Research paper on the affordable care act and african americans

Sociology, Population

Economics

Introduction

The concept of a ‘ right to health’ has been strongly emotive and politically charged in the United States. The politics of health have evolved in the United States in fits and starts. Political settings and the influence of organized groupings such as the American Medical Association and the American Association of Labor Legislation have played a major role in the evolution of the concept of the right to health.

Historical Background

In 1793, a yellow fever epidemic forced the central government to impose quarantine on cases suffering from yellow fever. This was the first instance when public health occupied the national center-stage (Center for Disease Control and Prevention, 2014).

Progress in healthcare legislation remained in limbo over the following decades as borders and communications took center stage for the government. The federal government took no action to subsidize voluntary funds or to make sick insurance compulsory. Public health was left to the states to monitor and safeguard.

The first calls for health insurance were heard in the Progressive Era, albeit more for ‘ disability compensation for work-induced illness’ rather than for general healthcare. Spurred by this demand, private insurance agencies began offering disability insurance in tandem with existing national programs (Saldin, 2010).

As costs of healthcare increased, liberal reformers began an increasing

clamor for healthcare coverage. At the end of the Great Depression, people clamored for jobs and health insurance. President Roosevelt commissioned a Committee on Economic Security to address old age and economic issues. The committee worked in private, and came to the conclusion that job-related insurance was of higher priority that a national health insurance (Kaiser Family Foundation, 2009). Thus, Franklin Roosevelt finally left out the aspect of health insurance from the final version of Social Security signed into existence. Private insurance firms once again came forward and filled the demand –resource gap of medical insurance (Saldin, 2010). While Roosevelt left out medical reform, he constituted a Technical Committee on Medical Care to advance the cause of medical insurance. The committee recommended a state run system for medical insurance, but left the implementation to the states. Recognizing the prospect of opposition from the American Medical Association (AMA) over any changes to the medical insurance landscape, the Committee proposed that doctors would continue to maintain control over the practice of medicine. Recommendations of changes in medial health were strongly opposed by the AMA, the health insurance industry, business and labor groups. At the end, even though Roosevelt left out a national health insurance from the national agenda, he provided funds to states for expanded health, maternal and child care services. Roosevelt tried to get national health insurance to the national stage in 1934 and 1938, but failed. BY 1938, Congress had creased to support government expansion (Kaiser Family Foundation, 2010).

During World War II, the War Labor Board recommended that certain work benefits, including health coverage, be excluded from wage and price

controls. This allowed employers to entice workers with attractive health insurance plans. Following the Second World War, American economy flourished due to the increased demand for infrastructure. As American companies became successful, unions began to negotiate for better medical coverage (Kaiser Family Foundation, 2010).

After the Second World War, President Harry Truman continued the push towards universal healthcare insurance. He called for universal medical insurance as part of his ‘ Fair Deal’ agenda. He echoed the reformers’ demands for a national, universal and comprehensive health insurance to be run as part of the Senate Security. Labor unions remained undecided over the question of support to a national healthcare plan. While the AFL-CIO and United Auto workers backed Truman, the United Auto Workers finally decided to favor the General Motors’ offer to provide health benefits and pensions. The AMA opposed Truman’s plans, publicly fearing the dangers of ‘ socialized medicine’. The AMA stoked an anti-communist fervor, which resulted in reduced support for the National Health Insurance. (Kaiser Family Foundation, 2010).

Meanwhile, the faith of the public in the ability of private industry to cater for healthcare requirements began to waver. Insurance firms began to carry out ‘ experience rating’ to set health premiums. The old and the poor became the new focus of healthcare reform. The Kerry-Mills Act was introduced in Congress in 1960, giving states additional funds to cater for healthcare for the elderly. However only 28 states chose to participate, rendering the Kerry Mills ineffective (Kaiser Family Foundation, 2010).

In 1965, the House Ways and Means Committee began its work on the

Medicare proposal. In 1965, alternative proposals began to be considered: an expansion of Kerr-Mills (“ Eldercare, supported by AMA) and a proposal for federal subsidies to purchase private coverage (“ Bettercare” from the insurer Aetna). These proposals were eventually merged into a single bill. Medicare Part A was created to pay for hospital care and limited nursing health, while an optional Medicare Part B (paid in part by premiums) was to help pay for physician care. Medicaid was the third part. Medicaid a totally separate program to assist states in providing long-term care for the poor and also to provide health insurance coverage for certain classes of the poor and disabled. The final bill left the elderly bereft of private coverage for some services such as prescription drugs, long-term care, and eyeglasses. No government cost controls were enacted (Kaiser Family Foundation, 2010).

President John F. Kennedy tried to push healthcare reform during his tenure as president as well, only to be thwarted. Traction in healthcare insurance finally arrived with Lyndon Johnson, who signed Medicare into existence in 1965. Medicare was a program designed to provide medical cover to the elderly. While Medicare was not universal in application, progressives considered Medicare as a building block towards the ultimate goal of universal health coverage (Saldin, 2010).

The next step forward occurred in 1972, when Medicaid was enacted to extend medical health coverage to the poor. Rising costs and inflation stalled further progress towards universal health coverage. Jimmy Carter’s efforts to enact a bill for universal health coverage failed, as did Bill Clinton’s efforts.

Incremental steps continued with President Bush expanding Medicare to provide a prescription drug entitlement (Saldin, 2010).

Evolution of Healthcare Legislation: Affordable Care Act

When Barrack Obama came to power in 2009, he called for healthcare reform legislation. When members of the congress met representatives in town hall meetings in Aug 2009, they were met with opposition. On 09 Sep 2009, Obama addressed a joint session of Congress on the specific issue of healthcare reform. ON 17 Sep 2009, a bill named Service Members Home Ownership Tax Act was introduced in the House. The original Patient Protection and Affordable Care Act Bill was later tacked onto this bill. The House passed the bill on 08 Oct 2009. The Senate passed the bill on 24 Dec 2009. The Patient Protection and Affordable Care Act became law on 23 March 2010. Obama signed the Health Care and Educational reconciliation Act into law on 30 March 2010 to patch issues in the PPACA regarding penalties and age limits. In April 2010, Obama signed into law a provision for military health insurance, TRICARE, to meet the provisions of the PPACA. The Republicans won a majority in the House in 2010, mainly on the anti-insurance plank. In Jan 2011, the House voted to repeal the Affordable Care Act. In Feb 2011, the House curtailed the spending provisions of the PPACA. In April 2011, the House voted to curtail discretionary spending under the PPACA. In April 2011, the House passed the FY 2012 budge, repealing and defunding the Affordable Care Act. In Oct 2011, the House prevented abortions to be performed under the aegis of the PPACA. In Nov 2011, the House voted to include social security benefits in the calculus for

determining the applicability of healthcare insurance, making it difficult for some to access healthcare. In Feb 2012, the House cut $11. 2 Billion from the ACA. In March 2012, the Supreme Court began hearings on the ACA. In June 2012, the Supreme Court upheld the major provisions of the Affordable Care Act. In Nov 2012, Obama was re-elected as President. He renewed the push to make the PPACA a reality. Obama sought bipartisan support for the ACA. Confrontation continued with the House, which repealed the ACA in its entirety in May 2013. IN Sep 2013, the House passed a funding measure to delay implementation of the ACA till 2015. Finally, on 01 Jan 2014, the bulk of the Affordable Care Act goes into effect (American Action Forum, n. d.).

Definition of the Problem of Affordable Care Act and African Americans

The Affordable Care Act opens Healthcare Benefits Exchanges. The Act ensures that adults with pre-existing conditions are not denied coverage. Large employers are mandated to extend coverage to workers who work for at least 30 hours per week. The ACA extends provisions of healthcare insurance to those covered under the Medi-Cal program. Small businesses that extend coverage gain tax benefits. Individuals and families who buy their insurance from Health Benefits Exchanges get tax benefits, provided their income is below $94, 200 for a family of four.

There are 37 million Blacks and non-Hispanics in USA, amounting to 12% of the population. Blacks are concentrated largely in the South, and they comprise a small share of the population in the Northwest and mid East. The black population is relatively more diverse than the rest of the population of the USA. While some black people are recent immigrants, most (92%) have

been in the USA for generations. There is diversity in socioeconomic status and demography. Compared to non-Hispanic whites, the black population is relatively younger; 40 % of the black population is under the age of 26, and Blacks are only half as likely as whites to be over the age of 65. (Duckett and Artiga, 2013).

Compared to whites, the black population is noticeably poor. A majority (70%) of Blacks are employed in blue-collar jobs that provide for low wages and are less likely than white-collar jobs to offer health insurance. As a corollary to the nature of jobs, Blacks are two and a half times as likely as whites to be below the poverty line (Duckett and Artiga, 2013).

As of 2011, there were over seven million uninsured non-elderly Blacks, making up 15% of the total non-elderly uninsured population. More than two thirds of this uninsured population is in a working family, including half that has at least one full-time worker. However, a majority of this population has low incomes and lies below the poverty line (Duckett and Artiga, 2013).

The combination of blue-collar jobs not providing health insurance and the fact that most Blacks are below poverty line results in a grim picture regarding the status of health insurance to Blacks. Across the nation, one in five Blacks do not have access to health insurance. Blacks consist of a majority of the uninsured in the southern states. Less than half the non-elderly Blacks have private health coverage. Medicaid coverage fills a small part of the gap of non-insurance, covering over half the Black children. However, there remains a sizeable Black population without access to health coverage (Duckett and Artiga, 2013).

The situation becomes grimmer for African Americans due to the fact that

racially, African- Americans are more prone to disease than their white counterparts. In general, African – Americans live for a shorter lifespan than their white counterparts. They have worse life expectancy, infant mortality, coronary heart disease, diabetes, stroke and HIV/AIDS than white contemporaries (David, 2012).

One of the key goals of the Affordable Care Act is to extend coverage to the uninsured. From 2014, Medicaid eligibility has expanded to adults with incomes upto 138% of poverty in states that have implemented ACA's Medicaid expansion. This expansion of the ACA would be complemented with new health insurance marketplaces enabling people to purchase coverage. There would be premium credit subsidies to help families with moderate income without employer-provided healthcare access (Duckett and Artiga, 2013).

The employment and financial status of Blacks render the Black population to be one of the major beneficiaries of the Affordable Care Act. Nearly 94% of the black population would be in the income range to qualify for the expansion of Medicaid and for premium tax credit. Uninsured Blacks would, therefore, be critically affected in states where they form a large part of the population; the decision of such states to expand Medicaid would largely impact the Black population (Duckett and Artiga, 2013).

The Affordable Care Act, therefore, has significant implications for the Black population. Increased healthcare insurance would serve to significantly reduce differences in the access to healthcare and in the general health and lifespan of the Black population (Duckett and Artiga, 2013).

The entire problem of lower health and well being of the African American

population, however, would not be addressed merely by access to healthcare. A larger, overarching framework of communication, overcoming of biases and inherent preferences of the African American population would have to be overcome if the community is to come of on par with whites in health and well being standards.

Problem Statement

The above discussion, therefore, yields the following problem statement:

“ The implementation of the PPACA would serve the African American population by mitigating their relatively larger predilection towards disease addressing the existing condition of lack of access to healthcare. The well being of the African American population requires a holistic treatment, in which access to universal healthcare is one aspect.”

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