Examining the Impact of the *Affordable Care Act* on Access to Care For Black Men and White Men: Implications for Policy and Practice

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Abstract of Dissertation

Examining the Impact of the *Affordable Care Act* on Access to Care For Black Men and White Men: Implications for Policy and Practice

Black men experience poor health outcomes across a spectrum of chronic medical conditions and co-morbidities that ultimately lead to lower quality of life and premature death. Lack of access to medical care is one of many factors that contributes to these poor outcomes. This study examines the impact of the *Patient Protection and Affordable Care Act of 2010* (ACA) on Black men's access to care compared to White men ages 18-64; and proposes strategies to help address any inequities. The ACA undergirds this study because it includes several provisions that are specifically meant to help address racial and ethnic health disparities and improve health outcomes.

This study took a longitudinal approach by examining access to care among non-Hispanic Black men and non-Hispanic White men ages 18-64 from 2011-2019. Using a publicly available secondary data source, the Medical Expenditure Panel Survey (MEPS), a descriptive and multi-variate analysis was conducted to examine the relationship between race, sociodemographic characteristics, and two indicators of health care access (insurance status and usual source of care). To statistically test hypotheses regarding the impact of the ACA on racial differences in these two indicators, an interaction term for race and two time periods (2011-2014 vs. 2015-2019) was included in regression models.

The analysis found that the ACA decreased the proportions of non-Hispanic Black men and non-Hispanic White men who were uninsured after 2014 by nearly 50%; however, racial disparities persisted. Other key findings are as follows: 1) race was a significant predictor of being uninsured, with non-Hispanic Black men having 30%

greater odds than non-Hispanic White men of being uninsured and 2) non-Hispanic Black men had 25% lower odds than non-Hispanic White men of having a usual source of care. Other factors significantly associated with a greater likelihood of being uninsured were being part-time and intermittently employed and living in a Southern state. Factors significantly associated with a greater likelihood of not having a usual source of care were education (i.e., completing high school, college degree) full-time, part-time, or intermittent employment, and region (living in the South or the West).

While the ACA achieved one of its goals of increasing health insurance coverage for men of both racial groups examined in this study, the racial gap between non-Hispanic Black men and non-Hispanic White men did not close for the two outcomes of interest – being uninsured or having a usual source of care post-ACA. These findings have implications for policy and practice to improve health care access. Specific policy recommendations proposed include: 1) develop pathways to coverage for states that have yet to adopt Medicaid expansion and 2) use a multilevel approach to expand the proportion of men with a usual source of care that includes: a) disseminating educational messages to improve men's awareness of the value of having a regular source of care and b) facilitating health care delivery and payment reforms that incentivize health care institutions to increase the number of Black men who are meaningfully engaged with a regular source of care.

Keywords: Black men, *Affordable Care Act*, access to care, equity, policy, advocacy

Table of Contents

Abstract of Dissertation ..... **iv**

Table of Contents ..... **vi**

List of Figures ..... **viii**

List of Tables ..... **ix**

Chapter 1: Introduction 1

Statement of the Problem and Purpose of the Study 8

Study Aim and Questions 8

Chapter 2: Literature Review 13

Background on the Patient Protection and Affordable Care Act of 2010 17

Evolving Concepts of Access to Care 19

Barriers in Access to Care 24

Chapter 3: Methodology 32

Study Questions and Hypotheses 32

Theoretical Frameworks 34

Study Design 38

Data Source 39

Variables of Interest 43

Dependent or Outcome Variables 44

Primary Independent or Predictor Variables 46

Covariates 46

Data Analysis and Management Plan 48

Chapter 4: Results 52

Description of the Study Populations 52

Indicators of Health Care Access....55
Insurance Status Regression Model One....59
Impact of Sociodemographic Characteristics (Model One)....60
Usual Source of Care Regression Model Two....62
Impact of Sociodemographic Characteristics (Model Two)....63
Summary of Key Findings and Null Hypotheses....65
Chapter 5: Discussion....70
Overview of Findings....71
Lack of Health Insurance Discussion and Implications....73
Usual Source of Care Discussion and Implications....75
Policy Recommendations....76
Strengths and Limitations....88
Strengths....88
Limitations....88
Future Research Recommendations....90
Conclusions....93
References....94
Appendix....123

List of Figures

Figure 1 *Model of Access to Personal Care Services* 21

Figure 2 *Aday-Andersen Access to Care Framework* 37

Figure 3 *The Andersen Model of Healthcare Services Utilization* 38

Figure 4 *Weighted Percentages of Non-Hispanic White Men and Non-Hispanic Black Men Uninsured (Pre-ACA, 2011–2014; Post-ACA, 2015–2019)* 55

Figure 8 *Weighted Percentages of Non-Hispanic White Men and Non-Hispanic Black Men Without a Usual Source of Care Across Regions of the Country (Pre-ACA, 2011–2014; Post-ACA, 2015–2019)* 59

Figure 9 *Weighted Percentages of Non-Hispanic White Men and Non-Hispanic Black Men With a Usual Source of Care Across Regions of the Country (Pre-ACA, 2011–2014; Post-ACA, 2015–2019)* 59

Figure 4 *Number of Non-Hispanic Black Men and Non-Hispanic White Men Ages 18–64 from MEPS Database (2011–2019)* 132

Figure 5 *Number of Non-Hispanic Black Men and Non-Hispanic White Men Ages 18–64 from MEPS Database (2011–2019)* 133

Figure 6 *Status of State Medicaid Expansion Decisions* 133

Figure 10 *MEPS Usual Source of Care Database Query* 134

Figure 1A *Intersectional Approach to Men's Health Disparities* 135

Figure 2A *John Kingdon's Three Streams Model* 136

List of Tables

Table 1. *Health, Access to Care, and Socioeconomic Indicators, Men 18–64 by Race/Ethnicity; 2006–2008* 16

Table 2 *Number of Non-Hispanic Black Men and Non-Hispanic White Men Ages 18–64 from MEPS Database (2011–2019) n = 46,277* 42

Table 3 *Variables Considered for Addressing Study Questions 1.1–1.3* 50

Table 4 *Weighted Percentages of Non-Hispanic White Men and Non-Hispanic Black Men by Age, Education, Employment, Income, and Region (Pre-ACA, 2011–2014; Post-ACA, 2015–2019)* 54

Table 5 *Comparing Non-Hispanic White Men and Non-Hispanic Black Men by Insurance Status (Pre-ACA, 2011–2014; Post-ACA 2015–2019)* 56

Table 6 *Comparing Non-Hispanic White Men and Non-Hispanic Black Men by Usual Source of Care (pre-ACA, 2011–2014; post-ACA 2015–2019)* 56

Table 7 *Weighted Percentages of Men by Race, Selected Sociodemographic and Usual Source of Care (Post-ACA, 2015–2019)* 58

Table 8 *Logistic Regression Predicting Adjusted Odds of Being Uninsured, 2011–2019 (Non-Hispanic Black Men and Non-Hispanic White Men 18–64)* 62

Table 9 *Logistic Regression Predicting the Adjusted Odds Ratios of Having a Usual Source of Care, 2011–2019 (Non-Hispanic Black Men and Non-Hispanic White Men 18–64)* 65

Table 10 *Summary of Null Hypotheses 1.1–1.3 and Key Findings* 69

Table 1A *Overview of Articles Outlining the Breadth of Key ACA-Related Findings Across Race, Ethnicity, and Gender* 123

Table 1B *Variance Inflation Factors for Regression Predicting Insurance Status*..... 127

Table 1C *Race x Time Interaction Logistic Regression Predicting Uninsured, 2011–2019 (Non-Hispanic Black Men and Non-Hispanic White Men 18–64)* 128

Table 1D *Variance Inflation Factors for Regression Predicting Usual Source of Care*..... 129

Table 1E *Race x Time Interaction Logistic Regression Predicting Usual Source of Care, 2015–2019 (Non-Hispanic Black Men and Non-Hispanic White Men 18–64)* 130

Table 1F *Dissertation Study Strengths and Limitations* 131

Table 1G *Recommendations for Future Research*..... 137

Chapter 1: Introduction

Black men experience poor health outcomes across a spectrum of chronic medical conditions and co-morbidities (e.g., cardiovascular disease, cancer, obesity, diabetes etc.) that ultimately lead to lower quality of life and premature death (Bond & Herman, 2016; Centers for Disease, 2019; Gilbert et al., 2016; Graham & Gracia, 2012; Williams, 2003a). Lack of access to medical care is one of many factors that contributes to these poor outcomes (Griffith, 2019; Lee et al., 2023). While the ACA was a landmark piece of bipartisan legislation that arguably helped reform the health policy field and health care ecosystem, recent studies have found that Black adults continue to fall behind other racial and ethnic groups in access to care (Artiga, 2021b; Baumgartner, 2020; KFF, 2019; Lee, 2022). Moreover, it has been well-established in the literature that a lack of health insurance is the most important predictor of not having a usual source of care (i.e., having an ongoing relationship with a health care provider or facility) (Akinyelure et al., 2022; Blewett et al., 2008; Davis, 2001; Fang et al., 2014; Hammond et al., 2011; IOM, 2002a; Toth-Manikowski et al., 2022; Xu, 2002).

Contextually, the ACA sought to: 1) expand health insurance coverage 2) reduce health care costs and 3) improve the quality and performance of the health care system (DHHS, 2022; KFF, 2013). Despite these goals, the law has been subjected to dozens of legal challenges at the federal and state levels since 2010 (Buchmueller & Levy, 2020; NCSL, 2021; Rosenbaum, 2011). For example, the 2012 United States Supreme Court case *National Federation of Independent Business (NFIB) v. Sebelius* argued the constitutionality of the ACA's individual mandate – which required that most people obtain health insurance or pay a tax penalty (Fiedler, 2020). The tax penalty was

effectively eliminated by the *Tax Cuts and Jobs Act of 2017*; thus, the individual mandate tax penalty was repealed (S. Glied, 2018). The repeal occurred despite several studies finding that the individual mandate reduced the number of uninsured Americans by at least several million since implementation of the ACA (Blumberg, 2018; Fiedler, 2018; S. Glied, 2018; S. C. Glied, Ougni, 2018). While improving access to care has remained a critical component of the health reform ecosystem for decades, further evidence is needed to assess the contributions of the ACA in achieving greater equity in access to care across racial and gender groups.

To be clear, Medicaid expansion is a key provision – along with a combination of new insurance Marketplaces and subsidies – that the ACA implemented in 2014 (Lee et al., 2021); and therefore, a critical component of this study. Throughout this study, "pre-ACA" and "post-ACA" refer to the periods before and after coverage expansions took effect in 2014, not the actual enactment of the ACA on March 23, 2010.

According to the National Academies of Sciences, Engineering, and Medicine (NAM) and the Agency of Healthcare Research and Quality (AHRQ), access to care is generally defined as having "the timely use of personal health services to achieve the best health outcomes" (AHRQ, 2014, 2022c; Institute of Medicine Committee on Monitoring Access to Personal Health Care, 1993). This NAM definition is informed by earlier work by Aday and Andersen, who first conceptualized an access to care framework in 1974 (Aday & Andersen, 1974). Their framework is the conceptual foundation for this dissertation and it will be discussed further in chapter three. Further, how one defines "health disparities" and "health equity" has important policy implications with practical consequences (Braveman, 2006, 2014; Braveman & Gruskin, 2003). For the purposes of

the study, health disparities are defined as "systematic, potentially avoidable differences in health between groups of people who have different relative positions in social hierarchies according to wealth, power, or prestige" (Braveman, 2006). Health equity will be defined as "minimizing avoidable disparities in health and its determinants–including but not limited to health care–between groups of people who have different levels of underlying social advantage or privilege" (Braveman, 1998). This is noteworthy because a purpose of this study is to propose ways to address any inequities, making the health equity definition fundamental to this study.

Notably, one recent study using Medical Expenditures Panel Survey data from 2016–2019 (after implementation of the ACA) found that racial and ethnic costs of health inequities cost the United States an estimated $421 billion (LaVeist et al., 2023). This health equity-focused study also found that the Black population bore 74% of the economic burden of racial and ethnic health inequities in the United States (LaVeist et al., 2023). While LaVeist and colleagues did not specifically examine the economic burden associated with men in their study (LaVeist et al., 2023), Thorpe and colleagues found that total indirect costs (e.g., loss of productivity) to the economy incurred by Black men's health disparities was $317.6 billion from 2006-2009 (Thorpe et al., 2013). Moreover, because the LaVeist study did not disaggregate by race and gender, this leaves a significant gap in the literature that should be addressed in future research. Nonetheless, these factors among others are of considerable policy interest to a variety of stakeholders in the health care ecosystem who examine health care access and utilization because despite Black men having a shorter life expectancy than almost every other racial/ethnic groups, they continue to be invisible on research and policy agendas that promote their

health, well-being, and access to care (Andersen & Davidson, 2007; Garrett, 2016; Griffith, 2020).

Several studies (Lee, 2022; NORC, 2022; Sugar, 2022) have examined access to care as measured by race, ethnicity, and other factors such as age, socioeconomic status, education, region etc. However, there is a dearth of ACA-related studies that have explicitly investigated and disaggregated their findings by sex or gender, or that specifically evaluated differences between non-Hispanic Black men and non-Hispanic White men (Adamson et al., 2021; Chen et al., 2016; Ladapo & Chokshi, 2017; Sugar, 2022). For example, one study found that Black men are at greater risk (18%) of being uninsured compared to White men (11%) (KFF, 2016). Disaggregating data by sex provides for a range of different disease prevalence and outcome measures; and is a vital first step in addressing gender disparities that may exist in terms of access to care and health outcomes (Colvin, 2023).

This study focuses on Black men for several reasons. One important reason why this study focuses on Black men is because of the long and storied history of structural racism in the United States; and how structural racism has shaped differential life outcomes (e.g., life expectancy, health care access, insurance coverage, health care utilization, blood pressure management etc.) between Black men and White men across the life course for decades (Bailey et al., 2021; Bailey et al., 2017; Coke & Hayman, 2021; Collins, 2021; Dean & Thorpe, 2022; Dennis et al., 2021; Gee & Ford, 2011; Gee & Hicken, 2021; Hardeman et al., 2016; Kendi, 2016; Metzl, 2013; Priest & Williams, 2021; Shelton et al., 2021; Williams et al., 2019; Yearby, 2020; Yearby et al., 2022). At the same time, gender differences are not independent of the impact that structural racism

has on Black people (Griffith, 2012). For example, Black men and women continue to experience higher cardiovascular mortality rates than their White counterparts (Carnethon et al., 2017; Kyalwazi et al., 2022; Williams, 2009). While this study will not be explicitly operationalizing structural racism, it is important to highlight its influence on racial differences in access to care and health outcomes among men.

Another critically important reason why this study focuses on Black men is because they are more likely to be demonized and criminalized (e.g., disparate mass incarceration rates between Black men and White men) in ways that require a more nuanced understanding of race and gender as salient determinants of men's access to care (Gilbert et al., 2016; Smiley & Fakunle, 2016). Further, race and gender (Jones, 2000; Springer et al., 2012; World Health, 2021) tend to constitute broader structural forces that shape historical, socio-economic, and political dynamics (e.g., the political determinants of health), which map on to cultural norms, institutional policies, and practices (Dawes, 2020; Griffith et al., 2011; Jones, 2000; Lin, 2022).

For example, the long-standing disparities and inequities that negatively impact Black men can potentially be mapped to the lack of sustainable, robust, and targeted research funding awards for researchers who desire to support Black men and their health (Ginther et al., 2011; Taffe & Gilpin, 2021). Studies have found that Black principal investigators were significantly underrepresented even after adjusting for career stage and degrees – with Black principal investigators being 40% less likely than their White colleagues to be a principal investigator (Nguyen et al., 2023). This lack of funding support manifests in a limited focus on the health of Black people and the invisibility of Black men's health on research and policy agendas. Effective policy-making incorporates

social and structural contexts that are informed by the researcher's agenda (CAR, 2022; CEPR, 2017; Douglas et al., 2019). Therefore, the disaggregated data that this study aims to provide seeks to align with the four principles that have been found to help bolster effective public health policy change: 1) evidence to inform policy 2) health equity 3) policy with implementation in mind and 4) practically translating the policy to relevant communal contexts (Pollack Porter et al., 2018).

Additionally, biopsychosocial factors have been found to put men at disproportionate risk of death (Griffith et al., 2020). For example, more men than women have died of COVID-19 in 41 of 47 countries, and the overall COVID-19 case-fatality ratio is approximately 2.4 times higher among men than among women (APHRC, 2020; Sharma et al., 2020; Smith et al., 2020). Another study found that Black men had the highest death rate of all race and gender groups due to COVID-19 (Rushovich et al., 2021). A biopsychosocial approach helps to identify why, how, and under what conditions key determinants of health affect the health outcomes of men. Consequently, there is a critical need to examine gender differences across race because of long-standing disparities and inequities like life expectancy, cardiovascular disease, and cancer among other diseases (Gilbert et al., 2016; Griffith et al., 2011; Griffith, 2019).

As noted earlier, gender has been found to be a fundamental social determinant of men's health that markedly delineates how socio-political, economic, cultural, and other factors impact health, health care access, and utilization (e.g., shorter life span, more risky health behaviors) (Bruce et al., 2015; Griffith et al., 2011; Griffith, 2019; Thorpe et al., 2015; Thorpe & Whitfield, 2018; Thorpe et al., 2013). Since implementation of the ACA, few studies have explicitly examined non-Hispanic Black men and non-Hispanic

White men in terms of access to care – as measured by insurance status and usual source of care (Barghi et al., 2019; Powell et al., 2020). Having insurance and a usual source of care enhances access to care, improves quality of care services, lowers health care expenditures, and conceivably decreases health care disparities (Lee et al., 2023). Having regular access to a primary care provider (PCP) is particularly important because PCPs directly provide integrated services to patients and develop sustainable relationships with patients – thus potentially improving health outcomes (Lee et al., 2023).

Therefore, Black men can serve as a salient model for examining key concepts, mechanisms, and pathways by which social drivers or determinants impact health because it has been well-established in the literature that Black men (compared to White men) continue to face significant structural barriers at the nexus of race and gender (Griffith, 2012; Griffith et al., 2013; Griffith et al., 2012; Griffith et al., 2021; Griffith et al., 2011; Griffith et al., 2010; Griffith, 2019; Jack & Griffith, 2013). These structural barriers have manifested in long-standing inequitable access to care between Black men and White men. Black men are also the population most in need of interventions because of their overall health profile, rates of insurance, and rates of healthcare utilization compared to their White counterparts (Griffith, 2019; D. Watkins, 2017). Ostensibly, these entrenched disparities continue to have a disproportionate impact on the Black community particularly in the context of life expectancy and the social determinants of health – social drivers that impact where we are born, live, work, play, age, and worship (Allana et al., 2022; Braveman & Gottlieb, 2014; Bruce et al., 2015; Caraballo et al., 2023; Catalyst, 2017; Cockerham et al., 2017; DHHS, 2021; Embrett & Randall, 2014; Flaskerud & DeLilly, 2012; Treadwell et al., 2012).

Statement of the Problem and Purpose of the Study

Non-Hispanic Black men are less likely to have access to care than non-Hispanic White men (AHRQ, 2022c; Gilbert et al., 2016; Hammond et al., 2011; Richardson et al., 2021). Therefore, the purpose of this study is to examine the association between the enactment and implementation of the *Patient Protection and Affordable Care Act of 2010* (ACA) with respect to Black men's access to care (as measured by insurance status and having a usual source of care) compared to White men ages 18–64; and to propose future strategies to help address any inequities. The ACA undergirds this study because it includes several provisions – to be discussed in greater detail in the literature review – that are specifically meant to help address health disparities and improve health outcomes (Buchmueller et al., 2016; Buchmueller & Levy, 2020; DHHS, 2022; Griffith et al., 2017; Thomas et al., 2012).

Study Aim and Questions

Prior ACA-related studies have examined racial and ethnic disparities in access to care and health care utilization from 2011–2015, physicians' provision of preventive cardiovascular services from 2006–2013, and timely cancer treatment from 2011–2019 (Adamson et al., 2021; Chen et al., 2016; Ladapo & Chokshi, 2017). However, little is known about the differences in access to care (as measured by insurance status and having a usual source of care) specifically for non-Hispanic Black men before and after implementation of the ACA in 2014. For example, the Adamson study found that Black patients accounted for 8.7% of patients diagnosed with cancer under Medicaid expansion vs. 14.5% of Black patients in non-Medicaid expansion states. However, the Adamson

study did not examine their data in the context of race and gender before and after ACA implementation.

Similarly, the Chen study found that the uninsured rates in 2014 were reduced by 7% for Black adults and 3% for White adults, compared with their uninsured rates in 2011; but their data was not disaggregated by race and gender. The Ladapo study was the first to analyze changes in use of cardiovascular preventive care after the ACA by directly assessing physician decision making. While they found that more men than women used aspirin before and after ACA implementation (11.1% in 2006-2010 to 13.5% in 2010-2013 respectively), they did not disaggregate their data further to compare Black men and White men. These findings highlight the gaps in the literature that this dissertation study seeks to examine and address.

Noted previously, Medicaid expansion was a key provision of the ACA that was implemented in 2014 (Lee et al., 2021). Consequently, the overall aim of this study is to further build an evidence base for improving access to care for non-Hispanic Black men. While this study will not explicitly be operationalizing a chronic condition like cardiovascular disease, the theory underlying this investigation is that increasing access to care provides for earlier diagnosis, better screening, more sustainable interventions, and improved outcomes for issues like chronic high blood pressure for non-Hispanic Black men who are disproportionately impacted by this type of chronic disease (Blyler & Rader, 2019; Ebinger et al., 2020; Releford et al., 2010; Victor et al., 2018; Victor et al., 2011; J. Williams, 2020).

Moreover, this study examines access to care since the 2012 Supreme Court case *NFIB v. Sebelius*. Ten states have yet to expand Medicaid to their citizenry, leaving a

"coverage gap" negatively impacting an estimated 5.8 million uninsured adults (many of whom are people of color) in those states (KFF, 2023). Likewise, the unique contribution to the field of public health and policy is to use a socio-demographically diverse national data set to specifically explore the extent to which the ACA has improved access to care and having a usual source of care for non-Hispanic Black men ages 18–64. Regarding age groups, this study seeks to focus on working age adults (18–64) because individuals in this age range are more likely to gain or have insurance coverage through the ACA (Angier et al., 2020). People aged over 65 are eligible for government Medicare insurance which is distinct from the goals and intent of the ACA (Aggarwal et al., 2022).

The specific aim, study questions, and hypotheses are delineated below.

Study Aim: Describe health insurance coverage (insured and uninsured) and usual source of care (with or without a usual source of care) before and after implementation of the ACA among non-Hispanic Black men and non-Hispanic White men ages 18–64.

Study Question 1.1: Are there racial differences in health insurance coverage and usual source of care between non-Hispanic Black men and non-Hispanic White men ages 18–64 during the pre-ACA period 2011–2014?

Study Question 1.2: Are there changes in health insurance coverage and usual source of care among non-Hispanic Black men and non-Hispanic White men ages 18–64 after implementation of ACA-related provisions from 2015–2019 (post-ACA)?

Study Question 1.3: To what extent did the ACA close the racial gap between non-Hispanic Black men and non-Hispanic White men ages 18–64 in terms of insurance status and having a usual source of care from 2015–2019 (post-ACA)?

Justification 1: One pre-ACA (2006–2008) study analyzing Current Population Survey data from the United States Census Bureau, found that 28.8% of Black men were uninsured compared to 15.7% of White men ages 18–64 (KFF, 2012). This study also found that 30.3% of Black men did not have a usual source of care compared to 22.6% of White men ages 18–64 (KFF, 2012). The 2012 Kaiser Family Foundation (KFF) study was the only one identified in the literature that specifically disaggregated Black men and White men in terms of different diseases like CVD and access to care indicators. While the 2012 KFF study did not specifically provide data on access to care indicators for women, a 2009 KFF study found similar racial and ethnic differences in health care access indicators between Black and White women (KFF, 2009). Thus, employing a dataset (to be discussed in chapter three) more specifically structured to collect data on insurance coverage, access to care, and utilization among other variables could potentially confirm prior study findings and identify changes in health insurance coverage and usual source of care specifically among non-Hispanic Black men and non-Hispanic White men ages 18–64 since 2012.

Moreover, it has been well-established in the literature that non-Hispanic Black men (compared to non-Hispanic White men) continue to face significant barriers at the nexus of race and gender in terms of their health (Griffith, 2012; Griffith et al., 2013; Griffith et al., 2012; Griffith et al., 2021; Griffith et al., 2011; Griffith et al., 2010; Griffith, 2019; Jack & Griffith, 2013). Thus, this study seeks to make a compelling case for advancing health equity on behalf of non-Hispanic Black men by comparing disaggregated data across racial and gender groups.

Given that context, the following hypotheses are proposed:

Null Hypothesis 1.1a: Before 2015, the proportion of uninsured non-Hispanic Black men was the same as the proportion of uninsured non-Hispanic White men ages 18–64.

Null Hypothesis 1.1b: Before 2015, the proportion of non-Hispanic Black men with a usual source of care was the same as the proportion of non-Hispanic White men ages 18–64 with a usual source of care.

Null Hypothesis 1.2a: Among non-Hispanic Black and non-Hispanic White men, the proportion of uninsured before ACA implementation was the same as the proportion of uninsured after ACA implementation.

Null Hypothesis 1.2b: Among non-Hispanic Black and non-Hispanic White men, the proportion of usual source of care before ACA implementation was the same as the proportion men with of usual source of care after ACA implementation.

Null Hypothesis 1.3a: The ACA has not closed the racial gap between non-Hispanic Black men and non-Hispanic White men ages 18–64 in terms of insurance status (i.e., percent uninsured) post-ACA.

Null Hypothesis 1.3b: The ACA has not closed the racial gap between non-Hispanic Black men and non-Hispanic White men ages 18–64 in terms of usual source of care post-ACA.

Chapter 2: Literature Review

For far too long, non-Hispanic Black men's health has been regarded as unimportant to the health and well-being of the communities where they are born, grow, live, work, or age (Brown et al., 2015; Bruce et al., 2015; Enyia et al., 2016; Gilbert et al., 2016; Griffith et al., 2013; Treadwell et al., 2012). As noted earlier, an examination of the literature found a dearth of health equity and policy-related studies that attempt to incorporate a more nuanced understanding of why non-Hispanic Black men are missing or invisible in the health care, public health, health policy and men's health fields (Gilbert et al., 2016; Griffith, 2018). For example, Black men are more likely than other population groups to have undiagnosed or poorly managed chronic conditions (e.g., high blood pressure, cancers, diabetes etc.) and to delay seeking medical care (Gilbert et al., 2016; Hammond, 2010).

This notion of non-Hispanic Black male "invisibility" is articulated metaphorically in the 1952 book, *Invisible Man* by Ralph Ellison, which poignantly describes a nameless Black man navigating the Great Migration from southern cities to northern cities (Black et al., 2015; Gilbert et al., 2016). His social experiences and the policies in place during the Great Migration reveal and remind him of the negative stereotypes (e.g., criminality, ineptitude, poor health behaviors) and caricatures that shape how he is perceived and treated by the socio-political power structures in place (Bailey et al., 2021; Hardeman et al., 2016; Kendi, 2016; Krieger, 2021; Schneider & Ingram, 1993).

Because the nameless Black man is seen as representative of an entire population group – as opposed to an individual with inherent value - his existence is relegated to the

margins of society (Griffith, 2018; Griffith, 2019). Dichotomously, Black men are hyper-visible in the criminal justice system (Rowell-Cunsolo et al., 2016; Wang et al., 2014; Williams et al., 2020). Yet woefully, they continue to be invisible in research and policies (i.e., policy neglect) aimed at improving their health and well-being (Gilbert et al., 2016; Griffith, 2018). Another component of this dichotomy is that significant movement on salient issues requires the political will of actors who have the power and resources to effect sustainable change; but this effort is made more difficult if the impacted communities are absent from research and legislative agendas intentionally or unintentionally (Baum et al., 2020; Hankivsky et al., 2014; Lin, 2022; Schneider & Ingram, 1993).

Consequently, the combination of issues like premature mortality (e.g., 526.3 Black men v. 396.0 white men per 100,000 cardiovascular mortality deaths) and mass incarceration (2,272 Black men v. 392 white men per 100,000 prison inmates) of non-Hispanic Black men continues to result in their disproportionate lack of representation in national survey samples compared to non-Hispanic White men (Gramlich, 2020; Kyalwazi et al., 2022). This is another reason why racial and ethnic minorities (more broadly) are oversampled in various study designs that use quantitative data to ensure adequate statistical sample size calculations (Vaughan, 2017). Further, the underrepresentation of non-Hispanic Black men in census data has a direct and measurable impact on the extent to which sustainable resources can be allocated to historically marginalized communities where they reside (Gilbert et al., 2016; Griffith, 2012).

This dynamic is further complicated by the fact that Black men are more likely to be unemployed than White men (12.6% of Black men v. 6.5% of White men as of 2020) – which means that Black men are less likely to have private or employer-based insurance (Gilbert et al., 2016; Reeves, 2020). Black men's unemployment rates are higher than Black women (11.1%) and White women (6.9%) (Reeves, 2020). As noted earlier, one study found that Black men are at greater risk (18%) of being uninsured compared to White men (11%) (KFF, 2016). Likewise, only one study (2012) was identified in the literature that specifically disaggregated Black men and White men in terms access to care indicators (KFF, 2012). The study, analyzing 2006–2008 data from the Current Population Survey (CPS) and Behavioral Risk Factor Surveillance Survey (BRFSS), found that the prevalence of cardiovascular disease for Black men was 3.8% compared to 3.2% for White men (see Table 1 below). The KFF analysis also found that Black compared to White men had higher rates of uninsurance, incarceration, and unemployment (KFF, 2012).

Since 2012, few studies have examined access to care and usual source of care before or after the ACA while intentionally disaggregating their findings to compare non-Hispanic Black men and non-Hispanic White men ages 18–64. This study seeks to fill that gap. Given this context, the next section will provide more background on the ACA, discuss the evolving concepts of access to care in greater detail, and describe barriers in access to care in terms of social determinants of health (SDOH) germane to non-Hispanic Black men.

Table 1. *Health, Access to Care, and Socioeconomic Indicators, Men 18–64 by Race/Ethnicity; 2006–2008*

All states	Prevalence					
	All men (ages 18–64)	White	Black	Hispanic	Asian and NHPI [a]	AIAN[b]
CVD[c]	3.5%	3.2%	3.8%	4.7%	2.5%	7.8%
Obesity	25.2%	24.7%	31.0%	28.1%	10.7%	30.7%
Self-reported fair or poor health	11%	8.5%	13.3%	22.3%	8.3%	18.8%
Mean # of unhealthy days/month	5.5	5.3	6.0	5.8	3.9	8.7
No health insurance coverage	22.4%	15.7%	28.8%	46.0%	21.0%	38.5%
No personal doctor/health care provider	28.0%	22.6%	30.3%	49.1%	25.8%	38.1%
No routine checkup [d]	25.5%	26.2%	15.1%	29.5%	22.9%	28.4%
No doctor visit in past year due to cost	13.2%	10.3%	18.2%	21.8%	10.9%	20.7%
Incarceration rate/100,000	981.9	609.7	3610.9	835.9	185.1	1572.2
Unemployment	6.4%	5.4%	13.1%	6.5%	5.0%	12.7%

Note. Adapted from (James et.al., 2012) *Putting Men's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level*, Kaiser Family Foundation, Washington DC, September 1, 2012. These data are drawn from the Behavioral Risk Factor Surveillance Survey (BRFSS) and the Current Population Survey from the United States Census Bureau.

[a] Native Hawaiian or other Pacific Islander. [b] American Indian and Alaska Native. [c] Cardiovascular disease. [d] Defined as a general physical exam, not an exam for a specific injury, illness, or condition.

Background on the Patient Protection and Affordable Care Act of 2010

The landmark *Affordable Care Act* (ACA), or "Obamacare," formally known as the *Patient Protection and Affordable Care Act* was signed into law on March 23, 2010 by then – President Barack H. Obama (DHHS, 2022). At 961 pages or 474,622 words (Haeder & Yackee, 2020), this law has three primary goals: 1) make affordable health insurance available to more people 2) expand the Medicaid program to cover all adults with income below 138% of the federal poverty level (FPL) (CMS, 2022) and 3) promote creative approaches to health care delivery that aim to reduce healthcare costs (DHHS, 2022). For example, the uninsured rate for Black adults is higher than that for White adults: 12 percent compared to 9 percent, respectively; and Black adults are more likely to report lacking a usual source of care in 2011, 2012, and 2018 compared to their White counterparts (Lee, 2022). Therefore, the ACA undergirds this study because it includes several provisions that help address these types of health disparities (Buchmueller et al., 2016; Buchmueller & Levy, 2020; DHHS, 2022; Griffith et al., 2017; Thomas et al., 2012).

For example, under Subtitle D (Support for Prevention and Public Health Innovation), section 4302 (Understanding Health Disparities: Data Collection and Analysis), the ACA amended the Public Health Services Act to ensure data collection (e.g., Bureau of Labor Statistics and the U.S. Census Bureau) on race, ethnicity, sex, primary language, and disability status for health care entities and public health programs (DHHS, 2022; KFF, 2013). High quality data collection is important because what is not measured, cannot be improved – as has been illustrated by the COVID-19 pandemic in terms of inadequate race and ethnicity data collection across the United States (Engler,

2020; Griffith et al., 2020; Khalatbari-Soltani et al., 2020; Kim Rin & Vann, 2020; Penman-Aguilar et al., 2016; V. Williams, 2020). For example, more than 40 percent of race/ethnicity data on COVID-19 cases were missing in states like Massachusetts and Pennsylvania at the beginning of the pandemic – which ultimately made it more difficult to determine how to best allocate resources, staffing, and tests (Hellmann, 2020).

After collecting the data, section 3101 (Data Collection, Analysis, and Quality) tasks the United States Department of Health and Human Services (DHHS) with analyzing the data to detect and monitor trends in health disparities at the federal and state levels (DHHS, 2022; KFF, 2013). Similarly, section 1946 (Addressing Health Care Disparities) of the ACA provides for the evaluation and reporting of data to help implement effective interventions (DHHS, 2022; KFF, 2013). Operationally, the ACA established the National Institute on Minority Health and Health Disparities (NIMHD) – giving the NIMHD authority to plan, review, coordinate, and evaluate minority health and health disparities research and activities conducted and supported by the National Institutes of Health (NIH) and other Centers (DHHS, 2022; KFF, 2013).

Further, sections 1101 and 1103 of the ACA ensure immediate access to insurance for uninsured individuals with a preexisting condition; and calls for information that allows consumers to identify affordable coverage options, respectively (DHHS, 2022; KFF, 2013). Regarding Medicaid expansion, the ACA incentivizes states to create health benefits exchanges through which individuals could purchase coverage; while section 1115 of the Social Security Act (as amended by the ACA) gives the Secretary of the DHHS authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance

Program (CHIP) programs (DHHS, 2022; Hoffman et al., 2000; KFF, 2013; Rachel West, 2017; Rosenbaum & Wilensky, 2020). Funding and technical assistance was also provided by the federal government to facilitate marketplace exchange outreach and enrollment particularly to historically underserved communities (DHHS, 2022; KFF, 2013; Thomas et al., 2012).

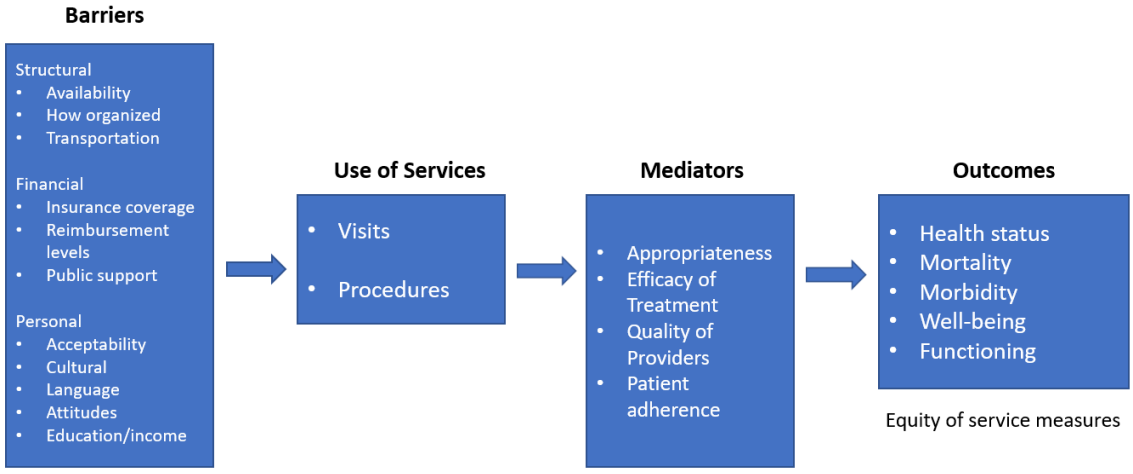
Because vulnerable populations share social characteristics that put them at higher risk of risks (e.g., Black adults are less likely than White adults to have insurance and have a usual source of care, lower socioeconomic status etc.), it has been argued that the vulnerable populations approach complement the population health approach (which serves to improve the health of the entire population) to help close health disparities gaps (Frohlich & Potvin, 2008). Therefore, this study will take a vulnerable populations approach because of its focus on access to care for Black men. The next section will describe the evolving concept of access to care.

Evolving Concepts of Access to Care

In 1993, the IOM Committee on Monitoring Access to Personal Health Care Services (hereafter referred to as the IOM Committee) developed a definition for the term 'access' to mean "a broad set of concerns that center on the degree to which individuals and groups are able to obtain needed services from the medical care system" (see Figure 1 below) (Institute of Medicine Committee on Monitoring Access to Personal Health Care, 1993). Utilization of health services and health outcomes are indicators used to judge whether access has been attained, which is an important aspect of the IOM Committees' expanded definition. Further, conceptualizing and measuring access is essential to better understanding and informing health policy in three ways: 1) predicting

the use of health care services 2) promoting social justice and 3) improving effectiveness and efficiency of health service delivery (Andersen & Davidson, 2007).

Figure 1
Model of Access to Personal Care Services



Note. From *Access to Health Care in America*, by Institute of Medicine, pp. 31–45 (https://doi.org/10.17226/2009). Copyright 2016 by The National Academies Press.

More recently, Andersen conceptualized a framework (to be discussed further in this study) that included several contextualized (e.g., health organization, provider-related, individual and community environments) dimensions of access to care: 1) potential access 2) realized access 3) equitable access 4) effective access and 5) efficient access (Andersen & Davidson, 2007). Andersen defines the contextual component of the model as health policy and financing, whereas the individual component of the model is defined as regular source of care, health insurance and income (Andersen & Davidson, 2007). As well, potential access to care is measured by the enabling variables of the conceptual framework at both the contextual and individual levels. Enabling is defined as the patients' ability to pay for services as determined by income or wealth (Andersen & Davidson, 2007).

Realized access to care is the actual use of services (e.g., the utilization of physician, hospital, dental and other health services); and this measure has been

employed to monitor and evaluate policies designed to influence health services use (Andersen & Davidson, 2007). Further, equitable access to care is determined by the extent to which predisposing variables account for most of the differences in utilization (Andersen & Davidson, 2007). Effective access to care examines the impact of health services utilization in the context of predisposing, enabling, need, and health behavior variables (Andersen & Davidson, 2007). Lastly, efficient access to care means that improved health outcomes can be attained while minimizing the resources required to improve health outcomes (Andersen & Davidson, 2007). For the purposes of this study, however, the original 1974 framework will be operationalized (Aday & Andersen, 1974). What follows are studies that have used this approach in order to specifically examine access to care.

Chen and colleagues (2016) used 2011–2014 National Health Interview Survey (NHIS) data to examine changes in health care access and utilization for the nonelderly US adult population (Chen et al., 2016). While this study used the Aday-Anderson Access to Care framework to account for predisposing, enabling, and need factors (e.g., race/ethnicity, age, gender, marital status, immigration status, health status, education, region, and income), it did not disaggregate the data by race/ethnicity and gender (Chen et al., 2016). Chen specifically examined access to care and utilization for Whites, Blacks, Latinos, and other minority groups; but did not include in their findings a comparison between non-Hispanic Black men and non-Hispanic White men (Chen et al., 2016). When data is disaggregated by sex data alongside sociodemographic factors, it allows for more detailed information about underlying determinants of health (Colvin, 2023).

Several studies examining men of color (e.g., Black, Hispanic, Asian, Native American etc.) have found that Black men experience more disparate cardiovascular-related health outcomes compared to their White counterparts (see Table 1 above) due to chronic high blood pressure linked to structural racism in the form of discrimination (Felix-Aaron et al., 2005; Krieger, 1990; Krieger & Sidney, 1996; Krieger et al., 2013; Lackland, 2014; Lukachko et al., 2014; Sulaica et al., 2020; Victor et al., 2018; Victor et al., 2009; Victor et al., 2011; Williams & Leavell, 2012; J. Williams, 2020). For example, one study found that the population attributable risk for high blood pressure and 30-year mortality among Black men was 45.2% compared to White men at 23.8% (Lackland, 2014). Racial discrimination, as a chronic stressor, partially explains the high blood pressure-related disparities between Black men and White men over the life course (Adam et al., 2015; Albert & Williams, 2011; Alvidrez & Tabor, 2021; Assari et al., 2018; Beatty Moody et al., 2019; L. C. Brewer & L. A. Cooper, 2014; LaPrincess C Brewer & Lisa A Cooper, 2014; Chae et al., 2020; Chae et al., 2012; Dolezsar et al., 2014; Dougherty et al., 2020; Ferdinand & Nasser, 2017; Hudson et al., 2016; Sims et al., 2012; Szanton et al., 2012; Williams et al., 2018). Further review of the literature identified several ACA-related studies that evaluated health insurance coverage and access to care across a wide array of demographic characteristics. Table 1A in the appendix provides an overview of the articles outlining the breadth of key ACA-related findings across race, ethnicity, and gender.

None of the noted studies in this access to care section appear to have explicitly nor intentionally considered the health and well-being of non-Hispanic Black men as some part of their analytical approach or disaggregated findings structure. While study

designs are informed by the goals of researcher, funding, and available data among other factors, the real or perceived manifestation of continued Black male invisibility speaks, in part, to the larger issue of structural racism embedded in policy and practice (Bailey et al., 2021; Bowleg, 2017; Bowleg & English, 2016; Boyd et al., 2020; Boyd, 2021; Ford et al., 2019; Ford & Airhihenbuwa, 2010; Hardeman et al., 2016; Jones, 2000; Kendi, 2016; Krieger, 2021; Pierce et al., 2014; Plough, 2022; Yearby, 2020). This next section will describe barriers in access to care in terms of social drivers of health (SDOH).

Barriers in Access to Care

Having defined access to care and considered some of the demographic disparities in access to care, it is important to identify what factors may be driving these disparities particularly in terms of social drivers of health (e.g., economic stability, education access and quality, health care access and quality, neighborhood and built environment, social and community context) (Braveman & Gottlieb, 2014; HP2030, 2021; Office of Disease et al., 2019). According to the IOM, there are three primary types of barriers to health care: 1) structural 2) financial and 3) personal and cultural (see Figure 1). The IOM Committee specifically defines structural barriers as "impediments to medical care directly related to the number, type, concentration, location, or organizational configuration of health care providers" (Institute of Medicine Committee on Monitoring Access to Personal Health Care, 1993). Here, structural is operationalized as having a usual source of care or having regular access to a health care provider.

Structural racism is defined as "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice" (Bailey et al., 2017).

Consequently, examples of structural barriers include the extent to which capacity allows for constructing hospitals, clinics, and community health centers (Yearby et al., 2022), increasing and diversifying the health care workforce (Wilbur et al., 2020), and addressing historically low Medicaid reimbursement rates for physicians (Institute of Medicine Committee on Monitoring Access to Personal Health Care, 1993). One study found that 5.8 million patients in the U.S. delayed medical care because they could not access transportation (Wolfe et al., 2020).

For example, men are 24 percent less likely than women to have visited a physician within the past year but are 32 percent more likely to be hospitalized; Black men are less likely to access health care than are White men or any group of women; and Black men of all income groups are 50 percent less likely to have had contact with physicians during the past year, even when they have health insurance (Hammond et al., 2011).

Where one resides also matters in terms of life outcomes and chronic conditions like cardiovascular disease (Diez-Roux et al., 1997; Khatana et al., 2019; Mujahid et al., 2017; Sallis et al., 2012; Williams & Collins, 2001). Studies that examined Medicaid expansion have also found significant variations in access to care dependent upon whether a state has expanded Medicaid (Artiga, 2021a, 2021b; KFF, 2019). The region of the country is also important to assess because studies have found that regional differences regarding issues like high blood pressure prevalence were significant for Black men and White men ages 40–59 particularly in the "Stroke Belt" (Howard et al., 2010; Obisesan et al., 2000). The "Stroke Belt" is usually defined as including the eight

southern states of North Carolina, South Carolina, Georgia, Tennessee Mississippi, Alabama, Louisiana, and Arkansas (Howard et al., 2010; Obisesan et al., 2000).

Another study found that approximately 16 million U.S. men are without health insurance – with affordability most often cited for why they do not enroll in a health plan (Gunja, 2022). Similarly, one study found that 15.5% of Hispanics, 13% of non-Hispanic Blacks, and 9.4% of non-Hispanic Whites report delaying/avoiding care due to costs (Booshehri, 2021). Other studies have found limited appointment availability in terms of after-hours care with a provider (Hammond, Matthews, Mohottige, et al., 2010).

Further, as a social determinant of health (HP2030, 2021), economic stability is less likely to be achieved and sustained by Black men compared to White men (Bruce et al., 2015; Gilbert et al., 2016). One study found that among working men, the median earnings gap between Black and White men has remained between 35–40 percent from 1980–2014 (Bayer, 2017). Another study found that historically, Black men are paid less than 75% of what White men are paid (Williams, 2003a). These issues are compounded by personal and cultural barriers.

Personal and cultural barriers (e.g., bias, language, notions of masculinity, etc.) restrict people who need medical attention from seeking it or, once they obtain care, from adhering to recommended posttreatment guidance (Institute of Medicine Committee on Monitoring Access to Personal Health Care, 1993). For example, racial bias (implicit and explicit) has been shown to negatively impact the patient-provider relationship and lead to poor health outcomes (Burgess et al., 2007; Enyia et al., 2016; van Ryn et al., 2006). Moreover, language barriers (OMH, 2018) and an overall mistrust of the health care system are pervasive issues in the health care system (Benkert et al., 2009; Hammond,

2010; Hammond, Matthews, Mohottige, et al., 2010). Non-Hispanic Black men are disproportionately impacted by several of the noted barriers due, in part, to the need for the public health and disparities literature to go beyond examining just race and ethnicity - to taking intersectional and bio-psycho-social approaches that better incorporate gender into study designs, analyses, and interpretation (Bowleg, 2021; Bowleg & English, 2016; Gilbert et al., 2016; Griffith, 2012; Griffith, 2016; Griffith et al., 2013; Griffith et al., 2011; Griffith et al., 2019; Griffith, 2019; Powell et al., 2016; Semlow et al., 2021; D. Watkins, 2017).

Paradoxically, in most industrialized societies around the world, there are social and economic advantages to being male, but ample evidence has found that these advantages do not translate to better health outcomes (e.g., longer male life expectancy, decreased cardiovascular disease prevalence) (Bruce et al., 2015; Griffith, 2019). In fact, despite poor outcomes for men's health, only nine countries have national health policies or strategies that specifically address men – due in part to the evolving definition of men's health (White, 2023). For non-Hispanic Black men in the United States and the diaspora, the paradox is that while they experience society as males in terms of privilege, power, and opportunity, structural racism that is associated with being non-Hispanic Black or African American elicits a variety of disadvantages (e.g., redlining, lack of access to care, mass incarceration, unemployment, educational barriers) that disproportionately impact their overall health and well-being (Gilbert et al., 2016; Griffith et al., 2021; Ray & Rosow, 2012; Wacquant, 2016).

Nevertheless, one study specifically identifying and examining barriers to health care and health-seeking behavior by Black men identified the following areas: 1)

socioeconomic status 2) masculinity 3) lack of awareness of the need for care 4) racism and mistrust of the medical establishment 5) religion and spirituality 6) criminal background 7) influence of family, friends, and neighborhoods and 8) lack of positive patient-provider relationships (Cheatham et al., 2008). Another study found that young Black men experience significant barriers when interfacing with the health care system in the following areas: 1) gaining trust and building rapport 2) caregivers (the role of women in the enrollment process) 3) identity verification (government-issued identification) 4) ACA health literacy 5) hospital integration (accessing violently injured patients) 6) privacy and confidentiality and 7) technological issues (Richardson et al., 2021). These barriers continue to lead to dire consequences for Black men and reflect the need to incorporate intersectional and bio-psycho-social approaches into men's health. An intersectional approach not only helps explain which social characteristics impact health; but *why* those factors impact health – while a bio-psycho-social approach accounts for not only the range of factors that determine risk; but the range of places that targeted interventions may be most impactful for Black men (Griffith, 2012; Griffith, 2016).

Moreover, studies have consistently found that despite controlling for several behavioral risk factors (e.g., smoking, obesity, physical activity), wide gaps persist between the mortality rates of middle-aged Black men and women and their White counterparts (IOM, 1993; Tajeu et al., 2020). The constellation of these barriers and their consequences speak to the need for targeted, sustainable policy attention and resources for non-Hispanic Black men and the communities in which they are born, grow, live,

work, and age – while considering race and gender (Gilbert et al., 2016; Griffith, 2015; Griffith, 2018; Griffith, 2019).

Although these broader race/ethnicity and gender analyses are critical and necessary to examine, to date, few ACA-related studies have been conducted specifically examining the association between the enactment and implementation of the ACA and Black men's access to care. For example, only two ACA-related studies to date were found to have explicitly focused on Black men or compared non-Hispanic Black men to non-Hispanic White men as part of their design, analysis, and interpretation (Powell et al., 2020; Richardson et al., 2021). Richardson et al., (2021) investigated strategies patient navigators used to sign up injured young Black men (from gun violence) in trauma centers for health insurance that were both culturally and structurally appropriate. A qualitative case study approach was used to explore how community health workers (CHWs) perceive and interpret information, solve problems, and interact with others in the context of enrolling young Black men into health insurance coverage. This study noted that verifying the young Black males' identity was the most significant challenge in attempting to enroll him for insurance coverage, followed by gaining and building rapport with health care personnel, and privacy issues in the trauma centers (Richardson et al., 2021).

Powell et al., (2020), investigated the impact of the ACA on colorectal cancer outcomes and economic costs between Black men and White men in North Carolina. This study used simulation modeling to look at different ACA policy scenarios from 2013 to 2023. The baseline or control scenario was "no ACA" coverage while other scenarios modeled various health insurance marketplace coverage and Medicaid expansion

iterations. For the analysis, the study focused on Black men and White men in North Carolina who were age-eligible for screening (between ages 50 and 75) during the noted study period (Powell et al., 2020). Compared to the control scenario (no ACA), the ACA health exchange scenario resulted in an average of 16.0 fewer deaths per 100,000 of Black males and 4.7 fewer deaths per 100,000 of White males (Powell et al., 2020).

Economically, each ACA policy iteration found higher per person expenditures for Black men compared to White men ($2.13 per person v. $0.63 per person respectively in 2018) (Powell et al., 2020). This study noted that future research should replicate similar simulation research in other states and estimate the potential impact of various proposed healthcare reform policies on additional health outcomes. This study, while focused on non-Hispanic Black men, was also notable because it contributes to the evidence base that the ACA marketplace exchanges could potentially improve health outcomes and reduce costs.

Access to care has been limited particularly for historically marginalized populations such as non-Hispanic Black men, as evidenced by the studies analyzed in this literature review. Conceptualizing, contextualizing, and measuring access to care is crucial to better understanding and informing health policy (Andersen & Davidson, 2007). The purpose of this study is to use the Aday-Anderson Access to Care framework (to be discussed in more detail in the next chapter) to examine the association between the enactment and continued implementation of the ACA with respect to non-Hispanic Black men's access to care compared to non-Hispanic White men ages 18–64; and to propose future strategies to help address any inequities.

In summary, only two ACA-related studies to date were found to have explicitly focused on Black men or compared non-Hispanic Black men to non-Hispanic White men as part of their design, analysis, and interpretation (Powell et al., 2020; Richardson et al., 2021). Further, while three ACA-related studies examined racial and ethnic health disparities in the context of access to care and health care utilization, they did not disaggregate, analyze, nor interpret their findings across race and gender (Adamson et al., 2021; Chen et al., 2016; Ladapo & Chokshi, 2017). Therefore, this dissertation study seeks to fill these gaps across four fields: 1) men's health 2) public health 3) health care utilization and 4) health policy.

Moreover, employing a dataset (to be discussed in chapter three) more specifically structured to collect data on insurance coverage, access to care, and utilization among other variables could potentially confirm prior study findings identifying changes in health insurance coverage and usual source of care specifically among non-Hispanic Black men and non-Hispanic White men ages 18–64.

Chapter 3: Methodology

Despite the plethora of ACA-related studies focused on insurance coverage, access to care, and racial/ethnic disparities, few ACA-related studies have specifically examined access to care for non-Hispanic Black men. Therefore, this study endeavors to fill this gap in the literature by critically analyzing the impact of the ACA on access to care for non-Hispanic Black men from 2011–2019 (pre-ACA to post-ACA) as a policy intervention. If this gap in the literature is examined, it may help provide future strategies for addressing health inequities for non-Hispanic Black men that can also potentially be mapped to other historically disenfranchised populations.

The purpose of this study is to examine the association between the enactment and continued implementation of the *Patient Protection and Affordable Care Act of 2010* (ACA) with respect to non-Hispanic Black men's access to care (as measured by insurance status and usual source of care) compared to non-Hispanic White men ages 18–64; and to propose future strategies to help address any inequities. This chapter will: 1) provide the study questions and hypotheses 2) describe the Aday-Andersen theoretical framework 3) discuss the study design and data source 4) outline the variables of interest 5) provide a data management and analysis plan and 6) delineate the study limitations and assumptions.

Study Questions and Hypotheses

Below are the study questions followed by the hypotheses to be tested:

Study Question 1.1: Are there racial differences in health insurance coverage and usual source of care between non-Hispanic Black men and non-Hispanic White men ages 18–64 during the pre-ACA period 2011–2014?

Study Question 1.2: Are there changes in health insurance coverage and usual source of care among non-Hispanic Black men and non-Hispanic White men ages 18–64 after implementation of ACA-related provisions from 2015–2019 (post-ACA)?

Study Question 1.3: To what extent did the ACA close the racial gap between non-Hispanic Black men and non-Hispanic White men ages 18–64 in terms of insurance status and having a usual source of care from 2015–2019 (post-ACA)?

Below are the hypotheses to be tested:

Null Hypothesis 1.1a: Before 2015, the proportion of uninsured non-Hispanic Black men was the same as the proportion of uninsured non-Hispanic White men ages 18–64.

Null Hypothesis 1.1b: Before 2015, the proportion of non-Hispanic Black men with a usual source of care was the same as the proportion of non-Hispanic White men ages 18–64 with a usual source of care.

Null Hypothesis 1.2a: Among non-Hispanic Black and non-Hispanic White men, the proportion of uninsured before ACA implementation was the same as the proportion of uninsured after ACA implementation.

Null Hypothesis 1.2b: Among non-Hispanic Black and non-Hispanic White men, the proportion of usual source of care before ACA implementation was the same as the proportion men with of usual source of care after ACA implementation.

Null Hypothesis 1.3a: The ACA has not closed the racial gap between non-Hispanic Black men and non-Hispanic White men ages 18–64 in terms of insurance status (i.e., percent uninsured) post-ACA.

Null Hypothesis 1.3b: The ACA has not closed the racial gap between non-Hispanic Black men and non-Hispanic White men ages 18–64 in terms of usual source of care post-ACA.

Theoretical Frameworks

To operationalize the study questions, the Aday-Andersen Access to Care Framework (also known as the Andersen behavioral model of health care utilization) was explored (see Figure 2 below) (Aday & Andersen, 1974). This framework (see Figure 3 below) was later adapted by Andersen (Andersen, 1995). Alternative theoretical frameworks like intersectionality and African American Male Theory (AAMT) were also considered (Bush & Bush, 2013; Griffith, 2012). An intersectional approach has been posited as a different way to conceptualize and contextualize the health of non-Hispanic Black men in the interest of advancing the men's health field (Griffith, 2012; Griffith et al., 2013; Griffith et al., 2011).

An intersectional approach not only helps explain which social characteristics impact health; but *why* those factors impact health (Agenor, 2020; Bauer, 2014; Bauer et al., 2021; Bowleg, 2021; Else-Quest & Hyde, 2016; Evans et al., 2018; Fehrenbacher & Patel, 2020; Griffith, 2012; Hankivsky et al., 2014; Homan et al., 2021; Laster Pirtle & Wright, 2021; Mandelbaum, 2020; Mena et al., 2019). Although this study will not employ an intersectional approach methodologically, it will fill a critical gap in the men's health, public health, health care, and health policy literature by operationalizing a well-established theoretical framework (i.e., Andersen behavioral model of health care utilization).

Overall, this study examines unique factors and barriers faced by non-Hispanic Black men such as disparate insurance coverage, lack of a usual source of care, and lower socioeconomic position among others (Cheatham et al., 2008; Gunja, 2022; Herd et al., 2007; Plowden & Young, 2003). These factors, among others, have been found to be responsible for the consistently higher mortality and morbidity rates of Black men for medical conditions like cardiovascular disease due to high blood pressure (Blyler & Rader, 2019; Centers for Disease & Prevention, 2010; Fuchs & Whelton, 2020; Joseph et al., 2022).

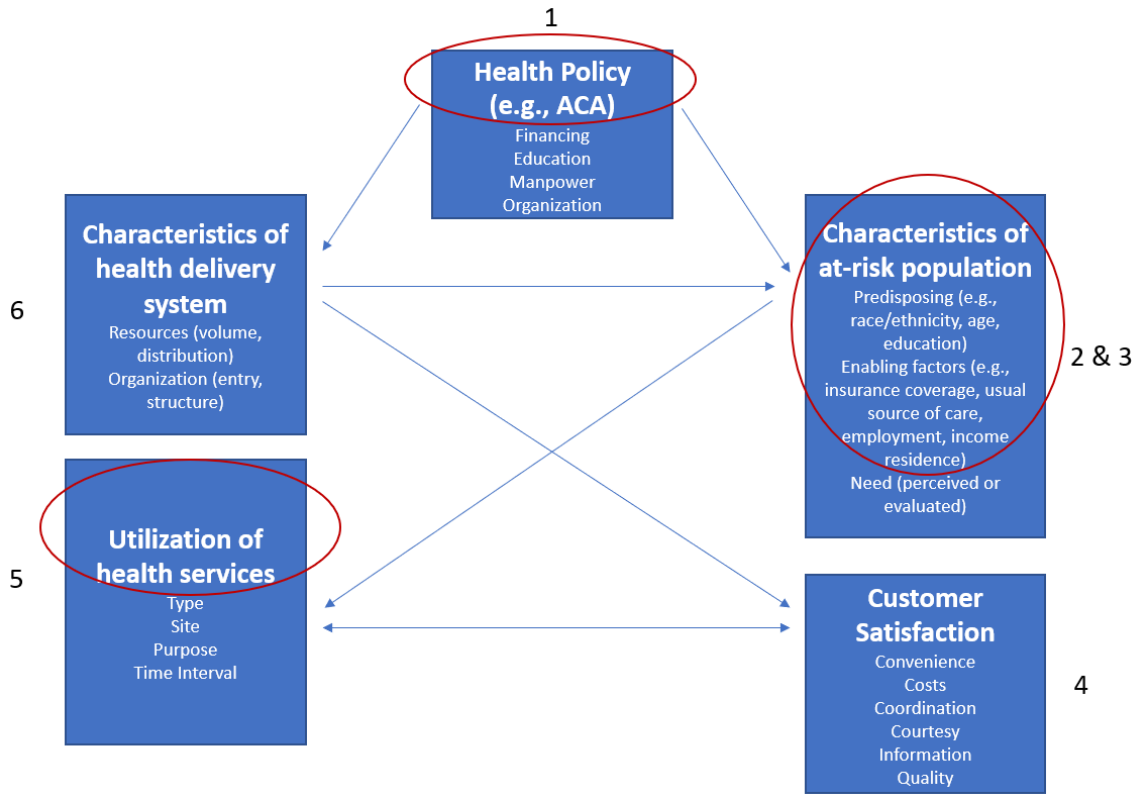
Given that context, the Aday-Andersen Access to Care model is an integrative framework that was first conceptualized in 1974 and used to explore how health policy influences access to care and health care utilization (see Figure 2 below) (Aday & Andersen, 1974; Institute of Medicine Committee on Monitoring Access to Personal Health Care, 1993; IOM, 2002b). Fundamental elements of the Aday-Andersen Access to Care framework include: 1) health policy (financing, education, manpower, organization) 2) predisposing factors (e.g., race/ethnicity, age, education) 3) enabling factors (e.g., insurance coverage, usual source of care, employment, income, residence) 4) customer satisfaction 5) health services utilization and 6) characteristics of health delivery system (Aday & Andersen, 1974; Andersen & Davidson, 2007).

The relationships proposed by the framework demonstrate how health policy (authoritative decisions made in the private sector, accrediting agencies, or the legislative, executive, and judicial branches of government at the local, state, and federal levels) directly impacts both the characteristics of at-risk populations and characteristics of the health delivery system. The delivery system, in turn, may directly impact customer

satisfaction; and indirectly impact the utilization of health services. Whereas characteristics of the at-risk population may directly impact health care utilization and consumer satisfaction. Health policy, characteristics of at-risk populations, and health care utilization represent the specific aspects of the framework that will be operationalized in this study. Noted earlier, the ACA established CHWs as integral members of the health care workforce (Islam et al., 2015b). Because CHWs have been found to improve health outcomes among low-income and minority populations, sustainable and robust funding should be provided to support targeted interventions for Black men.

More recently, Andersen adapted the framework depicted in Figure three below (Andersen, 1995). Notable differences between the original Aday-Andersen model and the more recently adapted Andersen model are the consideration of environmental factors (e.g., quality of housing, water, or air) and perceived and evaluated health status (Andersen, 1995). Perceived health status is defined as the extent to which a person can live a functional, comfortable, and pain-free existence. While evaluated health status is dependent on the judgment of the professional based on established clinical standards and state-of-the-art practices (Andersen & Davidson, 2007).

Figure 2
Aday-Andersen Access to Care Framework

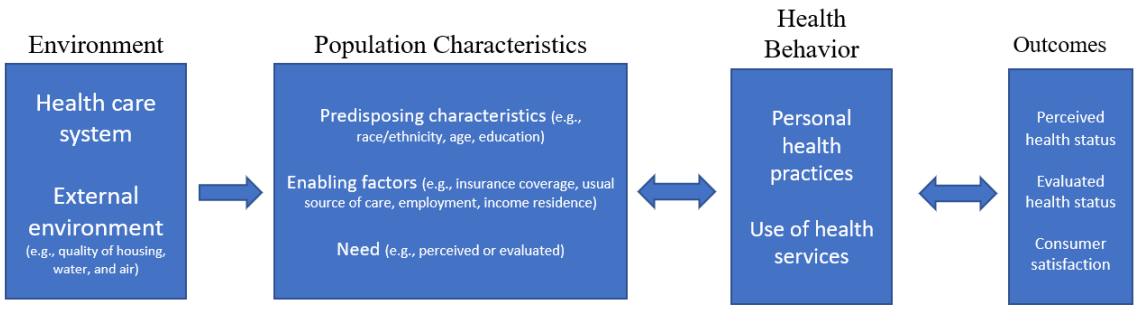


Note. Adapted from "A framework for the study of access to medical care," by L.A. Aday and R. Andersen, 1974, *Health Services Research*, *9*(3), pp. 208–20. This adapted depiction reflects the specific variables that were operationalized in this study.

The Agency for Healthcare Research and Quality (AHRQ) adopted key elements of the Aday-Anderson Access to Care framework (e.g., characteristics of the health delivery system and utilization of health services) to inform the annual federally-mandated National Healthcare Quality and Disparities Report (NHQDR) in 2003 - which began summarizing the status of health and health care delivery in the United States (Aday & Andersen, 1974; AHRQ, 2022a). Since that time, the NHQDR has been operationalized empirically in a variety of public health and health care-related contexts (Andersen & Aday, 1978; Bath et al., 2016; Derose et al., 2011; Lederle et al., 2021;

Powell et al., 2020; Travers et al., 2020; Zou et al., 2022) with a particular focus on the health care delivery system and policy (Aday & Andersen, 1974). For example, one study used several data sources including MEPS to examine the health care experiences of Black men compared to White men in the context colorectal cancer screening and end-stage renal disease (ESRD) – finding that Black men are significantly less likely to receive care for ESRD compared to White men (Felix-Aaron et al., 2005).

Figure 3
The Andersen Model of Healthcare Services Utilization



Note. Adapted from "Revisiting the behavioral model and access to medical care: Does it matter?" by R. M. Andersen, *36*(8), p. 8. 1995 by *Journal of Health and Social Behavior*.

Study Design

This study will be a longitudinal quantitative secondary data analysis of non-Hispanic Black men and non-Hispanic White men ages 18–64 from 2011–2014 (pre-ACA) to 2015–2019 (post-ACA). These time periods center ACA implementation in 2014 as the policy intervention. For example, Medicaid expansion was a key provision of the ACA that was implemented in 2014 (Lee et al., 2021). Further, this longitudinal approach is ideal because it tracks trends and helps to determine if potential proposed interventions and policy solutions would be successful (Thorpe et al., 2013). While

alternative approaches like qualitative and mixed methods (e.g.., quantitative and qualitative) were considered (Bryman, 2006; Creswell & Plano Clark, 2017; Tashakkori & Teddlie, 2003; D. C. Watkins, 2017; Young et al., 2020), quantitative analysis provides the opportunity to measure and assess changes in the proposed outcome(s) of interest over time and minimize costs (Smith et al., 2011; Watson, 2015). Although the more recent Andersen framework includes external environmental factors and health statuses that shape access to care (Aday, 1994; Aday & Andersen, 1974; AHRQ, 2022a; Davidson et al., 2004), based on current publicly available data, this study will focus on operationalizing: 1) predisposing factors (e.g.., race/ethnicity, age, education) and 2) enabling factors (insurance coverage and usual source of care) (Aday & Andersen, 1974; Andersen & Davidson, 2007; Luft et al., 1976). Several studies have operationalized these variables empirically (Chen et al., 2016; Hayes et al., 2017; Kominski et al., 2017; Powell et al., 2020).

Data Source

Because the study seeks to explore repeated measures or panel data from 2011–2019, a longitudinal quantitative analysis of the Medical Expenditure Panel Survey (MEPS) (a large, publicly available data set) will be employed (Cohen et al., 2009; Gai & Jones, 2020; Young et al., 2020). The Department of Health and Human Services (DHHS) conducted nationally representative population-based surveys of health care expenditures and utilization in 1977 and 1987 (Waldo et al., 1989). MEPS was initiated in 1996 to provide more timely information by adding a new panel or sample of households into the survey every year rather than every 10 years (AHRQ, 2014, 2022b; Cohen et al., 2009). MEPS provides annual estimates of health care utilization, insurance

coverage, expenditures, and sources of payment for the U.S. civilian non-institutionalized population (individual and household) (AHRQ, 2014, 2022b; Cohen et al., 2009). Cosponsored by two DHHS agencies, the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), and the National Center for Health Statistics (NCHS), the MEPS questionnaire consists of three interrelated surveys: the Household Component (MEPS-HC), the Medical Component (MEPS-MC), and the Insurance Component (MEPS-IC) (AHRQ, 2014, 2022b; Cohen et al., 2009).

The MEPS oversamples the following policy-relevant populations groups: Blacks, Hispanics, Asians, and low-income households to improve the precision of household estimates (Blewett et al., 2016; Cohen et al., 2009); and consists of an overlapping panel design in which the same individuals and households are interviewed a total of five times over a course of 30 months – yielding data for two calendar years (repeated measures) (Cohen et al., 2009). Aday and Andersen argue that a household survey is the best method for collecting data on at-risk populations (Aday & Andersen, 1974). Consequently, the MEPS was identified as an ideal data set because of its multi-year coverage, socio-demographic diversity, and large sample size (Cohen et al., 2009; Cohen & Cohen, 2013).

Additionally, this survey provides analysts with policy-relevant information across a variety of contexts; and has been used extensively in analyzing the impacts of the ACA (e.g.., health care expenses, utilization, insurance coverage, and access to care etc.) (Cohen et al., 2009; Cohen & Cohen, 2013). Following are the ways in which the MEPS defines insurance status: 1) any private insurance describes any individual who, at any time during the year, had insurance that provides coverage for hospital and physician

care 2) any public insurance describes any individual covered by Medicare, Medicaid/CHIP, or other public hospital/physician coverage at any time during the year and 3) uninsured describes anyone not covered by private hospital/physician insurance at any time during the survey year (Davis, 2001).

While MEPS provides for different gradients of insurance analysis over the course of months within a given year (i.e., having private or public insurance for 12 consecutive months, insured for part of the year, or insured for at least one month), part of the aim of this study was to examine for any insurance coverage. Thus, a data limitation is the potential diluting effect of evaluating insurance coverage in the aggregate. Future studies may consider further disaggregating the MEPS insurance gradient based on the researcher agenda.

The data for this study will be drawn from the household component of the survey because it aligns with the study questions and has relevant variables to assess specific components of the Aday-Andersen Access to Care framework (e.g., demographics, pre-disposing factors, enabling factors, need factors, health conditions, usual source of care, employment, income, insurance type, access to care etc.). Regarding power and sample size considerations, there has been some debate (Dziak et al., 2020) on the utility of conducting power and sample size calculations for analysis of data that have already been collected - as is the case with the MEPS data. Given that context, an exploratory analysis was conducted to determine the specific number of non-Hispanic Black and non-Hispanic White men who contributed at least one observation to the MEPS database between 2011 and 2019 (see Figure 4 and Figure 5 in the appendix). During that timeframe, the number of non-Hispanic Black men contributing at least one observation ranges from a low of

1001 (in 2019) to a high of 2024 (in 2012); and the smallest number of non-Hispanic White men contributing at least one observation ranges from a low of 3584 (in 2014) to a high of 4149 (in 2011 and 2012) (see Table 2 below) (AHRQ, 2022b).

Conservatively, using the smallest sample size for each year (1001 for non-Hispanic Black men) and assuming that there is only one observation from each subject in that year, a 95% confidence interval can be constructed for any proportion that is estimated (e.g., proportion of those without insurance and without a usual source of care) that has margin of error that is no larger than 4.3 percentage points. Studies have found that a survey margin of error between 1–10% is recommended (Needham & Vaske, 2008; Serdar et al., 2021). Since there are multiple observations for each male and the sample sizes are larger for both non-Hispanic Black and non-Hispanic White men at all other time points, the constructed confidence intervals will have a margin of error that is <4.3 percentage points. Thus, the MEPS data provides a large enough sample size to achieve excellent precision for reporting point estimates and proportions.

Table 2

Number of Non-Hispanic Black Men and Non-Hispanic White Men Ages 18–64 from MEPS Database (2011–2019) n = 46,277

Year	Black men	White men
2011	1700	4149
2012	2024	4149
2013	1897	3700
2014	1771	3584
2015	1712	3783
2016	1585	3654
2017	1326	3880
2018	1115	4164
2019	1001	4033

Variables of Interest

Data for this study will be extracted from the MEPS using cleaned full-year 2011–2019 consolidation files (AHRQ, 2019). Specifically, two access to care indicators will be operationalized: 1) predisposing factors (e.g., race/ethnicity, age, education) and 2) enabling factors (insurance coverage and usual source of care) (Aday & Andersen, 1974; Andersen & Davidson, 2007; Luft et al., 1976). Other variables of interest include: age, education level, employment status, income level, and region of the country (Northeast, Midwest, South, and West) – to be described in more detail below.

The specific variables identified from MEPS were as follows: RACETHX was used to represent race, POVCAT was used to represent income, EMPST31 was used to represent employment, REGION1X was used to represent region, INSCOV1X was used to represent insurance status, and HAVEUS42 was used to represent usual source of care. Regarding employment, this variable includes categories for "job to return to" and "job during" the survey interview. Because part of the focus of this study is on whether non-Hispanic Black men and non-Hispanic White men are employed, the previously mentioned categories will be recoded and labeled as "Intermittent Employment" in order to preserve the totality of the observations in the data. Specifically, MEPS defines full-time employment as working at least 35 hours per week; whereas, part-time employment is defined as working less than 35 hours per week (AHRQ, 2022b; Carroll, 2018). Because part-time workers typically do not have equal access to comprehensive benefits compared to full-time (year-round workers), this study will explore how these differences impact access to care (Brault & US, 2011; Su et al., 2019).

Regarding insurance status, while MEPS provides for different gradients of insurance analysis over the course of months within a given year (i.e., having private or public insurance for 12 consecutive months, insured for part of the year, or insured for at least one month), part of the aim of this study was to examine for any insurance coverage. Thus, a noted data limitation is the potential diluting effect of evaluating insurance coverage in the aggregate. However, this study is unique in that it is the first of its kind to specifically assess access to care in a granular way between non-Hispanic Black men and non-Hispanic White men pre- and post-ACA.

As the variable names for education level (EDUCYR) were not consistent across the years included in the sample, education was recoded into the following categories based on the variables available in each year: 1 = no degree, 2 = GED or high school degree, 3 = some college or two-year degree, 4 = bachelor's degree, 5 = master's, doctoral or professional degree, 6 = other degree. In order to preserve the totality of the data observations, category number three (some college or two-year degree) will be combined with category number four (bachelor's degree). Likewise, category number six (other degree) will be combined with category number five (master's, doctoral, or professional degree). Age (AGELAST) was recoded into a categorical variable with the following categories: 1 = 18 to 34, 2 = 35 to 49, 3 = 50 to 64. Time was coded as a categorical variable with the following categories: 0 = pre-ACA (2011 to 2014), 1 = post-ACA (2015 to 2019).

Dependent or Outcome Variables

In order to assess study questions 1.1–1.3, insurance status (e.g.., insured and uninsured) and usual source of care (i.e., yes, no) will be examined (Blewett et al., 2008;

Chen et al., 2016; Hammond et al., 2011; Stewart et al., 2019; Xu, 2002). The insured category will include any private and any public insurance. Insurance status will be specified as model #1 (see Table 3 below). The second key access to care indicator variable, usual source of care, ascertains whether there is a particular doctor's office, clinic, health center, or other place that the individual usually goes to if he/she is sick or needs advice about his/her health (AHRQ, 2019). This study will construct a dichotomous (yes/no) variable indicating whether the person's provider is in an office; but not a hospital nor an emergency room.

There are three main levels of care in a hospital: inpatient, outpatient, and emergency. Inpatient care is for patients who need to stay in the hospital for more than 24 hours. Outpatient care is for patients who can go home after their treatment. Emergency care is for patients who need immediate medical attention (Bovonratwet et al., 2017; Liu & Kelz, 2018). Further, studies have characterized the emergency room as outside of the usual source of care category due to its acute, transitory structure (Janke et al., 2015). Therefore, the emergency room component will not be categorized as being a usual source of care. However, usual source of care will be specified as the response (yes/no) for model #2 (see Table 3 below). Noted previously, having a usual source of care potentially increases timely receipt of preventive screenings (Powell et al., 2020) and has been implicated in previous studies examining the health of Black men and other segments of the population (Blewett et al., 2008; Hammond et al., 2011; Stewart et al., 2019; Wallace et al., 2022).

Primary Independent or Predictor Variables

The independent or predictor variables in this study will be race/ethnicity and time. The two time periods are 2011–2014 (pre-ACA) and 2015–2019 (post-ACA). Race and ethnicity will be classified as non-Hispanic Black and non-Hispanic White to assess the differences in outcomes by race. Hispanics or Latinos may be of any race (Aragones et al., 2014), and the U.S. Census Bureau and the Office of Management and Budget (OMB) reports Hispanics separately from non-Hispanics for each race group (OMB, 1997; United States Census, 2022); thus, this classification approach will be followed for this study (OMB, 1997; United States Census, 2022). The time variable will be operationalized as pre/post-ACA; and analyzed as a binary variable in order to estimate changes over time across study subjects in the database.

Covariates

Noted earlier, the Andersen Model of Health Care Utilization suggests the following factors are important predictors of access to care: 1) predisposing or demographic factors (e.g., race/ethnicity, age, education) and 2) enabling factors (e.g., insurance coverage, usual source of care, employment, income, region) (Aday & Andersen, 1974; Axon et al., 2022; Barker et al., 2021; Li et al., 2016). This list of potential covariates will therefore be operationalized for this study from the MEPS dataset to specifically include age, education level, employment status, income level, and region of the country (Northeast, Midwest, South, and West).

First, policy changes impact people differently by age (Sohn, 2017). Historically, young adults have been at the greatest risk for being uninsured and less likely to have a usual source of care compared to older adults (Monaghan, 2014). In a 2011 study, young

adult males were the least likely to have health insurance coverage, with 28.3 % of males ages 18–24 reporting no insurance coverage; and also found that only 77.9 % of women and 62.5 % of men aged 19–25 years reported a usual place for health care (Cohen, 2019). Data from the 2009 Medical Expenditure Panel Survey also found that young adults ages 18–26 had the lowest health utilization rate of any age group (Lau et al., 2014). Therefore, one of the sections (Dependent Coverage Mandate) of the ACA provides for children to remain on their parent's health insurance coverage up until age 26 (DHHS, 2022; Look & Arora, 2016). Noted earlier, this study seeks to focus on working age adults (18–64) because individuals in this age range are more likely to gain or have insurance coverage through the ACA (Angier et al., 2020). Therefore, this study stratifies age into three categories (18–34, 35–49, and 50–64) to explore how the ACA impacted access to care across age groups.

Many studies have found employment status, income, and region of the country to be significant determinants of health and access to care – which motivated their inclusion as covariates (Braveman & Gottlieb, 2014; Bruce et al., 2015; Buchmueller & Levy, 2020; Grogan & Park, 2017). Studies have found complex relationships between employment status and insurance status (Reichard et al., 2019). For example, one study found that those who worked full-time are more likely to report poor health outcomes than part-time workers, regardless of the type of employment (i.e., small employers, full and part time permanent employees, etc.) (Benavides et al., 2000).

While income is a critical determinant of health (Abdalla et al., 2020; Assari, 2018; Braveman & Gottlieb, 2014; Dubay & Lebrun, 2012; Thorpe et al., 2013; Wilson et al., 2017), respondents of color and other marginalized communities tend to skip

income-related questions in surveys (either because of lack of trust or the wording of the survey questions) (Pinto et al., 2022); however, it will be evaluated in this study. Lastly, region of the country is important to assess in order to build the evidence case for further expanding health insurance coverage and determining more sustainable interventions in disproportionately poor health outcome regions of the country like the South and Southeast (Howard, 1999; Obisesan et al., 2000; Perry & Roccella, 1998).

Data Analysis and Management Plan

This study will be taking a longitudinal approach by examining non-Hispanic Black men and non-Hispanic White men ages 18–64 in 2011-2014 (pre-ACA) and 2015-2019 (post-ACA). All outcome, predictor, and covariate variables described above will be assessed using descriptive statistics (e.g.., proportions) as well as histograms and bar plots as appropriate – by time (pre/post ACA) and race (non-Hispanic Black v. non-Hispanic White). To specifically assess study questions 1.1–1.3, logistic regression models will be computed to predict insurance status (i.e., insured, uninsured) and usual source of care. Because there are two insurance categories, logistic regressions will be used (Gibbons et al., 2010). However, the categories of 'any private' and 'any public' will be combined and recoded into a singular 'insured' reference category. Thus, only two insurance status categories will be operationalized: 1) insured and 2) uninsured. The goal will be to predict the odds of being uninsured comparing non-Hispanic Black men and non-Hispanic White men ages 18–64. All analyses will incorporate the relevant MEPS survey weights. Survey-weighting accounts for unequal probability of selection and stratified sample designs. Since all the analyses will incorporate the relevant MEPS survey weights, generalized estimation equation (GEE) or mixed effects modeling are

typically not needed if the analyses are performed with survey design weights (Ahrnsbrak, 2023).

Model #1 (Table 3 below) will employ a survey-weighted logistic regression model with insurance status as the outcome variable. Likewise, time, race, and race x time will be the primary predictor variables. If the race by time interaction effect is not statistically significant ($p < 0.05$), it will be removed from the model and the model will be refit without the interaction term included. All the models will be adjusted for the covariates noted earlier. Adjusted odds ratios (AORs) will be computed to compare the relevant pre- and post-ACA odds of being insured, and whether those odds differ by race. 95% confidence intervals for the AORs with corresponding p-values will be reported. For model #2 (Table 3 below), a survey-weighted logistic regression will be used; but with usual source of care as the outcome variable. For Model #2, the goal is to follow the same steps for assessing the relevance of the interaction term (race x time) and report the same types of adjusted effect estimates as computed for Model #1.

To account for any outliers or missing data, appropriate methods (e.g., winsorizing, pairwise deletion, maximum likelihood etc.) to handle any outliers will be employed; and any missing values will be reported for each variable (Kwak & Kim, 2017; Peugh & Enders, 2004). If there is a substantial amount of missing data for any variable, multiple imputation will be conducted by the proposed study author to handle the missing data (Jakobsen et al., 2017). If multiple imputation is employed, all analyses for both the imputed data; and the complete case data will be used to conduct a sensitivity analysis (Crameri et al., 2015; VanderWeele & Ding, 2017).

The reference category for insurance status will be "insured." The reference category for "race" will be White. The reference category for time will be "pre-ACA." The reference category for age will be "18 to 25." The reference category for education will be "no degree." The reference category for employment will be "not employed." The reference category for income will be "poor." The reference category for "region" will be "Northeast."

Multicollinearity will be assessed by calculating variance inflation factors. Multicollinearity will be investigated to account for any potential biased standard errors that could lead to unstable p-values. Multicollinearity occurs when at least two highly correlated predictors are assessed concurrently in a regression model (Vatcheva et al., 2016). Likewise, variance inflation factors measure the inflation in the variances of the parameter estimates due to multicollinearity potentially caused by the correlated predictors (Marcoulides & Raykov, 2019). Variance inflation factor values over 10 would suggest severe levels of multicollinearity (Marcoulides & Raykov, 2019; Menard, 2002). Use of the MEPS dataset was approved by the George Washington University Institutional Review Board (IRB) in September 2022. IBM SPSS 26 software will be used to run the analyses.

Table 3
Variables Considered for Addressing Study Questions 1.1–1.3

Dependent/outcome variables	Independent/predictor variables	Covariates
Model #1—Insurance status [a] (i.e., insured vs. uninsured)	Race/ethnicity (non-Hispanic Black, non-Hispanic white) Time Period: characterized as binary pre/post ACA Race/Ethnicity x Time Period (if relevant)	Age, education, employment, income, region
Model #2—Usual source of care (yes/no) [b]	Race/ethnicity (non-Hispanic Black, non-Hispanic white)	Age, education, employment, income, region

Time Period: characterized as binary pre/post ACA Race/Ethnicity x Time Period (if relevant)

[a] The categories of ‘any private’ and ‘any public’ will be combined and recoded into a singular survey-weighted ‘insured’ reference category. [b] This proposed study will construct a dichotomous (yes/no) usual source of care variable indicating whether the person’s provider is in an office.

Chapter 4: Results

This study took a longitudinal approach by examining how access to care among non-Hispanic Black men and non-Hispanic White men ages 18–64 was affected by the ACA. Given the interest in understanding barriers experienced by underrepresented racial and ethnic groups, one reason for comparing non-Hispanic Black men and non-Hispanic White men was to address the identified need in the literature for up-to-date and disaggregated data between these two subpopulations specifically in the context of insurance status and having a usual source of care. This study examined the impact of ACA provisions such as the Medicaid expansion on these two health indicators.

This chapter includes the following five sections:

- Description of study populations
- Indicators of health care access
- Insurance status regression (model one)
- Usual source of care regression (model two)
- Summary of key findings and null hypotheses

Description of the Study Populations

The total sample size for non-Hispanic Black men and non-Hispanic White men in the MEPS database was 46,227 from 2011–2019. In the results, pre-ACA refers to the period 2011–2014 and post-ACA refers to 2015–2019. Table 4 below provides descriptive characteristics of non-Hispanic Black men and non-Hispanic White men across age, education, employment, income, and region of the country. The largest percentage of non-Hispanic Black men were in the 18–34-year-old age group (40.90%

pre-ACA and 41.70% post-ACA) while the largest percentage of non-Hispanic White men were in the 50–64-year-old age group (36.40% pre-ACA and 35.80% post-ACA).

Non-Hispanic Black men and non-Hispanic White men differ considerably in terms of sociodemographic characteristics. A larger proportion of non-Hispanic White men than non-Hispanic Black men had some college education or higher before (54.9% v. 37.8% respectively) and after (44.0% v. 27.4% respectively) 2014. More non-Hispanic White men than non-Hispanic Black men were employed full time pre-ACA (67.0% v. 52.9%) and post-ACA (70.5% v. 56.6%).

Moreover, non-Hispanic White men (48.7%, pre-ACA; 54.7%, post-ACA) were more likely than non-Hispanic Black men (27.6%, pre-ACA; 33.1%, post-ACA) to be high-income. Non-Hispanic Black men were more likely than non-Hispanic White men to be poor pre-ACA (20.9% v. 8.7%) and post-ACA (16.3% v. 7.4%). Similarly, non-Hispanic Black men were more likely to be low-income than non-Hispanic White men both pre-ACA (15.5% v. 9.9%) and post-ACA (13.8% v. 8.4%) respectively. Also, more non-Hispanic Black men compared to non-Hispanic White men were unemployed pre-ACA (33.6% v. 19.7%) and post-ACA (28.1% v. 17.3%) respectively.

Geographically, the largest proportions of non-Hispanic Black and non-Hispanic White men (58.9% and 34.3% respectively) were in the Southern region. While the majority (58.9%) of non-Hispanic Black men live in Southern states, non-Hispanic White men reside more evenly across the four regions. This was the case before and after implementation of ACA.

Table 4

Weighted Percentages of Non-Hispanic White Men and Non-Hispanic Black Men by Age, Education, Employment, Income, and Region (Pre-ACA, 2011–2014; Post-ACA, 2015–2019)

Variable	Group (non-Hispanic)			
	White men	Black men	White men	Black men
Unweighted *n*	15,582	7,392	19,514	6,739
Weighted *n*	26,831,445	4,862,073	32,497,531	6,473,695
Age	Pre-ACA		Post-ACA	
	White men	Black men	White men	Black men
18–34	33.90%	40.90%	34.60%	41.70%
35–49	29.70%	29.70%	29.60%	29.10%
50–64	36.40%	29.30%	35.80%	29.30%
	Pre-ACA		Post-ACA	
Education	White men	Black men	White men	Black men
No degree	8.80%	16.40%	8.00%	13.00%
High school or GED	36.30%	45.80%	47.90%	59.60%
Some college or Bachelor's	40.00%	30.30%	22.80%	13.70%
Graduate or other degree	14.90%	7.50%	21.20%	13.70%
	Pre-ACA		Post-ACA	
Employment status [a]	White men	Black men	White men	Black men
Not employed	19.70%	33.60%	17.30%	28.10%
Employed full time	67.00%	52.90%	70.50%	56.60%
Employed part time	11.30%	11.30%	10.40%	13.10%
Intermittent employment	2.10%	2.20%	1.80%	2.20%
	Pre-ACA		Post-ACA	
Income [b]	White men	Black men	White men	Black men
Poor	8.70%	20.90%	7.40%	16.30%
Near poor	2.90%	5.60%	2.40%	4.70%
Low	9.90%	15.50%	8.40%	13.80%
Middle	29.80%	30.40%	27.00%	32.20%
High	48.70%	27.60%	54.70%	33.10%
	Pre-ACA		Post-ACA	
Region	White men	Black men	White men	Black men
Northeast	19.40%	16.30%	19.00%	15.70%
Midwest	26.20%	17.40%	26.30%	16.40%
South	34.50%	57.00%	34.30%	58.90%
West	19.80%	9.30%	20.30%	9.00%

[a] Full-time employment is defined as working at least 35 hours per week and part-time employment as working less than 35 hours per week. The intermittent employment variable includes categories for "job to return to" and "job during" the survey interview.
[b] Poor: 0%–100% federal poverty level (FPL); Near poor: 101%–125% FPL; Low income: 126%–200% FPL; Middle income: 201%–400% FPL; High income: over 400% FPL.

Indicators of Health Care Access

Table 5 below displays the survey-weighted percentages for the crosstabulation with insurance status. The data indicates that more non-Hispanic White men were insured post-ACA (7.2% increase) resulting in a 45.3% decrease in uninsured non-Hispanic White men post-ACA. Non-Hispanic Black men also experienced an increase in being insured (11.4% increase), resulting in a 36.5% decrease in uninsured non-Hispanic Black men post-ACA. In other words, the proportion of non-Hispanic White and non-Hispanic Black men who were insured increased after implementation of ACA. While fewer non-Hispanic Black men and non-Hispanic White men were uninsured post-ACA, the gap in insurance status between non-Hispanic Black men and non-Hispanic White men persisted each year from 2015 to 2019 (see Figure 4 and Table 5 below).

Figure 4

Weighted Percentages of Non-Hispanic White Men and Non-Hispanic Black Men Uninsured (Pre-ACA, 2011–2014; Post-ACA, 2015–2019)

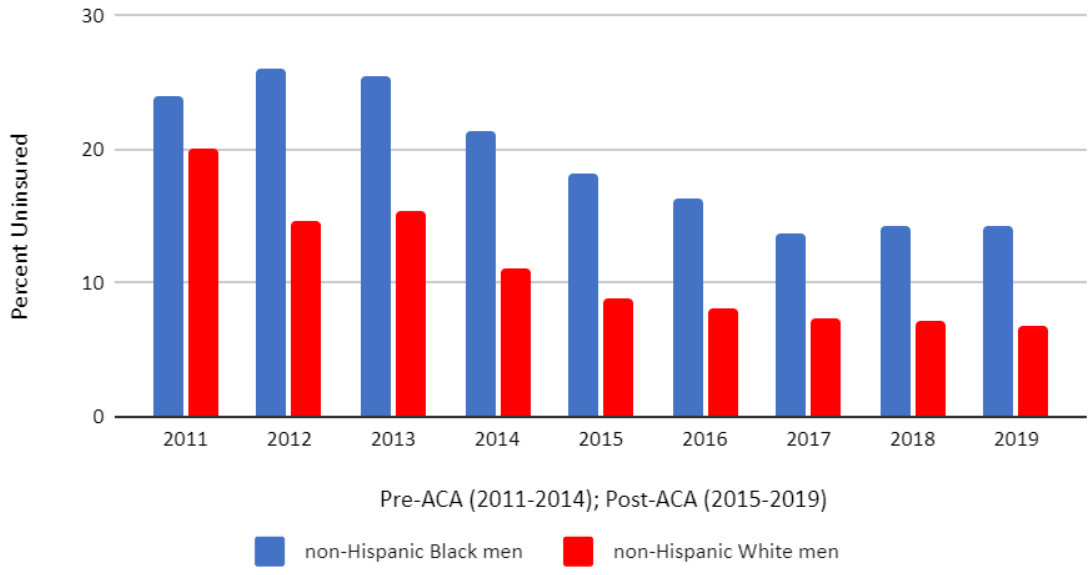


Table 5

Comparing Non-Hispanic White Men and Non-Hispanic Black Men by Insurance Status (Pre-ACA, 2011–2014; Post-ACA 2015–2019)

Variable	Group					
	Pre-ACA			Post-ACA		
Insurance status	White men	Black men	All men [a]	White men	Black men	All men
Insured [b]	86.10%	75.90%	84.60%	92.40%	84.70%	91.10%
Uninsured	13.90%	24.10%	15.40%	7.60%	15.30%	8.90%

[a] The all men category combines all non-Hispanic White men and non-Hispanic Black men across this time period.
[b] Any private and any public insurance status were combined and all percentages were survey-weighted.

Table 6 below displays the survey-weighted percentages of men with and without a usual source of care. The data demonstrates that there was a 3.7% decrease for non-Hispanic White men who had a usual source of care from pre-ACA to post-ACA. Similarly, there was a 4.1% decrease in having a usual source of care for non-Hispanic Black men pre- to post-ACA.

Table 6

Comparing Non-Hispanic White Men and Non-Hispanic Black Men by Usual Source of Care (pre-ACA, 2011–2014; post-ACA 2015–2019)

Variable	Group					
Usual source of care [a]	Pre-ACA			Post-ACA		
	White men	Black men	All men [b]	White men	Black men	All men
Yes	72.50%	61.00%	70.80%	69.80%	58.50%	68.00%
No	27.50%	39.00%	29.20%	30.20%	41.50%	32.00%

[a] All percentages were survey-weighted.
[b] The all men category combines all non-Hispanic White men and non-Hispanic Black men across this time period.

Additional crosstabulations were performed to probe the unexpected finding of increased coverage that did not show having increased usual source of care. Table 7 below displays the survey-weighted percentages for the crosstabulation of sociodemographic variables with race and usual source of care for the post-ACA period only. When compared with 18-34- and 35–49-year-old age groups, the 50-64 age group had the highest rates of having a usual source of care for both non-Hispanic White men (81.9%) and non-Hispanic Black men (74.8%). Those with graduate or other degrees had the highest rate of having a usual source of care for both non-Hispanic White men (73.8%) and non-Hispanic Black men (66.2%).

However, those who were unemployed had the highest rates of having a usual source of care for both non-Hispanic White men (74.5%) and non-Hispanic Black men (66.9%). The high-income group had the highest rates of having a usual source of care for both non-Hispanic White men (74.3%) and non-Hispanic Black men (65.1%). Among non-Hispanic White men, those residing in the Northeast had the highest rate of having a usual source of care (73.2%). Alternatively, for non-Hispanic Black men, the South region of the country is where they had the lowest percentage of having a usual source of care (see Figure 8 and Figure 9 below).

Table 7

Weighted Percentages of Men by Race, Selected Sociodemographic and Usual Source of Care (Post-ACA, 2015–2019)

Variable	Group					
	With a usual source of care			Without a usual source of care		
Age	White men	Black men	All men [a]	White men	Black men	All men a
18–34 (reference)	57.50%	46.00%	55.30%	42.50%	54.00%	44.70%
35–49	69.70%	60.30%	68.20%	30.30%	39.70%	31.80%
50–64	81.90%	74.80%	81.00%	18.10%	25.20%	19.00%
	With a usual source of care			Without a usual source of care		
Education	White men	Black men	All men	White men	Black men	All men
No degree (reference)	68.60%	60.30%	66.60%	31.40%	39.70%	33.40%
High school or GED	67.40%	55.20%	65.00%	32.60%	44.80%	35.00%
Some college or Bachelor's	70.30%	63.80%	69.60%	29.70%	36.20%	30.40%
Graduate or other degree	73.80%	66.20%	73.00%	26.20%	33.80%	27.00%
	With a usual source of care			Without a usual source of care		
Employment status [b]	White men	Black men	All men	White men	Black men	All men
Not employed (reference)	74.50%	66.90%	72.70%	25.50%	33.10%	27.30%
Employed full time	69.40%	56.10%	67.60%	30.60%	43.90%	32.40%
Employed part time	67.80%	56.00%	65.60%	32.20%	44.00%	34.40%
Intermittent employment	60.90%	50.80%	59.00%	39.10%	49.20%	41.00%
	With a usual source of care			Without a usual source of care		
Income [c]	White men	Black men	All men	White men	Black men	All men
Poor (reference)	63.00%	52.80%	60.00%	37.00%	47.20%	40.00%
Near poor	60.70%	58.60%	60.20%	39.30%	41.40%	39.80%
Low	60.30%	53.70%	58.80%	39.70%	46.30%	41.20%
Middle	66.40%	56.70%	64.50%	33.60%	43.30%	35.50%
High	74.30%	65.10%	73.30%	25.70%	34.90%	26.70%
	With a usual source of care			Without a usual source of care		
Region	White men	Black men	All men	White men	Black men	All men
Northeast (reference)	73.20%	61.80%	71.70%	26.80%	38.20%	28.30%
Midwest	71.90%	62.30%	70.90%	28.10%	37.70%	29.10%
South	66.40%	56.10%	63.80%	33.60%	43.90%	36.20%
West	69.80%	62.50%	69.20%	30.20%	37.50%	30.80%

[a] The all men category combines all non-Hispanic White men and non-Hispanic Black men across this time period. [b] Full-time employment is defined as working at least 35 hours per week and part-time employment as working less than 35 hours per week. The intermittent employment variable includes categories for "job to return to" and "job during" the survey interview. [c] Poor: 0%-100% federal poverty level (FPL); Near poor: 101%-125% FPL; Low income :126%-200% FPL; Middle income: 201%- 400% FPL; High income: over 400% FPL.

Figure 8

Weighted Percentages of Non-Hispanic White Men and Non-Hispanic Black Men Without a Usual Source of Care Across Regions of the Country (Pre-ACA, 2011–2014; Post-ACA, 2015–2019)

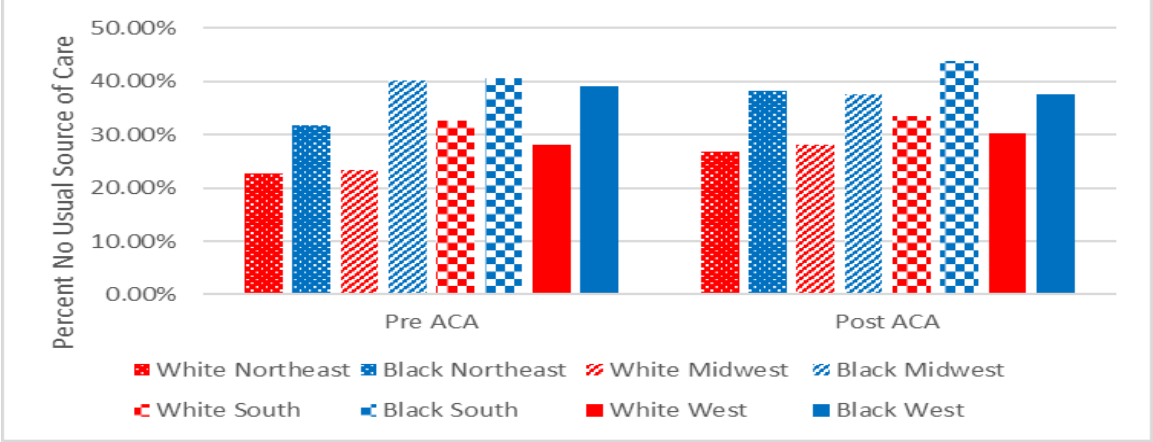
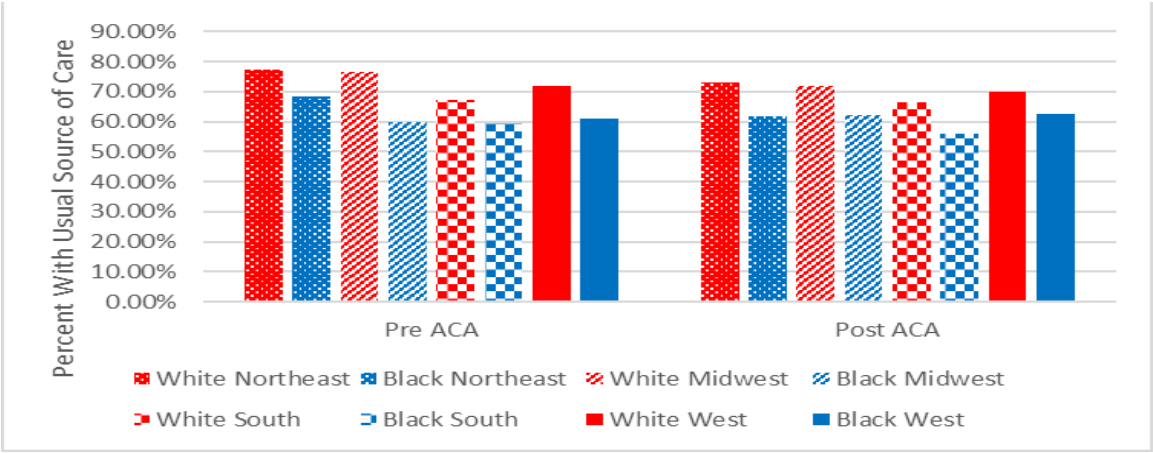


Figure 9

Weighted Percentages of Non-Hispanic White Men and Non-Hispanic Black Men With a Usual Source of Care Across Regions of the Country (Pre-ACA, 2011–2014; Post-ACA, 2015–2019)



Insurance Status Regression Model One

I performed a survey-weighted logistic regression analysis to assess the odds of being uninsured. The regression model controlled for race, time, the interaction between

race and time, age, education, employment, income, and region. Table 1B in the appendix displays the variance inflation factors for the insurance status regression. The race by time (pre- and post-ACA) interaction term was not a significant predictor of being uninsured ($p = .433$), indicating that the effect of the ACA on the odds of being uninsured was no different between non-Hispanic Black men and non-Hispanic White men (see appendix Table 1C).

The model was then refit without the interaction term and the results are given in Table 8 below. Race was a significant predictor of being uninsured ($p < .001$), indicating that non-Hispanic Black men had 1.30 times (or 30%) greater odds than non-Hispanic White men of being uninsured before and after implementation of the ACA in 2014 (adjusting for all covariates in the model). Noted previously, Medicaid expansion in 2014 was a key policy intervention examined in this dissertation study.

The time period (pre-ACA, 2011–2014; post-ACA, 2015–2019) was a significant predictor of being uninsured ($p < .001$), with men post-ACA had 47% lower odds of being uninsured compared to men pre-ACA. However, a significant main effect of race showed that non-Hispanic Black men have higher odds of being uninsured than non-Hispanic White men.

Impact of Sociodemographic Characteristics (Model One)

In this section, I report if and how age, education, employment, income, and region are significant predictors of men's health insurance status. Men aged 50 to 64 had 23% lower odds of being uninsured than men aged 18 to 34 ($p < .001$). Men with some college or a Bachelor's degree had 42% lower odds of being uninsured ($p < .001$), and men with a graduate or other degree had 55% lower odds of being uninsured ($p < .001$)

compared to men with no degree. Men who were employed part time had 83% greater odds of being uninsured ($p < .001$) compared to men who were not employed, and men who were intermittently employed had 53% greater odds of being uninsured ($p < .001$) compared to men who were not employed. Men in higher income categories had lower odds of being uninsured than men in the lowest (poor) income category (all p-values < .05), with men in the highest income category having 80% lower odds of being uninsured than men in the lowest income category. Men residing in the South had 63% higher odds of being uninsured than men residing in the Northeast ($p < .001$).

Table 8

Logistic Regression Predicting Adjusted Odds of Being Uninsured, 2011–2019 (Non-Hispanic Black Men and Non-Hispanic White Men 18–64)

Variables	*B*	Std. Error	Sig.	AOR	95% CI AOR Lower	95% CI AOR Upper
Uninsured (Reference: Insured [a])						
(Intercept)	-1.01	0.11	<.001	0.37	0.29	0.45
Race [Black]	0.26	0.05	<.001	1.30	1.17	1.44
Time [Post ACA]	-0.65	0.05	<.001	0.53	0.48	0.58
Age [Reference: 18 to 34]						
35 to 49	0.00	0.06	0.955	1.00	0.89	1.12
50 to 64	-0.27	0.06	<.001	0.77	0.68	0.86
Education [Reference: No degree]						
GED/HS degree	-0.07	0.07	0.357	0.94	0.81	1.08
Some college or Bachelor's	-0.55	0.09	<.001	0.58	0.49	0.69
Graduate or other	-0.80	0.11	<.001	0.45	0.36	0.56
Employment [Reference: Unemployed] [b]						
Employed full time	0.04	0.07	0.508	1.04	0.92	1.19
Employed part time	0.60	0.07	<.001	1.83	1.58	2.11
Intermittent	0.42	0.11	<.001	1.53	1.23	1.90
Income [Reference: Poor]						
Near poor	-0.23	0.08	0.006	0.79	0.67	0.94
Low	-0.13	0.06	0.039	0.88	0.78	0.99
Middle	-0.77	0.07	<.001	0.46	0.41	0.53
High	-1.60	0.09	<.001	0.20	0.17	0.24
Region [Reference: Northeast]						
Midwest	0.14	0.10	0.164	1.15	0.94	1.41
South	0.49	0.09	<.001	1.63	1.36	1.96
West	0.22	0.12	0.063	1.24	0.99	1.56

[a] Insured combined any private and any public insurance holders as the reference category. [b] Full-time employment is defined as working at least 35 hours per week and part-time employment as working less than 35 hours per week. The intermittent employment variable includes categories for "job to return to" and "job during" the survey interview.

Usual Source of Care Regression Model Two

In this section, I report if and how age, education, employment, income, age, and region are significant predictors of men having a usual source of care. This dissertation study found that there was a significant main effect of race showing that non-Hispanic

Black men were less likely to have a usual source of care than non-Hispanic White men. The time period (pre-ACA, 2011–2014; post-ACA, 2015–2019) examined in this dissertation study was also a significant predictor of having a usual source of care ($p <$ .001), indicating that all men post-ACA had 16% lower odds of having a usual source of care compared to all men pre-ACA. Moreover, the lack of a significant race by time interaction term provided evidence that the ACA did not significantly decrease the racial gap.

A survey-weighted logistic regression was performed with race, time, a race by time interaction, age, education, employment, income, and region predicting usual source of care. Table 1D in the appendix displays the variance inflation factors for the usual source of care regression. The race by time (pre- and post-ACA) interaction term was not a significant predictor of having a usual source of care ($p = .306$) (see Table 1E in appendix). In other words, the lower odds of having a usual source of care were consistent for non-Hispanic Black men and non-Hispanic White men across the post-ACA time period of 2015–2019 and the pre-ACA time period 2011–2014.

Table 9 below displays the parameter estimates for the usual source of care regression model – which was refit without the interaction term. This dissertation study found that race was a significant predictor of having a usual source of care ($p < .001$), indicating that non-Hispanic Black men had 25% lower odds than non-Hispanic White men to have a usual source of care before and after implementation of the ACA in 2014.

Impact of Sociodemographic Characteristics (Model Two)

In this section, I report if and how age, education, employment, income, and region are significant predictors of men having a usual source of care. Men aged 35 to 49

had 84% greater odds of having a usual source of care ($p < .001$), and men aged 50 to 64 had 244% greater odds of having a usual source of care ($p < .001$) than men aged 18 to 34. Men with a GED or high school degree had 18% lower odds of having a usual source of care ($p < .001$), and men with some college or a Bachelor's degree had 13% lower odds of having a usual source of care ($p = .019$) compared to men with no degree.

Men who were employed full time, employed part time, or intermittently employed were less likely to have a usual source of care (all p-values < .001) compared to men who were not employed. Men in higher income categories had greater odds of having a usual source of care than men who were poor (all p-values < .05), with men in the highest income category having 134% greater odds of having a usual source of care than men who were poor. Men residing in the South had 31% lower odds of having a usual source of care ($p < .001$), and men residing in the West had 18% lower odds of having a usual source of care ($p = .007$) than men residing in the Northeast.

Table 9

Logistic Regression Predicting the Adjusted Odds Ratios of Having a Usual Source of Care, 2011–2019 (Non-Hispanic Black Men and Non-Hispanic White Men 18–64)

Variables					95% CI AOR	
	B	Std. Error	Sig.	AOR	Lower	Upper
Usual source of care: Yes (Reference: No)						
(Intercept)	0.58	0.09	<.001	1.79	1.50	2.14
Race [Black]	-0.29	0.04	<.001	0.75	0.69	0.81
Time [Post ACA]	-0.18	0.04	<.001	0.84	0.78	0.90
Age [Reference: 18 to 34]						
35 to 49	0.61	0.04	<.001	1.84	1.70	1.99
50 to 64	1.24	0.04	<.001	3.44	3.17	3.73
Education [Reference: No degree]						
GED/HS degree	-0.20	0.05	<.001	0.82	0.74	0.91
Some college or Bachelor's	-0.14	0.06	0.019	0.87	0.78	0.98
Graduate or other	-0.04	0.07	0.587	0.96	0.84	1.11
Employment [Reference: Unemployed] [a]						
Employed full time	-0.56	0.04	<.001	0.57	0.53	0.62
Employed part time	-0.41	0.05	<.001	0.67	0.60	0.74
Intermittent	-0.53	0.10	<.001	0.59	0.49	0.72
Income [Reference: Poor] [b]						
Near poor	0.22	0.08	0.005	1.24	1.07	1.44
Low	0.22	0.05	<.001	1.24	1.12	1.38
Middle	0.51	0.05	<.001	1.66	1.50	1.84
High	0.85	0.06	<.001	2.34	2.10	2.61
Region [Reference: Northeast]						
Midwest	0.01	0.07	0.875	1.01	0.88	1.16
South	-0.37	0.07	<.001	0.69	0.61	0.79
West	-0.20	0.08	0.007	0.82	0.71	0.95

[a] Full-time employment is defined as working at least 35 hours per week and part-time employment as working less than 35 hours per week. The intermittent employment variable includes categories for "job to return to" and "job during" the survey interview.
[b] Poor: 0%–100% federal poverty level (FPL); Near poor: 101%–125% FPL; Low income :126%–200% FPL; Middle income: 201%–400% FPL; High income: over 400% FPL.

Summary of Key Findings and Null Hypotheses

Table 10 below provides a summary of the study questions and null hypotheses. One of the goals of the ACA was to expand access to insurance coverage; and thus, access to care. To better understand the impact of the ACA on men ages 18–64, this dissertation study asked three questions.

Study question 1.1 was: Are there racial differences in health insurance coverage and usual source of care between non-Hispanic Black men and non-Hispanic White men ages 18–64 during the pre-ACA period 2011–2014?

This dissertation study found racial differences in health insurance coverage and usual source of care between non-Hispanic Black men and non-Hispanic White men ages 18–64 during the pre-ACA period 2011–2014. More specifically, race was a significant predictor of being uninsured ($p < .001$), with non-Hispanic Black men having 1.30 times or 30% greater odds than non-Hispanic White men of being uninsured, and non-Hispanic Black men having 25% lower odds than non-Hispanic White men of having a usual source of care. The lack of a significant race by time interaction term indicates that these differences existed before and after the ACA time frame examined in this dissertation study. These findings illustrate and confirm that there were racial differences in health insurance coverage and usual source of care among men before 2015.

To assess changes over time, study question 1.2 was: Are there changes in health insurance coverage and usual source of care among non-Hispanic Black men and non-Hispanic White men ages 18–64 after implementation of ACA-related provisions from 2015–2019?

This dissertation study found changes in health insurance coverage and usual source of care between non-Hispanic Black men and non-Hispanic White men. More specifically, the time period (pre-ACA, 2011–2014; post-ACA, 2015–2019) was a significant predictor of being uninsured ($p < .001$). Men had 47% lower odds of being uninsured post-ACA compared to pre-ACA. These findings illustrate that the ACA decreased the proportions of non-Hispanic Black men and non-Hispanic White men who

were uninsured after 2014. The lack of a statistically significant race by time interaction ($p = .433$), indicates that the effect of time (pre- v. post-ACA) did not differ by race. Overall, the results indicate that although the proportions of uninsured men decreased after ACA, differences in insurance status among non-Hispanic Black and non-Hispanic White men persisted in the post-ACA time frame examined in this dissertation study. These findings confirm that the ACA achieved one of its goals of increasing health insurance coverage despite the persistent racial gap between non-Hispanic Black men and non-Hispanic White men.

The time period examined in this dissertation study was also a significant predictor of men having a usual source of care ($p < .001$); however, the findings were not as anticipated. The odds of having a usual source of care decreased for men after implementation of the ACA. While the ACA decreased the odds of being uninsured for non-Hispanic Black men and non-Hispanic White men, it did not increase the odds of having a usual source of care for non-Hispanic Black men or non-Hispanic White men – as would have been expected. The lack of a statistically significant interaction term for race by time indicates that the effect of time did not differ by race.

To assess the impact of the ACA on the racial gap in access to care between non-Hispanic Black men and non-Hispanic White men, study question 1.3 was:

To what extent did the ACA close the racial gap between non-Hispanic Black men and non-Hispanic White men ages 18–64 in terms of insurance status and having a usual source of care from 2015–2019 (post-ACA)?

The ACA did not close the racial gap between non-Hispanic Black men and non-Hispanic White men ages 18–64 in terms of insurance status and having a usual source of

care from 2015–2019 (post-ACA). The lack of a statistically significant interaction effect between race and time on either being uninsured or having a usual of care provides evidence that the racial gap persisted after implementation of the ACA. This next section is a summary of key findings and null hypotheses. Chapter five will discuss the interpretation of these key findings, strengths and limitations, practice and policy implications, and recommendations for future research.

Table 10

Summary of Null Hypotheses 1.1–1.3 and Key Findings

Null hypotheses	Key findings (fail to reject/reject)
Null Hypothesis 1.1a: Before 2015, the proportion of uninsured non-Hispanic Black men was the same as the proportion of uninsured non-Hispanic White men ages 18–64.	Key finding: non-Hispanic Black men were 1.30 times more likely (or had 30% greater odds) to be uninsured compared to non-Hispanic White men both pre-ACA and post-ACA ($p < .001$). Null Hypothesis 1.1a rejected.
Null Hypothesis 1.1b: Before 2015, the proportion of non-Hispanic Black men with a usual source of care was the same as the proportion of non-Hispanic White men ages 18–64 with a usual source of care.	Key finding: non-Hispanic Black men had 25% lower odds of having a usual source of care compared to non-Hispanic White men both pre-ACA and post-ACA ($p < .001$). Null Hypothesis 1.1b rejected.
Null Hypothesis 1.2a: Among non-Hispanic Black and non-Hispanic White men, the proportion of uninsured before ACA implementation was the same as the proportion of uninsured after ACA implementation.	Key finding: All men had 47% lower odds of being uninsured post-ACA ($p < .001$). The lack of a significant race by time interaction provides no evidence that the effect of the ACA differed between non-Hispanic Black men and non-Hispanic White men. Null Hypothesis 1.2a rejected.
Null Hypothesis 1.2b: Among non-Hispanic Black and non-Hispanic White men, the proportion of men with a usual source of care before ACA implementation was the same as the proportion of men with a usual source of care after ACA implementation.	Key finding: All men had 16% lower odds of having a usual source of care post-ACA ($p < .001$). The lack of a significant race by time interaction provides no evidence that the effect of the ACA differed between non-Hispanic Black men and non-Hispanic White men. Null Hypothesis 1.2b rejected.
Null Hypothesis 1.3a: The ACA has not closed the racial gap between non-Hispanic Black men and non-Hispanic White men ages 18–64 in terms of insurance status (i.e., percent uninsured) post-ACA.	Key finding: non-Hispanic Black men were 1.30 times more likely (or had 30% greater odds) than non-Hispanic White men to be uninsured pre- and post-ACA. The lack of a significant race by time interaction shows that the implementation of ACA did not affect this gap. Null Hypothesis 1.3a failed to be rejected.
Null Hypothesis 1.3b: The ACA has not closed the racial gap between non-Hispanic Black men and non-Hispanic White men ages 18–64 in terms of usual source of care post-ACA.	Key finding: non-Hispanic Black men had 25% lower odds than non-Hispanic White men to have a usual source of care. The lack of a significant race by time interaction shows that the implementation of ACA did not affect this gap. Null Hypothesis 1.3b failed to be rejected.

Chapter 5: Discussion

The purpose of this study was to examine the association between the enactment and implementation of the *Patient Protection and Affordable Care Act of 2010* (ACA) with respect to Black men's access to care (as measured by insurance status and having a usual source of care) compared to White men ages 18–64; and to propose future strategies to help address any inequities. Because men historically live shorter lives than women and are more likely to delay seeking care among other issues, this dissertation study sought to amplify the unique health care access needs of men; and help explain the more nuanced barriers experienced by Black men. To do so, this dissertation examined the impact of the ACA on men, and on racial differences in two indicators of the potential to access to care – insurance status and usual source of care.

Because affordability was seen as the primary barrier to accessing and utilizing health care in the United States, part of the premise of the ACA was to help make insurance more affordable by providing premium subsidies on a sliding scale to those earning between 100% and 400% of the federal poverty level (Gaffney & McCormick, 2017); in addition to expanding Medicaid coverage to adults under age 65 with incomes up to 138 % of the federal poverty level (Buchmueller & Levy, 2020). Thus, the first-of-its-kind evidence generated in this dissertation study is of considerable policy interest to a variety of stakeholders in the health care ecosystem who examine access to care and utilization. Moreover, the findings in this dissertation study help in defining health care access challenges facing Black men in the post-ACA era – an important first step in developing policy and programmatic solutions for Black men and White men.

Because policy interventions can impact communities differentially, part of the goal of this dissertation study was to build upon the benefits of a vulnerable population approach by addressing the conditions that put social groups like Black men at greater exposure to other risks (Frohlich & Potvin, 2008). This dissertation examined the study questions below:

Are there racial differences in health insurance coverage and usual source of care between non-Hispanic Black men and non-Hispanic White men ages 18–64 during the pre-ACA period 2011–2014?

Are there changes in health insurance coverage and usual source of care among non-Hispanic Black men and non-Hispanic White men ages 18–64 after implementation of ACA-related provisions from 2015–2019 (post-ACA)?

To what extent did the ACA close the racial gap between non-Hispanic Black men and non-Hispanic White men ages 18–64 in terms of insurance status and having a usual source of care from 2015–2019 (post-ACA)?

This chapter will be structured as follows:

- Overview of findings
- Policy recommendations
- Strengths and limitations
- Recommendations for future research
- Conclusions

Overview of Findings

This analysis found that in the post-ACA era of 2015-2019, an estimated 15.3% of non-Hispanic Black men and 7.6% of non-Hispanic White men ages 18-64 were

uninsured and an estimated 41.5% of non-Hispanic Black men and 30.2% of non-Hispanic White men ages 18-64 lacked a usual source of medical care. While provisions of the ACA helped to improve health insurance coverage for all men, the ACA did not close the racial gap between non-Hispanic Black men and non-Hispanic White men in the proportion uninsured or lacking a usual source of care. Moreover, men ages 18-64 were less likely to have a usual source of care after implementation of the ACA – compared to the 2011-2014 time period. These findings have pivotal implications in terms of policy and practice that will be discussed in this chapter.

Specifically, the study questions found the following:

1.1) Race was a significant predictor of being uninsured, with non-Hispanic Black men having 30% greater odds than non-Hispanic White men of being uninsured and 2) non-Hispanic Black men having 25% lower odds than non-Hispanic White men of having a usual source of care. The health insurance coverage finding confirms previous studies that found racial differences in health insurance coverage between Black men and White men (KFF, 2012, 2016); however, the usual source of care finding was unexpected because it has been generally understood in the literature that having health insurance facilitates having a usual source of care (Akinyelure et al., 2022; Blewett et al., 2008; Davis, 2001; Fang et al., 2014; Hammond et al., 2011; IOM, 2002a; Toth-Manikowski et al., 2022; Xu, 2002). This unexpected usual source of care finding will be discussed further in this chapter.

1.2) The time period (i.e., pre-ACA, 2011–2014; post-ACA, 2015–2019) was a significant predictor of being uninsured. Men had 47% lower odds of being uninsured post-ACA compared to pre-ACA. These findings illustrate that the ACA decreased the

proportions of non-Hispanic Black men and non-Hispanic White men who were uninsured after 2014; and comports with previous study findings that the ACA decreased uninsured rates for adults since its implementation (Artiga, 2021b; CMWF, 2022; Lee, 2022).

1.3) While the ACA achieved one of its goals of increasing health insurance coverage for men of the two racial groups examined in this study, the racial gap between non-Hispanic Black men and non-Hispanic White men did not close for the two outcomes – being uninsured or having a usual source of care post-ACA. The lack of a statistically significant interaction effect between race and time on either being uninsured or having a usual source of care provides evidence that the racial gap persisted after implementation of the ACA. Partly due to the Supreme Court decision that made Medicaid expansion optional for states, administrative delays, and funding cuts to enrollment efforts, the ACA was limited as an effective policy intervention to eliminate racial/ethnic differences in the health care access indicators examined in this study.

Lack of Health Insurance Discussion and Implications

This study found that the ACA helped to reduce rates of uninsurance among non-Hispanic Black and non-Hispanic White men; however, the racial disparity persisted. As noted, several Southern states that include sizable Black populations have yet to expand Medicaid. These state decisions have an impact on men generally, and Black men specifically. This dissertation study adds to the evidence base regarding the need to expand Medicaid in the remaining states to achieve progress in reducing rates of uninsured among Black men. This finding along with the following sociodemographic findings have implications for the health care ecosystem as it is currently structured.

When considering predictors of men being uninsured, it was found that race (being Black), being part-time and intermittently employed, and living in a Southern state were statistically significant predictors of uninsurance. In contrast, men ages 50-64, with at least some college education, and/or middle to high income had a greater likelihood of being insured than their respective counterparts. While the findings that higher levels of education and income were associated with a greater likelihood of being insured is consistent with what is known about the private health insurance market, the findings regarding employment tell a more nuanced story than what is generally known. The combination of these social drivers of health and health care access have implications for expanding insurance coverage.

Men who were employed part time or intermittently employed had greater odds of being uninsured than men who were not employed. One possible explanation for this finding is that unemployed men may have qualified for Medicaid related to a disabling health condition (Dong et al., 2022; Reichard et al., 2019). For example, one study found that pre-ACA, many individuals with disabilities did not seek employment in fear that an increase in their income would jeopardize their Medicaid eligibility (Hall et al., 2017).

However, when Medicaid income guidelines were expanded in 2014, they were then able to enter the workforce, increase earnings, and maintain insurance coverage (Hall et al., 2017). This employment finding also suggests that the ACA insurance marketplaces were not as effective at providing affordable coverage for men across the employment spectrum. This suggests that broader structural forces (e.g., income linked to part-time employment) may have impacted access to insurance coverage. Lastly, where one resides also matters in terms of life outcomes (Diez-Roux et al., 1997; Khatana et al.,

2019; Mujahid et al., 2017; Sallis et al., 2012; Williams & Collins, 2001). This dissertation study found that men residing in the South were more likely to be uninsured than men in the Northeast. Given that almost 60% of Black men in the U.S. live in the South, this finding is conceivably one of the drivers of the racial disparity in insurance coverage among men.

Usual Source of Care Discussion and Implications

Although the ACA helped to improve rates of insurance coverage among non-Hispanic Black men and non-Hispanic White men, more needs to be done to increase the proportion of either racial group with a usual source of care. This finding was not expected; and is of concern because it is generally understood that having health insurance facilitates having a usual source of care – which can lead to better health outcomes (Davis, 2001; DeVoe et al., 2011; KFF, 2016). Further, the decline observed in this study comports with a MEPS data query on the growing percentage of the population – men and women – without a usual source of care (see Figure 10 in the appendix).

This dissertation study also found that race (being Black), education (completing a high school degree or no more than a college degree), employment (being full time, part time, or intermittently employed), and region (living in the South or West) were significant predictors of men not having a usual source of care. In contrast, men ages 50 to 64 were at least three times more likely to have a usual source of care than men ages 18-34. This dissertation finding is consistent with previous studies illustrating that as people age, they are more likely to have a usual source of care (Drootin, 2011).

This is an indication that health care needs may be a driver of the shift in the share of the population with or without a usual source of care. Perhaps younger men, who tend

to be healthier men, are less well connected to the health care system by choice. Another plausible explanation for this finding may be that men are more likely to seek medical care from an emergency department or urgent care facility despite the expansion of health insurance coverage provided by the ACA (Milani et al., 2016). The Richardson patient navigator model noted earlier may serve as a helpful way to deputize CHWs into the community contexts where Black men are known to socialize and build relationships (e.g., barbershops, faith-based institutions, civic organizations, mentoring programs etc.). Additional study and analyses are needed to understand the decline observed in the proportion without a usual source of care. These findings, however, can help advance the men's health, public health, health care, and health policy fields by encouraging decision-makers (e.g., policymakers, payors, health care providers, grant funders etc.) to identify whether racial differences continue to persist after policy interventions such as the ACA; and if necessary, design more effective and targeted interventions.

Policy Recommendations

Given what has been argued in this dissertation study regarding the invisibility of men on policy agendas; and as this new evidence illustrates, a critical next step to consider is how to strategically leverage what are called "policy windows" in terms of agenda-setting – as devised by John Kingdon (Kingdon, 2010). Kingdon's Three Streams or Multiple Streams Framework (MSF) is a well-regarded model for analyzing policy-making that has been used in countries around the world since 1984 (see Figure 2A in appendix) (Hoefer, 2022). It is composed of three streams: 1) the problem stream 2) the policy stream and 3) the political stream.

When these three streams converge, a policy window opens that facilitates movement on issues of interest in terms of advocacy – defined as one who pleads the cause of one's self or on behalf of someone else (Marshall, 1994). Specifically, the problem stream is the current understanding of the issue(s) at hand by stakeholders. The policy stream is the real or potential policy solutions under consideration by key decision-makers. The political stream is the set of conditions, institutions or external events that could impact the extent to which the policy window remains open or closes. When such conditions are met, policy entrepreneurs or champions serve to promote the goals of a specific agenda in the interest of shaping policy (Colvin, 2023; Hoefer, 2022). Based upon the findings in this study, policy entrepreneurs can promote the need to take a multilevel approach that centers men's health as they consider funding targeted interventions for men throughout the policy-making process at the federal, state, and local levels.

Noted earlier, vulnerable populations are defined as a subgroup who, based on shared social characteristics, are at higher risk of poor health or health care outcomes (e.g., Black men uninsured and without a usual source of care) (Frohlich & Potvin, 2008). Taking a vulnerable populations approach can help shape policies and practices that aspire to serve everyone equitably by enabling different interventional strategies based on the needs of different groups (Powell, 2019a). The vulnerable populations approach can potentially also help incorporate an intersectional context to men's health in terms of race, gender, and other social identities that impact access to care and utilization (Griffith, 2012; Griffith et al., 2013; Griffith et al., 2021; Griffith et al., 2011). Specifically, the

vulnerable populations approach can be incorporated into the policy stream as a solutions-centered component of the policy-making process for men.

This dissertation study found that the ACA decreased the proportions of non-Hispanic Black men and non-Hispanic White men who were uninsured after 2014 by nearly 50%. However, race remained a significant predictor of being uninsured, with non-Hispanic Black men having 30% greater odds than non-Hispanic White men of being uninsured; and non-Hispanic Black men having 25% lower odds than non-Hispanic White men of having a usual source of care – demonstrating that the racial gap persisted. Therefore, efforts should be made to incorporate a vulnerable populations approach to policy formulation for men.

Moreover, effective policy should ideally help shape population-health interventions in order to change the social context that influences health risk (Frohlich, 2014; Powell, 2019a, 2019b). These health risks can also potentially be mitigated by employing eco-social theory that accounts for social phenomena (e.g., structural racism) and social drivers of health (Frohlich, 2014). Numerous empirical studies informed by eco-social theory have operationalized issues like structural racism to help address inequalities and inequities in health (Bailey et al., 2017; Krieger, 2001, 2012, 2020). Because eco-social theory seeks to address inequalities and inequities at multiple levels across the life course, it is well-suited to complement policy formulation and targeted interventions for men in general; and particularly for Black men who continue to have the shortest life expectancy than almost any other racial or ethnic group in the United States (Gilbert et al., 2016; Griffith, 2019; Stewart et al., 2019).

By examining the implementation of the ACA with respect to non-Hispanic Black men's access to care, this dissertation helps shape future policies by providing robust equity-centered evidence for practical advocacy efforts. Based on the key findings from this dissertation study, the policy recommendations below are proposed.

Policy Recommendation 1: Develop pathways to coverage for states that have yet to adopt Medicaid expansion

This dissertation study found that Black men were more likely than White men to be uninsured after ACA provisions such as the Medicaid expansion went into effect in 2014. As of May 2023, 41 states (including DC) have adopted the Medicaid expansion; however, 10 states have yet to adopt the expansion (see Figure 6 in appendix) (KFF, 2023). More recently, two prior non-expansion states (North Carolina and South Dakota) have adopted Medicaid expansion and plan to implement it in the summer of 2023 (KFF, 2023). Seven of the ten states that have chosen to not expand Medicaid are in the South.

Specifically, this study found that 59% of non-Hispanic Black men ages 18-64 reside in the South compared to 34% of non-Hispanic White men. Given that a large percentage of non-Hispanic Black and non-Hispanic White men live in the South and are lower income (i.e., poor or near poor), expanding Medicaid coverage in the remaining states should help achieve one of the aims of addressing health coverage inequities for Black men. Although the ACA achieved one of its goals of expanding insurance coverage for men in this dissertation study, it did not close the racial gap between non-Hispanic Black men and non-Hispanic White men regarding insurance status nor usual source of care. This is because the ACA is an example of a population health approach that can potentially be bolstered by a vulnerable populations approach noted earlier.

While successful outreach may not always translate to enrollment (Gurley-Calvez et al., 2017; Richardson et al., 2021), individuals that need support with signing up for Medicaid or the marketplace exchanges can potentially be engaged and enrolled without incurring exorbitant costs. Moreover, because of the overall success of patient navigators or CHWs in enrolling individuals for insurance coverage, care coordination, and facilitating access to care for Black men noted earlier, policy-makers should continue to support and expand these efforts particularly in the South where almost 60% of Black men reside (Brownstein et al., 2011; Brownstein et al., 2007; Enard & Ganelin, 2013; Islam et al., 2015a; Martinez et al., 2011; Richardson et al., 2021; Spencer et al., 2011b).

Specifically, patient navigators can be health care professionals or lay persons trained to: 1) facilitate access to health-related programs and services for patients/families and caregivers and 2) promote continuity of care among other supports. The broad goal of patient navigator programs is to link patients to primary care services, specialist care, and community-based health and social services (Valaitis et al., 2017). For example, the patient navigator approach has been operationalized by the ACA as the community health worker (CHW) model (Islam et al., 2015b).

Moreover, CHWs are trusted front-line community leaders that help "facilitate accurate data collection, program enrollment, and provision of culturally and linguistically appropriate, patient- and family-centered care" (Islam et al., 2015a). Several studies have found that CHWs improve service delivery and care coordination, decrease health disparities, expand health care access, and decrease costs (Brownstein et al., 2011; Brownstein et al., 2007; Enard & Ganelin, 2013; Islam et al., 2013; Martinez et al., 2011; Spencer et al., 2011a). Further incorporating CHWs into the health care delivery

infrastructure can potentially help close gaps in insurance coverage and help facilitate connecting Black men to health care providers.

Additionally, encouraging consumers to obtain in-person enrollment assistance from ACA-created assistance programs and by partnering with community-based organizations (e.g., National Urban League, NAACP, civic organizations, faith-based institutions etc.) for outreach activities can help buttress enrollment for Black men (Giovannelli & Curran, 2016; Richardson et al., 2021). Likewise, expanding the availability of both public insurance and affordable private coverage for men living in low-income communities is an important way of potentially reducing gender disparities and inequities in access to care (Merzel, 2000).

Health inequities are a social justice and an economic issue; and arguably, the costs of inaction far outweigh the costs of sustainable investments in historically disenfranchised communities. Racial inequities incur billions of dollars in direct and indirect costs and Black men bear a disproportionate burden of these health and economic disparities (Thorpe et al., 2013). One study estimated the total direct medical care expenditures for Black men were $447.6 billion – of which $24.2 billion were excess medical care expenditures (Thorpe et al., 2013). Another recent study found that racial and ethnic health disparities cost the U.S. economy $451 billion, a 41% increase from the previous estimate of $320 billion in 2014 (LaVeist et al., 2023). These costs could be reduced if sustainable investments are made to address the racialized and gendered structural barriers identified in this dissertation study.

At different levels, several efforts have been made to encourage the adoption of measures to expand insurance coverage and having a usual source of care over the years.

For example, the Department of Health and Human Services (HHS) Action Plan to Reduce Racial and Ethnic Health Disparities coordinates efforts and assesses the nation's progress toward addressing racial and ethnic disparities in health and health care (DHHS, 2015). To create a more equitable health care system, one of the specific goals of the 2015 DHHS Action Plan is to expand opportunities for racial and ethnic minorities to obtain and understand how to use insurance coverage; and to expand access to health care services. Additionally, the Office of Minority Health (OMH), the Assistant Secretary for Planning and Evaluation (ASPE), and the Administration for Children and Families (ACF) are funding research to identify promising outreach, enrollment, and messaging strategies to connect low-income men to health insurance and connect them to a usual source of care. The investments from OMH, ASPE, and ACF would be particularly helpful because this study found that non-Hispanic Black men were more likely to be low-income than non-Hispanic White men ages 18-64 post-ACA (13.8% v. 8.4%).

The 2011 National Stakeholder Strategy for Achieving Health Equity – engages federal, state, and local partners to work toward reducing racial and ethnic health disparities (Beadle & Graham, 2011). Key components of the National Stakeholder Strategy include developing strategic partnerships, mobilizing networks, and improving awareness and communications about health disparities through different media outlets. Based upon the key findings in this study, the infrastructure that is currently in place can serve to facilitate educational messaging to men specifically about ways in which they can engage the health care delivery system in terms of insurance status and having a usual source of care.

More recently, the Biden-Harris Administration signed Executive Order (EO) 13985 that calls for a comprehensive approach to advancing equity for all by embedding fairness into executive agency decision-making processes (Biden-Harris, 2021). The executive order specifically calls for a study to help identify the best methods, consistent with applicable law, to assist agencies in assessing equity with respect to race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability. This executive order also presents an opportunity to dismantle structural racism throughout and across a variety of government-funded research infrastructures. As noted earlier, because Black principal investigators are less likely to be awarded funding grants that can help the Black community, barriers persist in terms of funding interventions that can improve access to care for Black men (Lauer, 2021). In response, the Department of Health and Human Services Health Equity Action Plan put forward a plan to advance equity as a fundamental component of the decision-making framework at the executive agency level (Beard et al., 2022).

Regarding health insurance coverage specifically, the HHS Health Equity Action Plan notes that the Centers for Medicare and Medicaid Services is examining ways to address inequities through providing guidance on streamlining Medicaid and CHIP enrollment and renewal processes across states (HHS, 2022). For example, noting that each state has unique policy and political contexts, the initial adoption of state-level approaches to expanding insurance coverage fall under four broad categories: 1) a standard legislative process 2) section 1115 waivers 3) gubernatorial executive action and 4) ballot initiatives (Antonisse, 2019). At the state level, Kingdon's Multiple Streams approach referenced earlier can still be operationalized to help expand health insurance

coverage, access to care and having a usual source of care for men. Moreover, the key findings in this study can be used as additional evidence to support civic engagement with elected officials and their staff. However, decisions about expansion adoption in many states has been predicated upon financing for the state share of expansion costs (Antonisse, 2019).

Policy Recommendation 2: Use a multilevel approach to expand the proportion of men with a usual source of care that includes: a) disseminating educational messages to improve men's awareness of the value of having a regular source of care and b) facilitating health care delivery and payment reforms that incentivize health care institutions to increase the number of Black men who are meaningfully engaged with a regular source of care

This dissertation study found that while there was improved health insurance coverage, there was a decrease in the proportion of men with a usual source of care post-ACA implementation. Moreover, non-Hispanic Black men were less likely than non-Hispanic White men to have a usual source of care which suggests that structural racism continues to pose as a significant barrier for Black men compared to White men. Addressing this issue will take a multilevel approach (T. Agurs-Collins et al., 2019). Multilevel interventions specifically require action targeting at least two or more levels of influence (i.e., up-stream and downstream factors) at the same time or in close temporal proximity (Braveman & Gottlieb, 2014; Gehlert et al., 2008).

Because social drivers of health are multifaceted in terms of impact, addressing health disparities and health inequities requires the dynamic interplay of multiple levels of influence to be effective (Tanya Agurs-Collins et al., 2019). The National Institutes of

Minority Health and Health Disparities (NIMHD) invests in research and fosters collaborations and partnerships to promote and support evidence-based science to inform practice and policy. For example, the National Institutes of Minority Health and Health Disparities Research Framework is a model well-suited to operationalize a variety of policy-relevant variables like insurance coverage and having a usual source of care across multiple domains for men (Alvidrez et al., 2019; Alvidrez & Tabor, 2021). The NIMHD Research Framework has been adapted and operationalized in different contexts in several studies over the years (Lafarga Previdi & Vélez Vega, 2020; Mujuru et al., 2022; Pérez-Stable & Rodriquez, 2023); and there is growing evidence that taking a multilevel approach has improved health outcomes for historically marginalized populations (Lewis et al., 2014; Paskett et al., 2016). The NIMHD Research Framework is therefore an additional way to help address the unique access to care needs of men.

Recommendation 2a

Improving men's awareness of the value of having a regular source of care is one step that can be taken to encourage men to identify a physician or other health care provider that serves as their medical home. The following are specific mechanisms to focus educational messages particularly for Black men: barbershops, educational institutions, faith-based institutions, civic organizations, public service messages, and social media (D. Watkins, 2017; Watkins et al., 2020; Watkins & Griffith, 2013; Watkins et al., 2009). Studies have found significant positive health outcomes like lowered blood pressure readings for Black men when targeted interventions have been provided in these types of contextual settings (Blyler & Rader, 2019; Ebinger et al., 2020; Releford et al., 2010; Victor et al., 2018; Victor et al., 2009; Victor et al., 2011). These studies have

found that barbershops, faith-based institutions, and partnering with civic organizations have improved access to care and having a usual source of care for Black men.

Noted previously, older age is an important predictor of having a usual source of care for men of both racial groups; and studies have found that older Black men desire mentoring younger Black men in terms of health promotion (Stewart et al., 2019). Moreover, incorporating other members of the family (e.g., mothers, spouses, aunts, uncles, daughters, nieces, nephews etc.) into the support system has been found to facilitate increased help-seeking behavior for Black men (Murray et al., 2017; Stewart et al., 2019). Therefore, the combination of intergenerational and familial relationships can serve as a force multiplier for promoting positive educational messaging about the importance of having a usual source of care over the life span (Jones et al., 2019; Thorpe et al., 2015).

Recommendation 2b

Structurally, provisions in the ACA sought to reform how health care is paid for and delivered such as care coordination, patient-centered medical homes, and accountable care organizations (McClellan, 2017). There is growing evidence that these types of efforts can help incentivize health care providers and institutions to better support patients like Black men (Mitchell & Perry, 2020; Stewart et al., 2019; Swietek et al., 2020). Moreover, previous studies (Hammond, Matthews, & Corbie-Smith, 2010; Metzl, 2013) have found that the health care delivery system can potentially be structured to facilitate and support men's unique needs. Federally qualified health centers (FQHCs) have also been found to reduce the gap in primary care provider supply and mitigate

uneven distribution of the primary care workforce (Xue et al., 2018). These efforts are likely to have a significant impact of improved access to care for Black men.

Given that implicit biases prohibit the development of rapport and honest dialogue between Black males and their providers, it is also critically important to sustainably address the ways in which biases among providers may impact the health care experience for Black men (Cooper et al., 2012; Enyia et al., 2016; Stewart et al., 2019). Proposed federal legislation such as the *Health Equity and Accountability Act of 2022* (HEAA) does not include specific language in the bill to address issues influencing the health care delivery systems that serve Black men or White men (Senate, 2022).

Moreover, while HEAA explicitly builds on several provisions centered on expanding the Office of Women's Health, there are currently no commensurate provisions in the legislation that calls for an Office of Men's Health. An Office of Men's Health would ostensibly center men; and provide for targeted outreach across the life course for Black men and other historically disenfranchised men. To date, a federal Office of Men's Health has yet to be realized despite years-long efforts calling to stand up such an office (Nuzzo, 2020; Thorpe et al., 2013). This study found that the ACA was an effective policy tool for reducing the proportion of men who were uninsured, but not for improving the share of men with a usual source of medical care. Future legislation will need to consider the dynamics of race, gender, and social conditions on efforts to improve the extent to which men have a regular source of medical care.

Additionally, the *Men's Health Awareness and Improvement Act of 2021* would establish an Office of Men's Health within the Department of Health and Human Services to create, support and promote programs and activities to improve the state of men's

health nationwide (House, 2021). This bill specifies the need for further study of whether health care is underutilized in this population and calls for the need to understand why underutilization may occur. This study provides additional evidence to support this legislation particularly in terms of increasing access to care, health care utilization, and having a usual source of care for men.

Strengths and Limitations

Strengths

This dissertation study is the first of its kind to disaggregate publicly available data comparing Black men and White men's health care access before and after implementation of the ACA in 2014. Noted previously, disaggregating data by race and gender is a pivotal step in addressing gender disparities that may exist in terms of access to care for populations that may not have benefitted equally or as much as others from the ACA.

One way in which this dissertation study contributes to the health policy literature was that it provides evidence of the barriers that non-Hispanic Black men face as they navigate the health care system and social structures in place. Second, the national MEPS database provided for adequate sample sizes to explore racial differences among men. Third, taking a longitudinal approach to the data allowed for the examination of the impact of the ACA over time.

Limitations

Despite these strengths, this dissertation study had some limitations. While the MEPS has data available to examine the proposed variables (e.g., race/ethnicity, age, gender, education, employment, income, access to care) in this study, the data set was

limited in that it could not provide for community, environmental, timeliness or workforce variables that would have been helpful to assess from 2011–2019. It has been found that examining factors such as these helps provide context for the ways in which social drivers of health impact health outcomes (Braveman & Gottlieb, 2014; IOM, 2002b). Another limitation is the potential diluting effect of evaluating insurance coverage in the aggregate (MEPS provides for the ability to disaggregate insurance by type of coverage and at different time intervals over the course of months). This dissertation study also did not control for health status – which would have assessed whether men with greater health needs (e.g., men with a disability or chronic health condition) had a greater likelihood of having insurance coverage or a usual source of care) than other men. Future research should also investigate patterns of health care utilization among people with disabilities by employment status among a nationally representative sample (Reichard et al., 2019).

As noted previously, although the comparative approach has been found to be a critical component of monitoring health status and policy in the United States, it is limited in that research has found that comparative studies alone cannot yield an enhanced contextual understanding of ways to promote health-related outcomes among racial and ethnic minority groups (LaVeist et al., 2023; Thorpe et al., 2013); thus, there is need for robust mixed methods approaches. Additionally, while this dissertation study did not operationalize structural racism, recent studies have proposed several techniques to consider (e.g., linking variables across interdisciplinary data sets, mixed methods, multi-level modeling etc.) (Williams, 2003b; Williams et al., 2019; Williams & Mohammed, 2009, 2013). An area for future research would be to develop a study that operationalizes

structural racism, access to care, and Black men – informed by eco-social theory (Krieger, 2001, 2020).

Lastly, this dissertation study did not examine heterogeneous differences among Black men (i.e., African, Caribbean Black, U.S.-born Black men etc.). Studies have found that having health insurance was associated with higher odds of reporting a usual source of care for Black men but lower odds among Caribbean Black men (Hammond et al., 2011). Thus, comparing Black men and Caribbean Black men (or immigrants from other African nations) can help clarify whether new health policies aimed at reducing health insurance and other socioeconomic barriers would improve access to care; and better tailor culturally-relevant interventions for these subgroups. The following section will propose areas for future research outlined in Tables 1F and 1G in the appendix.

Future Research Recommendations

When making Black-White comparisons, the extant literature tends to combine Black men with Caribbean men (or other men of African descent); thus, limiting the capacity to provide more nuanced policy recommendations for heterogeneous subpopulations of Black men who may face unique access to care barriers. This is important to note because while this dissertation study examined insurance status and usual source of care for non-Hispanic Black men, it was limited in that the MEPS data set does not provide variables for examining documented immigration status (Tarraf et al., 2012). Future research specifically examining African immigrant or foreign-born status can potentially yield insights to support culturally-tailored interventions for men of African descent. Further, there is a need to further explore the unexpected usual source of care findings.

Regarding future research specifically in the men's health disparities field, an intersectional approach (see Figure 4A in Appendix) has been posited as a different way to conceptualize and contextualize the health of Black men (Griffith, 2012). Taking a more deliberate approach to examining the impact of socially-defined characteristics (i.e., race, ethnicity, gender, sexual orientation, disability etc.) within and across different subpopulations can help inform policy and culturally-tailored interventions.

Although this analysis was limited in that it did not analyze some of the variables that might have influenced the outcomes examined, future research should explore additional analyses by linking data sets with community-level characteristics. For example, MEPS provides for different gradients of insurance over the course of months within a given year (i.e., having private or public insurance for 12 consecutive months, insured for part of the year, or insured for at least one month), future studies should consider examining these time periods for non-Hispanic Black men. This is important because uninterrupted access to insurance coverage has been found to improve coverage and health care access (Goldman & Sommers, 2020). Further, evaluating the effects of state and federal health policies on patient out-of-pocket costs and financial hardship will be important for future research.

Future studies can explore linking variables across interdisciplinary data sets, mixed methods, and multi-level modeling to determine differential access to care issues for men of African descent; thus, adding to the evidence base for policy-makers and other key decision-makers to potentially support interventions for men of African descent. Moreover, there is a significant gap in the health policy literature that can potentially be addressed with an actionable approach in support of Black men and other interested

stakeholders. Noted earlier, Kingdon's Multiple Streams Framework can provide the infrastructure for operationalizing a Policy Advocacy in Action Framework for Black men.

Because of the historical invisibility of Black men on policy agendas – ideally designed to support their health and well-being (Gilbert et al., 2016; Griffith, 2018, 2021; Griffith et al., 2021), it will require structuring advocacy efforts that are explicitly tailored to influencing the policy-making process. Noted previously in this dissertation study, an intersectional approach not only helps explain which social characteristics impact health, but *why* those factors impact health. For example, as a tenet of intersectionality, political intersectionality helps to explain the invisibility and political ambivalence to Black men's health in general – demonstrated by disproportionate COVID-19 mortality rates for Black men (Griffith et al., 2021). Further, men are not explicitly named as a population of focus in policy despite their poor health profile, and Black men are even less explicitly named as the population of interest in seeking to define success in policies to improve health and healthcare (Griffith et al., 2021).

Strengthening the knowledge of the impact of public policies such as this on Black men's access to the health care system will require advocates (e.g., Black men and other interested stakeholders) to: 1) build a more robust, nuanced, and diverse research evidence base about the problem 2) meaningfully package and strategically pitch the evidence to relevant audiences and 3) leverage interest in existing areas of concern (Colvin, 2023). Thus, much more work needs to be done to advance the unique access to care needs of Black men; however, this study provides a vital first step in addressing race and gender disparities that exist in terms of access to care and health outcomes for men.

Conclusions

In closing, it was hypothesized that the health care disparities-related provisions in the ACA would potentially close the racial gap between non-Hispanic Black men and non-Hispanic White men in terms of insurance coverage and having a usual source of care. However, this first-of-its kind study provided evidence that racial disparities on these two outcomes persisted in the years after implementation of ACA. While the ACA was effective in reducing the number of uninsured men, it did not expand the share of men with a usual source of care, nor did it have a statistically significant impact on the racial gap in these two outcomes.

This study found that race, after adjusting for differences in socio-demographics (i.e., age, education, employment, income, and region) remained a significant factor in both outcomes – demonstrating the continuing impact of racial identity on men's access to health care services.

This study provides strong evidence of the need to accelerate policy and programmatic efforts -- at the federal and state level -- to eliminate racial inequities in health care access between Black and White men. Further, this study has the potential to revolutionize the policy landscape because it proposes practical steps garnered from reputable advocacy organizations and lived experience to make an indelible impact on domestic health care ecosystems.

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Appendix

Table 1A

Overview of Articles Outlining the Breadth of Key ACA-Related Findings Across Race, Ethnicity, and Gender

Author & year	Study objective	Data source(s)	Key findings by race/ethnicity & gender	Other key findings
Chaudry (2019)	To determine the extent to which the ACA has reduced disparities in insurance coverage among different racial and ethnic groups.	American Community Survey [a] (2013–2017)	Assessed non-Hispanic Black, non-Hispanic white, and Hispanics. The proportion of nonelderly adults lacking health insurance fell from 20.5 percent in 2013 to 12.3 percent in 2017, a decline of 40 percent. The coverage gaps between blacks and whites declined from 11.0 percentage points in 2013 to 5.3 percentage points in 2017.	The ACA's disparity-reducing effects have been strongest in states participating in the Medicaid expansion.
Kaiser Family Foundation (2021)	To examine gains in coverage across racial/ethnic groups under the ACA from 2010–2019 (pre-post ACA implementation).	American Community Survey (2010–2019)	Uninsured rates for non-elderly Blacks in 2010 were at 19.9% and dropped to 11.4% in 2019, compared to 13.1% in 2010 and 7.8% for non-elderly whites in 2019.	However, uninsured rates began increasing for Hispanic, Black, and White people between 2016 and 2019.
Simmons (2012)	To estimate the number of women (ages 15–64) to receive guaranteed women's preventive health services without cost-sharing under the ACA by race and ethnicity.	Current Population Survey [b] (2010)	38.6 million white women, 5.1 million Black women, 4.9 million Latina women, 2.5 million AAPI, and 300,000 American Indian women were estimated to receive guaranteed women's preventive health services.	Private health insurance enrollees were examined.

[a] The American Community Survey was designed to replace the information that was traditionally gathered every 10 years as part of the decennial census "long form" and to improve intercensal estimates. It began including health insurance coverage data in 2008 (Davern et al., 2009).

[b] The Current Population Survey has been measuring health insurance coverage since 1980 and allows for important state-level comparisons and trend information on the changing characteristics of the uninsured over time (Davern et al., 2009).

Table 1A (continued)

Author & year	Study objective	Data source(s)	Key findings by race/ethnicity & gender	Other key findings
Simmons (2015)	To outline new coverage options for women and children in the Health Insurance Marketplaces and Medicaid	American Community Survey (2014)	Of the total number who have selected a Marketplace Plan during the 2015 Open Enrollment period, more than half (56 percent) are women and nine percent are children aged 0 to 17.	Because of the Affordable Care Act, an estimated 48.5 million women are benefiting from preventive services coverage with no out-of-pocket costs.
Pilkey (2013)	To determine the number of eligible adolescents and youth (ages 10–19) who are uninsured by race and ethnicity.	American Community Survey (2011) and National Health Interview Survey [c] (2011)	Young adults of color experience worse outcomes in a variety of areas (obesity, teen pregnancy, tooth decay, and educational achievement) compared to their white counterparts. An estimated 2.2 million (53%) are male and 1.9 million are female.	An estimated 9.8 percent of adolescents ages 12–17 lack health insurance and 4.7 percent have no usual source of health care.
Henderson (2012)	To estimate the number of Latinos who would gain insurance coverage through the ACA by 2016.	Current Population Survey (2011)	RAND suggests that 5.4 million Latinos who would otherwise be uninsured will gain coverage by 2016 through the expansion of Medicaid eligibility and the creation of ACA marketplace exchanges.	An estimated 30.7 percent of Latinos are uninsured, compared with 16.3 percent of all Americans.
Chu (2012)	To estimate the percent of Asian Americans and Pacific Islanders who are uninsured.	American Community Survey (2008–2010), National Health Interview Survey (2010), Current Population Survey (2011)	An estimated 18.1 percent of Asian Americans and Pacific Islanders are uninsured, compared with 16.3 percent of all Americans.	However, the extent of uninsurance varies considerably by Asian American and Pacific Islander subgroups.
Zeno (2015)	To understand the tailored outreach and enrollment activities in support of LGBTQ individuals and families within the marketplaces.	National Health Interview Survey (2013)	The rate of uninsurance among lesbian, gay, or bisexual adults aged 18–64 at that time was comparable to that of the heterosexual population (19.0 percent versus 20.1 percent, respectively).	Organizations reported a need for more health literacy and insurance literacy workshops because many LGBTQ individuals are not aware of health insurance concepts and how to shop for coverage.

[c] The National Health Interview Survey is the primary source of information (collected by the National Center for Health Statistics) for monitoring the health and health care use of the US population since 1957 (Blewett et al., 2016).

Table 1A (continued)

Author & year	Study objectives	Data source(s)	Key findings by race/ethnicity & gender	Other key findings
Avery (2016)	To estimate the percent of rural and urban non-elderly adults in terms of insurance coverage and access to care.	Gallup Healthways Well-Being Index (2012–2016), National Health Interview Survey (2015), Urban Institute Health Reform Monitoring Survey (2013–2015)	Coverage rates among non-elderly adult increased similarly in urban and rural areas, rising by 8.0 percentage points in rural areas and 7.9 percentage points in urban areas.	Individuals in rural areas have seen improvements in access to care, the share who reports being unable to afford needed care declined by nearly 6 percentage points from before the first open enrollment period through early 2015.
Ladapo (2017)	To determine whether the ACA was associated with changes in physicians' provision of preventive cardiovascular services – with a particular focus on patients with employer-sponsored health plans.	National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey data (2006 to 2013)	High blood pressure screening increased (73.2% in 2006–2010 to 76.4% in 2010–2013); but this data point was not disaggregated across race/ethnicity and/or gender.	While this study noted a sex disparity regarding the use of aspirin for cardiovascular care among women and men, it did not disaggregate its findings comparing Black men and white men ages 18–64.
Angier (2020)	To evaluate the impact of Medicaid expansion on health insurance rates and receipt of cardiovascular-related preventive screenings for cancer survivors (2012–2017).	Accelerating Data Value Across a National Community Health Center Network (ADVANCE)	The weighted sample was 71% female and 59% non-Hispanic white. Nearly 30% had 5 or more chronic conditions (28% in non-expansion states and 31% in expansion states).	A substantial decline in uninsured visits among cancer survivors in Medicaid expansion states. Yet, 1 in 5 cancer survivors living in a state that did not expand Medicaid remained uninsured.
Barghi (2019)	To evaluate the impact of the ACA on insurance coverage, access to care, and racial/ethnic disparities among non-elderly adults (ages 18–64) with cardiovascular disease in the pre-ACA (2012–2013) and post-ACA (2015–2016) periods.	Behavioral Risk Factor Surveillance System [d] (BRFSS) (2012–2016)	Using adjusted difference-in-differences analyses, a 2.7 percentage point increase in coverage among Blacks relative to whites and a 5.7 percentage point increase among Hispanics relative to whites.	Following ACA implementation, insurance coverage increased by 6.9 percentage points not having to forgo a physician visit increased by 3.6 percentage points, having a check-up increased by 2.1 percentage points, and having a personal physician increased by 1 percentage point.

Table 1A (continued)

Author & date	Study objective	Data source(s)	Key findings by race/ethnicity & gender	Other key findings
Barghi (2019)	To evaluate the impact of the ACA on insurance coverage, access to care, and racial/ethnic disparities among non-elderly adults (ages 18–64) with cardiovascular disease in the pre-ACA (2012–2013) and post-ACA (2015–2016) periods.	Behavioral Risk Factor Surveillance System [d] (BRFSS) (2012–2016)	Using adjusted difference-in-differences analyses, a 2.7 percentage point increase in coverage among Blacks relative to whites and a 5.7 percentage point increase among Hispanics relative to whites.	Following ACA implementation, insurance coverage increased by 6.9 percentage points not having to forgo a physician visit increased by 3.6 percentage points, having a check-up increased by 2.1 percentage points, and having a personal physician increased by 1 percentage point.
Richardson (2021)	To determine what strategies ACA patient navigators used to sign up injured young Black men for health insurance that were both culturally and structurally appropriate.	Qualitative case study from Level I and Level II Trauma Centers in Prince George's County Maryland (2015).	This study found that young Black men experience significant barriers when interfacing with the health care system.	A key strength of the case study was that it was the first of its kind to explicitly explore ways to bring voice to the needs of Black men specifically in the context of the ACA.
Powell (2020)	To investigate the impact of the ACA on colorectal cancer outcomes and economic costs between Black men and white men in North Carolina (a non-Medicaid expansion state).	A simulation model using a combination of health insurance claims and Behavioral Risk Factor Surveillance System (BRFSS) data (2013–2023)	Compared to the control scenario (no ACA), the ACA health exchange scenario resulted in an average of 16.0 less deaths per 100,000 of Black males and 4.7 fewer deaths per 100,000 of white males.	Economically, each ACA policy iteration found higher per person expenditures for Black men compared to white men ($2.13 per person v. $0.63 per person respectively in 2018).

[d] BRFSS is a state-based telephone survey of non-institutionalized civilians conducted every year by state health departments and the Centers for Disease Control and Prevention (Rolle-Lake & Robbins, 2023). This evaluation did not include high blood pressure in their main analysis because BRFSS data on these conditions was not collected in 2012 or 2016 (Barghi et al., 2019).

Table 1B

Variance Inflation Factors for Regression Predicting Insurance Status

Variable	VIF
Race [Black]	1.15
Time [Post ACA]	1.05
Age [35 to 49]	1.37
Age [50 to 64]	1.36
Education [GED/HS degree]	2.86
Education [Some college or Bachelor's degree]	2.78
Education [Graduate or other degree]	2.28
Employment [Employed full time]	1.87
Employment [Employed part time]	1.39
Employment [Intermittent employment]	1.07
Income [Near poor]	1.27
Income [Low]	1.80
Income [Middle]	2.77
Income [High]	3.31
Region [Midwest]	1.87
Region [South]	2.05
Region [West]	1.71

Table 1C

Race x Time Interaction Logistic Regression Predicting Uninsured, 2011–2019 (Non-Hispanic Black Men and Non-Hispanic White Men 18–64)

Variables	*B*	Std. Error	Sig.	AOR	95% CI AOR Lower	95% CI AOR Upper
Uninsured (reference: Insured [a])						
(Intercept)	-1.00	0.11	<.001	0.37	0.30	0.46
Race [Black]	0.22	0.07	0.002	1.25	1.09	1.43
Time [Post ACA]	-0.66	0.06	<.001	0.52	0.46	0.58
Race x Time	0.08	0.10	0.433	1.08	0.89	1.32
Age [reference: 18 to 34]						
35 to 49	0.00	0.06	0.954	1.00	0.89	1.12
50 to 64	-0.27	0.06	<.001	0.77	0.68	0.86
Education [reference: No degree]						
GED/HS degree	-0.07	0.07	0.353	0.94	0.81	1.08
Some college or Bachelor's	-0.55	0.09	<.001	0.58	0.49	0.69
Graduate or other	-0.80	0.11	<.001	0.45	0.36	0.56
Employment [reference: Unemployed] [b]						
Employed full time	0.04	0.07	0.513	1.04	0.92	1.19
Employed part time	0.60	0.07	<.001	1.82	1.58	2.11
Intermittent	0.42	0.11	<.001	1.53	1.23	1.90
Income [reference: Poor]						
Near poor	-0.23	0.08	0.006	0.79	0.67	0.94
Low	-0.13	0.06	0.038	0.88	0.78	0.99
Middle	-0.77	0.07	<.001	0.46	0.41	0.53
High	-1.60	0.09	<.001	0.20	0.17	0.24
Region [reference: Northeast]						
Midwest	0.14	0.10	0.164	1.15	0.94	1.41
South	0.49	0.09	<.001	1.63	1.36	1.96
West	0.22	0.12	0.063	1.24	0.99	1.56

[a] Insured combined any private and any public insurance holders as the reference category.

[b] Full-time employment is defined as working at least 35 hours per week and part-time employment as working less than 35 hours per week. The intermittent employment variable includes categories for "job to return to" and "job during" the survey interview.

Table 1D

Variance Inflation Factors for Regression Predicting Usual Source of Care

Variable	VIF
Race [Black]	1.15
Time [Post ACA]	1.06
Age [35 to 49]	1.37
Age [50 to 64]	1.36
Education [GED/HS degree]	2.86
Education [Some college or Bachelor's degree]	2.78
Education [Graduate or other degree]	2.28
Employment [Employed full time]	1.88
Employment [Employed part time]	1.39
Employment [Intermittent employment]	1.07
Income [Near poor]	1.27
Income [Low]	1.79
Income [Middle]	2.76
Income [High]	3.30
Region [Midwest]	1.88
Region [South]	2.06
Region [West]	1.72

Table 1E

Race x Time Interaction Logistic Regression Predicting Usual Source of Care, 2015–2019 (Non-Hispanic Black Men and Non-Hispanic White Men 18–64)

Variables	*B*	Std. Error	Sig.	AOR	95% CI AOR Lower	95% CI AOR Upper
Usual Source of Care: Yes (reference: No)						
(Intercept)	0.59	0.09	<.001	1.81	1.51	2.16
Race [Black]	-0.33	0.06	<.001	0.72	0.64	0.80
Time [Post ACA]	-0.19	0.04	<.001	0.83	0.76	0.90
Race x Time	0.08	0.07	0.306	1.08	0.93	1.24
Age [reference: 18 to 34]						
35 to 49	0.61	0.04	<.001	1.84	1.70	1.99
50 to 64	1.24	0.04	<.001	3.44	3.17	3.73
Education [reference: No degree]						
GED/HS degree	-0.20	0.05	<.001	0.82	0.74	0.90
Some college or Bachelor's	-0.14	0.06	0.019	0.87	0.78	0.98
Graduate or other	-0.04	0.07	0.583	0.96	0.84	1.11
Employment [reference: Unemployed] [a]						
Employed full time	-0.56	0.04	<.001	0.57	0.53	0.62
Employed part time	-0.41	0.05	<.001	0.67	0.60	0.74
Intermittent	-0.53	0.10	<.001	0.59	0.49	0.72
Income [reference: Poor] [b]						
Near poor	0.22	0.08	0.005	1.24	1.07	1.44
Low	0.22	0.05	<.001	1.24	1.12	1.38
Middle	0.51	0.05	<.001	1.66	1.50	1.84
High	0.85	0.06	<.001	2.34	2.10	2.61
Region [reference: Northeast]						
Midwest	0.01	0.07	0.875	1.01	0.88	1.16
South	-0.37	0.07	<.001	0.69	0.61	0.79
West	-0.20	0.08	0.007	0.82	0.71	0.95

[a] Full-time employment is defined as working at least 35 hours per week and part-time employment as working less than 35 hours per week. The intermittent employment variable includes categories for "job to return to" and "job during" the survey interview.
[b] Poor: 0–100% Federal Poverty Level (FPL); Near Poor:101%-125% FPL; Low income:126–200% FPL; Middle income: 201–400% FPL; High income: over 400% FPL.

Table 1F

Dissertation Study Strengths and Limitations

Strengths	Limitations
The first-of-its-kind to disaggregate publicly available data comparing non-Hispanic Black men and non-Hispanic White men's health care access before and after implementation of the ACA in 2014.	Data set was limited in that it did not provide for community, environmental, timeliness or workforce variables from 2011–2019 (pre- and post-ACA).
The national MEPS database provided for adequate sample sizes (n=46,227) to explore racial differences among men.	Potential diluting effect of evaluating insurance coverage in the aggregate (MEPS data provides for the ability to disaggregate insurance coverage at different time intervals over the course of months).
Confirmed several findings from previous study regarding how the Affordable Care Act helped improve insurance coverage for millions of Americans.	Did not operationalize structural racism. Recent studies have proposed several techniques to consider (e.g., linking variables across interdisciplinary data sets, mixed methods, multi-level modeling etc.).
Highlighted and helped explain the structural barriers that non-Hispanic Black men must overcome – to better inform the men's health, health equity, and health policy fields.	This dissertation study did not examine heterogeneous differences among Black men (i.e., African, Caribbean Black, U.S.-born Black men etc.).
Proposed a first-of-its-kind Policy Advocacy in Action Framework for Black men.	Did not control for health status – which would have assessed whether men with greater health needs (e.g., men with a disability or chronic health condition) had a greater likelihood of having insurance coverage or a usual source of care) than other men.

Figure 4

Number of Non-Hispanic Black Men and Non-Hispanic White Men Ages 18–64 from MEPS Database (2011–2019)

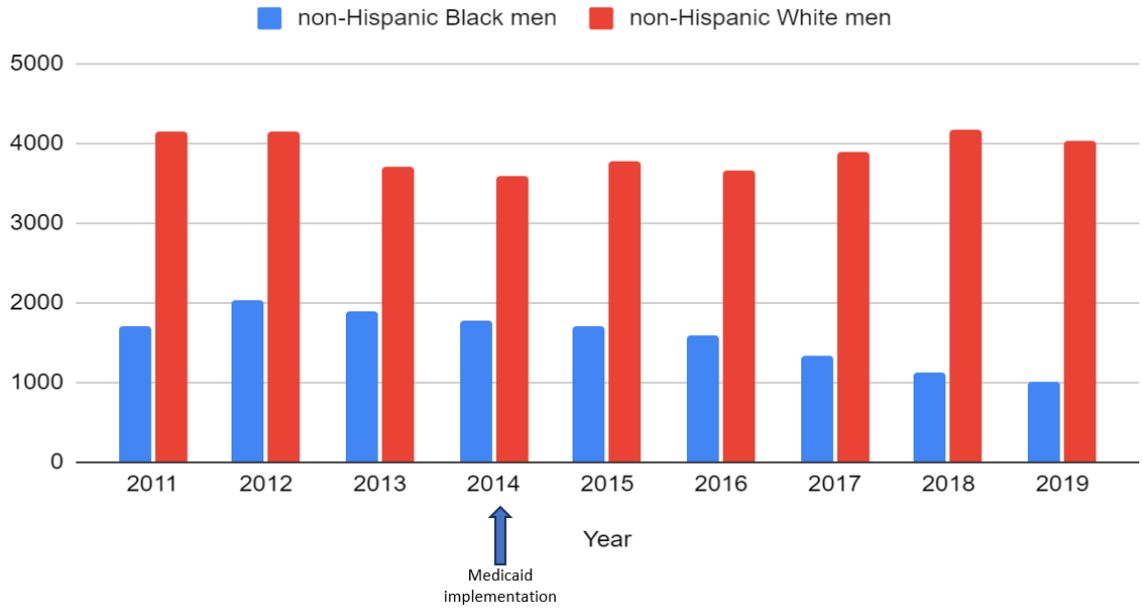


Figure 5

Number of Non-Hispanic Black Men and Non-Hispanic White Men Ages 18–64 from MEPS Database (2011–2019)

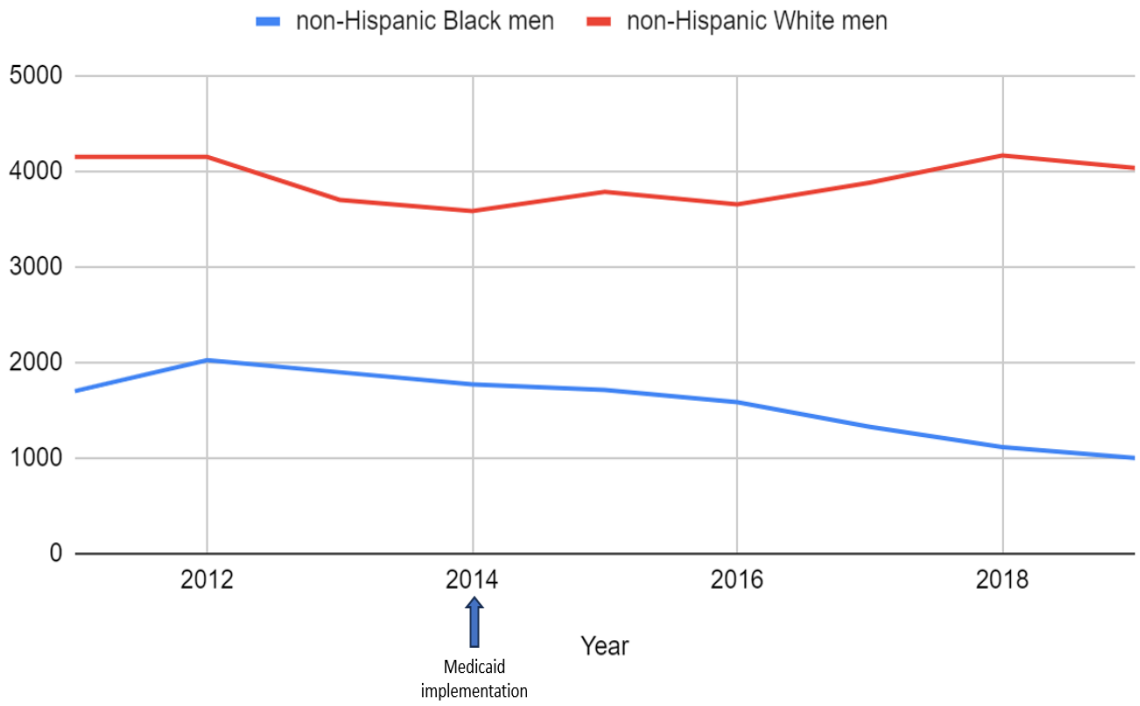
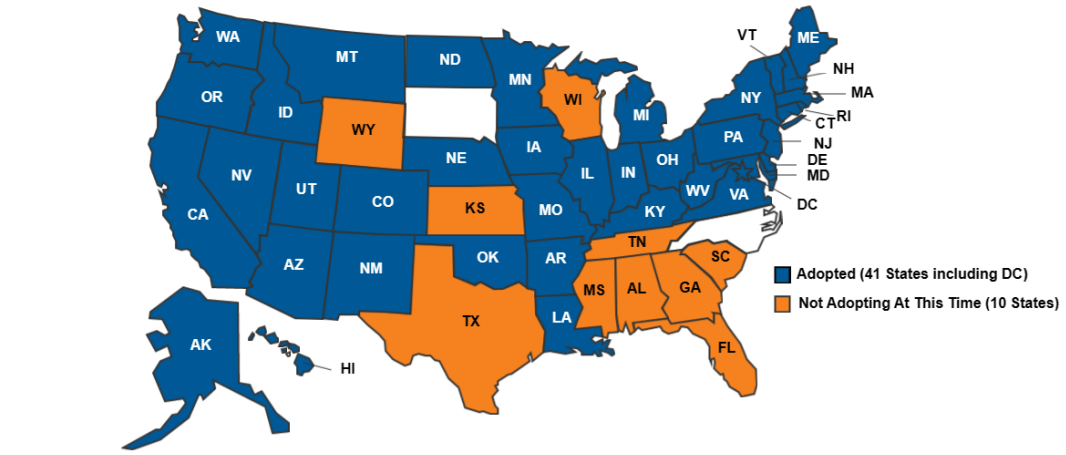


Figure 6

Status of State Medicaid Expansion Decisions



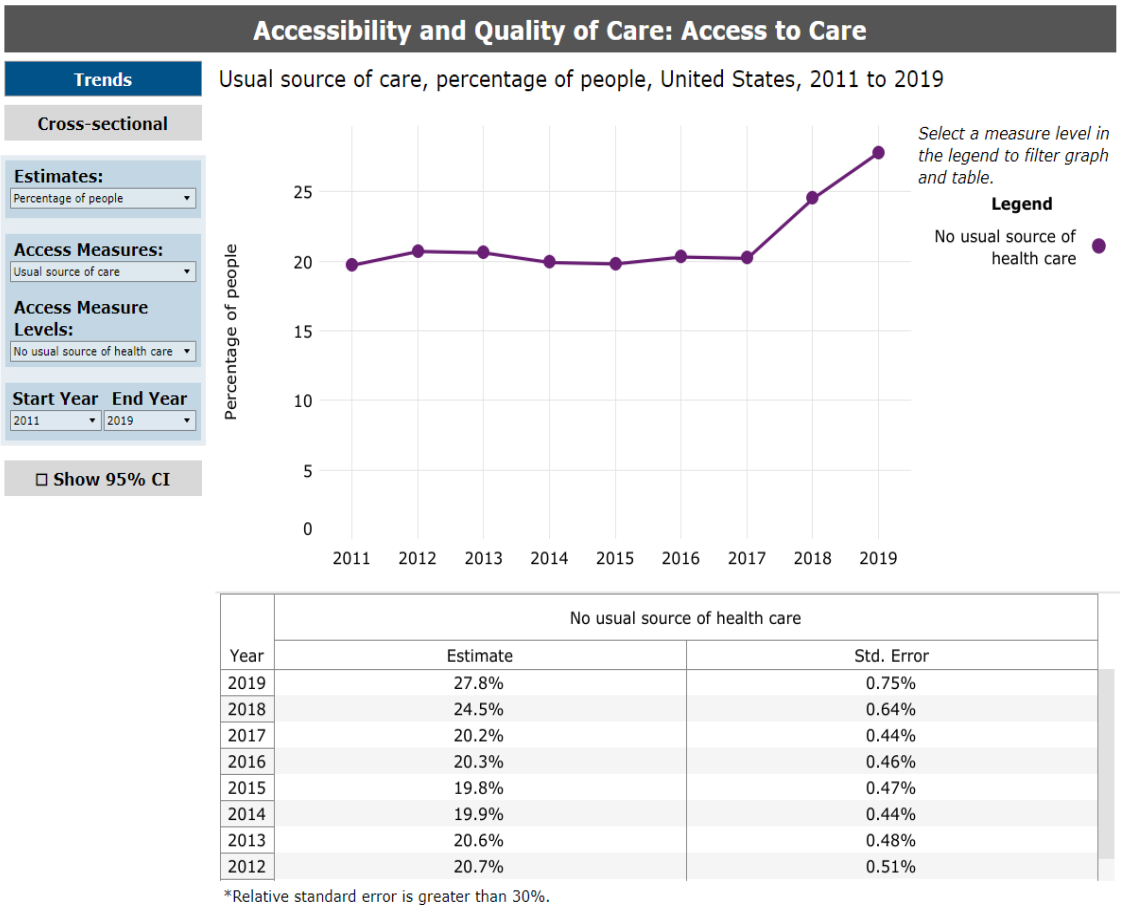
NOTES: Current status for each state is based on KFF tracking and analysis of state activity. ◊Expansion is adopted but not yet implemented in SD. ^Implementation of Medicaid expansion is contingent on appropriations in the SFY 2023-2024 biennial budget in NC. See link below for additional state-specific notes.

SOURCE: "Status of State Medicaid Expansion Decisions," https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

KFF

Figure 10

MEPS Usual Source of Care Database Query



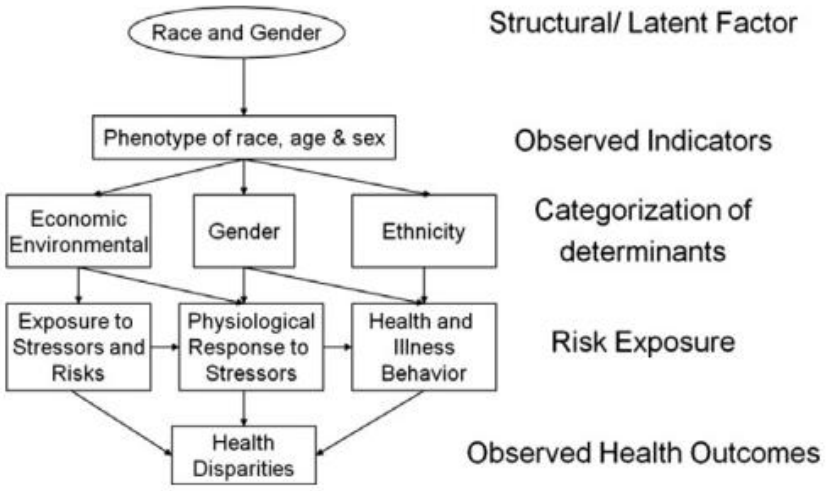
Year	No usual source of health care	
	Estimate	Std. Error
2019	27.8%	0.75%
2018	24.5%	0.64%
2017	20.2%	0.44%
2016	20.3%	0.46%
2015	19.8%	0.47%
2014	19.9%	0.44%
2013	20.6%	0.48%
2012	20.7%	0.51%

*Relative standard error is greater than 30%.

Note. Agency for Healthcare Research and Quality. Usual source of care, percentage of people, United States, 2011 to 2019. Medical Expenditure Panel Survey.

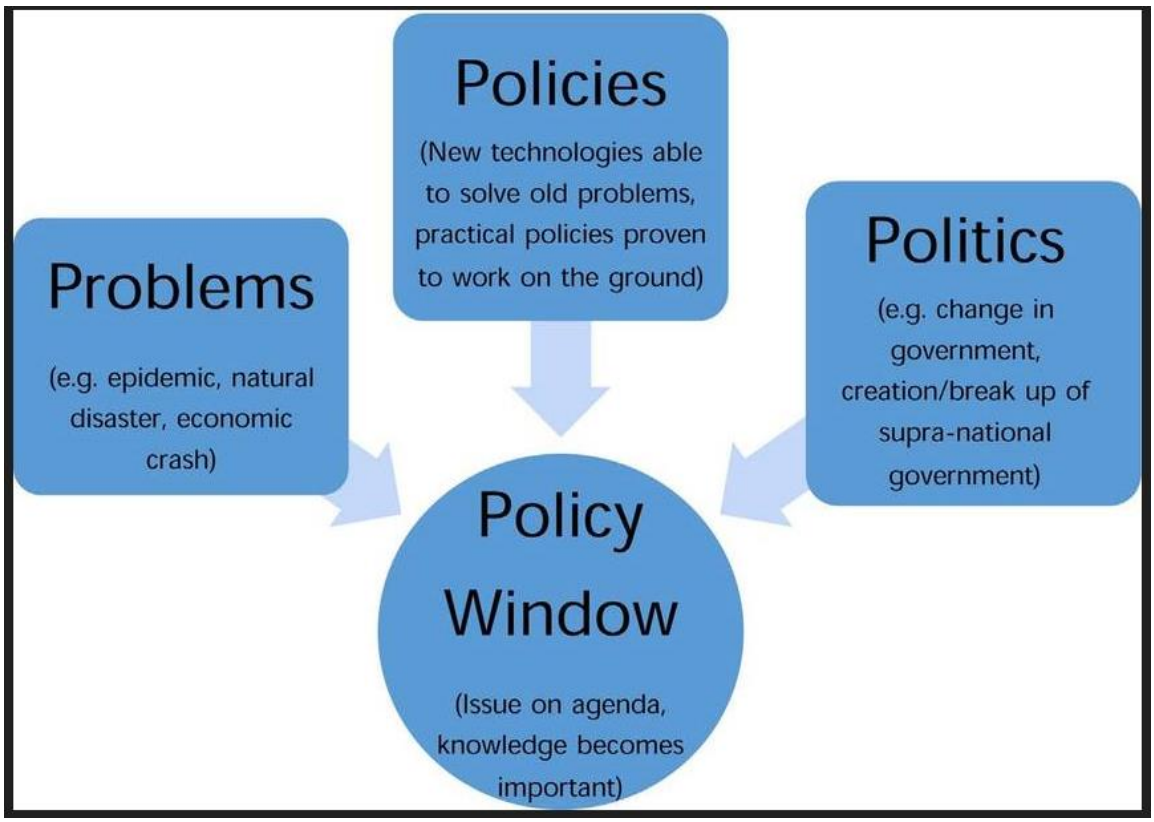
Figure 1A

Intersectional Approach to Men's Health Disparities



Note. From "An Intersectional Approach to Men's Health," by D. Griffith, 2012, *Journal of Men's Health*, *9*(2), pp. 106–112 (https://doi.org/10.1016/j.jomh.2012.03.003)

Figure 2A
John Kingdon's Three Streams Model



Note. Figure based on "Policy windows for the environment: Tips for improving the uptake of scientific knowledge," by J. Kingdon, *Environmental Science & Policy*, July 2017, pp. 1-8 (https://doi.org/10.1016/j.envsci.2017.07.013)

Table 1G

Recommendations for Future Research

Limitations	Areas for Future Research
The MEPS data set was limited in that it did not provide for community, environmental, timeliness, or workforce variables from 2011–2019.	Future research should explore data sets that provide these variables or consider linking data across different data sets.
When making Black-White comparisons, the extant literature tends to combine non-Hispanic Black men with Caribbean men (or other men of African descent).	Future research specifically examining African immigrant or foreign-born status can potentially yield insights to support culturally-tailored interventions for men of African descent.
MEPS provides for different gradients of insurance analysis over the course of months within a given year (i.e., having private or public insurance for 12 consecutive months, insured for part of the year, or insured for at least one month).	Operationalize a Policy Advocacy in Action Framework for men whereby any interested stakeholders can directly influence policy through civic engagement and advocacy at all levels of government.
Did not operationalize structural racism.	
	Uninterrupted access to insurance coverage through an apparatus like Medicaid has been found to decrease coverage disruptions for low-income individuals, men, and enrollees of color after implementation of the ACA in 2014.
	There is a need to further explore the unexpected usual source of care findings related to employment status.
	Evaluating the effects of state and federal health policies on patient out-of-pocket costs and financial hardship will be important for future research.
	Future studies can explore linking variables across interdisciplinary data sets, mixed methods, and multi-level modeling to determine differential access to care issues for men of African descent – informed by eco-social theory.