

The Impact of the Affordable Care Act on the Health of Racial and Ethnic Minority Communities in North Carolina

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North Carolina is one of the most racially and ethnically diverse states in the country, with a total minority population exceeding one-third of the state's total population, which is approximately 25% African American and nearly 10% Hispanic/Latino ethnicity [1]. North Carolina also has the largest American Indian population of any state east of the Mississippi River (approximately 2% of the state's population) with its American Indian residents represented by eight state or federally recognized tribes and four Urban Indian Centers across the state [2].

Health disparities among racial and ethnic minorities in North Carolina are well documented. For example, African American infants are approximately 2.5 times more likely to die in their first year of life; African Americans and American Indians are approximately 2.5 times more likely to die from diabetes; and Hispanic/Latinos are nearly five times more likely, and African Americans nearly 10 times more likely, to be diagnosed with HIV/AIDS compared to their white counterparts [3]. Many of these health disparities arise from preventable health conditions based on limited access to screening and treatment options in these communities. Racial and ethnic minorities in our state, particularly African Americans, American Indians, and Hispanics, are significantly more likely to report not having health insurance and not being able to see a doctor due to costs [4-5]. These persistent disparities are also deeply rooted within the complex context of the social determinants of health, which play an outsized role in racial and ethnic minority communities [3]. Furthermore, North Carolina has one of the largest rural populations in the country, with approximately 2.2 million people—roughly 20% of its citizens (many of whom are racial/ethnic minorities)—living in rural communities [6], further exacerbating the challenges in addressing health disparities.

A goal of the Patient Protection and Affordable Care Act (ACA), implemented in 2010, was the elimination of these persistent racial and ethnic health disparities in our country. The ACA was responsible for the creation of the National Institute on Minority Health and Health

Disparities (NIMHD) (www.nimhd.nih.gov), one of the 27 institutes and centers of the National Institutes of Health (NIH). The primary mission of the NIMHD is to lead and support scientific research to understand and address health disparities. The National Standards for Culturally and Linguistically Appropriate Services (CLAS), published by the US Department of Health of Health and Human Services Office of Minority Health, originally launched in 2000, were enhanced in 2010-2012 to align with the efforts by the ACA to eliminate health disparities [7].

The ACA prioritized the elimination of racial and ethnic health disparities through increased provision of affordable health insurance. Notable successes toward this goal have been documented since 2010. A report by the Kaiser Family Foundation indicated that between 2010 and 2016 all major racial/ethnic minority groups showed significant increase in insurance rates, although gaps in access to health insurance between non-Hispanic whites and racial/ethnic minorities still persist, and uninsurance has started to increase in racial/ethnic minority groups since 2016 [8].

One of the most important provisions of the ACA was the allocation in 2014 of federal funding to states that agreed to expand Medicaid to most low-income adults at or below 138% of the federal poverty level [9]. Since many racial and ethnic minorities fall within this coverage gap, Medicaid expansion has the potential to significantly impact racial and ethnic health disparities [10]. To date, 38 states and Washington, DC, have expanded Medicaid [11], with these states experiencing significant improvements in health insurance coverage [12] and health outcomes [13-14]. For example, a 2019 National Bureau of Economic Research report indicated Medicaid expansion saved 19,200 lives of adults aged 55 to 64 (2014-2017) with nearly 15,600 lives lost as a result of the decision by states to not expand Medicaid [13].

Unfortunately, as of this writing, North Carolina is one of the 12 states that has not adopted Medicaid expansion, leaving approximately 400,000 adults in our state who would otherwise be eligible for Medicaid without

health insurance [15]. Not only would there be a significant impact on enhancing health care coverage, Medicaid expansion could provide a significant economic benefit to the state, which would enhance efforts to impact the social determinants of health to reduce racial and ethnic health disparities [15].

On this 10th anniversary of the adoption of the ACA, racial and ethnic health disparities are persistent and pervasive in our state. Our state is recognized as a national leader in addressing health care through its innovative approaches, such as the statewide coordinated care network NCCARE360 and the proposed Medicaid transformation [16]. However, without taking advantage of all the opportunities available through full implementation of the provisions of the ACA, we may continue to do injustice to our most vulnerable populations and fail to achieve health equity. NCMJ

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