



The Patient Perspective: Receiving Care in the Post-ACA Era

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Scholarly Report Title: The Patient Perspective: Receiving Care in the Post-ACA Era

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TITLE: The Patient Perspective: Receiving Care in the Post-ACA Era

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The purpose of this study was to explore patients' experiences and perceptions regarding the accessibility of healthcare services within a low-income, culturally diverse community in the post-Affordable Care Act era. We conducted a cross-sectional qualitative analysis of 32 interviews with patients that presented to a community emergency department in South L.A with one or more adult ambulatory care sensitive conditions. Both insured and uninsured patients shared many of the same experiences and perceptions when accessing healthcare services. The most prominent commonalities were related to healthcare cost, difficulty qualifying for insurance, lack of awareness of existing services, and healthcare service availability. Increased insurance coverage had a positive impact on patients' perceived ability to access outpatient primary and specialty healthcare services. However, patients still cited significant barriers to healthcare access, including lack of awareness of covered services and limited service availability.

Before we designed the project, my mentor and I had a discussion about the purpose of the project. Together, we formulated the objectives of the project, and then I proceeded to write the proposal. I used public health data provided to me by my mentor to craft the background section of the proposal. I also performed a literature review to place our research question within the context of the existing body of literature. I wrote the entire proposal, and it was edited and revised by my mentor.

Once the proposal was finalized, I submitted an IRB application to the University of California, Los Angeles. After the IRB was approved, I proceeded to carry out the project at Martin Luther King, Jr. Community Hospital. I conducted and recorded thirty-two interviews in both English and Spanish based out of the emergency department. I then submitted the recordings to be transcribed through an outside service. Once the transcripts were returned, I began to pull major themes from each interview. My mentor and I reviewed four transcripts together to ensure our inter-rater reliability score was high. Once the score was adequate, I proceeded to code the rest of the interview transcripts.

I organized the results of the thematic coding into various tables and discussed them with my mentor. We generated some conclusions based on the results and then I proceeded to draft the manuscript for publication. After I had written a rough draft of the manuscript, my mentor read and revised it. We sent out the manuscript to various administrators (including the CEO of the hospital) and took their input into consideration before developing the final draft. With the final draft complete, I began to identify journals for potential publication of the manuscript. We settled on the Journal of Health Disparities Research and Practice. I reformatted the manuscript according to the journal's guidelines and submitted it.

Shortly after we submitted the work, we received request for major revisions. I discussed these revisions with my mentor and together we decided which revisions we would implement, and which we would omit. I then revised the paper accordingly and resubmitted the work. The work was recently accepted with minor revisions. I made those revisions and submitted the final draft.

APPENDIX

INTRODUCTION

After several previous failed healthcare reform attempts, the Obama Administration successfully enacted the Patient Protection and Affordable Care Act (ACA) in 2010 to increase the accessibility of healthcare services nationwide. The objectives of the ACA were to expand health insurance coverage, lower healthcare costs, and enhance the quality of healthcare services by holding insurance companies more accountable for the services provided. In addition, the ACA was structured to provide Americans with more choice in regard to insurance options (United States, 2010).

According to the U.S. Department of Health and Human Services, 16.4 million people nationwide became newly insured as a result of the ACA ("The Affordable Care Act," 2014). One strategy that contributed to the increase in the number of insured was the expansion of Medicaid eligibility for low-income Americans. This strategy was significant because it targeted economic and medically underserved communities that were historically precluded from obtaining health insurance due to lack of financial resources. South Los Angeles (South L.A.) is an example of such a community. According to a report released by the LA County Department of Public Health in 2013, South L.A. was composed of 67.7% Latino residents and 28.5% black residents, with over 50% of its population speaking mostly Spanish in the home and 50% of adults stating they were not born in the United States. Less than 12% of adults in South L.A. possessed four-year college degrees and over 30% earned less than 100% of the Federal Poverty Line (Los Angeles County Department of Public Health, 2013). South L.A. has also suffered from decades of persistent healthcare workforce shortages. Numerous areas of South L.A. have state and federal designations of being medically underserved areas (MUA) and health professional shortages areas (HPSA) for primary and specialty care (State of California, 2010). These designations are defined by several contributing factors including community poverty level, ratio of physicians to the patient population, and known access barriers to medical care.

Following the ACA legislation enactment, the percentage of uninsured individuals in South L.A. decreased from 19.4% in 2007, prior to the ACA legislation, to 16% in 2014 after the enactment as compared to the state of California whose percentage of uninsured decreased from 13.2% to 11.9% during this same time period (UCLA Center for Health Policy Research, 2007a, 2014a). These results demonstrate that the proportion of uninsured individuals pre-ACA was not only higher in South L.A., but also experienced a greater decrease following the legislation implementation than the state as a whole (3.4% vs. 1.3% respectively) (UCLA Center for Health Policy Research, 2007b, 2014b). This finding directly correlates with the findings of other recent survey-based studies that demonstrate that the ACA tactics to reduce the rate of uninsured individuals nationwide were successful, especially in low-income communities (Sommers, Gunja, Finegold, & Musco, 2015; Wherry & Miller, 2016).

The enactment of the ACA was based on the premise that an expansion of healthcare insurance, especially Medicaid, would subsequently increase access to healthcare services for low-income patients. State Medicaid programs tend to be comprehensive, covering inpatient and outpatient hospital-based encounters, physician clinic visits, laboratory tests, and radiology services. Several recent studies have attempted to explore how the receipt of Medicaid insurance relates to a patient's access to primary and hospital-based medical

care. The results of these studies vary and do not meet a consensus. A California Foundation (CHCF) report illustrated that children and adults insured by Medicaid used primary care services at much higher rates than their uninsured counterparts. However, adults insured with Medicaid were nearly twice as likely to report difficulty getting a primary or specialty care appointment than other insured adults in California (California Health Care Foundation, 2013). Wherry and Miller (2016) also observed significant increases in general physician visits and overnight hospital stays among states that implemented Medicaid expansion programs; however, there was no difference in the emergency department (ED) utilization rates or other access measures among those states that expanded Medicaid coverage and those that did not (Wherry & Miller, 2016). In contrast, results from the Oregon Health Insurance Experiment (OHIE) suggested that expanded Medicaid coverage was correlated with an increase in overall ED visits by newly insured individuals, including visits for conditions most readily treatable in primary care settings (Taubman, Allen, Wright, Baicker, & Finkelstein, 2014). However, the OHIE study did not delve into why increased coverage led to increased ED visits.

The aforementioned studies attempted to investigate the relationship between insurance and healthcare services access/utilization (Wherry & Miller, 2016; Sommers et al., 2015; Taubman et al., 2014). However, these analyses were based on fixed response surveys and/or administrative data. To our knowledge, no studies have been published that directly examine the healthcare-related experiences of patients following the receipt of healthcare insurance. Therefore, the purpose of this study was to qualitatively explore patients' experiences and perceptions regarding the accessibility of healthcare services within a low-income, culturally diverse community in the post-ACA era.

METHODS

We conducted a cross-sectional qualitative analysis of patients that presented to a community ED in South L.A with one or more ambulatory care sensitive condition (ACSC). ACSCs are medical conditions that can be optimally managed in the primary care setting thus preventing complications or severe disease that would lead to an ED visit or hospitalization (Agency for Healthcare Research and Quality, 2001).

Patients were eligible for the study if they met the criteria outlined in Table 1. Eligible ED patients were identified as potential study participants by either their treating emergency physician, nurse or care manager after their immediate medical needs were addressed. The patient was then provided with a study information fact sheet and asked if they were willing to participate in an interview during their ED visit. If the patient expressed interest, they were visited immediately by a member of the research team, who further explained the purpose and aim of the study. Informed consent was then obtained and a recorded interview was conducted in the patient's exam room. The patient was made aware that their responses would be kept entirely confidential. If any other persons entered the room (i.e. nurses, patient registration staff), the interview was temporarily halted and subsequently completed upon their exit. Eligible patients were recruited from both night and day shifts during each day of the week from the emergency department. Interviews were continued until thematic saturation was reached. For the purposes of this study, thematic saturation was defined as five consecutive interviews for which no new themes or pertinent information emerged that contributed to the study. Thematic saturation was reached after approximately eight weeks of data collection.

Table 1. Patient Eligibility Requirements

Inclusion Criteria	Exclusion Criteria
18 years of age or older	History of dementia, cognitive impairment or acute psychiatric illness
English or Spanish as primary language	Resides in a skilled nursing facility or assisted living housing
Presenting with one of the following ambulatory care sensitive conditions: <ul style="list-style-type: none"> - Bacterial pneumonia - Dehydration - Hypertension - Asthma - Urinary tract infection (UTI) - Chronic obstructive pulmonary disease (COPD) - Uncontrolled diabetes - Diabetes complications (e.g. diabetic foot, hypoglycemia, diabetic nephropathy) - Angina (stable chest pain) - Congestive heart failure (CHF) - Lower-extremity amputation among patients with diabetes. 	Emergent condition requiring immediate medical intervention
Capable of providing informed consent	Emergency department high utilizers (i.e. 2 or more visits per week)
	Patients triaged to “fast track” area due to low clinical acuity

Each participant underwent a 45-minute face-to-face interview in the emergency department prior to discharge. All interviews were conducted in either English or Spanish by the same member of the research team to help ensure the process was standardized. Baseline demographic information was collected on each participant including, but not limited to age, gender, ethnicity, highest level of education obtained, employment, income, and insurance status. Open- and closed-ended probing questions were asked to explore the following domains: contributing factors to the current ED visit, past/contextual experiences with healthcare services in the community, perceived access or social barriers to outpatient follow-up care and community resource utilization, and experiences accessing healthcare services following Medicaid expansion. Additional questions relating to patient healthcare experiences at the Martin Luther King, Jr. Community Hospital (MLKCH) were independently assessed and are not presented in this paper.

The audio files from the interviews were transcribed in their original language by an outside commercial agency. The research team reviewed and verified the transcripts for accuracy. The transcripts were then imported into qualitative data management software, ATLAS.ti Version 6. Each interview transcript was coded for themes using the grounded theory method of qualitative data analysis. The coded themes were based on the participants’ independent and free responses transcribed from the interviews. Two members of the research team independently coded several interviews, verifying an inter-rater reliability of 0.854 using the Cohen’s Kappa Index Value calculation. A member of the research team then proceeded to code repeated themes, perspectives, and experiences in the remaining interviews with validation by the rest of the team. The study was approved by the University of California, Los Angeles IRB.

RESULTS

Of 45 patients approached in the emergency department, 32 participants were recruited and interviewed. Twelve patients declined to be interviewed, and one participant was unable to complete the interview due to needed medical treatment. Table 2 provides a summary of the demographics of the interviewed participants. Notably, all except for one of the Spanish language participants had no greater than a high school education. This observation is consistent with the large immigrant population residing in South L.A. The majority of participants were between the ages of 20 and 60 years of age and had lived in South L.A. for six years or more. The latter characteristic is important, as long-term residents are more familiar with the community's history, the availability of services within the community, and how the community has been impacted by recent changes in health policy. Lastly, Table 3 reports the insurance status and healthcare utilization patterns of the interviewees. Approximately 50% of the study participants had a prior ED visit within the past six months and about 70% of the participants had been hospitalized at least once in their lifetime. This might not only reflect the relative poor state of health of South L.A. community members compared to other parts of the nation, but also the relative lack of access to adequate primary care that would reduce preventable ED visits and hospital admissions.

Table 2. Demographic Data (n = 32)

	Variable	Total Number of Respondents (n=32)
Ethnicity	African American	14 (43.8%)
	Hispanic/Latino	14 (43.8%)
	White	1 (3.1%)
	Other	3 (9.4%)
Language	English	21 (65.6%)
	Spanish	11 (34.4%)
Age	20-30 years	2 (6.3%)
	31-40 years	10 (31.3%)
	41-50 years	2 (6.3%)
	51-60 years	13 (40.6%)
	61+ years	5 (15.6%)
Sex	Male	17 (53.1%)
	Female	15 (46.9%)
Education	<HS	14 (43.8%)
	HS	8 (25.0%)
	Some college	6 (18.8%)
	College	4 (12.5%)
	Grad/Prof	0 (0%)
Employment	Employed	16 (50.0%)
	None/Unemployed	16 (50.0%)
Length of South LA Residence	0-5 years	6 (18.8%)
	6-10 years	4 (12.5%)
	11-15 years	3 (9.4%)
	16-20 years	3 (9.4%)
	21+ years	16 (50.0%)

Table 3. Healthcare Utilization (n=32)

	Variable	Total Number of Respondents (n=32)
Insurance	Medicare	2 (6.3%)
	Medicaid*	22 (68.8%)
	Commercial	4 (12.5%)
	Self-Pay	4 (12.5%)
	Unknown**	1 (3.1%)
Usual Source of Care	Same doctor (PMD)	12 (37.5%)
	Single clinic with various providers***	12 (37.5%)
	ED/Urgent Care	10 (31.3%)
# of ED visits (past 6 mo.)	0	16 (50.0%)
	1 to 2	7 (21.9%)
	3 to 4	5 (15.6%)
	5 to 6	1 (3.1%)
	7+	3 (9.4%)
# of Hospitalizations (past 6 mo.)	0	10 (31.3%)
	1 to 2	10 (31.3%)
	3 to 4	7 (21.9%)
	5 to 6	0 (0.0%)
	7+	5 (15.6%)

*One patient with Medicaid also qualified for Medicare.

**“Unknown” refers to patients who were unsure of their insurance status.

***Two patients received their care from both clinics with various providers and a PMD.

Qualitative analysis of the interviews demonstrated that both insured and uninsured patients shared many of the same experiences and perceptions when accessing healthcare services. The most prominent commonalities were related to healthcare cost, difficulty qualifying for insurance, lack of awareness of existing services, and healthcare service availability. See Table 4 for a complete list of the themes that emerged regarding healthcare access.

Table 4: Leading Themes Regarding Healthcare Access

Theme	Frequency*	Total Number of Respondents (n=32)	Insured (n=28)	Uninsured (n=4)	Exemplary Quotes

Availability of medical services	114	28 (88%)	24 (86%)	4 (100%)	"She got there at 6:00 in the morning and did not get out of there until really late, 11:40PM?"
Insurance and affordability	105	29 (91%)	25 (89%)	4 (100%)	"...pero la verdad como yo le digo no llevábamos dinero para cubrir el estudio." ["...but the truth, like I'm telling you, we didn't have the money to cover the [xray] study."]
Awareness of medical services	42	19 (59%)	16 (57%)	3 (75%)	"But even in my community, I'm not aware of [services]. Where is it, where do I go? Who do I talk to?"
Legal status	18	9 (28%)	7 (25%)	2 (50%)	"La falta de papeles, porque no soy la única, verdad, hay mucha gente que no tiene papeles que siempre está esperanzada como yo con el MediCal de emergencia y a menos de que no sea una emergencia, no te atiendan." ["The lack of legal documents... there are many people who don't have documentation who are always waiting, like myself, for MediCal Emergency insurance, and unless it's an emergency, they won't treat you."]
Mistreatment and discrimination	18	6 (19%)	6 (21%)	0 (0%)	"And they need to make sure they nurses talk to people better, and treat us like we're human beings, not because we live Black and we on the streets. Not that I'm on the street, but I know some of them come off the streets, and they look like bums, and nobody don't want to say nothing to them and touch them, but they human beings...They're human beings. Because they ain't got nothing, don't make them no human being."
Social barriers	17	9 (28%)	9 (32%)	0 (0%)	"If I don't have no gasoline, sometimes, I've got to call a fire truck to take me [to the hospital]. I don't like [doing] that."
Health comorbidities	12	7 (22%)	6 (21%)	1 (25%)	"Because I was going to my dentist and my dentist told me my blood pressure was a little too high, so I need to check it out. I was supposed to have another surgery with my teeth and stuff and he told me he couldn't do it because my blood pressure was little to high."

*Frequency refers to the total number of times the theme was mentioned in each interview—including instances the theme was mentioned multiple times in the same interview.

DISCUSSION

The results of this study demonstrate that increased insurance coverage did have a positive impact on patients' perceived ability to access outpatient primary and specialty healthcare services. However, patients still cited significant barriers to healthcare access, including lack of awareness of covered services and limited service availability. Interestingly, the same barriers to healthcare access were cited across all racial and ethnic groups. The one exception was that immigrant patients noted that one's immigration status often served as a direct hindrance to qualifying for Medicaid services.

Approximately one third of insured patients described their insurance as having a positive effect on their healthcare experiences—including decreased cost and increased quality of care. However, almost all of the insured patients (24 of 28) complained of long wait times and limited availability of primary and specialty care services in their community. These results are consistent with the previously referenced findings presented by the CHCF, which stated that Medicaid patients reported increased difficulty obtaining primary and specialty care appointments as compared to their insured counterparts (California Health Care Foundation, 2013). This experience may be directly related to the lack of local facilities and providers, which in turn causes existing community clinics to accrue an overwhelming number of patients and extended lead times before an appointment can be scheduled. This finding implies that the expansion of Medicaid insurance did have a positive effect on patients' ability to access healthcare services; however, insurance alone is not sufficient. The infrastructure of facilities and providers willing to accept Medicaid insurance needs to be present as well in order to ensure patients are able to obtain covered medical services in a timely manner.

One factor that may contribute to this scarcity is a lack of providers who are willing to accept new Medicaid patients into their practice. Decker (2013) demonstrated that primary care physicians, especially those in California, are less likely than other types of physicians to accept new Medicaid patients (Decker, 2013). Many factors likely contribute to physicians' willingness to accept Medicaid patients; however, poor Medicaid reimbursement payments have been shown to directly correlate with physician refusal to care for new Medicaid patients (Decker, 2009).

Patients who participated in this study also cited their own lack of awareness as another significant hindrance to obtaining care. Patients were often unaware of how to qualify for healthcare services or insurance. In addition, they did not know where they could go to receive these services. As a result, the insured patients interviewed in this study did not seem to take full advantage of the range of services potentially available to them. These findings are consistent with those highlighted by Paez and Mallery (2014), which reported that populations who were younger, minority (specifically black and Hispanic), and less educated had more difficulties navigating health insurance and were more likely to incorrectly estimate out-of-pocket costs resulting in not receiving needed healthcare despite having insurance coverage (Paez & Mallery, 2014).

Lastly, several patients believed that qualifying for Medicaid was a challenge in itself due to strict financial and documentation requirements. These patient-perceived financial eligibility barriers may be a reflection of patients' experiences prior to the expansion of Medicaid or a knowledge gap regarding the needed documents to be eligible for insurance. California extended its Medicaid coverage to persons with higher income levels [133% FPL] following the ACA legislation, which should cover the vast amount of households in South L.A. However, patients must be able to provide proper documents to verify their income and/or legal immigration status to qualify for comprehensive Medicaid coverage. Based on the patients' experiences, streamlined education on eligibility requirements does not appear to exist, which presents unintended barriers to care.

Our study revealed that patients perceive lack of community-based medical services, decreased awareness of insurance coverage, and complex insurance eligibility requirements as the main barriers to receiving care. Knowing this, we can begin to propose potential solutions to enhance patient education and strengthen the health service delivery

environment in medically underserved communities. Comprehensive, targeted education campaigns are needed to address patients' knowledge of various insurance programs and service coverage details. Providing such education to patients will allow them to take full advantage of covered medical services. The implementation of education campaigns might be best accomplished through hospital outreach representatives or patient navigators/community health workers in the outpatient setting. One example of such an outreach program is the "Know Your Basics" campaign, which has been launched at MLKCH. This program attempts to educate community members about their healthcare options, in addition to connecting them with on-site social workers, who can help them access available insurance programs. Patient navigators can also be used to provide individualized assistance to help patients navigate through the healthcare system and access needed medical services.

Enhanced patient education will greatly assist in mitigating patients' knowledge gaps of eligible services. However, educating patients about covered medical benefits is not of any value if there is an insufficient number of clinics and providers readily available in the community to provide these services. As noted by patients in this study, a significant barrier to healthcare access in medically underserved, low-income communities is the scarcity of services altogether. This highlights the importance of incentivizing providers and healthcare systems to develop a sustainable infrastructure to recruit and retain high quality primary and specialty care physicians. Doing so would broaden the range of available services in these areas and decrease the overwhelming patient demand experienced by existing clinics.

The main limitation of this study was the use of convenience sampling from a single ED, which could affect the study's generalizability. However, this limitation is minimized due to the recruitment of patients from each ED shift during different days of the week, which helped capture a variety of patient perspectives from the community. In addition, the South L.A. community shares several demographic and insurance status characteristics with other medically underserved communities throughout the country. We predict that the patient perceptions obtained in this study can be reasonably applied to other low-income, communities of color.

The passage of the ACA led to a tremendous expansion of insurance coverage nationwide. However, the expansion of insurance alone did not fully eliminate barriers to healthcare access, especially in medically underserved communities. In these areas, enhanced patient education and a stronger health service delivery infrastructure are necessary to ensure that services are available in communities of need and that patients understand how to utilize them. Without these two components, the expansion of insurance created by the ACA will not fully realize its goal to increase healthcare access.

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