Chapter 14
Health Policy: Toward Achieving Respiratory Health Equality

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Introduction

Access to affordable and high-quality healthcare varies widely in the United States (US). Pervasive disparities in access exist across multiple domains, including geographic locations, gender, racial and ethnic groups, and socioeconomic status (SES). Variability in health insurance coverage is a key factor that interacts with these domains and plays an important role in disparities in both healthcare access and health outcomes among patients with respiratory disease or critical illness. For example, relative to the insured, individuals who lack health insurance have a greater incidence of lung cancer, are often diagnosed at a later stage of disease, and experience worse survival [1]. Similarly, among those with asthma (see Chap. 10), lack of health insurance has been associated with markers of poor outpatient care, such as lack of inhaled corticosteroid use and decreased likelihood of admission to the hospital from the emergency

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department (ED) [2]. Uninsured critically ill patients are less likely to receive potentially life-saving critical care procedures [3, 4], receive less post-acute care after a critical illness [5], and have greater mortality than those with insurance [6–8].

Racial or ethnic minorities are more likely to be uninsured. US census data from 2012 to 2013 shows that non-Hispanic (NH) blacks and Hispanics were one and a half times and twice as likely to be uninsured, respectively, than NH whites. NH blacks and Hispanics were also more likely to be without a usual source of care, with 43 % of Hispanics versus 21 % of whites reporting no usual source of care. Minorities were also more likely to go without care because of cost, with 24 % of NH blacks and 29 % of Hispanics versus 15 % of whites reporting going without healthcare because of associated cost. Such racial and ethnic disparities in access persisted after accounting for health status and income [9]. Given that noninsurance is common among minorities, health insurance expansion may significantly mitigate racial/ethnic disparities in healthcare.

The Patient Protection and Affordable Care Act

To address health disparities from lack of insurance, President Obama signed the Patient Protection and Affordable Care Act into law in March of 2010, the most comprehensive healthcare reform since the creation of Medicare and Medicaid in 1965. The Affordable Care Act (ACA) protects patient by eliminating insurance discrimination for those with pre-existing conditions, and establishes minimal standards for health insurance policies under the Essential Health Benefits. The ACA also expands access to health insurance through several mechanisms: children up to age 26 can be covered under their parents' policies, and the ACA mandates insurance exchanges to provide insurance to individuals without access to employer coverage. The ACA also created an employer mandate, which requires businesses with over 50 full-time employees to provide health insurance to ≥95 % of their employees and dependents, or pay a fine. In addition, the ACA created an individual mandate that requires most US citizens and legal residents to have health insurance or face a tax penalty. The ACA also increased access to health insurance for those with low or moderate income, through increasing Medicaid income eligibility to individuals with an income up to 138 % of the federal poverty level (FPL), as well as by creating insurance premium subsidies for those with incomes between 138 and 400 % of the FPL (as tax credits). While several of these policies expand the private insurance market, the largest proportion of uninsured Americans is expected to gain health insurance under the ACA through Medicaid expansion.

Medicaid Expansion

Created by the Social Security Amendments of 1965, Medicaid and the Children's Health Insurance Program (CHIP) were designed as the nation's healthcare safety net. Prior to the ACA, Medicaid and CHIP provided insurance coverage to nearly

18 % of nonelderly Americans [10], including many low-income individuals, such as children, their parents, pregnant women, and those with disabilities. While federal law required states to provide coverage for school-aged children up to 100 % of the poverty level, this was only mandated for those with incomes below an individual state's 1996 welfare eligibility levels. Ultimately, two-thirds of states limited parental eligibility to less than 100 % of the current poverty level [11], with states such as Alabama limiting the parental eligibility to as low as 23 % the federal poverty level in 2013 [10]. Individuals without children have typically been ineligible for Medicaid coverage regardless of income, with only nine states providing non-Medicaid, state-funded benefits to childless adults in 2009 [12]. Medicaid plays an important role in providing access to healthcare for minorities, with approximately 21 % of Medicaid beneficiaries—over 11 million Americans—being African-American [13].

The ACA was designed to expand Medicaid eligibility, particularly for adults. In its initial design, the ACA required states to provide Medicaid for both parents and those without dependent children with incomes at or below 138 % the FPL—$33,465 for a family of four in 2015—or lose federal Medicaid subsidies. To offset the financial burden of covering more individuals, the ACA stipulates that the federal government would cover the full cost of Medicaid expansion for each state, with a stepwise decrease in federal government cost-sharing down to 90 % in 2020. Anticipating that hospitals will be responsible for less uncompensated care as patients gain coverage, the ACA will also reduce the Disproportionate Share Hospital payments, federal payments that help hospitals offset the cost of care for low-income individuals. Slated to begin in 2014, but delayed until Fiscal Year 2017 by subsequent legislation, these reductions will start at 1.2 billion dollars per year, increasing yearly to 4 billion dollars in 2020. The annual reduction each state will receive will vary and has yet to be determined [14].

Supreme Court Challenge: *National Federation of Independent Business v Sebelius*

Under new eligibility requirements, the Congressional Budget Office estimated that 17 million nonelderly adults would have gained coverage under Medicaid expansion [15]. However, in June 2012 the ACA underwent judicial challenge in the Supreme Court in *National Federation of Independent Business v Sebelius*. While the Supreme Court ruling in this case upheld the challenge to the individual mandate that requires all individuals to purchase health insurance or face a tax penalty, the Court also ruled that the states could not be compelled to participate in the proposed Medicaid expansion, giving states the option to expand Medicaid under the ACA or keep their pre-existing level of Medicaid benefits without loss of federal funding. As of October 2015, the number of states expanding Medicaid continues to increase and is at 32 (Fig. 14.1) [16, 17]. While the Congressional Budget Office anticipates that most states will eventually participate in Medicaid expansion despite initially declining, the revised enrollment estimates project 4 million fewer new enrollees by 2023, or ~25 % fewer than initially anticipated under mandated Medicaid expansion [15].

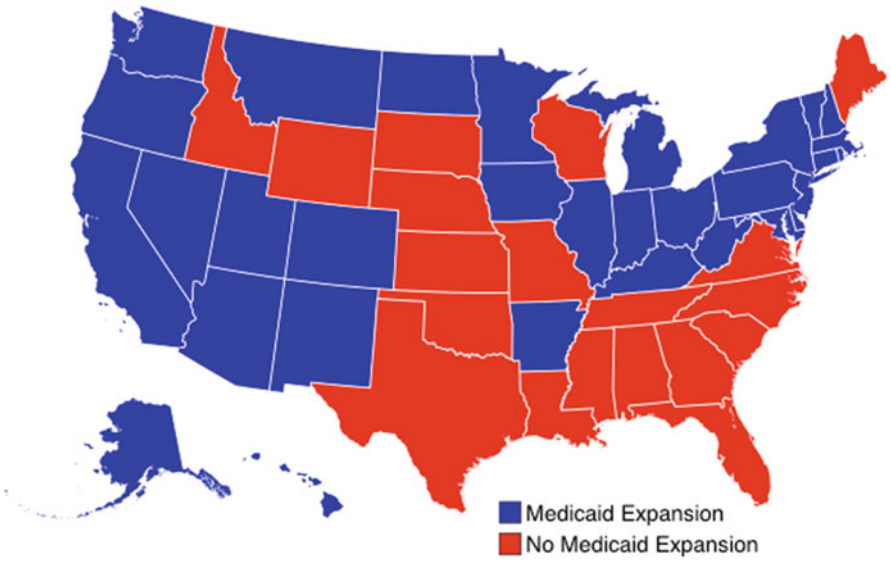

Fig. 14.1 Medicaid expansion October 2015

Nonparticipation in Medicaid Expansion Increases Disparities

In states that fail to expand access to Medicaid, millions of low-income parents and childless adults may remain without health insurance. Paradoxically, many states choosing not to expand Medicaid coverage have the most to gain, as they have a greater proportion of residents without health insurance (Table 14.1). Many uninsured individuals in these states are low-income, have no access to employee-based coverage, and will remain ineligible for their state's current Medicaid coverage after reform. Furthermore, their incomes will be too low (i.e., less than 100 % of the FPL) to qualify for health insurance premium credits, which would otherwise offset the expense of purchasing insurance coverage through state insurance exchanges. These individuals are left in a "coverage gap" where they are ineligible for both subsidies to purchase private insurance (because their income is too low) and Medicaid (because their income is too high). Although subsidies are not required to purchase insurance through the exchange, the cost of purchasing coverage without premium credits will likely remain prohibitive for those in this coverage gap, as the average US premium for a single adult making $20,000 per year (171 % of the FPL) without subsidies is $216 a month for a silver plan [18].

Failure to expand Medicaid has important implications for minorities. Uninsured NH blacks with incomes that would qualify for Medicaid under expansion are more likely to live in states that continue to forgo Medicaid expansion [19]. Two of the six states with large Hispanic populations (Florida and Texas), and all six of the states with the largest percentage of African-American residents are among those that continue to decline Medicaid expansion (Table 14.2). The Kaiser Family Foundation estimates that failure to expand Medicaid has left 3.6 million Hispanics and 2.9 million NH black adults ineligible for subsidized health plans [19].

Table 14.1 2015 Medicaid expansion among states with highest and lowest rates of nonelderly uninsured

State	% Nonelderly uninsured 2011–2012 [1]	Expanding Medicaid in 2015	% Below 100 % poverty level [46]	Life expectancy at birth (State's rank)
United States	17.9		15.0	
Texas	26.8	No	17.4	32
Nevada	26.5	Yes	15.5	38
Florida	24.7	No	14.9	23
New Mexico	24.3	Yes	22.2	34
Louisiana	22.4	No	21.1	50
Connecticut	9.5	Yes	10.1	5
Vermont	9.3	Yes	11.6	8
Hawaii	9.1	Yes	12.1	1
District of Columbia	9.1	Yes	19.9	45
Massachusetts	4.4	Yes	10.6	6

Table 14.2 2015 Medicaid expansion among states with highest percentage of African-American and Hispanic residents

State	% African-American US census 2013	% Hispanic US census 2013	Expanding Medicaid in 2015
Mississippi	37.4		No
Louisiana	32.4		No
Georgia	31.4		No
South Carolina	27.9		No
Alabama	26.6		No
North Carolina	22.0		No
New Mexico	47.3		Yes
California	38.4		Yes
Texas	38.4		No
Arizona	30.0		Yes
Nevada	27.5		Yes
Florida	23.6		No

Failure to expand Medicaid access in these states may also have consequences for insured patients who access care through the safety net. Those who fall into the coverage gap will likely continue to face barriers to nonemergent care, with associated worse health outcomes and potentially serious financial hardships when they do seek care. Failure to expand Medicaid will likely have adverse effects on the health of indigent women: more than half of states who elected not to expand Medicaid have higher than average rates of women without health insurance [20]. Safety net health service providers and hospitals in these states—systems that typically serve minorities and the poor—are also likely to suffer from limitations in resources and reduced Disproportionate Share Hospital payments, as they continue to shoulder the burden of uncompensated care costs. For example, safety-net hospitals tend to have slower gains in the quality of care provided to patients with

pneumonia and tend to be poorer performers relative to non-safety-net hospitals [21, 22]. Importantly, these deficiencies in care quality spill over to impact all of those served by safety-net health systems, not just those who lack insurance. Without the infusion of resources from newly covered Medicaid patients, these disparities in quality will likely persist.

Does Insurance Expansion Improve Health Equality?

Several recent studies highlight the potential benefits—and challenges—of Medicaid expansion on healthcare access, health outcomes, and financial peace of mind for the poor. Yet, Medicaid is an imperfect program that may not reach the full potential of private plans.

One can gain insight into the expected impact of Medicaid expansion from prior observational and quasi-experimental analyses of health insurance expansion in the US. Massachusetts initiated health insurance reform in 2006, in a program that includes many provisions incorporated in the ACA, including having most new insurance beneficiaries obtain insurance through Medicaid expansion. In Massachusetts, health insurance reform was associated with increased primary care utilization [23], decreased ED visits for low-severity conditions [24] and nonurgent conditions [25], decreased hospitalizations for preventable conditions [23, 26], and fewer critically ill patients without health insurance. However, intensive care unit (ICU) utilization (as measured by ICU admissions per capita or ICU admissions per hospitalization) was unchanged, and there were no changes in mortality or use of post-acute care facilities among patients admitted to the ICU [27]. Massachusetts health insurance reform was also associated with an increase in outpatient surgical referrals among lower income racial/ethnic minorities in the post-reform period [28]. In addition, after Massachusetts implemented health insurance reform, Hispanic adults with a primary care provider rose significantly but still remained lower than for NH whites [9].

Several states expanded Medicaid benefits before the advent of the ACA. Arizona, Maine, and New York significantly expanded Medicaid access to poor parents and childless adults between 2000 and 2005. Compared to neighboring states that did not undertake expansion, these states had an increase in Medicaid coverage and a concomitant decrease in the numbers of uninsured. States that expanded Medicaid also experienced a reduction in overall mortality compared to those that did not expand. Furthermore, the decrement in All-Cause Mortality was most significant in non-whites and in counties with the highest levels of poverty, suggesting that Medicaid expansion may significantly improve health outcomes for minorities and the poor. Finally, Medicaid expansion was associated with increased rates of self-reported health status of “excellent” or “very good” [29].

Perhaps the most definitive study of the impact of gaining Medicaid insurance was the Oregon Health Insurance Experiment. In 2008, Oregon offered Medicaid coverage to ~30,000 uninsured poor adults from a waiting list of almost 90,000

people. Individuals selected for Medicaid coverage were chosen via lottery, effectively randomizing those on the wait list to either coverage or no coverage, setting up the largest randomized controlled trial of insurance expansion in history. Medicaid coverage was responsible for increments in preventive healthcare (e.g., mammograms, cholesterol screening, and pap smears), improvements in self-reported general health and quality of life, and reduced incidence of depression. Although gaining Medicaid did result in greater use of medications for those with diabetes, it did not improve hemoglobin A1C levels. Other preventive health outcomes, such as blood pressure and cholesterol levels, were also unchanged, but residents of Oregon had lower rates of hypertension and hypercholesterolemia than the national average. The impact of gaining insurance on the care for patients with asthma or chronic obstructive pulmonary disease (COPD, see Chap. 10) has not yet been reported. Access to, and use of primary care, prescription drugs, and preventive services were improved among Medicaid beneficiaries. Medicaid also dramatically reduced Medical debt and the need to borrow money to pay for medical bills [30]. In the year following health insurance acquisition, hospital admissions increased by 30% in 1 year for those who gained insurance [31]. Similarly, those who acquired Medicaid insurance had a 40% relative increase in ED visits compared to controls [32]. While this suggests that acquiring health insurance provides financial stability and decreases financial barriers to healthcare for low-income individuals, it did not provide subgroup analyses of the impact of insurance acquisition for minority populations within the study.

Overall, findings from studies of prior state-level expansions suggest that individuals who gain Medicaid coverage have greater access to healthcare and preventive care, and discrete improvements in health outcomes while experiencing reduced financial strain. Despite increased access to health services in Massachusetts, health insurance expansion did not significantly increase intensive care use, suggesting that in the short term, there may be similarly no increase in critical care utilization after national healthcare expansion. It is reasonable to anticipate that the ACA's Medicaid expansion provision will begin to address some of the insurance-related disparities in healthcare in the US.

Insurance Expansion: Important But Not Sufficient

Medicaid expansion under the ACA represents an important step toward mitigating disparities related to health insurance. However, availability of insurance does not guarantee high-quality healthcare. Even when insurance is available, patients must enroll and overcome deficiencies in access to covered services, clinicians and institutions, and deficiencies in access to high-quality primary care and specialty services [33]. In this regard, Medicaid is often underfunded compared to private insurance, potentially impairing its ability to eliminate insurance-related disparities.

Even with Insurance, Black and Hispanic Patients Experience Disparities in Healthcare Access

Data prior to the ACA shows that health insurance can significantly reduce, but not eliminate, disparities in access to care, with NH black and Hispanic patients with insurance reporting smaller, but still significant, differences in access to a regular provider [9]. Access to high-quality care is also not likely to be solved with insurance expansion. Studies in disparities in outcomes for patients with in-hospital cardiac arrest show that a significant proportion of disparities in outcomes for NH blacks can be due to care in poorer performing hospitals, where all patients do worse [34].

There is also variation in quality in the types of hospitals that provide care to large percentages of Medicaid patients. Previous research has shown that hospitals that treat higher percentages of Medicaid patients are less likely to meet quality indicators for critical illnesses [21]. As Disproportionate Share Hospital payments are reduced, disparities in quality of care at hospitals caring for most Medicaid patients are likely to increase.

There is also regional variability in quality of care. A 2009 study showed significant regional variation in survival to hospital discharge for patients who had an out-of-hospital cardiac arrest. Whereas the survival to hospital discharge rate in Seattle was 39.9 %, those in Portland and Dallas were 22.5 % and 9.5 %, respectively [35]. While the cause of this disparity requires investigation, it is likely multifactorial and could include regional variation in access to preventive care, high-quality prehospital emergency services care, and inpatient hospital quality.

Deficiencies in Essential Health Benefits Package

The ACA includes an essential health benefits package, which establishes a comprehensive set of the minimum necessary services that a Medicaid expansion plan must provide (Table 14.3). The ACA mandates coverage in ten essential health benefits categories. Coverage is thus assured for most services commonly performed and billed by pulmonary and critical care providers. However, states ultimately have discretion to determine how many services within each of the ten categories their Medicaid plans will cover, which may lead to state-to-state variability in benefits. Furthermore, newly eligible groups may not receive benefits as comprehensive as traditional Medicaid, provided they cover at least one service within each of the ten categories [36].

Variability among individual states' interpretation and implementation of the essential health benefits when expanding Medicaid may impact patients with pulmonary disease, critical illness, or sleep disorders. The essential health benefits requirement for prescription drug coverage does not guarantee access to the range of *necessary* medications that could best meet a patient's needs, but instead stipulates that patients must have access to a specific *number* of medications. Lung transplant recipients, for example, typically require at least three immunosuppressant medications, which are in the same class and category. Under the current essential

Table 14.3 Services required for an insurance plan to be considered compliant with the essential health benefits package

The essential health benefits package	
Ambulatory patient services (e.g., initial and subsequent visits, procedures, pulmonary function studies)	Prescription drugs
Emergency services	Rehabilitative and habilitative services and devices (e.g., physical therapy)
Hospitalization (e.g., inpatient initial and subsequent visit, consultation, procedures, critical care, transplantation)	Laboratory services
Maternity and newborn care	Preventive and wellness services and chronic disease treatment (e.g., vaccination)
Mental health and substance use services, including behavioral health treatment	Pediatric services including oral and vision care

health benefits, health plans are only required to cover two drugs per class, potentially limiting access to these life-saving medications [37]. The current prescription drug rule could also impact providers' ability to treat drug-resistant tuberculosis. Combination therapies (e.g., fluticasone/salmeterol inhaler) are also not recognized under the current proposal, which may affect the health of patients with cystic fibrosis, bronchiectasis, asthma, and pulmonary hypertension [37, 38]. Tobacco cessation aides, which are more effective in combination [39], will also potentially be limited to one medication per class or category, limiting therapeutic options for this vulnerable population [37, 38].

Beyond the limitations of the prescription drug benefit, the essential health benefits also fail to adequately address other services essential to the care of patients with pulmonary, critical care, and sleep disorders. In particular, the essential health benefits does not describe whether patients will have access to durable medical equipment such as ventilators, nebulizers, and continuous positive pressure machines, leaving open the possibility that patients will have to pay for these life-saving devices out of pocket [37]. Lastly, diagnostic testing, evaluation and treatment of sleep disorders, and patient-physician counseling regarding end-of-life and palliative care are not included in minimum benefit standards under the current essential health benefits proposal, such as that provided to current Medicaid or Medicare beneficiaries [37].

Cost-Sharing: A Barrier to Access to Necessary Services

In addition to the significant variability in state's Medicaid benefit benchmark, the ACA allows states to set cost-sharing limits for certain services. By requiring individuals to share in the costs of accessing the healthcare system, cost-sharing is an effective means through which insurance plans can reduce unnecessary healthcare utilization. Several studies have shown that for the poorest and sickest patients,

cost-sharing plans worsen outcomes relative to free plans, because cost-sharing reduces the likelihood that individuals will seek necessary care. Among the poor, patients with cost-sharing plans are also less likely to fill prescriptions for essential medications, and as a result experience increases in emergency department visits, and a greater likelihood of adverse health events [40].

States can set their own cost-sharing limits for nonemergency use of the ED for individuals with incomes greater than 150 % of the FPL. In many areas of the country, EDs are the only healthcare facilities continuously available for the treatment of urgent respiratory illness such as asthma [41]. Cost-sharing in this context may be a significant deterrent to seeking timely care and could lead to worse outcomes. Patients who gain Medicaid insurance will also be required to share in the costs of preventive services, whereas individuals that are newly insured under a private-market insurance plan can receive preventive services and immunizations recommended by the US Preventative Task Force without cost-sharing [38, 41]. Cost-sharing is also proposed for tobacco cessation counseling and medications for all nonpregnant Medicaid recipients. Together, these cost-sharing policies have the potential to adversely impact the health of Medicaid beneficiaries [38].

Medicaid and Access to Specialty Care

Medicaid patients with pulmonary or sleep disorders may experience disparities that result from providers and groups choosing not to accept Medicaid insurance in their practices [42]. Medicaid typically reimburses physicians at a lower rate than Medicare or private insurance; yet Medicaid patients often present with equally complicated medical illness in the context of social situations that complicate medical treatment. Recognizing this financial disincentive for providers to accept new Medicaid patients, the ACA requires states to pay physicians Medicaid fees that are at least equal to Medicare's for inpatient and outpatient eval uation and management services, including E/M codes (99201 through 99449). This group of E&M codes includes many of the services commonly performed and billed by pulmonary and critical care providers. However, there is no similar parity in physician fees for other subspecialty services, including but not limited to procedures or interpretation of pulmonary function tests and sleep studies. As such, some of the financial disincentives for pulmonary, sleep, and critical care providers to deliver care for Medicaid patients will persist. Even when providers do accept Medicaid insurance, access and outcomes disparities will remain. At least one study showed that children with Medicaid faced significant delays in accessing specialty care, even when specialists accepted Medicaid, compared to those with private insurance [43]. For patients with cystic fibrosis, Medicaid insurance was associated with a 1.56 odds of *not* being listed for lung transplant, independent of other socioeconomic factors [44]. Similarly, while outcomes for those with Medicaid are generally better than for the uninsured, Medicaid beneficiaries continue to experience delays in diagnoses (lung cancer [1]) and increased mortality (cancer [1], critical care [27]) when compared to those with private health insurance.

Faced with decreasing reimbursements, specialty service providers will need to adopt innovative and creative approaches to sustain economic viability and ensure high-quality care. Potential options to support Medicaid expansion while mitigating expenses include distributing Medicaid patients proportionately across providers in the area, expanding the role for mid-level providers, and group-clinic management for patients with chronic diseases.

Medicaid's Reach Will Not Be Universal Under the ACA

Even if Medicaid expansion were implemented in all states, important segments of the population would remain marginalized under the current program. Undocumented immigrants, and lawfully present immigrants who have been in the US for fewer than 5 years, remain ineligible for Medicaid. Undocumented migrants make up approximately 25 % of the uninsured population (see Chap. 5). Access to coverage for women's health established by the ACA, particularly contraceptives, is mired in complex legal challenges [20]. Such disparities in access to and delivery of healthcare represent complex policy issues that require a more comprehensive legislative response. As Medicaid expands, and states become more responsible for bearing the costs of expansion, alternative safety-net resources for those in coverage gaps may be further limited.

In a positive step toward universal coverage, the Supreme Court's landmark case on marriage equality, *Obergefell v. Hodge*, held that the Fourteenth Amendment requires a State to license a marriage between two people of the same sex and to recognize a marriage between two people of the same sex when their marriage was lawfully licensed and performed out-of-State [45]. This important victory in the gay rights movement opens access to both state and federal benefits, and protections for same-sex couples that marry (see Chap. 7). In healthcare, this includes equal status as parents, recognition for spousal surrogate decision-making or healthcare proxy, and access to spousal employer-sponsored health insurance. A study showed that implementation of New York's Marriage Equality act was associated with increases in employer-sponsored health insurance for both men and women, and a reduction in Medicaid coverage [46], suggesting that same-sex marriage equality may increase private health insurance for US patients.

Supreme Court Challenge: *King v. Burwell*

In 2015, the ACA survived what may be the last significant judicial challenge to the law: *King v. Burwell*. Through the ACA, low- and moderate-income individuals and families with incomes of 138–400 % of the FPL are eligible for insurance premium subsidies when purchasing policies on the health insurance marketplace exchanges. In *King v. Burwell*, the plaintiffs challenged whether people who purchased health insurance in states that chose to use the federal insurance marketplace healthcare.gov, rather than set up a state-run marketplace, were eligible to receive insurance

premium subsidies under the ACA. At the time of the ruling, 34 states use the federal exchange for their marketplace, and as a result nearly 7.5 million people could have lost their health insurance if the court had ruled in favor of the plaintiffs [1, 2]. However in *King v. Burwell* the Court ruled 6–3 in supporting the legality of subsidies regardless of type of marketplace states use, thereby ensuring not only continued health insurance coverage for our patients in states using the federal marketplace exchange, but also that the ACA is likely here to stay [47, 48].

Impact of the ACA on Health Equality

Results from the 2014 National Health Interview Survey were recently released, and show that among Hispanics younger than 65 years, the rate of uninsured subjects decreased from 30.3 % in 2013 to 25.2 % in 2014. Among African Americans, the rate of uninsured dropped from 18.9 % in 2013 to 13.5 % in 2014. Nearly 1.7 million African Americans have gained insurance through the ACA, and roughly 8 million African Americans with pre-existing medical conditions have gained coverage [49]. While these represent significant gains in coverage, they are still well behind the rates of coverage for NH whites, whose rate of noninsurance is 9.8 % [50].

Healthcare Access Disparities: Room for Improvement

Although those who have gained health insurance are satisfied with their coverage, continued efforts to improve the ACA are needed. Issues such as the "family glitch," where affordability of plans for low- and moderate-income families is based on the cost for individual-only coverage, without considering the often substantially higher cost of family plans [51], need to be addressed. Increasingly, private health insurance plans are also relying on out-of-pocket spending, with high deductibles, copayments, and co-insurance putting those with health insurance and moderate incomes at risk of forgoing care because of cost [52]. From a provider perspective, reduced reimbursement for Medicaid patients will likely continue to be a hurdle to access to care, particularly subspecialty care. Although the ACA provided a 2-year increase in reimbursements for Medicaid patients to primary care physicians (likely improving access) [53], most states returned to pre-ACA reimbursement levels in 2015 [54].

Even though we have largely addressed the impact of health insurance expansion on healthcare disparities through the ACA, key health policy efforts are needed to address disparities in Medicare outcomes for minority patients. African-American Medicare beneficiaries have higher poverty rates than older white Americans, with 65 % of African-American Medicare recipients versus 41 % of white Medicare recipients living below the poverty line [55]. From a health outcomes perspective, 43 % of African-American Medicare recipients report living in poor health versus

26 % of whites. As an important first step in addressing these disparities, the Centers for Medicare and Medicaid Services (CMS) announced an "Equity Plan" in September 2015 to improve quality of care for minority recipients [56].

Conclusions

As of the first quarter of 2015, the average rate of noninsurance has dropped from about 17.1 to 10.1 % [57]. African Americans and Hispanics have benefited significantly, with approximate 5.4 % and 5.1 % decreases in rates of noninsurance as a result of the ACA [49]. Those who have gained insurance report a decrease in health-related financial concerns [58] and high satisfaction with their coverage [59]. Despite these gains, public opinion of the ACA remains divided along party lines. In a recent poll, 62 % of Americans agree with the recent *King v. Burwell* decision, but only 29 % of Republicans supported the decision. Overall, only 43 % of Americans have a favorable opinion of the ACA, and 40 % polled report an unfavorable opinion [60].

Medicaid expansion under the ACA is an important step forward in addressing gaps in safety net coverage in the US for low-income individuals, thus providing an important remedy for health disparities in the US. Evidence from prior insurance expansions, as well as early reports from the ACA insurance expansion, suggests that increasing access to health insurance will improve self-reported health, increase utilization of preventive and primary care services, and decrease financial strain due to medical illness. Importantly, increasing access to health insurance may help mitigate disparities in healthcare access for African-American and Hispanic patients. While Medicaid expansion continues to gain traction in the states, lack of Medicaid expansion remains perhaps the most important barrier to improving rates of health insurance for US minorities. Without national adoption of Medicaid expansion, and wide variation in income eligibility thresholds across states electing to expand, coverage gaps will exist for millions of Americans, potentially exacerbating health disparities for minorities and the poor in these areas.

Although expanding health insurance should improve access to healthcare for minority patients with respiratory diseases, sleep disorders, and critical illness, health insurance acquisition alone is unlikely to eliminate all disparities in access to high-quality care. Among contributors to health, access to healthcare is essential but plays only a partial role. Until society definitively addresses disparities in social and economic domains that are key to health, such as behaviors, education, income, and environment, health disparities will persist (see Chap. 15). Nonetheless, medical practitioners, researchers, and their professional societies should constructively support health insurance expansion under the ACA, advocating for improving existing policies to expand patient access to pulmonary, critical care, and sleep medicine services, and reducing barriers for providers, with the goal of facilitating access to outpatient and acute care services for all of our patients and improving health outcomes at both the individual and societal level.

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