The Affordable Care Act and the California Medicaid Expansion:
Exploring Deficiencies in Access to Care and Overall Health in Racial and Ethnic Communities

A graduate project submitted in partial fulfillment of the requirements
For the degree of Master of Arts in Public Administration, Health Administration

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Abstract

The Affordable Care Act and the California Medicaid Expansion: Exploring Deficiencies in Access to Care and Overall Health in Racial and Ethnic Communities

By

Renee Antoinette Brazell

Master of Arts in Public Administration, Health Administration

Lack of medical insurance impacts a person’s ability to obtain and maintain primary healthcare, and lack of primary care is consistently linked to poorer health outcomes. To address this healthcare disparity in the United States, the Affordable Care Act was implemented to make insurance available to millions of uninsured Americans. This study looked at the connection between the Affordable Care Act’s Medicaid expansion in California, its effects on primary care access, and better health in communities of color, where health disparities are most pronounced. The method used is a secondary literature analysis of peer-reviewed research found in various databases such as JSTOR, California Healthcare Foundation, PubMed, and Health Affairs. Additionally, non-peer-reviewed data were obtained through organizations such as the Department of Health Services, Kaiser Family Foundation, and the Center for Disease Prevention and Control. Pertinent material was analyzed and revealed that despite one-third of California’s population being covered under the Medi-Cal program, there is no clear evidence that health outcomes have improved, and barriers to healthcare still exist. Access limitations are
more likely to have an adverse effect on persons with public insurance, low income, poor health, and members of racial and ethnic minorities. It is crucial to close the health inequality gap to improve our country’s general health and reduce health care costs. A deeper understanding of the barriers to access must be explored to allow legislation to promote equitable healthcare.
Introduction

Healthcare coverage is essential to favorable health outcomes across a person’s life span (Gaines & MBA, 2019). The capacity to reach optimum well-being depends on the ability to receive health care, preventative screenings, and treatment when necessary. Without health insurance, individuals are significantly less likely to undergo preventive examinations and receive treatment for chronic illnesses, including diabetes, hypertension, and heart disease (Gaines & MBA, 2019). These conditions and others can lead to severe and sometimes deadly consequences without detection and intervention. Nevertheless, in 2010, an incredible number of Americans were without healthcare, a trend that had continued to grow exponentially since 2000 (Finegold, 2013). Millions of people in the US went without the essential ability to maintain good health.

Understanding the value of healthcare, the United States passed the Affordable Care Act (ACA), a health reform law, to extend healthcare coverage to more uninsured Americans in March 2010 (Kaiser Family Foundation, 2017). At the time of its introduction to Congress, millions of Americans lacked the ability to receive and pay for healthcare. One of the main goals of the ACA was to make health insurance more affordable for those who qualified and to expand Medicaid to those who couldn’t afford it. The legislation has provided upward of 17 million people with health insurance (Allen et al., 2017); however, recent research indicates that barriers to healthcare still exist. According to Brian et al. (2018), California ranked thirty-ninth in a 2018 report on access and other healthcare markers, down three points from 2016, despite being at the forefront of expanding the State’s Medicaid program.

California is an ideal setting for examination because it has the most Medicaid recipients of any US state (Rowan, 2020). With an unparalleled increase in Medi-Cal, the State’s Medicaid
program, California's public health care systems rose to the top in the implementation of the ACA and the shift in the delivery system. As a result, California increased the eligibility for coverage for low-income groups that had not previously qualified. (Rowan, 2020). One may equate access to services that promote population health would be correlated with having the most comprehensive Medicaid program in the country. However, reports suggest that California still has significant health disparities, particularly for persons of color (Gaines & MBA, 2019), which raises substantial concerns. This research paper explores the deficiencies in California’s Medicaid program’s access to care and overall health in racial and ethnic communities.
Background

Healthcare in the United States

The government does not provide health insurance in the United States; however, healthcare policy and reform have a long history in our country, including many failed attempts at universal healthcare (Jost, 2021). Influenced by progressivism at the beginning of the 20th century, the US and many European countries made efforts to achieve universal healthcare coverage. Although the ACA legislation is a giant step in the right direction to providing healthcare to our citizens, it is also described as highly compromised and incomplete (Jost, 2021). While many large industrialized nations have attained some form of Universal healthcare, the US has made only incremental gains.

Several US presidents from both Republican and Democratic parties have proposed healthcare reform policies with varying degrees of success and failure (Manchikanti et al., 2017). The Social Security Act, signed by President Lyndon Johnson in 1965, established Medicaid, which gave public health coverage to low-income families receiving Aid to Families with Dependent Children, and Medicare, which offered public health coverage to seniors over 65 (Ballotpedia, 2013). President Richard Nixon signed an amendment to the Social Security Act in 1972 that expanded Medicare coverage to include benefits for Social Security beneficiaries disabled for a minimum of two years and people with severe renal disease (Ballotpedia, 2013).

In a determined effort to progress toward a comprehensive national healthcare strategy, President Nixon signed the Health Maintenance Organization Act (HMO) in 1973 (Ballotpedia, 2013). Instead of the more conventional and expensive fee-for-service approaches, this legislation supported prepaid group practice service plans or HMOs (Ballotpedia, 2013). Under President Reagan, advances were made to Medicaid as it became a mandated program instead of one of
each state’s discretion as a result of the Omnibus Budget Reconciliation Act in the late 1980s (Sparer, 2015). President Bill Clinton also introduced the Health Security Act of 1993, but it failed in the Senate (Ballotpedia, 2013). The legislation proposed several mandates, such as healthcare coverage for all Americans through either employer-sponsored programs or a State program at twice the rate. Furthermore, the bill also included insurance industry regulations to control costs and provide parameters for minimum coverage (Ballotpedia, 2013). While these policies made advances in healthcare, gaps in access to vital healthcare in America continued to grow, specifically among low socioeconomic and ethnic groups.

The US healthcare system was in poor shape before passing the Affordable Care Act in 2010. Healthcare disparities were notable; healthcare costs were higher than in any industrialized nation, yet, health outcomes were not reflective of the financial investment (Center for Public Impact, 2017). Approximately half of the country relied on costly private insurance that excluded individuals who got sick or had pre-existing conditions and were deemed high risk (Center for Public Impact, 2017). If a person lost their employment, they also lost their health insurance. When individuals lose insurance, they often change health providers or have inconsistent care and are less likely to maintain ongoing relationships with their care providers. Inconsistent care can severely affect one’s overall health, specifically for chronic conditions. Lapses in monitoring, testing, or medication treatment can lead to uncontrolled symptoms and higher rates of emergency department utilization, which are more costly than routine primary care.

According to the US Census, out of 170 million people, approximately 170.9 million (54.9%) had employer-sponsored health insurance, 16.4 percent (50.9 million) were Medicaid subscribers, and 15.2 percent (48.9 million) were Medicare beneficiaries prior to the ACA
(Finegold, 2013). Furthermore, compared to other ethnic groups, Caucasian Americans were more likely to have health insurance coverage. (Finegold, 2013). About 20 percent of individuals without insurance were not US citizens. About 79 million, more than one in four Americans, either lacked health insurance or were underinsured. Inequalities in insurance coverage in the US primarily depended on a person’s place of residence, race, and citizenship status. (Charles & McEligot, 2018). Disproportionally, marginalized low-socioeconomic communities of color were experiencing disparity in healthcare coverage, access, and overall health.

**Affordable Care Act**

To promote population health, the Affordable Care Act focused on strengthening three components of healthcare: access, quality, and cost control. The expansion of Medicaid, federal subsidies like the Health Insurance Exchange, and enabling unmarried dependents to remain on their parent’s health insurance until they turn 26 were the key focus areas for the rise in access. (National Conference of State Legislatures, 2011). The focus was specific and intentional, as the vast majority of uninsured were from low-socioeconomic households and may not have employer-sponsored health insurance. Cost-cutting measures were enacted, including individual and company health insurance mandates, fines and penalties, and the provision of public alternatives for consumers. (National Conference of State Legislatures, 2011). The program is the closest the United States has come to universal healthcare coverage and not without critique.

Federalism specifies which areas of policy the state, regional, and national governments should focus on, even though choices about health policy are made at the federal, state, and local levels of government. The federal government should delegate regulatory policies, operations, research, and program funding. For instance, the federal government controls access to the
standard level of healthcare through extensive policies. Resources are then provided to state governments for public health, Medicaid, CHIP, health insurance, and the licensing and regulation of healthcare professionals. Republicans’ worries about the spread of socialized medicine served as the impetus for their opposition to the Affordable Care Act (Pacheco et al., 2020). Not all states chose to expand Medicaid under the ACA; however, California was at the forefront of the expansion (Rowan, 2020). California has the largest Medicaid-covered population of all the states.

**Medicaid Expansion**

Increasing the number of low-income Americans who are eligible for Medicaid was one of the ACA’s provisions. Adults up to the age of 64 with incomes up to 138 percent of the federal poverty level would be eligible for Medicaid under the expansion. (Center for Public Impact, 2017). Medicaid was generally inaccessible to non-disabled persons under the age of 65 unless they had young children prior to the ACA. In addition, the income thresholds for caregiver/parent status were quite low. By expanding Medicaid, the ACA allowed millions of low-income adults to obtain medical insurance.

The ACA initially mandated a nationwide Medicaid expansion. The decision to participate or not was left up to each state when the Supreme Court declared in June 2012 that the Federal government could not compel individual states to expand their Medicaid programs. Only 26 states and DC offered Medicaid expansion when it originally started in 2014. The number of states embracing Medicaid expansion has gradually but consistently increased over the following years. Medicaid will now be available in 38 states and the District of Columbia beginning of 2022.
Prior to the ACA Medicaid expansion, California had the highest percentage of uninsured residents of any state, making up 14% of all uninsured Americans who are not elderly. (Kaiser Family Foundation, 2015) (*Figure 1*).

*Figure 1*

Uninsured Rates in 2013 United States and California

(Kaiser Family Foundation, 2015)
Babey et al. (2022) report that as a result of the expansion, the number of Californians covered by Medi-Cal increased 50% between the years 2013 to 2018. Currently, one in three Californians, or 14 million individuals, are covered by Medi-Cal; however, gaps between Medi-Cal and private insurance still exist in some access indicators. Issues of provider availability, timely appointments, and knowledge of program navigation are prominent.
Methodology

This study uses historical information from papers in peer-reviewed journals and statistics from official government websites to do qualitative analysis. The articles were located using several academic resources, including JSTOR, Google Scholar, PubMed, and CSUN Library. The terms “Affordable Care Act AND Primary Care Physician AND California healthcare AND Medicaid Expansion California” were used in the search. Search filters were used to arrange the results. The filters applied were English-language, peer-reviewed papers with the most recent at the top. Additionally, data were retrieved from the websites of the Department of Health Services, Kaiser Family Foundation, Centers for Disease Control, World Health Organization, and California Health Care Foundation. Several peer-reviewed articles and government documents were chosen for review based on a systematic approach to examining the effects of the ACA on California healthcare. The results were examined, divided into groups, and pooled after the data had been gathered. The first search turned up a total of 93 items. The titles and publication dates of each article were examined. Several pieces were eliminated based on the title and date, resulting in 45 references for this paper (Figure 2).
Figure 2
Methodology Flow Chart

- 90 records identified through databases and other resources including government websites
  - 46 peer abstracts screened
    - 24 records excluded for content relevance
      - 22 peer reviewed articles read
  - 45 non peer reviewed articles and websites screened and reviewed
    - 23 records excluded for content relevance
      - 22 non peer reviewed articles read
- 44 citations added
Primary Care

Primary care is typically the foundation of favorable health outcomes (Shartzer et al., 2016). It is the practice where providers are specifically trained and skilled in routine care, providing disease prevention, patient education, and diagnosing and treating acute and chronic illnesses. As such, primary care is an efficient basis for achieving overall well-being while promoting cost control by fostering routine and consistent medical treatment that can mitigate the need for more expensive emergency care. Yue et al. (2018) indicate success in expanding coverage among the low-income, non-elderly adult population through the Medicaid expansion by 7.10 percent and a 6.63 percent increase in having personal doctors (Table 1). This rise in primary care access was a key goal of the ACA’s intent.

Table 1
Difference-in-Differences Estimates of Effects of Medicaid Expansion on Access to Primary Care (Yue et al., 2018)

<table>
<thead>
<tr>
<th></th>
<th>Health Insurance Coverage</th>
<th>Having Personal Doctors</th>
<th>Unable to See Doctors Because of Cost</th>
<th>Received a Flu Shot</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DiD</td>
<td>p</td>
<td>DiD</td>
<td>p</td>
</tr>
<tr>
<td>All</td>
<td>7.1</td>
<td>&lt;.01</td>
<td>6.63</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>11.02</td>
<td>&lt;.01</td>
<td>5.67</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Non-Hispanic black</td>
<td>7.67</td>
<td>0.06</td>
<td>12.63</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Hispanic</td>
<td>-1.21</td>
<td>0.76</td>
<td>4.93</td>
<td>0.24</td>
</tr>
<tr>
<td>Non-Hispanic others</td>
<td>2.5</td>
<td>0.57</td>
<td>9.98</td>
<td>0.04</td>
</tr>
</tbody>
</table>
The ACA aimed to enable access to primary care and reduce the overuse and need for emergency services. McConville et al. (2018) identified frequent emergency department (ED) use as a marker for access to non-emergency ambulatory care. More than two-thirds of frequent ED users post ACA have Medicaid as their primary coverage source. In comparing the payor mix for emergency department patients in California, a Medicaid expansion state, with Florida, a non-expansion state, Barakat et al. (2017) showed that Medi-Cal enrollees account for a larger portion without a significant shift in ED or hospital utilization. Additionally, Brown et al. (2021) analyses revealed that a decrease in preventable hospitalization rates, a measure of access to primary care, was noted but not significant (co-efficient estimate: -0.0059, CI -0.0225, 0.0107, p=0.4856). These results indicate some improvement, though not at the expected level.

**Access To Healthcare**

Access to healthcare means that an individual can get medical services without delay in order to achieve the best state well being. Access to healthcare is crucial to overall health because it provides the conduit for obtaining necessary medical care, such as detecting and treating illness or chronic health conditions. It depends on several components, including health insurance coverage, availability of health care services, and qualified medical professionals when needed (Agency for Health Research and Quality, 2016). Medical care is expensive, and individuals without health insurance cannot often pay for the costs associated with care, such as doctor fees, tests, and medication.

Under the ACA, the lowest income individuals are eligible for participation in the expanded Medicaid program. The Medi-Cal health insurance program covers around one in three Californians and 40% of the state’s children (Rowan, 2020). Overall, 70% of Californians report positive feelings about the program, with 91% reporting that it is essential to California
and almost 60% indicating that it is personally important to them and their families (Bion, 2019). Research from Babey et al. (2022) suggests that when comparing Medi-Cal enrollees to employee-sponsored insureds (ESI), most gaps in access to medical care improved. Although it costs one-third of California’s annual budget, the state ranks among the states with the lowest access, according to the Healthcare Access and Openness Project report (Brian et al., 2018).

Research from Sharif et al. (2019) further highlights variations in reported improved healthcare access among some ethnic groups. Compared to non-Hispanic Whites, some subgroups of Asian Americans, such as Korean, reported significantly worse access to care than Chinese and Vietnamese (Nguyen & Trivedi, 2019). Outreach and advocacy may bridge services that members of specific communities may need to understand and access care.

According to Allen et al. (2017), healthcare coverage is only one of many factors contributing to disparities in quality and access to care. Their study, which made use of information from 2194 adults enrolled in Minnesota’s public healthcare programs, discovered that even people with insurance have trouble using healthcare services because of significant hurdles to access. The report lists a number of obstacles, including perceived discrimination from doctors based on patients’ insurance, humiliating provider-patient interactions, lack of acceptance of public insurance, language hurdles, and racial/ethnic prejudice. These barriers led to a high incidence of foregone care, delayed care, and no preventative care (Allen et al., 2017). Impediments to care can have devastating effects on the ability to detect and treat chronic conditions.

**Barriers**

While some research indicates gains in healthcare access in the first three years post ACA, reports of improvement in the likelihood of excellent health are driven mainly by the non-
Medicaid expansion portion of the policy (Courtemanche et al., 2018). For example, participants may report feelings of well-being because they now have coverage without improved physical status or healthcare utilization. Perception can also negatively impact a person’s behavior in seeking care. A 2008 survey of adult participants of public healthcare programs revealed that system-level barriers and perceived discrimination contributed to delays and lack of preventative and other medical services (Allen et al., 2017). Although this research may be deficient because the methods used were limited to self-reports and subject to participant recall bias, they are still relevant due to their impact on behavior. For example, a participant may have better memory recall when faced with difficulty obtaining care compared to a seamless encounter with a provider. However, it is essential to acknowledge that even the perception of discrimination, correct or not, is likely to impact individuals seeking or choosing not to seek medical care. Patients rarely want help from an entity where they perceive the provider as not supportive or discriminatory.

Lack of program enrollment may contribute to the absence of medical coverage for many who may be eligible. People may find it challenging to comprehend how to select a coverage, utilize their benefits, and navigate the healthcare system due to the complexity of health insurance. Research from Molina and Briggs-Malonson (2017) indicates that a deficiency of awareness of the ACA among Latinos contributes substantially to low enrollment and higher rates of uninsured persons from this population. Furthermore, by being informed about covered benefits, finding a doctor, filling a prescription, out-of-pocket costs, and free preventative care services, consumers may take charge of their health care and improve outcomes. This research highlights the need for outreach to inform people of available resources. Outreach should be designed to reach people with limited English proficiency. Research indicates that adults who
speak Spanish and have limited English language skills have higher uninsured rates (Molina & Briggs-Malonson, 2017). Examples would be working with local organizations to distribute information and provide enrollment assistance, conducting in-language outreach, and seeking in-language media coverage to raise awareness and meet the language needs among eligible but not enrolled groups.

Another critical barrier to healthcare in California is the limited availability of primary care physicians accepting Medi-Cal. A notable contributing aspect revealed in research by Ercia (2021) is the rapid expansion of newly insured patients and the increased demand for provider services. The supply of doctors is not meeting the demands of Medi-Cal participants (Coffman & Fix, 2017). Newly insured participants in the Medi-Cal program found that many providers were not accepting new patients or did not have timely appointments available. In research by Melnikow et al. (2020), only 19% of primary care physicians had available appointments within a state-mandated ten-day period overall in California. When patients cannot receive primary care, chronic conditions can manifest into urgent or emergency needs, increasing the utilization of emergency departments. The number of emergency room visits increased in the counties with the lowest primary care appointment rates (Melnikow et al., 2020). Higher emergency department utilization results in higher costs of care.

**Racial and Ethnic Disparities in Healthcare**

Disparities in healthcare are prominent in low socioeconomic and ethnic populations throughout the US (Charles & McEligot, 2018). Health disparities are the population-specific variations in disease occurrence, overall health, quality of health care, and access to health care services. The disparities across racial and ethnic groups are preventable and lead to unnecessary health inequities (Dolan & Mejia, 2020). Examples of disparities include mortality, life
expectancy, the burden of chronic illness, lack of access to care, uninsured and mental health. According to research by Lee et al. (2021), Blacks exceed Whites for most of the fifteen leading causes of death. Furthermore, Blacks and Hispanics have higher rates of diabetes and obesity, lower self-reported health, and higher rates of preventable hospitalizations than non-Hispanic Whites despite being more likely to be uninsured for decades (Lee et al., 2021).

Table 2
2013 Estimated Uninsured Rates by Age and Race/Ethnicity

<table>
<thead>
<tr>
<th>Age</th>
<th>Uninsured Rate</th>
<th>Percent of the Total Population</th>
<th>Percent of the Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-18</td>
<td>9.20%</td>
<td>25.10%</td>
<td>15.00%</td>
</tr>
<tr>
<td>19-25</td>
<td>27.20%</td>
<td>9.70%</td>
<td>17.10%</td>
</tr>
<tr>
<td>26-34</td>
<td>27.20%</td>
<td>12.10%</td>
<td>21.30%</td>
</tr>
<tr>
<td>35-44</td>
<td>21.10%</td>
<td>12.80%</td>
<td>17.60%</td>
</tr>
<tr>
<td>45-64</td>
<td>16.20%</td>
<td>26.30%</td>
<td>27.60%</td>
</tr>
<tr>
<td>65 and above</td>
<td>1.50%</td>
<td>13.90%</td>
<td>1.30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Uninsured Rate</th>
<th>Percent of the Total Population</th>
<th>Percent of the Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latino (any race)</td>
<td>29.10%</td>
<td>17.10%</td>
<td>32.30%</td>
</tr>
<tr>
<td>African American (alone)</td>
<td>19.00%</td>
<td>12.90%</td>
<td>15.90%</td>
</tr>
<tr>
<td>Asian American (alone)</td>
<td>15.10%</td>
<td>5.30%</td>
<td>5.20%</td>
</tr>
<tr>
<td>White (Non-Latino)</td>
<td>11.10%</td>
<td>62.80%</td>
<td>45.00%</td>
</tr>
</tbody>
</table>

Schwehr et al. (2021) show that the ACA’s coverage, specifically Medicaid expansion, increased insured persons across all income levels, among children and adults, and disparities in coverage between races and ethnicities have been reduced. Prior to the implementation of the ACA, non-elderly adults without children did not qualify for Medicaid regardless of income.
level (Lee et al., 2021). However, disparities in key health measures, such as healthcare access, have persisted and become more complex in California. In evaluating racial and ethnic groups, researchers identified that Latino adults have lower rates of routine medical care, Asian American adults have low doctor visit rates, and non-Latino whites forgo needed care at a high percentage (Charles & McEligot, 2018). These results held regardless of insurance type. The following data (Table 3) from the Kaiser Family Foundation (2015) highlights the disparities in health status and access between races and ethnic groups in California and the US.

Table 3

Selected Measures of Health Status and Health Access for Adults by Race/Ethnicity in California Compared to the United States, 2013

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>California</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>Black</td>
</tr>
<tr>
<td>Fair or poor health</td>
<td>13%</td>
<td>20%</td>
</tr>
<tr>
<td>Mental Distress</td>
<td>36%</td>
<td>39%</td>
</tr>
<tr>
<td>Smoke</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8%</td>
<td>20%</td>
</tr>
<tr>
<td>Are overweight or obese</td>
<td>57%</td>
<td>74%</td>
</tr>
<tr>
<td>Have a usual source of care</td>
<td>81%</td>
<td>82%</td>
</tr>
</tbody>
</table>

Data may not sum to 100% due to rounding and data restrictions. Data for Whites and Blacks exclude Hispanics.

(Kaiser Family Foundation, 2015)

Studies have categorized key factors for analysis to understand the nature of the obstacles existing with accessing care. Obstacles such as difficulty obtaining timely care, knowledge of navigating primary care, preferring emergency or urgent care, or perceived discrimination have been identified (Saluja et al., 2019). Despite coverage, many are still not receiving the care they are entitled to and need.
Overall Health Improvement

The World Health Organization (2021) describes overall health as multifaceted, comprised of several factors and not merely the absence of disease. According to the Centers for Disease Control and Prevention, “Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. They are also leading drivers of the nation’s $3.8 trillion in annual health care costs” (CDC, 2021, para. 1).

One such chronic disease, the Human immunodeficiency virus (HIV), used to be a death sentence but is now manageable with proper care and medication. For people with undiagnosed HIV, testing is the first step in maintaining a healthy life and preventing HIV transmission. Although the Medicaid expansion increased HIV testing overall, Menon et al. (2021) reported that “despite having baseline higher rates of HIV diagnosis, Black and Hispanic females did not have increased rates of ever having HIV testing following Medicaid expansion.” Additionally, the study noted that African American females, disproportionately affected by HIV, were not likely to receive help from the expansion relative to increased testing (Menon et al., 2021). We must understand and correct the deficiency in testing rates for this population. Without testing, detection, and treatment, a manageable disease such as HIV becomes fatal.

Economic Impact

Medicaid expansion influences a range of economic effects, including reductions in state spending, increased revenue, and expansion of the economy as a whole (Guth, 2020). According to numerous studies, Medicaid expansion could save the state money by balancing expenses in other areas. For example, with expanded Medicaid coverage, states can reduce the amount of allocated funds for other State-funded programs for the uninsured (Ward, 2020).
More research has revealed that Medicaid expansions reduce the amount of money that hospitals and clinics must pay for uncompensated care.

Through incentives to raise the value of care, improve beneficiary outcomes, and improve quality, the Affordable Care Act (ACA) enhances the healthcare delivery system. The promotion of Accountable Care Organizations is one of these crucial delivery system improvements (ACOs). ACOs help organizations and provider collaboration to improve the standard of care for Medicare beneficiaries and cut back on wasteful expenses (Abrams et al., 2019). When all the parts work cohesively, providers in an ACO can bring down prices and improve care quality while earning incentive payments.

Primary care has lacked significant support in the United States despite being a pivotal component of a successful health system (Abrams et al., 2019). This underinvestment in primary care is typically caused by the fact that clinicians profit financially from the customary fee-for-service reimbursement system (Abrams et al., 2019). Medical professionals could charge what they deemed appropriate instead of participating in managed care reimbursement model with caps on costs. Moreover, although the fee-for-service system benefited providers, the result was higher medical costs for US patients. One of the most critical questions related to the ACA and its consequences on the economy is whether or not state Medicaid expansion is a good idea (Ward, 2020). Analysis suggests that the Affordable Care Act positively impacted California’s economy, with variation across regions based mainly on their socioeconomic makeup upon full implementation in California (Ward, 2020). According to an analysis by Ward (2020), Medicaid expansion yielded a reduction in state spending on traditional Medicaid by over 4 percent. Although each state’s Medicaid expansion cost varies, there is often little to no net impact on general funds.
Conceptual Framework (Kingdon’s Model)

Kingdon’s (2011) multiple streams theoretic framework model can be applied to identify and understand the formation and implementation of the ACA policy. According to Kingdon (2011), three “streams” are required for issues to be put on the national agenda. The three distinct streams address various facets of agenda-setting: problems, policies, and politics. When two or more streams intersect or overlap, a window of opportunity opens (Kingdon, 2011). Though typically brief, this open window allows policymakers to move an issue forward onto the legislative agenda (see figure 3).
Figure 3

Kingdon’s Model Illustration

Problem Stream
- 50 million Americans had no health insurance
- High cost and rising faster than GDP
- Low quality coverage

Policy Stream
- Healthcare Reform Proposal

Political Stream
- Newly elected Democratic President
- Majorities in both houses of congress
- Young voters inspired

Window Of Opportunity

Policy Agenda
(H.R.3590 - Patient Protection and Affordable Care Act)

Problem Stream

The problem stream refers principally to issues in society that potentially require attention. Kingdon (2011) distinguishes between conditions such as poverty, bad weather, and
housing costs versus problems that attract lawmakers’ attention and motivate them to act. Millions of people were previously uninsured, which put them in a position to incur rising medical care expenditures, according to the indicators reported in the problem stream related to the ACA (National Conference of State Legislatures, 2011). Fifty million people were without health care coverage, the healthcare system was not reliably delivering at the highest quality, and the US had one of the costliest systems without comparable health outcomes (Jost, 2021). Studies have consistently provided evidence that primary health care achieved through insurance coverage provided benefits and lower costs directly associated with access to routine medical care (Shartzer et al., 2016). Despite the United States having one of the highest healthcare costs per person of any nation, it does not provide healthcare for everyone (Center for Public Impact, 2017). Next, the ACA was used to revive the insurance market by fostering fair competition between the public and private insurance markets, which was a policy alternative to address the lack of insurance coverage.

Policy Stream

The policy stream consists of a blend of ideas created by a variety of experts in the field of policy, including lawmakers, congressional staffers, academics, advocacy organizations, and researchers. (Kingdon, 2011). While many ideas circulate in the policy stream, only a few are ever cultivated, and concepts that are administratively and politically viable have the most probability of success (Kingdon, 2011). To ensure that participants in the policy stream are prepared with policy solutions when a problem appears on the government agenda, people and organizations in the policy stream continuously promote proposals for various situations or problems. (Kingdon, 2011). With healthcare in the US a problem too significant to ignore, Democrats and Republicans had policies ready to offer should the window of opportunity arise
(Manchikanti et al., 2017). While there were numerous suggestions for fixing the healthcare issue, Republican policy solutions typically lean toward limited government intervention, and Democratic solutions tend to view the government as a means to provide a public good (Brian et al., 2018). President Obama, a Democrat, had made healthcare reform a campaign promise, so when he won the election, it opened the window for government-run healthcare to be a priority issue (Center for Public Impact, 2017). When the Affordable Care Act was passed in 2010, statements from pro-ACA governors were useful in boosting support for the law in neighboring states (Pacheco et al., 2020). The passing of the Affordable Care Act (ACA) and the formulation of policies regarding the public option, the individual mandate, and Accountable Care Organizations required the participation of healthcare providers, healthcare organizations, payers, and insurers (Abrams et al., 2019). Many factors were in alignment to help the passing of the legislation.

**Political Stream**

The three main elements of the politics stream are the state of the nation, interest group campaigns, and changes in the legislative or executive branch (Kingdon, 2011). Differences in the problem stream might result from changes in the country's mood, which are often detected through public opinion polls. For example, sudden or extraordinary economic periods such as high unemployment or inflation can cause national-level mood changes, decreasing public confidence in the government and national policy (Kingdon, 2011). Changes in the political party in control of the White House or Congress, as well as large-scale public campaigns on behalf of interest groups, may cause political currents to shift. Many policy communities had comprehensive health care reform agendas waiting, including numerous interest groups, activists, organizations, religious groups, politicians, and more. When President Obama was
elected in 2008, the Democrats controlled the Presidency, the House of Representatives, and a majority in the Senate, which created an open window for reform (Manchikanti et al., 2017). President Obama made healthcare reform a priority of his administration and advanced the concept throughout his campaign (Center for Public Impact, 2017). The incoming president's supporters used the election to elevate healthcare reform to the top of their list of priorities for their constituency. Although there was deep division along party lines (Center for Public Impact, 2017), both houses of Congress worked to deliver a healthcare reform policy initiative known as the ACA. The ACA expanded Medicaid to low-income families, called for creating a healthcare market exchange where subsidized health insurance could be purchased, and mandated that employers and some individuals and employers provide healthcare.
Findings/Analysis

This research intended to examine why California is behind on access to care and overall patient health in communities of color despite having the most substantial Medicaid expansion under the Affordable Care Act. One-third of the people in the State of California have Medi-Cal, the State’s Medicaid program, as their only source of healthcare insurance coverage (Rowan, 2020). This study also looked at new approaches to health policy, which are covered in the section on its policy implications. Three themes emerged from the literature assessment of the peer-reviewed journal articles and supplementary materials:

1. Barriers to healthcare are more complicated than lack of insurance coverage.
2. Access to primary care is complex, and insurance does not equal access.
3. Despite California’s extensive expansion of Medicaid, healthcare disparities still exist among marginalized ethnic groups.

Barriers

Barriers to healthcare are more complicated than a lack of insurance coverage, despite expanding medical coverage to over one-third of the state’s population (Rowan, 2020). Studies examined for this paper indicate that various obstacles create challenges and hinder medical care. Low Medi-Cal reimbursement fees lead to limited provider acceptance of patients with this coverage (Coffman & Fix, 2017). Ercia (2021) reports that the rapid expansion of newly insured patients and the increased demand for provider services resulted in the supply of doctors not meeting the needs of Medi-Cal participants. Although the ACA Medicaid expansion led to substantial increases in Californians insured, many cannot obtain timely routine appointments and forego primary care (Dolan & Mejia, 2020). Delaying routine medical care leads to frequent
emergency department utilization. Results indicate that emergency department utilization has not decreased with the increase in insured individuals but instead has resulted in changes to the payor mix of emergency department patients from uninsured to those now covered by Medi-Cal (Barakat et al., 2017). Fewer people without health insurance are utilizing the ED; however, the total number of patients has not changed significantly. These results lead us to examine the ability to access primary care.

**Access to Primary Care**

Access to primary care is critical to navigating good health; however, insurance is complex and does not equal access. Health insurance can be confusing and difficult for people to understand (Saluja et al., 2019). Many may not know how to choose a health plan, use their benefits, and move through the Medi-Cal system (Saluja et al., 2019). Research from Molina and Briggs-Malonson (2017) indicates that an absence of knowledge of the ACA among Latinos substantially influences low enrollment and higher rates of uninsured persons from this population. Conversely, when participants know about benefits and how to access providers or preventive care services, they can take responsibility for their health care and achieve improved outcomes.

Although Medi-Cal expanded coverage to a significant number of Californians, the number of primary care providers did not increase proportionally (Saluja et al., 2019). Reports indicate participants have difficulty finding providers that accept MediCal, or providers reach a maximum number of patients and cannot care for more (Melnikow et al., 2020). Many providers cannot schedule timely appointments, and patients are left waiting for needed care.
Health Disparities Among Racial / Ethnic Groups

Despite California’s extensive expansion of Medicaid, healthcare disparities still exist among marginalized ethnic groups (Gaines & MBA, 2019). Although disproportionately affected by many chronic illnesses, racial and ethnic communities historically have less routine medical care (Lee et al., 2021). In evaluating racial and ethnic groups, researchers identified that regardless of insurance type, non-white participants forego needed care at a high percentage and have lower rates of routine medical care and doctor visit rates (Charles & McEligot, 2018). According to an investigation by the LA Times, some of our most socioeconomic disadvantaged Californians are subject to wait times so long that some have died before receiving the care they need (Dolan & Mejia, 2020).
Policy Implications

Kingdon’s (2011) three-stream policy framework provides an appropriate context to the present State of Medicaid policy and California’s delivery system Medi-Cal. First, the problem stream is evident in the lack of access and other barriers to primary care that hinder routine medical care, coupled with the continued healthcare disparity in communities of color (Lee et al., 2021). Second, the political environment reflects a variety of advocacy and interest groups both in favor of and opposed to using Medicaid monies for social determinants of health (Department of Health Care Services, 2019a). Third, solutions are currently being implemented through initiatives that aim to address deficiencies of the Medi-Cal program (Department of Health Care Services, 2019a).

California has the most extensive Medicaid program in the US, with 14.5 million recipients as of January 2022 (Department of Health Care Services, 2019b). Additionally, one-third of the state’s annual budget goes toward the state’s program, Medi-Cal (Gaines & MBA, 2019). A key finding of this research is that having insurance coverage does not equal access to care, and barriers to care are complex and numerous (Charles & McEligot, 2018). These findings support the argument that Medi-Cal offers low-income Californians necessary insurance coverage and that additional investments and enhancements are required to guarantee appropriate access to treatment for all participants.

Legislators may consider several improvements to the program to address the issues raised, such as boosting provider compensation to encourage physicians to accept Medi-Cal patients or enhancing opportunities for medical students to practice in areas with the most significant physician shortages (Saluja et al., 2019). Other considerations could be implementing
payment modifications for health plans and providers or encouraging low-cost alternative healthcare delivery such as language-specific telehealth (Saluja et al., 2019).
Limitations

Qualitative research methodology was necessary due to the nature of the research questions and the study’s topic. Only historical data was looked at in this study; no primary research was done. Peer-reviewed journals provide data and findings that contribute to our existing knowledge regarding the gap in health insurance and routine medical care, though not without limitations. There exists an inability to measure differences in populations, including the differences in Medicaid enrollment, marketing strategies, and patient care-seeking behavior. At the same time, similarities among racial and low socioeconomic groups are persistently present concerning access to quality care despite a substantial increase in insured rates in California.

Access to healthcare has been shown to be hampered by low patient satisfaction, prejudice, and a shortage of appointments and doctors. However, self-reported data has limits and is subject to bias from various causes, such as social desirability or recollection bias (being embarrassed to admit you haven’t sought care).

Most academic works consulted in this study relied on secondary data, questionnaires, and interviews to arrive at their conclusions. The lack of comprehensive study tools constrains the information and conclusions reached in this research. The selection of the articles was based on inclusion and exclusion criteria, which could introduce unconscious bias into the decision-making process. Additionally, the cited qualitative research is constrained to the keywords used during database searches, resulting in a limited collection of articles. Other relevant keywords could be used to trigger peer-reviewed studies with outcomes different from those examined in this study. The limited application of quantitative data analysis to this study is another limitation.
Recommendations for Future Research

The California Department of Health Care Services (DHCS) recently launched a new healthcare initiative transforming the Medi-Cal delivery system. Beginning January 1, 2022, California Advancing and Innovating Medi-Cal (CalAIM) to “strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory” (Department of Health Care Services, 2019a). This effort seeks to make the shift to a population health approach that prioritizes preventative care and whole-person care, including taking social determinants of health into account. By implementing value-based initiatives, modernizing the system, and reforming the payment system, the program hopes to "improve quality outcomes, minimize health inequities, and revolutionize the delivery system" (Department of Health Care Services, 2019a). As the program is in its beginning stage, no data is currently available on the impact it may have on existing barriers that exist within the Medi-Cal system. Future studies should consider the effectiveness of CalAIM and its intended outcomes with specific attention to its effect on marginalized communities of color.

Furthermore, the LA Times just published an article stating that a new program to hold the Department of Health Care Services, which manages Medi-Cal, accountable for its services, is set to take effect in 2024 (Wolfson, 2022). According to officials, the initiative will enhance care by requiring participating health plans, which are used by almost 12 million of the 14 million Medi-Cal consumers, to meet stricter requirements. (Wolfson, 2022). By strengthening oversight of treatment shortcomings and implementing sanctions for health plans that fail to satisfy the needs of the insured, the managed care contract seeks to decrease health inequities and improve health outcomes.
Conclusion

Medical care is a fundamental need for all individuals, and lack of access can have devastating effects. The ACA was implemented to address the gap in insurance coverage to provide individuals with vital routine medical care and reduce the costly impact of a lack thereof (Kaiser Family Foundation, 2017). The policy has achieved its goals on many levels by providing medical insurance to over seventeen million previously uninsured individuals, specifically with Medicaid expansion (Allen et al., 2017). According to research, expansion states have financial advantages that lower the costs of unpaid care for institutions and medical providers (Guth, 2020). However, having insurance is just one determining factor for receiving care; many barriers still exist, and overall, we have not seen a significant improvement in overall patient health in California (Courtemanche et al., 2018). Low-income individuals, those in poor health, members of racial and ethnic minorities, and public insurance recipients are at higher risk of encountering access restrictions. Closing the gap in health disparity is crucial to improving our country’s overall health (Schwehr et al., 2021) and thus reducing health care costs.

Furthermore, some existing research for California shows that health care access has improved post ACA enactment (Courtemanche et al., 2018). Nevertheless, California scores among the lowest in terms of access compared to other states (Gaines & MBA, 2019). While gains in insurance coverage have improved in California, the complexity of primary care access for insureds exists specifically in racial and ethnic groups (Yue et al., 2018). Disparities occur across many dimensions, including race, ethnicity, and socioeconomic status. Although Medi-Cal is an entitlement program, qualified racial/ethnic minority populations, particularly Hispanics, may face more obstacles to enrollment and receiving benefits from this social welfare program (Molina & Briggs-Malonson, 2017). These barriers to accessing healthcare include
income inequalities, low understanding of the ACA, low rates of physicians accepting Medi-Cal, and other health system barriers (Yue et al., 2018). California, the state with the largest cultural diversity, has a crucial stake in solving the health inequalities that plague people of color. Research is needed to examine and formulate effective measures and targeted interventions to improve access and remove barriers to care within the MediCal program in California, specifically to address the persistent racial and socioeconomic inequalities in healthcare.
References


