provision may serve to deepen the health insurance disparity seen between the citizens and non-citizens of the United States. And with Latinos representing a vast majority of the undocumented citizens in the United States, the health insurance disparity seen among the Latino population is likely to persist. Therefore, measures must be taken to develop comprehensive immigration reform to provide undocumented immigrant workers with some rights to health care.

Location

The geographical disparity is addressed given that the law is enacted on the federal level. Every state is required to establish AHBEs and SHOPS, and if they elect not to develop the infrastructure necessary to carry out these provisions the federal government will step in and manage the exchanges for them. The state-based exchanges and programs promise every state citizen access to a health insurance plan. Increase in funding to support community health centers and school-based programs also allows for rural communities to have improved access to health care facilities, which will in turn increase health insurance rates given the correlation between health care and health insurance (Pagan and Pauly 2006). Furthermore, community transformation grants are made available for underserved communities to receive additional funding to ensure the benefits of the ACA reach the geographically or socially isolated populations in need of access to care.

Recommendations

While the provisions of the ACA succeed in addressing some of the key determinants of health insurance status, there are a few key areas that remain unaddressed by the ACA. Specifically, the law does not address the problem of racism that leads to adverse employment and educational opportunities for Latinos or Blacks and the law does not fully accommodate individuals or families that are have limited literacy capacities or are minimally acculturated. Fortunately, the ACA provides states the flexibility to design, develop and enforce supplemental health insurance components to better areas that are in need of addressing to better meet the needs of their citizens. With this in mind, the author will offer recommendations on how the new health insurance paradigm may further be modified to more effectively intervene on the ecosocial processes that lead to health insurance and health disparities.

The first recommendation is to make wellness incentives available to those participating in the AHBEs and SHOPS. These incentives would require beneficiaries to participate in evidence-based interventions that are geared towards eliminating social inequality. Employers enrolling in the SHOP, for example, could be offered the opportunity to participate in an annual intervention that is proven to dissolve racism in the work place in return for receiving a discount on their employment health benefits package. Parents who are enrolled in an AHBE may participate in workshops geared towards addressing ways to overcome the disparity in the public education system. These approaches serve to better educate the public about these social inequalities as well as mobilize a community to take action to resolve these injustices. In doing so, these incentives serve to advance the ecosocial model and the concept that health is determined on four different societal levels. Additional wellness incentives may adopt the

principles of the “good driver discount” implemented in the auto insurance industry where people who are making positive individual decisions to promote their health are rewarded with a discount on their premium cost. Other types of innovative wellness incentives should be explored to maximize the benefits of health insurance and further promote population health.

The second recommendation is to develop a rigorous advocacy component. This recommendation is modeled after the best practice health insurance model being developed by Dorothy Leone-Glasser, a highly respected and nationally-recognized patient advocate. The proposal is to incorporate a third party advocacy division into the AHBEs and SHOPS that allows for beneficiaries to reach a personal advocate to assist them with their questions or concerns regarding their health insurance. Modeling the system off of the current advocacy division offered by the Internal Revenue Service, this system would better assist low-income, weakly acculturated, low literate, and low English proficient populations with their health insurance problems. The system will be designed to offer a completely transparent system of healthcare coverage that enhances communication between the physicians, insurance providers and beneficiaries. In addition, these advocacy divisions would be required to reflect the racial and ethnic diversity of the serviced population and be able to communicate in a number of different languages to reduce instances of discrimination and cultural incompetency.

With the additions of the recommended health insurance components, the ACA is perceived to have the capacity to successfully intervene on the processes that lead to the inequitable distribution of health insurance. However, the degree to which the ACA is implemented is dependent upon the states to promote the law and educate their citizens about

the services and benefits that the law provides. The extension of Medicaid and the subsidies available to economically disadvantaged individuals and families, for example, will not be utilized if the low income individuals and families are not aware of these options. Therefore, the third recommendation is for states to be aggressive in facilitating outreach efforts to effectively reach health care consumers and educate them about the ACA. It will also be the responsibility of the states to assess what supplementary health insurance components are needed to address the health care disparities specific to their residents. To mobilize support and effective implementation of the ACA Consumer Assistance Programs or CAPs should be effectively utilized to educate the public, assist with enrollment and renewal of coverage, navigate coverage and benefits, and report back to policy makers about problems with existing programs and regulations (Tracy, Benjamin et al. 2010). The success of the ACA is dependent upon states taking these initiatives.

Finally, it is recommended that organizations and institutions committed to promoting population health become advocates for the full and equitable implementation of the ACA. As this paper depicts the law effectively intervenes to promote more equitable access to health insurance, and in turn makes advancements towards achieving health equity. However, the law is not being equitably enforced across states. For example liberal states are taking advantage of rate review grants to help them improve the health insurance rate review and reporting process to ensure that the insurance rates are truly affordable for their citizens (Office of Consumer Information and Insurance Oversight 2010). California is actively collaborating with the National Academy for State Health Policy to gather data from stakeholders to develop health exchanges that overcome the health disparities that are specific to the state of California

(California Health Foundation 2010). Moreover, states in the South that are in the greatest need of the full implementation of the ACA and the recommended secondary health insurance components are not only being the least proactive on developing the infrastructure for the law, they are making a group effort to repeal the law all together. It is therefore, recommended that health care organizations and institutions that are committed to improving the health of the public advance efforts to ensure the law is fully implemented in the South. In the state of Georgia, for example, Emory University's Rollins School of Public Health may best address the health disparity in Georgia by publically advocating for the implementation of the ACA and the secondary health insurance components that best meet the health care needs of the socioeconomically disadvantaged Latinos and Blacks of Georgia as well as Georgia's large immigrant population.

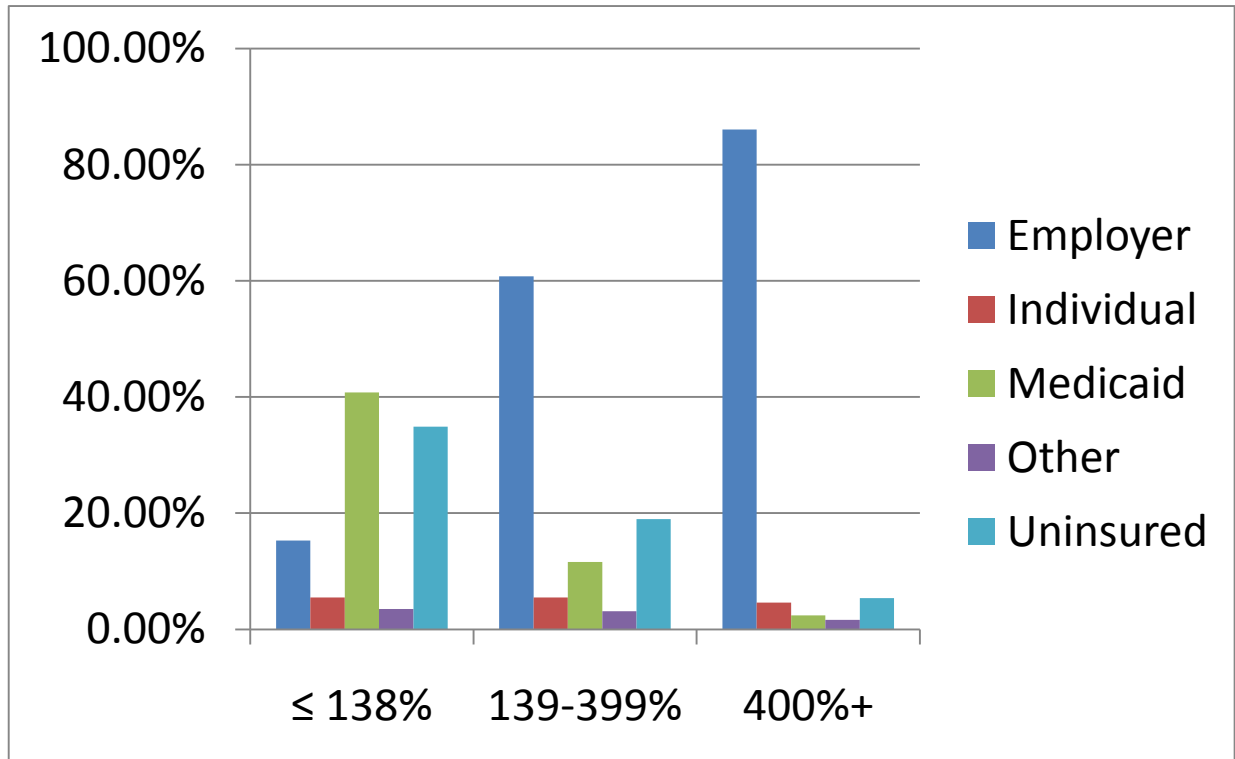
Conclusion

In summary, it is crucial that we address the disparity in health insurance to correct for the disproportionate distribution of adverse health outcomes that are attributed to lack of health insurance. Understanding the etiological pathways that lead to the disproportionate allocation of health insurance allows us to identify the social determinants of health insurance and the ecosocial pathways in which they manifest. With this understanding we are better equipped to identify areas where we need to change the existing health insurance standard to accommodate the poor and ethnically diverse groups of people. The implications of the ACA on addressing the social economic and racial disparity are profound, but the efficacy of the law is entirely dependent on those that work to implement it. As public health professionals we have a responsibility to advance the ecosocial model and advocate in favor of the interventions that

address the social determinants of health at all four societal levels. It is, therefore, critical that we act swiftly to ensure the ACA is implemented to its full potential to best serve the American population, in its entirety.

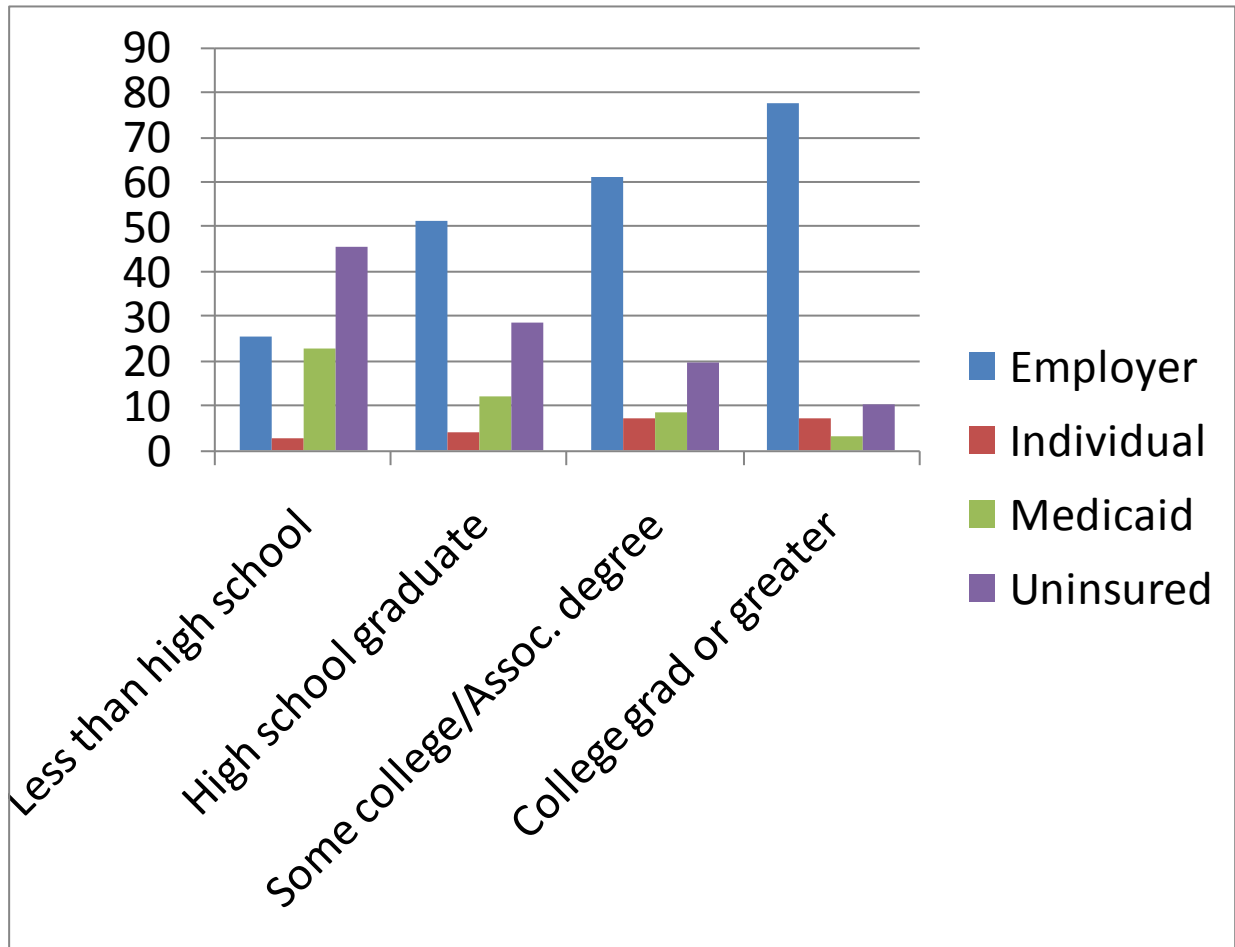
Appendix A

Health Insurance Status and Type by Family Poverty Level (CPS, 2009)



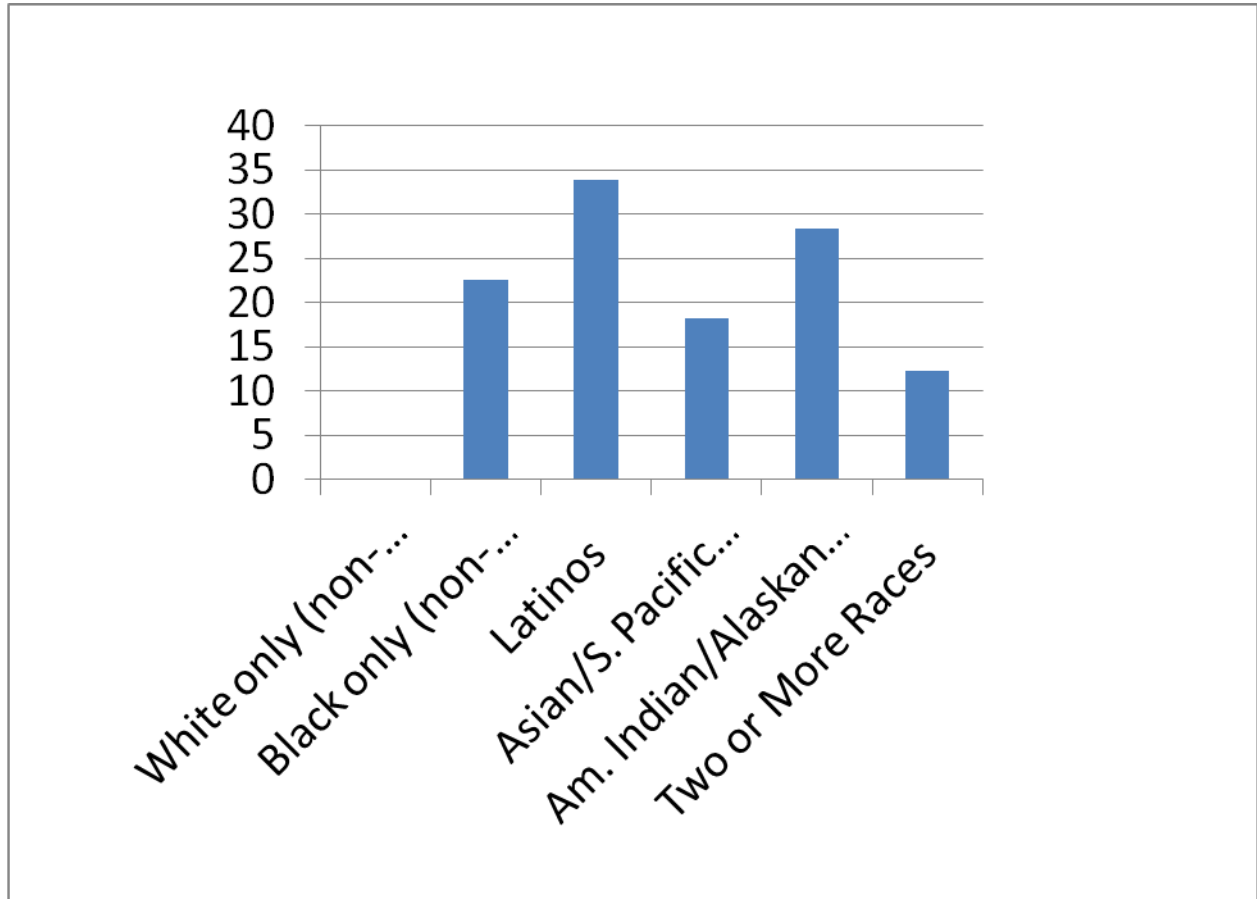
Appendix B

Health Insurance Status and Type by Educational Attainment (CPS, 2009)



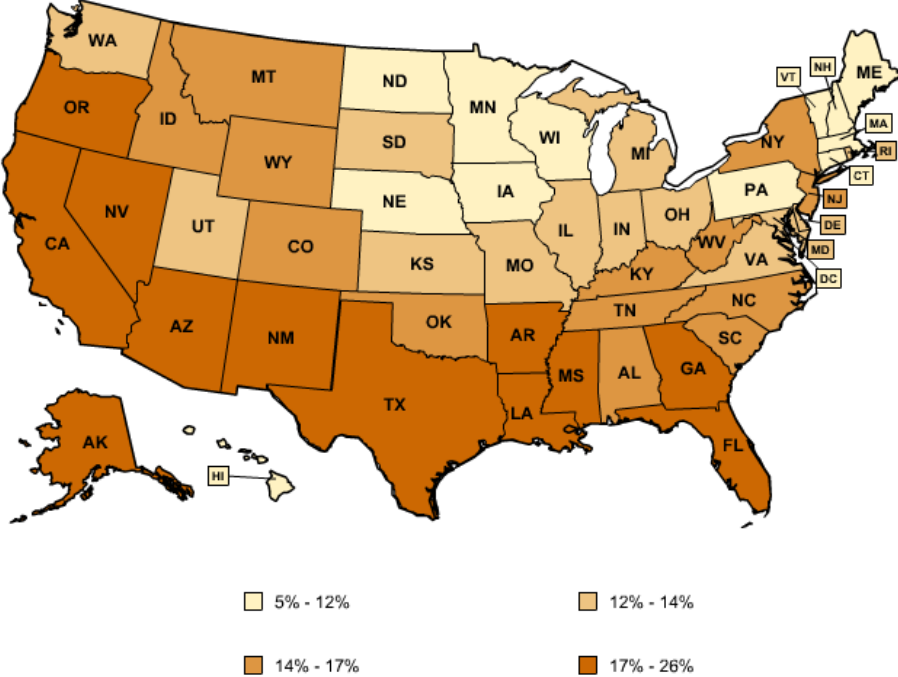
Appendix C

Percent Uninsured by Race (CPS, 2009)



Appendix D

Number Uninsured of Total Population by State (CPS, 2009)



Adapted from www.statehealthfacts.org

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