2023

Relationship Between Type of Health Insurance and Access to Care Among African American Males

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Walden University
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Abstract

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MS, Walden University, 2018

BA, University of Florida, 2016

Doctoral Study Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Healthcare Administration

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Abstract

Insurance based discrimination is a bias that has the potential to harm patients by limiting their access to care and widen health disparities between patients with private and public insurance. The purpose of this study was to examine whether there is a relationship between type of health insurance (private and public) and access to care factors (acceptability and availability) among African American males ages 25–64 with chronic conditions. The Andersen healthcare utilization model framework supported this research in focusing on the determinants that influences a patient's ability to access to health care. The research questions examined whether a relationship existed between type of health insurance (public and private) and acceptability (told by a doctor that they do not accept your coverage) and availability (trouble getting an appointment at a doctor's office or clinic, etc.) among African American males ages 25–64 with chronic conditions. The research questions were answered with secondary data collected from the Health Reform Monitoring Survey 3rd Quarter 2018. This quantitative retrospective study involved a descriptive comparative research design using chi-square. Findings showed that there was no statistically significant relationship between type of health insurance and acceptability ($p > .05$), nor was there a statistically significant relationship between type of health insurance and availability ($p > .05$), among African American males ages 25–64 with chronic conditions. The implication for positive social change of this research includes information related to patient prioritization, equity among public insurance users, and the examination of implicit and explicit biases toward African American males and publicly insured patients.

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Dedication

First and foremost, I would like to dedicate this paper to my Lord and Savior Jesus Christ. Without Him I would have nothing, I would be nothing, I could do nothing. I hope in some way that this will be the start of the work You have called me into and that I can serve you best by serving others. "He who began a good work in you will carry it on to completion until the day of Christ Jesus." To my Mother, who has been my rock, my cheerleader, my confidante. I dedicate this to you, thanking you for your prayers, your words of wisdom, and your ability to always look at things through the eyes of faith. To my dad, who encouraged me to go back to school and gave me constant support and feedback. I also thank you for your prayers and work ethic, which inspires me to work harder and learn when to rest. To my brother, who has always been in my corner. Thank you for your gifts, your genius, and your imagination. My world is better because you're in it. To my aunt Zena, who passed before she could see this complete. I hope you are proud of me. You called me a doctor before I ever thought of becoming one. You saw the good in me when I couldn't find it in myself. Your infectious laughter lives in my internal ear. Your smile constantly replays in my memory. I pray it never goes away. Lastly, to my grandfather, who also passed before he saw this complete. I wish you would have lived forever. I would not be the person I am without God placing you in my life. I've learned most of my life lessons sitting in your room watching Gunsmoke and Kenneth Copeland. You taught me how to live for God, to enjoy life, and use my gifts to help others. It was a joy to love you and an honor to serve you the way you selflessly served your family. I have no doubt that we will meet again.

Acknowledgments

I would like to thank God for entrusting me with the task of completing this dissertation. Without You, none of this would be possible. I would like to thank my family, friends, and church members for their constant prayers and encouragement. I would like to thank Walden University and the librarians, statisticians, and other staff members for helping me find resources and continued support through this process. I would also like to thank the special teachers I have had in my life: my mother, Mrs. Delena Simmons, Mrs. Lily Wallace, Mrs. Melinda Diaz, Mrs. Pack, Dr. Richard Dickson, and last, but certainly not least, I would like to thank Dr. Edessa Jobli. Dr. Jobli, you have been a constant support of encouragement during this time. You have been understanding, truthful, and ready to guide me in the right direction. I want to not only acknowledge your efforts but thank you for being a true source of support and help.

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Section 1: Foundation of the Study and Literature Review

Research claims that privately insured patients are perceived to have better access to care compared to patients with government sponsored insurance (Han et al., 2015). This study was conducted to find the relationship between type of health insurance and access to care among African American males, 25–64, with chronic conditions. This exploration was necessary to inform general audiences if insurance discrimination is a threat to access to care quality among patients with government-sponsored assistance (public insurance) and if it could further marginalize people of color. Discovery in this study contributes to positive social change by informing the need find if biases are present, and if so, to create policies that can end inequitable practices, make type of insurance less of a priority when serving patients, and create an equal opportunity for all to obtain quality care without payment being a primary factor. This section consists of the background, problem statement, purpose, research questions and hypotheses, theoretical framework, nature of study, the literature search strategy, literature review, definitions, assumptions, scope and delimitations, limitations, significance, summary, and conclusions.

Background

In 2017, the president of Mayo Clinic stated that if conditions are similar between Medicaid patients and commercially insured patients that Mayo Clinic will “prioritize the commercially insured patients to help strengthen their fiscal year revenue” (Whitman, 2019, p. 10). Though the goals of hospitals are to be financially stable and to reduce uncompensated care costs, prioritizing the commercially insured patients should not compromise nor impede access to care over a patient’s ability to pay (Dyrda, 2017). Furthermore, the need for prioritization of commercially insured patients over patients with government-sponsored assistance or public insurance, such as Medicaid, can be perceived as racially discriminatory as nearly 60% of Medicaid patients are minorities with 20% being African American (Kaiser Family Foundation, 2020). On average, African American males are already predicted to experience more discrimination in a health care setting than white males and this even further proved among nonpoor African American individuals who statistically experience chronic discrimination more so than White and non-White Hispanic individuals of the same socioeconomic status (Colen et al., 2016). The presence of discrimination in health care settings widens health disparities, particularly for African American males, which creates barriers in their access to health care (Gilbert et al., 2016).

The access to care is comprised of five components: acceptability, accommodation, affordability, availability, and accessibility (Penchansky & Thomas, 1981). The acceptability component of access to care contains the patients’ willingness to accept the conditions and characteristics of the providers and it is also the providers’ willingness to accept the characteristics of the patients and their health coverage (McLaughlin & Wyszewianski, 2002). Availability refers to the resources necessary to meet the needs of the patient (McLaughlin & Wyszewianski, 2002). The remaining components such as affordability references the patient’s willingness to pay for services rendered and the charge of these services by the provider, accommodation in access to care refers to the providers’ operational mobility that can fit the needs of the patient and accessibility is the patient’s ability to reach the provider according to their geographic locale (McLaughlin & Wyszewaianski, 2002).

This study was conducted to describe and compare the use of insurance-based discrimination and whether there is a relationship to African American males that have private insurance and government sponsored (public) insurance and their access to case. Insurance-based discrimination is the act of unfair treatment towards patients based on the type of coverage the patient has (Han et al., 2015). This type of treatment has been evident in the 2013 Minnesota Health Access Survey, which showed that the perception of being discriminated against resided more in patients who were either uninsured or were using public insurance such as Medicare or Medicaid, versus a patient with private insurance (Han et al., 2015). Though it is not illegal to prioritize patients, this issue can be perceived as a racial issue. As there are more African American patients that use Medicaid, this group faces the potential of being further marginalized if health care systems decide to prioritize private insurance over government sponsored insurance. This topic needed to be studied to determine whether there is a fair opportunity to obtain access to health care among African Americans males who have public and private insurance.

Problem Statement

Discrimination and barriers are present in access to health care for African American males, however there is little known about health insurance type in relation to African American males’ access to care (Colen et al., 2018). So far, the African American males’ ability to be accepted and accommodated in a health care setting has not been measured by the type of health insurance. The gap in the literature showed a lack of information that supports type of health insurance as a of disparity in accessing within African American communities, specifically among African American males. For example, Han et al. (2015) found that publicly insured and the uninsured experience discrimination in source of care, confidence in getting care, no care due to cost, and provider barriers at higher rates than privately insured patients, thus reducing their access to care. Han et al. also found a relationship between race and insurance-based discrimination but did not to provide data supporting the claim. Conversely, Alcala and Cook (2018) were able to provide evidence for positive correlation between patients perceived racial or ethnic discrimination based on insurance type, but these relationships were only specified to the state of California.

This doctoral study addressed the gap by using a nationwide survey to find if a statistically significant relationship existed between the type of health insurance and access to care among African American males ages 25–64 with chronic conditions. As factors such as poverty, racial inequities, and income inequalities contribute to chronic conditions in African Americans (as opposed to their non-Hispanic White counterparts) it became necessary to find if the type of health insurance one has is an indicator of access to care, even within a marginalized group (Benjamins et al., 2021; Gilbert et al., 2016). The gap of mortality, disparities, and decreased health care utilization is more prevalent in African Americans without insurance in comparison with African American males with insurance (Cunningham et al., 2017). However, there is little to no information on studies between disparities and access to care between African American males who have difference insurance types. This doctoral study specifically focused on the presence of a relationship between type of insurance (i.e., private and public type of health insurance) and the two components of access to care (i.e., acceptability and availability), which have not been explored in previous studies among African American males.

Purpose of the Study

The purpose of this quantitative study was to examine the relationship of the type of health insurance (private and public type of insurance) and access to health care (i.e., acceptability and availability) among African American males ages 25–64 with chronic conditions. The independent variable in this study was type of health insurance private insurance (commercial or employer provided) and public insurance (government-provided assistance). The dependent variable in this study is access to health care, which was measured using two out of the five characteristics in access to care (i.e., acceptability, accommodation, affordability, availability, and accessibility; McLaughlin & Wyszewianski, 2002). The two characteristics of access to care that were used in this study are acceptability and availability to health care. Acceptability was measured by the question "Were you told by a doctor that they do not accept your health coverage?" and availability was measured by the question "Did you have trouble getting an appointment at a doctor's office or clinic as soon as you thought you needed one?"

Research Questions and Hypotheses

RQ 1: Is there a relationship between type of health insurance (private vs. public type of insurance) and acceptability of care (i.e., told by a doctor that they do not accept your health coverage?) among African American males 25–64 years old with chronic conditions in an outpatient clinic?

$H_0$1: There is no statistically significant relationship between type of health insurance (private vs public type of insurance) and acceptability of care (i.e., told by a doctor that they do not accept your health coverage?) among African American males 25–64 years old with chronic conditions in an outpatient clinic?

H_a1: There is a statistically significant relationship between type of health insurance (private vs public type of insurance) and acceptability of care (i.e., told by a doctor that they do not accept your health coverage?) among African American males 25–64 years old with chronic conditions in an outpatient clinic?

RQ 2: Is there a relationship between type of health insurance (private vs public type of insurance) and availability of care (i.e., Trouble getting an appointment at a doctor's office or clinic as soon as you thought you needed one) among African American males 25–64 years old with chronic conditions in an outpatient clinic?

$H_0$2: There is no statistically significant relationship between type of health insurance (private vs public type of insurance) and availability of care (i.e., trouble getting an appointment at a doctor's office or clinic as soon as you thought you needed one) among African American males 25–64 years old with chronic conditions in an outpatient clinic?

H_a2: There is a statistically significant relationship between type of health insurance (private vs public type of insurance) and availability of care (i.e., trouble getting an appointment at a doctor's office or clinic as soon as you thought you needed one) among African American males 25–64 years old with chronic conditions in an outpatient clinic?

Theoretical Framework

The theoretical framework used to support this study is the Andersen healthcare utilization model founded by Andersen and Newman (2005). This framework includes individual and contextual determinants that influence health care utilization and access to care among patients (Andersen & Newman, 2005). To find the correlation between the variables, Andersen's model helped frame the questions related to access to care (Anderson, 1995). The model comprised three components: predisposing factors, enabling factors, and need factors (Babitsch et al., 2012). Predisposing components are characteristics a person has before getting sick that are related to health and sickness including demographics, social structure, and attitude-beliefs (Andersen & Newman, 2005). In this study, the individual predisposing factors in this study are age (25 to 64), as age is related to African American male mortality, and males, as the targeted gender for this study at the individual level. Additionally, ethnicity (African American) at the social level, and health beliefs (medical distrust) are the contextual predisposing factors that influence behaviors around seeking health services (Andersen & Newman, 2005). The enabling components creates the ability or unavailability for a patient to seek health care services (Andersen & Newman, 2005). The enabling factor for this study is type of health insurance (Medicaid and Commercial). Lastly, the need component symbolizes the necessity for the patient to use health services according to their perception of illness (Andersen & Newman, 2005). For this study, the need factor is the presence of one or more chronic conditions.

Nature of the Study

The nature of the study was quantitative retrospective descriptive review of data to examine the relationships between the type of health insurance (private vs. public) and the patients' access of care (measured as acceptability and availability) among African American males ages 25 to 64 with chronic conditions. Using a quantitative descriptive comparative design was useful for this study in defining the correlation between type of health insurance and access to care. Specifically, the study determined if there was a statistically significant relationship among African Americans males 25–64 years old with chronic conditions that either have public insurance or private insurance and the acceptance of their health care coverage in an outpatient setting and their availability to be seen by a health care provider. This study used chi-square to determine a relationship between the independent and dependent variables type of health insurance and access to care from the Urban Institute's Health Reform Monitoring Survey (HRMS) 3rd Quarter 2013. A chi-square test helped to determine if there is a relationship present between type of health insurance and access to care.

Literature Search Strategy

Walden University has access to a myriad of databases that were used to aid in the literature search process. Initially and most frequently, searches were found through the databases provided by Thoreau. Other notable used and helpful tools were EBSCO, SAGE, ProQuest, and PubMed. Utilizing the advanced settings by using a combination of words is necessary in finding articles that will complete the scope of the literature. For this study, the scope encompasses the topics of insurance type, availability access to care, African American and chronic conditions. The literature search included peer-reviewed articles that had been published between 2014-2020. Combinations of words included: discrimination or racism, African American, males or men or man healthcare, and providers of health care or physicians, or advanced practical nursing; disparities in healthcare, discrimination in health care, and differences; bias, healthcare, insurance, united states or America or USA or U.S.; and discrimination and Medicaid. Other search words included, racial discrimination, insurance-based discrimination, provider bias, healthcare, access to care, availability, appointment, medical mistrust, and disparities.

Literature Review

Insurance-Based Discrimination

To understand why public and private insurance matters when it comes to access to care, it is important to look at previous cases of public and private insurance use and how it has affected access to care. In 2010, the Patient Protection and Affordable Care Act (ACA) was established to eliminate barriers that denied access to care through the lack of coverage or health status (Guo et al., 2017). However, some barriers still exist, such as insurance discrimination. Insurance-based discrimination is the act of treating patients with a certain type of insurance or without insurance in a prejudice or discriminatory way that can result in barriers in obtaining care, reduced use of needed care, and subpar care (Han et al., 2015). This is not to be confused with coverage discrimination, established as a discriminatory practice by the ACA, which is the act of adjusting insurance plans for individuals with complex and costly conditions that would prevent them from accessing care for those conditions (i.e., formulating HIV/AID medications with the highest co-pays; Guo et al., 2017). Previous studies have shown that adults ages 18–64 who had public insurance (i.e., Medicaid) and those who were uninsured experienced insurance discrimination and had reduced access to care than those who had private insurance (Han et al., 2015). Evidence also showed race and ethnicity were factors that affected care like patient delays in accessing medical care, harder time getting an appointment, and negative emergency care experiences (Alcala & Cook, 2018). Other research also supported that Medicaid patients experienced higher perceived discrimination, forgoing care, delaying care, and racial bias (Weech-Moldando et al., 2012).

Insurance-based discrimination can result in health providers forgoing acceptance of new patients with public insurance such as Medicaid due to lower reimbursement rates (Bindman & Coffman, 2014). Non-acceptance of Medicaid patients is not an illegal practice as physicians hold the right to accept or deny Medicaid patients (Bindman & Coffman, 2014). However, provider refusal can have a negative impact on Medicaid patients. Provider refusal has led to increased emergency department usage with data showing a 13.25% increase in delaying care compared to privately insured and Medicare patients (Bhandri et al., 2016). In contrast, privately insured patients are recorded to have better access to care, easier acceptance as a new patient, and timely access to care, which contribute to better overall outcomes for the privately insured (Bhandari et al. 2016; Spencer et al., 2013). It is even suggested that physicians may alter their treatment practices in favor of privately insured patients (Spencer et al.2013). These practices might include taking preventive care measures and providing innovative treatments that are not utilized at the same rates as Medicaid and uninsured patients (Spencer et al., 2013). For example, the National Inpatient Sample 2003-2008 data showed that in relation to heart disease privately insured patients were receiving DES or BMS treatment at higher rates than Medicaid and uninsured patients (Epstein et al., 2012). Additionally, privately insured patients with acute myocardial infractions are also more likely to be offered and use percutaneous coronary intervention and coronary artery graft bypass treatments than publicly insured and uninsured patients (Niedzwiecki et al., 2018).

Patient-reported data also indicates that publicly insured patients experience limited access to care such as with preventive and specialty care (Niedzwiecki et al., 2018; Nguyen & Sommer, 2016). For example, Medicaid patients have almost a 5% lower probability to receive percutaneous coronary intervention treatment than those who are privately insured (Niedzwiecki et al., 2018). Research has also shown limited access among Medicaid patients with at least one chronic condition (Nguyen & Sommer, 2016). The presence of barriers limits access for Medicaid patients and is particularly harmful for the population in this study who have genetic predispositions to certain chronic diseases. For African American males who are 25–64, having chronic conditions such as diabetes and heart disease makes specialty and preventive care a necessity in reducing negative health outcomes (Gilbert et al., 2016). But limitations in accessing specialty care can lead to lower quality care, poorer health outcomes, and widening disparities for those with Medicaid (Kaiser Family Foundation, 2020; Nguyen & Sommer, 2016).

While being privately insured is not an issue, it is the unspoken “privilege” that comes with private insurance that contributes to inequities in healthcare access. Such inequities widen the gap of disparities between public and private insurance users and creates barriers towards public insurance users attaining adequate healthcare. The standard that privately insured patients are accustomed to should be extended to those of all insurance types. However, research shows that this standard is not inclusive and is only exacerbated by demographics such as race, gender, health status, and age.

African American Men: Age, Gender, and Chronic Conditions

A history of racism leading to discrimination and medical mistrust has had long-term effects on African American men, leading to disparities and inequities in health and access to care (Wolinetz & Collins, 2020). Disparities are consistently creating distance between African American men and their ability to be seen by providers and receive timely care (Carnethon et al., 2020; Jones et al., 2019; Wolinetz & Collins, 2020). Discrimination (racial and insurance-based) leads to mistrust, mistrust leads to disparities, disparities lead to poorer health outcomes, and the cycle continues. Discriminatory practices lead to less engagement by patients in health care settings and is particularly impactful for those with chronic conditions (Nguyen et al., 2018). Patients with chronic conditions need extensive and watchful care; being discriminated against can make it hard for those to seek care in a perceived safe and judgement free environment (Nguyen et al., 2018; Powell et al., 2016). Chronic conditions as defined by the Center of Disease Control and Prevention (CDC, 2020) are conditions that are ongoing for more than a year.

Chronic diseases greatly affect people of color, specifically for this study African American men who historically have preconditions to heart disease, high cholesterol, and diabetes (Cunningham et al., 2017). African American males began to experience early onset of chronic conditions between the ages of 25–64 and are at risk for higher mortality rates in comparison to their White male and African American female counterparts (Gilbert et al., 2016). There is insufficient evidence to determine if African American males, age 25–64 with chronic conditions are experiencing discrimination or limited access to care based on their chronic conditions, age or gender and is underrepresented in research. However, age, gender, and chronic conditions (among other factors) are determinants that help define the intersectionality that contributes to how easily one can access care.

Intersectionality is a framework that explains the experience individuals have in identifying with two or more disenfranchised groups that directly correlates to their privilege or disadvantage (Cole, 2009; Lewis & van Dyke, 2018). Intersectionality is an important concept when looking at how groups view their healthcare experiences. Negative experiences with discrimination in relation to physical health for African Americans seem to have more impact on women, than men (Beydoun et al., 2017; Richman & Jonassaint, 2008; Roberts et al., 2008). However, the intersectionality that African American men possess leaves them balancing between the privilege that comes with being a male today (such as making more money than their female counterparts) juxtaposed with the discrimination of being African American (such as being stopped by police or followed in a store), which leads to more stressors and disparities in health (Lewis & van Dyke, 2018). The social context in which African American men stand between intersectionality is even more defined as the privilege of public and private insurance is considered. Factors such as income, job status, the wealth gap, and more influences whether an individual has private insurance, public insurance, or any insurance at all.

Although a group can be different based on a social identity such as type of insurance, socially due to the more commonalities they possess (such as same race, age, gender, socioeconomic status, and other determining factors that can negatively disenfranchise a particular group) they are more than likely to have share the same experiences (of discrimination) due to their shared social identities (Lewis & van Dyke, 2018). For example, both poor and non-poor African American men are more likely to be discriminated against in a health care setting than White and non-White Hispanic men, despite a non-poor African American man having a higher socioeconomic status (Colen et al., 2018; Gilbert et al., 2016). However, the uniqueness of intersectionality in this example is that an African American man has the privilege of being a male and having a high SES, and the disadvantage of being African American or the racial minority (Lewis & van Dyke, 2018). To be an African American male, which by historical measures is automatically a target for discrimination, it makes it harder for this population to take advantage of positive social identities (such as higher socioeconomic status, private insurance, higher education status, etc.), which would grant their white counterparts' privileges (timely service, patient prioritization, etc.) that African American males do not have access to (Lewis & van Dyke, 2018; Thomas, 2015).

Following this framework, intersectionality would suggest that an African American male with private insurance has a high probability of sharing the same discriminatory experience as an African American male with Medicaid, even though those with private insurance are recorded to have better access to care and healthcare experiences (Niedzwiecki et al., 2018; Thomas, 2015). This phenomenon would be attributed to the fact this group is Black and male (shared race and gender) with the only difference being type of insurance, which would not render the same implications or even experiences if one had public and private insurance and were White and male, White and female, or non-Hispanic and male. More research is necessary to understand how intersectionality influences African American males with different types of insurance, their ability to access care, and their physical health (Lewis & van Dyke, 2018).

Access to Care: Acceptability and Availability

Acceptability

Providers are not exempt from exhibiting aversive racism towards African Americans or displaying implicit bias towards patients with chronic conditions. Providers may also refuse serving patients with government sponsored assistance, such as Medicaid, based on the reimbursement rates (Penner et al., 2010; Chapman et al., 2013). Discriminatory experiences can place a burgeoning strain on the experience between patient and provider as well as the care they receive. There are two forms of bias: implicit and explicit. While explicit bias consciously reinforces beliefs in negative stereotypes about groups of people, implicit bias is unconscious awareness of reinforcing stereotypes that might contradict the individual’s beliefs (Chapman et al., 2013).

Following the adoption of the Patient Protection and Affordable Care Act, policies made it easier for all patients to access healthcare (Tipirneni et al., 2019). After

Medicaid expanded in Michigan, factors such as practice capacity, specialist availability and reimbursement became more of a priority in primary care providers' decision to accept new Medicaid patients (Tipirneni et al., 2019). Evidence in Tipirneini et al.'s (2019) study showed at least 78% of PCPs were actively accepting new Medicaid patients under Medicaid Expansion (Tipirneini et al., 2019). Tipirneni et al. (2016) also cited availability of appointments increased favorably for Medicaid patients. Patients in Tipirneni et al.'s (2016) study consisted of the nonelderly population and in one year after Medicaid Expansion greater proportional appointments were available to patients seeing nonphysician providers; percentage from before expansion to after is 11% to 21%. Yet disparities still exist as wait times did not decrease (remaining within a two-week window) and appointment access slightly increased for privately insured patients seeing nonphysician providers (Tipirneini et al., 2016). More so, Bhandari et al. (2016) show a relation that Medicaid patients have more difficulty finding primary care physicians who accept their coverage. Coverage refusal also leads to delayed needed care, and the utilization of emergency departments than primary care physicians for services among Medicaid patients (Bhandari et al.,2016).

Availability

Prior research from Rhodes et al. (2017) explored availability access by primary care providers after Medicaid expansion in 2014. The basis of Rhodes et al.'s study was to examine if primary care capacity could effectively handle the influx of new patients after expansion by insurance type. Results show that while privately insured patients remained consistent before and after ACA expansion, Medicaid patients increased in their appointments and their acceptability (Rhodes et al., 2017). These findings are consistent with Tipirneni et al. (2016), yet neither Rhodes et al. (2017) or Tipirneni et al. (2016) controlled for race, which is a factor in how discrimination can affect patient wait times and delayed care (Wineseicki &Walker, 2020). While Medicaid patients are moving away from the stigma of lower availability access to care in some states, there is no evidence supporting increased access to care for African Americans with Medicaid.

Winseicki and Walker (2020) arranged a simulated study with black, white, and Hispanic callers in order to request appointments for primary care providers. Their study found that under the simulation black and Hispanic callers are facing higher levels of delayed care which could be attributed to implicit provider and staff bias (Winseicki & Walker, 2020). Black and Hispanic simulated callers were asked about their insurance status more often and were given appointments further into the future in contrast with their white counterparts, even while having the same insurance status (Winseicki & Walker, 2020). The results from Winseicki & Walker's study is not coincidental but discriminatory. Statistical discrimination refers to the inferences providers and medical staff members make upon hearing minorities names and other monikers that allude to race (Becker, 1957). Stereotypical conclusions of insurance coverage for minority patients are made and patients are then placed in position where their care is delayed due to bias (Ray et al., 2015). Among black and Hispanic names, insurance coverage was most asked at 43% and 25% points, respectively (Winseicki & Walker, 2020). Winseicki and Walker's (2020) study shows that their patients are experiencing barriers attributing to bias (albeit racial or insurance-based) in delayed care. These biases can establish negative long-lasting effects on the patient-provider relationship as insurance and racially discriminatory experiences become commonplace in healthcare administration (Winseicki & Walker, 2020).

Definitions

Acceptability: the ability of the provider to accept the characteristics and health coverage of their patients (McLaughlin & Wyszewianski, 2002).

Access to Care: access to care is defined by the factors which pertain to the patient's experience of care. The five factors are: acceptability, availability, accessibility, accommodation, (Penchansky and Thomas, 1981). For this study only acceptability and availability will be examined.

Availability: the resources necessary to meet the need of the patient (McLaughlin & Wyszewianski, 2002).

Discrimination: discrimination in healthcare is the unequal treatment of people due to factors beyond their control, such as race, religion, sexual orientation, health insurance, etc. (Weech-Maldolnaldo et al., 2012).

Disparities: health care disparities are difference between groups of people with higher health risks due to (Artiga et al., 2020).

Perceived Discrimination: perceived discrimination in healthcare is the negative treatment the patient receives due to their race, religion, sexual orientation, health insurance and the like (Weech-Maldonaldo et al., 2012).

Private insurance: for this study private insurance will be defined as insurance purchased through a private entity, not government-sponsored or employer-sponsored

(Alcala & Cook, 2018).

Public insurance: for this study public insurance is government sponsored assistance, more specifically, Medicaid (Alcala & Cook, 2018).

Type of Insurance: type of insurance refers to the health insurance status one has; for this study, private insurance and public insurance will be used (Alcala & Cook, 2018).

Assumptions

Assumptions made in this study surround the accuracy of the Health Reform Monitoring Survey. The Health Reform Monitoring Survey utilizes self-reported data as the method of research. The first assumption for the data is that the sample population is an accurate depiction of the United States population. The Health Reform Monitoring Survey's collection of data utilizes surveys submitted on a voluntary basis. Accuracy for the sample population's representation is assumed for this study. Secondly, the self-reported data contains questions based on the participants 'experience and recall. As experiences and recall vary from one person to another, emphasis is placed on how the participant interprets the questions asked from the Health Reform Monitoring Survey as it relates to the research questions. This study assumed the participants' opinions and perspectives are valid regarding their experiences. Lastly, this study also assumed that all other questions not based on experience (insurance type, race, age, etc.) are accurately reported by the participant.

Scope and Delimitations

The research problem addresses type of insurance and access to care variables with a specific race, age range, gender, and the presence of chronic conditions. This research has been conducted previously across different races, ethnicities, and genders, but not between public and private type of health insurance among African American males, ages 25-64 with chronic conditions. There are studies that confirm that Medicaid patients have less access to care than privately insured patients. These studies include publicly insured patients being less satisfied with their care (compared to their white counterparts of similar standings), negative Emergency care experiences, delayed care due to perceived discrimination and more difficulty in creating timely appointments (Alcala & Cook, 2018; Alcala et al., 2020). The research also shows opportunities for preventive care and specialty care are not offered to Medicaid patients (Niedzwiecki et al. 2018)

Additionally, there are studies that show minorities have less access to care compared to white patients such as with Nguyen et al. (2018) and Cunningham at al. (2018) which showed that African Americans (both men and women) are most consistently discriminated against in a healthcare setting than any other race and suffer longstanding poor health outcomes due to implicit as well as explicit biases (Winseicki & Walker, 2020). However, there is a lack of information that shows a relationship between type of insurance and access to care within a particular race, specifically, with African Americans that have history of discrimination. The overarching goal is to confirm if better access to care as a privately insured patient applies when the patient is from a marginalized group – e.g., African American males. Implicit bias needs to be addressed in accessing healthcare among those with different types of insurance; if accessing care is not better, then explicit racial bias also needs to be addressed for accessing health care.

The focus of this research can potentially apply to many other minority groups in the United States such as Latinos/-as, Asian-Americans, Native Americans, and so forth.

Limitations

The limitations this study has found is in the internal validity of its research design. This study is a quantitative retrospective descriptive comparative research design. Being that this study is retrospective, the study relies solely on past literary information and data sets to explore the relationship between access to care and type of health insurance among African American males, 25-64, with chronic conditions. The dataset used in this study is the Health Reform Monitoring Survey (HRMS), 3rd Quarter 2018. In addressing the internal validity limitation for the retrospective dataset, this study limited the results found to be in correlation with the responses given by the HRMS 3rd Quarter 2018 and are therefore not generalizable. Additionally, the population demographics used in this study (African American, males, 25-64, chronic conditions) limits its external validity to be used by researchers outside of this study, rendering the application of these results not generalizable. However, utilizing the design of testing the relationship of access to care and type of health insurance can be applied to other population demographics such as other minority or majority groups, different ethnicities, religions, and genders. Lastly, there are no biases that could have potentially influenced the studies outcomes, as this research design is descriptive comparative, and only observed and recorded the data results. However, biases the literature presented stating that privately insured patients have better access to care in comparison to publicly insured patients, and that African Americans (particularly males) have poorer access to care, has been tested through the chi-square test which observed the possibility of a relationship between access to care variables (acceptability and availability) and type of health insurance (private and public) amongst African American males, 25-64, with chronic conditions.

Significance

Healthcare administration is the well-oiled machine that serves to manage the patient-care experience. The study addresses the problem of access to care varying in terms of appointments and insurance acceptance by types of health insurance. Patients with government sponsored assistance, specifically Medicaid patients, have a history of providers refusing their coverage, thus limiting their access to care. This is shown through various studies that exclude Medicaid patients from specialty care and preventive screenings and treatments that could help mitigate disparities between public and private insurance users (Niedzwiecki et al., 2018); Nguyen et al., 2016; and Bhandari et al., 2016). These studies, however, did not account for racial bias until the recent ones made by Alcala et al. (2020) and Wineseicki & Walker (2020) which infers minority patients are often judged by their insurance status prior to the knowledge of their health needs. These implicit and explicit biases from providers and medical staff lead to delayed care which continues to widen disparities in access to care for African American males ages 25-64 with chronic conditions compared to their white male counterparts.

Summary

The literature for this study shows the main components that contribute to accessing care for publicly and privately insured African American males, ages 25-64 with chronic conditions. The first contributing factor is insurance-based discriminations.

As defined by Han et al. (2015), insurance-based discrimination is the implicit or explicit biases that are perpetuated upon patients that are publicly insured and the uninsured. Alcala & Cook (2018) and Alcala et al. (2020) confirm the disparities in access to care that occur in publicly insured and uninsured patients including failure to create timely appointments and exclusion from preventive services and specialty care. Access to care inhibitions is most harmful for patients with chronic conditions, where limiting access to care perpetuates longstanding negative health outcomes (Gilbert et al., 2016). For African American males, experiencing full access to care becomes vital in finding active, preventive solutions that can slow down the development of early onset chronic conditions.

Alcala and Cook (2018) and Alcala et al. (2020) also added to the previous studies made by Weech-Maldonaldo et al. (2012) and Han et al. (2015), by emphasizing age, gender and race as factors that are associated with insurance-based discrimination and patients with public insurance and patients who are uninsured. The combination of age, race, health status and gender become important when adding insurance type as a factor due to the uniqueness that African American men face in their intersectionality. While African American males are most likely to have certain privileges that come from being a male, such as being on the positive end of the wage gap, they also endured racial discrimination due to being African American. Having private insurance or even a higher social economic status will not afford African American men the same privileges of having private insurance as a white man or even a white woman. Negative health care experiences and access to care is most consistent with being a minority with public insurance (Wineseicki &Walker, 2020 and Nguyen & Somer, 2016). For African-America males, access to care factors like acceptability and availability can be a potentially negative experience based on their race and type of health insurance.

Conclusions

For the healthcare administration discipline, this study informed a need to check for implicit and explicit biases in healthcare administrators when creating appointments, scheduling preventive services, and allowing access to specialty care amongst African American males with public insurance and publicly insured patients. This study can create positive social change by adding to the research needed in addressing implicit and explicit bias in the health care system. Systemic discrimination has perpetually kept minorities, the underprivileged and the marginalized in positions of inferiority when it comes to accessing care. What is most needed is evidence that can prove these experiences of discrimination exist in an effort to close the health gap for groups of people that are subjected to such treatment. The social change for this study is for healthcare administrators to be an ally in the solution of accessing care for African American males and publicly insured patients. Additionally, this information can help others to recognize and not perpetuate the practices that would exclude minorities and publicly insured patients from positive health seeking behaviors as seen in previous studies.

Solutions to these biases may consists of changing the types of questions staff ask before making appointments and valuing the patient as a person in need of care and not by their insurance type, reimbursement rate, or marginalized status. More importantly, health care administrators should create systems of checks and balances, racial training, and address the challenges in the ethical treatment of publicly insured and uninsured patients. Healthcare administrators can also inform staff members what implicit and explicit biases are, what they look like, how to correct past behaviors resulting in racial and insurance biases and how to de-escalate discriminatory practices made by other staff members. These changes will ultimately help with better access to care and better well-being among African American males ages 25-64 with chronic conditions having public or private insurance. Additionally, administrators and providers can begin encouraging and advocating the use of preventive services and procedures for patients with government sponsored assistance to create an inclusive environment that is dedicated to reaching all individuals regardless of race and type of health insurance. The gap that is addressed in the study is the dynamic between type of insurance and access to care among an African American male population, age 25-64 with chronic conditions. This intersectionally similar group lacks information and this study contributed to the gap and extended the knowledge of whether a relationship is present in how patients are experiencing access to care with various insurance types within a marginalized group. Section 2 provided a better understanding of the research design and data collection that created validity for the results garnered in Sections 3 and 4.

Section 2: Research Design and Data Collection

The purpose of this study was to determine whether there is a relationship between type of health insurance and access to care measured as acceptability to care and availability to care among African American males between the ages of 25–64 with chronic conditions. This information can help determine if patients with the same demographic characteristics (race, gender, age, and chronic conditions) are accessing care at the same rates across different types of health insurance. Topics covered under this section are research design and rationale, methodology, sampling, instrumentation, and operationalization. This section also includes data analysis, threats to validity, ethics, and a summary on the research design and methodology.

Research Design and Rationale

This study is a quantitative retrospective descriptive study used to explore the relationship between public and private insurance and access to care (i.e., accessibility and availability to care) among African American males 25–64 with chronic conditions. The independent variable for this study is type of health insurance, categorized as public (Medicaid) or private. The dependent variables are acceptability to care measured by response to the question “Were you told by a doctor they do not accept your health coverage?” and availability to care measured by the response to the questions “Did you have trouble making an appointment as soon as you thought you needed one?”

The research design for this study was a descriptive comparative study. Descriptive comparative research designs are used to identify a relationship between the independent and dependent variables (Sacred Heart University Library, 2022). The descriptive comparative design helped to best answer the research questions in this study on a relationship between type of health insurance and access to care (acceptability and availability) among African Americans, males, 25–64, with chronic conditions. The decision for this research design is on par with current literature from Alcala & Cook (2018), whose research observed different relationships between insurance type, discrimination, and usual source of care, and their variance by race (Alcala & Cook, 2018). This study included a retrospective dataset from the Health Reform Monitoring Survey, 3rd Quarter 2018. For the health care administration discipline, utilizing a descriptive comparative model helped to determine a relationship between acceptability and availability of health care services by type of health insurance among same-race patients with similar demographics.

Methodology

Population

The population of a study is the group or groups of people whose specific characteristics serve to provide information for the research study (Banjaree & Chadhury, 2010). For this research study, the population demographics included African American (race) males (gender) ages 25–64 (age) with chronic conditions (health status). Including intersectionality in quantitative research aid in understanding the population's behavior in seeking and utilizing health care. Intersectionality in quantitative research can also provide correlation in how social inequities regarding race and insurance status influences a population's ability to access care (Cantrell, 2011). The population for this study has a unique intersectionality, whose makeup provides social context on how patients with the same race, age, gender, and health status access care with different types of health insurance. Walden University's Institutional Review Board (IRB) approved the collection of data for this study (approval number 02-15-22-0675159).

Sampling and Sampling Procedure

The data used in this study were secondary data provided by the Urban Institute's HRMS, 3rd Quarter 2018. The HRMS is a survey used to question the nonelderly population on policy issues under the Affordable Care Act (Holohan & Long, 2020). HRMS uses stratified random sampling to select 9609 participants per quarter and is drawn on a semi-annual basis in the Months of March (1st Quarter) and September (3rd Quarter; Holohan & Long, 2020). The HRMS used stratified random sampling to represent the population of the sample into subpopulations or subcategories in accordance with the sub-population's demographics (Elfil & Negida, 2017). This type of sampling enables researchers to clearly find the effect size of a subpopulation as well as formulate samples out of the subpopulations as individual studies (Elfil & Negida, 2017). Sampling is derived from the knowledge panel, which is an address-based sampling method that randomizes addresses across the United States to be selected for the panel (Holohan & Long, 2020). The knowledge panel has 55,000 participants. Participants are between ages 18–64, with or without Internet access (if without, a laptop and internet access will be provided for them) and can be completed in English or Spanish. The HRMS is a sample of the knowledge panel. To access and use the HRMS data, users need to create an account on the Inter-University Consortium for Political and Social Research (ICPSR) website and agree to the Terms of Service.

There are no permissions necessary to access and use the data as it is public data. Sampling the data for this study required selecting cases from the survey to best fit the targeted characteristics of the population being studied. The exclusion criteria for the study were anyone who is not African American, ages below 25 or over 64, females, and participants without chronic conditions.

A G*Power analysis was conducted to determine the minimum number of participants to create an adequate sample size representation of the population being studied (see Kaliyadan & Kulkarni, 2019). A power of .80 is a normal power and an alpha of .05 are the minimum corresponding power and significance level accepted to maintain accuracy for sample size estimation (Kaliyadan & Kulkarni, 2019). To calculate the sample size, I used the G*Power 3.1.9 calculator, which has been used as a reliable tool for the UCLA: Statistical Consulting Group (2021). The sample size needed is 209 participants for African American males between the ages of 25–64 years and with chronic condition with private and public insurance. However, I planned to sample 500 participants using stratified random sampling and using the type of health insurance as the stratum in sampling (i.e., 250 with private insurance and 250 with public insurance). Stratified random sampling represents the population of the sample into subpopulations or subcategories in accordance with the subpopulation's demographics (Elfil & Negida, 2017).

Instrumentation and Operationalization of Constructs

Instrumentation

The data set used for this study is the Urban Institute's Health Reform Monitoring

Survey 2018 Quarter 3 as collected by John Holohan and Sharon Long. Due to this study's need for information to compare differences between private and public insurances in African American males 25–64 with chronic diseases, this dataset is relevant to this current study. The HRMS contains data pertaining to topics such as health insurance coverage, access to health care, insurance affordability. Demographics such as race, age, income, education and citizenship are also included in the survey. The HRMS has sufficient data to answer the research questions pertaining to acceptability, availability, and health insurance type. No written permission to use the data is necessary; however, user agreement and compliance to the terms of service from the ICPSR was necessary in creating an account to access the data. Student user access is provided by Walden University. Many researchers have used the HRMS datasets ranging from the years 2013 -2019 and has been used in various research and published in several articles. For example, research by authors Barnes et al. (2019) used the HRMS dataset to examine how designs for distributing information about health insurance plans under the ACA can lead to educated decision making in choosing market-place plans. More research from Chen and Page (2020) used the HRMS data set to measure deductible levels and their influence on the patients' health care experience (routine, access to care, satisfaction, out of pocket costs, and affordability) (Chen & Page, 2020).

Operationalization

This study conducted its research by exploring relationship between one independent variable and two dependent variables. Independent variables are also defined as explanatory variables that seek to determine whether there is a statistically significant relationship with the dependent variable, also known as the outcome variable (Kaliyadan & Kulkarni, 2019). This study utilized a descriptive, observational approach to analyzing data. The independent variable, type of health insurance (a categorical variable), compares whether there is statistically significant relationship among patients/participants with private and public (government sponsored assistance) insurance and the way they access care. Access to care is the dependent variable for this study and is categorized by the two of the five access to care factors: acceptability and availability. Acceptability refers to the patient's ability to be accepted by the provider, whereas acceptability is the patient's ability to be seen and the resources the provider has to see the patient (McLaughlin & Wyszewianski, 2002). For this study, the HRMS survey questions, "were you told by a doctor or a healthcare provider that they do not accept your health care coverage" serves as the operational definition of the acceptability variable. Similarly, the availability variable will be defined by the HRMS survey question, "did you have trouble getting an appointment at a doctor's office or clinic as soon as you thought you needed one." The response categories to these two questions ranged from "yes" (coded as 1), "no" (coded as 2), and "did not care" (coded as 3). This study will only analyze answers 1 (yes) and 2 (no), and responses of "did not need care" will be classified as missing data.

The independent variable for this study is the type of health insurance categorized by private insurance and public insurance. Public insurance is defined as government-sponsored assistance (e.g., Medicaid). Private insurance will be defined as insurance types that are not government sponsored assistance which will include individual private health plans. For the independent variable, this study used the question on the HRMS survey “Are you currently covered by the following insurance types?” Privately insured patients utilized option B from the survey: Insurance purchased directly from an insurance company (by you or another family member). This would include coverage purchased through an exchange or marketplace, such as Healthcare.gov. For publicly insured patients, they utilized the survey option D: Medicaid, Medical Assistance (MA), or any kind of state or government-sponsored assistance plan based on income or a disability. To response to the survey questions pertaining to private and public insurance coverage, the HRMS use the responses covered (coded as 1), not covered (coded as 2), and not sure (coded as 3). This study only included in the analyzes the response to covered for private and covered for public insurance; and responses that are “not sure” will be classified as missing data.

Data Analysis Plan

This study will use the IBM Statistical Product and Service Solutions 27 (SPSS) to analyze the data from the HRMS questionnaire. Screening for data use includes the race, age, gender and chronic condition factors in accordance with the independent (type of health insurance) and dependent variables (acceptability and availability). The study sample of African American, 25-64, male and have chronic conditions with either private or public insurance. Quantitative analysis used Chi-square in observing and analyzing the relationships of the dependent and independent variables. Chi-square is useful to this study to examine nominal or categorical data for statistical significance between observed and expected data (Kim, 2017; McHugh, 2013). The chi-square test will observe whether the difference in proportion between type of health insurance (categorical data) and access to care (dichotomized data) among African American males with chronic conditions in ages 25-64 is statistically significant. Results for interpreting Chi-square will use a p-value that is equal to or less than 0.05 for determining statistical significance within the relationship (Kent State University Libraries, 2021)). Research Questions are as follows:

RQ1: Is there a relationship between type of health insurance (private vs public type of insurance) and acceptability of care (i.e., Told by a doctor that they do not accept your health coverage?) among African American males 25-64 years old with chronic conditions in an outpatient clinic?

H01: There is no statistically significant relationship between type of health insurance (private vs public type of insurance) and acceptability of care (i.e., Told by a doctor that they do not accept your health coverage?) among African American males 25-64 years old with chronic conditions in an outpatient clinic?

Ha1: There is a statistically significant relationship between type of health insurance (private vs public type of insurance) and acceptability of care (i.e., Told by a doctor that they do not accept your health coverage?) among African American males 25-64 years old with chronic conditions in an outpatient clinic?

RQ2: Is there a relationship between type of health insurance (private vs public type of insurance) and availability of care (i.e., Trouble getting an appointment at a doctor’s office or clinic as soon as you thought you needed one) among African American males 25-64 years old with chronic conditions in an outpatient clinic?

H02: There is no statistically significant relationship between type of health insurance (private vs public type of insurance) and availability of care (i.e., Trouble getting an appointment at a doctor’s office or clinic as soon as you thought you needed one) among African American males 25-64 years old with chronic conditions in an outpatient clinic?

Ha2: There is a statistically significant relationship between type of health insurance (private vs public type of insurance) and availability of care (i.e., Trouble getting an appointment at a doctor’s office or clinic as soon as you thought you needed one) among African American males 25-64 years old with chronic conditions in an outpatient clinic?

Threats to Validity

Validity in research shows how true the findings are from the research study and how applicable it is to other groups outside of the study’s population (Patino & Ferreira, 2018). There are two categorizes of validity: external and internal. Internal validity refers to how true or valid the results are towards the population that is being observed and studied whereas external validity references the applicability of a study’s results outside of the study’s target population (Patino & Ferreira, 2018). Threats to the internal and external validity of the research design can negatively impact the ability for the research outcomes’ to be utilized in other similar groups (Patino &Ferreira, 2018).

In identifying threats to external validity, the specificity of variables in this study concludes that the observations of this study will not apply outside of this study’s population (i.e., participants that are younger than 25, older than 64, females and those without chronic conditions). While the method of isolating patients/participants by demographics and determining their access to care by type of insurance can be utilized in other studies, the observations concluded from this study are only applied to African American males with chronic conditions between the ages 25-64 in this study.

Another threat to external validity includes location. During the time of the survey, there is no conclusive information that identifies if the participants/patients' ability to access care are due to a state-by-state practice or policy. As a result, this study did not attempt to explain patients' experience in terms of policies based on the location of the participant/patient. Rather, the study focused on the survey as the entirety of the United States and drawing random samples from the United States pool.

A threat to internal validity is the use of HRMS' self-reported data. This data could potentially have errors or biases due to the patients' experience, forgetfulness, changes in providers, etc. The study assumes that the patient-reported data is correct at the time of the study.

Ethical Procedures

While there are no permissions needed from the authors to conduct the study, the IRB has the agreed user terms of service page that account for the conditions needed to use the ICPSR account. The data in the HRMS survey are all de-identified and can be publicly accessed on the ICPSR account. This study did not attempt to de-identify respondents for any reason within this study, leading to minimal possibilities of harmful use of the secondary data. Attempts to identify participants in the data by the researcher is strictly prohibited and can be punishable by the authors and result in the loss of data usage for the study. Respondents for this study were ethically sourced by the HRMS using an address-based stratified random sample from the Knowledge Panel. The study finds respondents reported their answers of their own volition based upon their healthcare status and personal experiences.

Summary

This study is a quantitative retrospective descriptive study that describes and compares the relationship between type of health insurance and access to care factors among African American males, ages 25-64 with chronic conditions. The research design used a descriptive comparative research design that observed these relationships to determine if there was a relationship there is between type of health insurance and acceptability of care and availability of care among African American males, ages 25-64 with chronic conditions. Utilizing chi-square as the method of analysis helped to determine whether there was a statistically significant relationship between type of health insurance and access to care (acceptability and availability). The results were determined in Section 3 using SPSS. Section 3 features data collection of the data set, results, and summary of findings.

Section 3: Presentation of the Results and Findings

The purpose of this quantitative descriptive retrospective study was to examine the relationship between type of health insurance (private and public type of insurance) and access to health care (i.e., acceptability and availability) among African American males ages 25–64 with chronic conditions. The research questions align with the purpose. Section 3 includes reviews the data collected for the secondary data set as well as a compilation of the results.

Data Collection of Secondary Dataset

The secondary data for this study were collected by the Health Reform Monitoring Survey by Holohan and Long (2020). The HRMS collected this data of 9,500 participants in from September 11 to September 30, 2018 and published them in 2020. The data in the survey collected patient-reported responses, which are assumed to be accurate to the patient’s knowledge during the timeframe of this study. Additionally, the HRMS concerns topics on policy issues such as health insurance coverage, access, affordability, self-reported health status and implementation issues under the ACA. As ACA implementation policies differ across the United States, this study did not consider respondents’ location as a basis for their response. The information the dataset provided only acknowledges the responses patients provide as part of the whole United States and not to any specific regions or states. Lastly, the representation of the sample available for this study are specific to the population of this study, African American males, 25–64, with chronic conditions and therefore are not generalizable.

The demographic characteristics of the population in this study include African

American males, ages 25–64, with diagnosed chronic conditions (diabetes, heart disease, high blood pressure, high cholesterol, etc.). Though the goal of the study was to reach 500 participants (250 participants for privately insured patients, 250 for publicly insured patients), after filtering and sorting out cases in SPSS 27 the descriptive statistics yielded 345 participants with Medicaid (i.e., public insurance) and 342 participants who are privately insured. After additional filtering of cases that were either missing or selected "did not need care," there were only 304 patients with public insurance and 306 participants with private insurance (see Table 1) to answer the question "Did your provider accept your coverage?" Congruently, Research Question 2, "Did you have trouble getting an appointment as soon as you though you needed one?" resulted in 303 participants with private insurance and 305 patients with public insurance (see Table 1) after filtering missing and "did not need care" cases. As a result, this study used all available participants to strengthen the probability for statistically significant data, with a sample size of 610 participants for RQv1 and 608 participants for RQ 2. Answers for questions determining acceptability and availability of care were labeled 1 for "yes" and 2 for "no."

Table 1

Comparisons of African American Males with Medicaid and Private Insurance

Research Question 1			Research Question 2		
Group	N	Percentage	Group	N	Percentage
Private	304	49.8%	Private	303	49.8%
Public (Medicaid)	306	50.2%	Public (Medicaid)	305	50.2%

Total	610	100%	Total	608	100%

Results

Research Question 1 (RQ1): Is there a relationship between type of health insurance (private vs public type of insurance) and acceptability of care (i.e., told by a doctor that they do not accept your health coverage?) among African American males 25–64 years old with chronic conditions in an outpatient clinic? To find the answer to the research question, I used a chi-squared nonparametric analysis to identify whether there is a statistically significant relationship between type of health insurance and acceptability of care. The first step to find a statistically significant relationship between type of health insurance and acceptability of care was to use crosstabulations. Crosstabulations are descriptive data that help to show the number of times a combination of categories can occur (Kent State University, 2022). Crosstabulations were useful in quantifying the rate in which privately and publicly insured patients were able to experience their insurance acceptance (see Table 2). The data Using 2x2 crosstabulations, statistics show that 47.7% (291) of privately insured patients and 47.9% (292) of publicly insured patients responded “No” to the question “were you told by your healthcare provider that do not accept your insurance?” whereas the number of privately insured participants and publicly insured participants responded “yes” at 2.3% (13) and 2.4% (14), respectively (Table 2). More than 95% of the responses were “no” for both privately insured and publicly insured patients. This shows that both private and publicly insured patients had similar experiences in their access to care due to insurance acceptance, and a small margin of both private and publicly insured patients experienced denial in their access to care due to insurance coverage.

Table 2

Relationship Between Type of Health Insurance and Acceptability of Care Crosstabulations

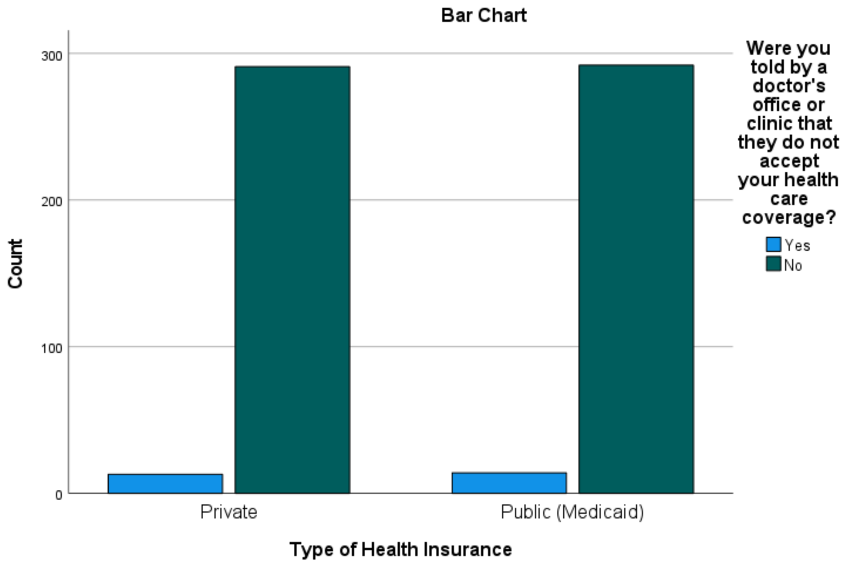
	Were you told by a doctor's office or a clinic that they do not accept your health care coverage?		
Type of Insurance	Yes	No	Total
Private	13 (2.3%)	291 (47.7%)	304
Public (Medicaid)	14 (2.4%)	292 (47.9%)	306
Total	27 (4.4%)	583 (95.6%)	610 (100%)

To find the correlation between acceptability of care between private and publicly insured patients, I used the chi-square test. The chi-square value shown for private and publicly insured patients and acceptability of care is .032. Values closer to zero show little to no correlation between the variables (Sullivan, n.d.). The value of .032 shows that there is no relationship between private and publicly insured patients and acceptability of care. The p value for the chi-square value is .858 against the alpha set at .05 for significance. As this value is greater than the alpha of .05, this also signified that there is no statically significant relationship between type of health insurance (private and public) and acceptability of care.

Further examination of the relationship between type of health insurance and acceptability is shown by the bar graph in Figure 1. The rates between private and publicly insured patients are visually and numerically similar. Thus, the study failed to reject the null hypothesis, meaning there is no statistically significant relationship between type of health insurance (private vs. public) and acceptability of care (i.e., told by a doctor health provider that they do not accept your coverage) among African American males, 25 to 64, with chronic conditions.

Figure 1

Relationship between Type of Health Insurance and Acceptability of Care



Research Question 2 (RQ2): Is there a relationship between type of health insurance (private vs public type of insurance) and availability of care (i.e., trouble getting an appointment at a doctor’s office or clinic as soon as you thought you needed one) among African American males 25–64 years old with chronic conditions in an outpatient clinic? RQ2 also utilized the chi-squared test of independence to determine a statistically significant relationship between type of health insurance and availability of care. Crosstabulations for this question resulted in a total of 608 participants (see. Among these 608 participants, 4.6% (28) privately insurance patients and 4.6% (28) publicly insured patients both answered “yes,” there was trouble getting an appointment at a doctor's office or clinic as soon as they thought they needed it shown in Table 3). For those who responded "no," there were 45.2% privately insured patients and 45.5% publicly insured patients. The crosstabulations showed majority of publicly and privately insured patients (a little over 90%) that did not have trouble getting an appointment at a doctor's office as soon as they thought they needed it. The descriptive statistics here informed this study of the rates publicly and privately insured patients experienced in availability of care. The rates in the responses showed little to no difference between the variables in this study (Table 3).

Table 3

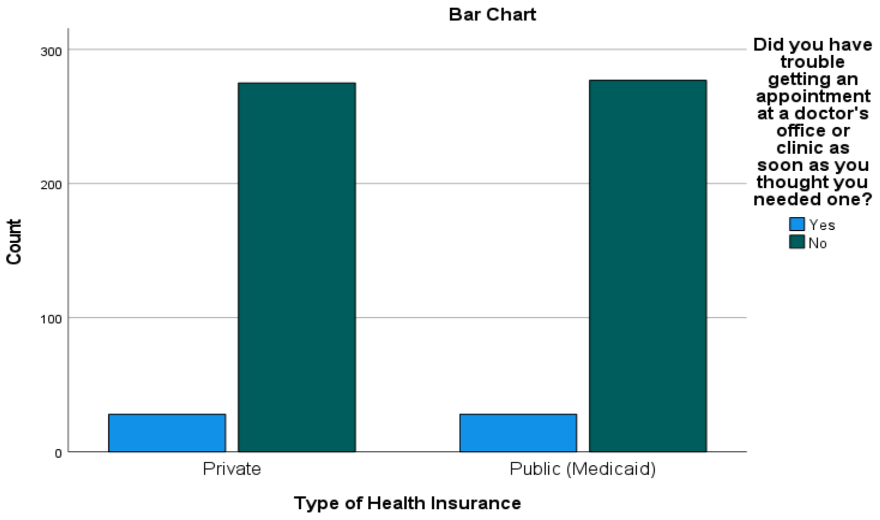
Relationship between Type of Health Insurance and Availability of Care

	Did you have trouble getting an appointment at a doctor's office as soon as you thought you needed one		
Type of Insurance	Yes	No	Total
Private	28 (4.6%)	275 (45.3%)	303
Public (Medicaid)	28 (4.6%)	277 (45.5%)	305
Total	56 (9.2%)	552 (90.8%)	608 (100%)

To examine if a relationship is present between type of health insurance and availability of care, RQ2 also involved a chi-square. The chi square value for type of health insurance and availability of care was .001, a value that is substantially lower than the value needed to establish a relationship between the variables. This chi square value of .001 on the chi-square signifies no correlation between the variables. Thus, this study also failed to identify a relationship between publicly insured patients and availability of care in the form of the question "trouble getting an appointment at a doctor's office or clinic as soon as you thought you needed one." The *p* value for the critical chi-squared value is .979, higher than the alpha set at .05 for significance. This further indicates that the relationships between type of health insurance and availability of care are not significant and are independent of each other. As there was no statistically significant relationship between type of health insurance and availability of care, neither variable (private vs. public) were more likely than the other to experience more availability, as both variables exhibited similar frequencies of care as shown in Figure 2. This study fails to reject the null hypothesis and concludes there is no statistically significant relationship between type of health insurance and availability of care among African American males, 25–64 with chronic condition in an outpatient clinic.

Figure 2

Relationship Between Type of Health Insurance and Availability of Care



Conclusion

To summarize the results of the data, the study began with the basis of the research which used quantitative descriptive retrospective analysis that examined the prospects of statistically significant relationships between type of health insurance (public and private) and access to care (acceptability and availability). Results for RQ 1 signified that there is no statistically significant relationship between type of health insurance and acceptability to care among African American males, 25–64, with chronic conditions in an outpatient clinic. Moreover, the results for RQ 2 showed that there is no statistically significant relationship between type of health insurance and availability of care among African American males, 25–64, with chronic conditions in an outpatient clinic. In both research questions, private and publicly insured patients had observed and expected frequencies that showed little to no difference in the way the two groups accessed care. The frequencies were further explained using bar graphs to compare types of health insurance and access to care. Section 4 extends the interpretation as to what these results meant for the study, the limitations that are attached to the secondary dataset, recommendations on how to further advance the current research, and its positive effects for social change in the health care administration discipline.

Section 4: Application to Professional Practice and Implications for Social Change

The primary purpose of this study was to examine the relationship between type of health insurance (private and public) and access to care (acceptability and availability) among African American males, ages 25–64, with chronic conditions. This comparative design identified any statistical significance between privately insured patients and publicly insured patients and how they differ among access to care factors acceptability and availability. In the case of acceptability of care, there was no statistically significant relationship between type of health insurance and acceptability of care among African American males, ages 25–64, with chronic conditions in an outpatient setting. There was also no statistically significant relationship between type of health insurance and availability of care among African American males, ages 25–64, with chronic conditions in an outpatient setting. Section 4 further elaborates on these findings and what it adds to the literature and limitations found in conducting the research. This discussion also has recommendations for further research and implications for social change in the health care administration discipline.

Interpretation of Findings

RQ 1

The results of this research study add to the findings found in the literature review. RQ 1 pertains to the acceptability of care among African American males, 25 to 64, with chronic conditions and their status as privately and publicly insured patients. The results showed that there is no statistically significant relationship between type of health insurance (private and public) and acceptability of care among African American males, 25–64, with chronic conditions. These findings differ with previous findings suggesting a significant negative relationship between type of health insurance and access to care for privately and publicly insured patients, indicating acceptance amongst primary care providers as difficult, limited, and showing either implicit or explicit bias (Alcala & Cook, 2018; Bhandari et al., 2016; Nguyen & Somer, 2016). There were also negative relationships in access to care among African Americans males, citing discrimination (implicit or explicit) as a primary factor for delaying care (Carnethon et al., 2020; Jones et al., 2019; Wolinetz & Collins, 2020).

However, the results for RQ1 are consistent with research indicating that the gap between privately insured patients and publicly insured patients is closing (Tipirenini et al., 2019), and more Medicaid patients are being accepted by primary care providers (Rhodes et al., 2017). This phenomenon is shown to be happening particularly in states that have expanded Medicaid (Rhodes et al., 2017; Tipirenini et al., 2019). As African Americans have higher risks of chronic conditions such as heart disease and high blood pressure, this increases their need for medical services (Albert et al., 2021). However, long-term illnesses and low-income populations provide a way for this age group (25–64) to be eligible for programs like Medicaid in states where Medicaid is not expanded (Albert et al., 2021). At the time of this study, 31 states and the District of Columbia had expanded Medicaid, which led more people to gain access to healthcare (Buettgens, 2018). With more access to care in states that expanded Medicaid, more providers have begun to accept Medicaid patients (Tipirenini et al., 2019). With the acceptance of more patients, privately and publicly insured patients can begin to see gap closure in rates of acceptability. Increased acceptance of Medicaid might provide an explanation as to why the frequencies in acceptability of care showed similar rates between private and publicly insured patients among African American males in this study. The results for this study are not generalizable and only pertain to this study. Nevertheless, the results of the data can add to the current literature showing that privately and publicly insured patients that are African American males, 25–64 with chronic conditions are having generally similar experiences pertaining to their acceptance by a primary care provider.

RQ 2

The results from RQ2 also showed that there is no statistically significant relationship between type of health insurance (private and public) and availability of care amongst African American males ages 25–64 with chronic conditions. The results of RQ 2 reinforce research that indicates appointments for Medicaid patients increased and reduced delayed care after Medicaid expansion (Rhodes et al., 2017; Tipirenini et al., 2019). However, these studies were not able to control for race, gender, or chronic conditions. Results showed that 90% of both privately and publicly insured African American males ages 25–64 with chronic conditions did not have trouble getting an appointment as soon as they thought they needed one. But the population studied is an in-group study of African American males, with similar ages and chronic conditions, varying only in type of insurance, which makes this group intersectionally similar, sharing perceptions of discrimination and bias experiences (Winseicki & Walker, 2020). This study does not suggest there are no differences in perceived discrimination between African American males and other racial groups, rather that the experiences in availability of care is similar amongst African American males, 25–64, with chronic conditions with public and private insurance.

Conceptual Framework

In terms of the conceptual framework, results for both questions indicated that the predisposing components in Andersen's healthcare utilization model did not affect patients accessing care with private and public insurance. Results for this study shows that the predisposing components (ethnicity-African American, gender-male, age-25–64), enabling components (type of health insurance -Medicaid and Private), and need components (chronic conditions) did not have a relationship to each other that added meaningful insight to the current literature. Specifically, African American males, 25 to 64, with chronic conditions did not experience care differently between type of health insurance and had no statistically significant relationship. Previous research also did not find a relationship between type of health insurance amongst a marginalized group to compare differences in access to care. However, this study is able to report that privately insured and publicly insured African American males, 25–64 with chronic conditions are accessing care in similar ways that possibly denotes a trend towards gap closure between private and publicly insured patients.

Ultimately, one of the primary goals for this study was to find if a marginalized group of people with different health insurances would have different experiences in accessing care. The chi-square test informed the researcher and the audience that there is no relationship between type of health insurance and access to care among African American males, 25 to 64, with chronic conditions. This group did not have different experiences in acceptability or availability of care due to type of health insurance. These results from RQ1 and RQ2 add to the health administration field by checking for disparities which add to the current levels of efforts being made to find if gap closure is occurring between Medicaid patients and privately insured patients. By providing updated information, social change can occur by helping publicly insured patients make informed decisions about their access to care, provide more information about lessened-disparities between private and publicly insured patients and help create positive health-seeking behaviors for African American males and publicly insured patients that have generally have experiences of discrimination.

Limitations

The limitations of this study start with the study's design. This study is a quantitative descriptive retrospective comparative research design that described and compared the results that were found. While this design helped provide information that observed if there was a relationship between type of health insurance and access to care (among African American males, 25 to 64, with chronic conditions) it does not really explain why there was not a statistically significant relationship. The study would have benefited from a causal comparative design, which would have provided more information on what factors led to the lack of a statistically significant relationship. Additionally using a non-parametric study, the chi-square test, limited the ability to probe further into relationships between the variables. Chi-square also fails to explain the "why," as opposed to just observing the relationships between variables.

Another limitation with the study is in its use of access to care measures. This study only used two of the five access to care measure: acceptability and availability. The other measures: accessibility, affordability, and accommodation, might also have helped to provide more information on the relationships between type of health insurance and access to care, and find if disparities amongst African American males, 25 to 64, with chronic conditions occur in those measures.

The primary limitation with secondary data is that it does not give the researcher the ability to go into greater detail about the research. The questions asked on availability and acceptability were sufficient, but not adequate to follow up with personal experience that could have been answered through different categorical data. For example, the availability question (Trouble getting an appointment at a doctor's office or clinic as soon as you thought you needed one) could have been followed up with "what was the time frame between scheduling an appointment and the appointment itself?" and could have been answered using "1-2 days, 2-3 days, 3-4 days," etc. Asking the time frame could have better determined any disparities happening between privately and publicly insured patients, whereas the question asked in RQ2 is more general and dichotomous, only giving the participants the ability to answer, "yes or no." Secondly, while participants from the dataset are drawn from a pool of participants from the United States, the results of this study are only limited to those who are within the specific population of this study (i.e. public and privately insured, African American, males, 25-64, with chronic conditions). These results do not apply to anyone outside of this specified study and are not generalizable. The last limitation this dataset has was the inability to have location (specific states) as a factor to determine if participants were in states that expanded

Medicaid. Due to this limitation, the research viewed the population of the study as the whole United Stated and did not attempt to find if state policies contributed to the participants' experience.

Recommendations

Through understanding the literature and analyzing the data, future researchers can benefit from understanding the challenges that surround this study in order to improve on their study and add to the literature. The first challenge to be mentioned is the survey/dataset. The Health Reform Monitoring Survey serves the purpose of providing data that answers questions about acceptability and availability into relationship to the study's population (private and public, African American, males, 25-64, chronic conditions). However, the answers did not sufficiently delve into the patients/participants'' individual experience. To fully understand the patients' experience about their care, there needs to be a dataset that can further build on the foundational elements of "yes" and "no" questions. This study recommends using a dataset with different ordinal data, such as a 5-point Likert scale, to further gauge the patents' experiences beyond yes or no.

Additionally, due to the inability of locating where the patients are from (by state), more evidence is needed to provide why the gap between public and privately insured patients (even within the same demographics) is closing. Tipiernini et al. (2016) and Rhodes et al. (2017) agree in their studies that Medicaid patients were experiencing better access to care, more acceptance by providers, reductions in delaying care, and increases in appointments. However, both authors' research was conducted in states that had expanded Medicaid. The recommendation for future researchers is to find a dataset belonging to a particular state of interest. This will help the researchers understand the laws and policies of that singular state that could influence the patients' access to care. Future researchers can also compare access between participants of different states (ones that have expanded Medicaid and ones that have not) to see if access care is similar or different.

This study's research population not only focuses on private and publicly insured patients, but also centered around a marginalized group of persons, in this case African Americans males. The purpose of this study is to find if the disparities that happen in privately and publicly insured patients would also be found in patients of marginalized groups. African Americans have a history of medical distrust among healthcare providers due to unfair practices, racial discrimination, and implicit and explicit bias (Colen et al., 2018; Lewis & Dyke, 2018). Similarly, future researchers can use other minority groups (Native American, Asian-Pacific Islander, Hispanics, Indians, etc.) in the United States to search for disparities within other marginalized groups. This would help researchers understand if race is still a factor in accessing care for minorities. Conversely, future researchers could compare with populations that are not marginalized to find disparities access to care by type of insurance as well. These findings in this research might explain a different factor outside of race that could contribute to the relationships between type of health insurance and access to care.

The last recommendation for this study is towards access to care. For this study, the research uses access to care factors acceptability and availability to determine if disparities are present between public and privately insured African American males, 25-64, with chronic conditions. It might benefit future researchers to look towards the other access to care factors (affordability, accommodation, and accessibility) to determine if disparities occur in those areas as well.

Implications for Professional Practice and Social Change

There are key moments from this study that have strong implications for the professional practice as a health care discipline. These effects can also lead to positive social change for the culture of the hospital and the community it serves. Current research has the ability to create conditions that would institute longstanding policies against experiences of discrimination as well as the continued reduction of disparities between types of health insurances. Moreover, it is will also aid in informing marginalized groups and patients with non-prioritized insurance coverages that the threats of disparities are seeming to decline amongst private and publicly insured patients are experiencing access to care at the same rates. The implication for professional practice is in why the research needed to be conducted.

While profit and non-profit hospitals have certain standards that are needed to keep their hospitals running, insurance-based biases can have negative effects for patients and should not impede quality care for individuals with non-prioritized insurance. Instead, hospitals should try and create a culture of equity, even amongst staff members, to mitigate discriminatory practices. Creating this culture can include a myriad of solutions such as, quarterly meetings with staff members on implicit and explicit bias, a pledge of non-discrimination towards patients with different insurances, provide opportunities for all patients the chance for preventive services (regardless of insurance and when appropriate) and reinforce the idea that patients with the greatest need will be served first. Additional solutions maintain that insurance-based questions and information can be asked after a service is performed and exit surveys can be used to evaluate patients' satisfaction and service. Administrators can use these surveys to determine which areas need improvement and to regularly see if there are differences amongst the patients' experience when accessing care within their healthcare system.

To generate social change, mitigating these biases can help promote positive health seeking behaviors. Creating equitable opportunities for communities to access care will create better health outcomes for populations that have experienced discrimination due to insurance type. Publicly insured patients are less likely to be offered preventive services and acceptance by a provider, leading them to forgo care. Additionally, African American men are cited as being discriminated against more than their white and Hispanic counterparts, and are more likely to delay care, miss appointments, and generally have negative experiences in a healthcare setting. Both publicly insured patients and African American men experiences are generally due to implicit or explicit bias by staff members. Regular research and data analytics can help identify problems within a healthcare system and help reverse the effects of access to care limitations on African American men and publicly insured patients. It should be the desire of healthcare systems to alleviate stigma surrounding of any forms of discrimination. This might include providing surveys and analyzing data yearly, having exit surveys in outpatient settings, and open the conversations towards access to care and experiences of disparities with

African American men and publicly insured patients.

Conclusion

The purpose of this quantitative retrospective descriptive comparative study was to determine the relationship between type of health insurance (public and private) and access to care (acceptability and availability) among African American males, 25-64 with chronic conditions. While healthcare systems need revenue to stay in working order, the literature shows that insurance can be a dividing factor in a patient’s ability to be seen by providers. As seen in Andersen’s Healthcare Utilization model, the ability to access care is fundamentally difficult for those who are poor, have chronic conditions, minorities, and those with public insurance. The literature shows two opposing views on the gap between public and privately insured patients. The first is that there are great disparities between public and privately insured patients including: not being seen by a provider, not being offered preventive services, and appointments given at a time in a more distant future for publicly insured patients. The second view is that the gap between public and privately insured patients is closing in states that have expanded Medicaid under similar circumstances (acceptance by providers, appointments scheduled in shorter times, etc.). The research in this study adds to the literature and provides meaningful data that both public and privately insured patients are accessing care at the same rates in a positive way, showing gap closure. Without understanding specific locations of patients in the research, there is no way to prove that the gap has lessened in states that did not expand, showing need for further research. The study also shows that there is not a statistically significant relationship between type of health insurance and access to care measures acceptability and availability among African American males, 25 to 64, with chronic conditions. However, the research here is specific to this study, and presents that there still might be other barriers in accessing care, beyond the scope of this study. This study seeks to encourage healthcare systems and administrators to creating equitable practices that would sustain positive health seeking behaviors, positive health outcomes and opportunities to advance the lifespan and decrease the onset of early chronic conditions for African American males and publicly insured patients.

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