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Lobbying Impact: Assessing the Effects of Lobbying on Healthcare Access for Minority Communities

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Lobbying Impact: Assessing the Effects of Lobbying on Healthcare Access for Minority Communities

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ABSTRACT

The United States healthcare system suffers from significant flaws stemming from the absence of universal healthcare and entrenched systemic racism, resulting in a predominantly market-driven approach to healthcare provision. Unfortunately, this has created barriers that disproportionately limit access to healthcare for minority communities. The unequal healthcare landscape reflects the culmination of disparate health policies and social determinants of health. Moreover, the influence of large corporations and Washington's K Street on the legislation through lobbying further exacerbates these systemic disparities. This paper aims to explore the impact of lobbying on healthcare access for minority communities by analyzing two bills. By identifying the emerging trends in each bill, one of which successfully transitioned into law, we can better understand the relationship between healthcare access for minority communities and lobbying.

INTRODUCTION

The relationship between healthcare access and lobbying is crucial in determining whether Americans have healthcare access. Based on a National Health Interview survey from 2019-2023, 24.5 million Americans experience restricted access to healthcare and do not have health insurance coverage (Cohen & Martinez, 2023, 1). The same report highlights that the percentage of uninsured adults among White and Asian adults was lower than that among Black and Hispanic adults (Cohen & Martinez, 2023, 5). People without insurance are less likely to have a primary care provider and often cannot afford necessary healthcare services (Health Care Access and Quality). Thus, minority communities (referred to as Black and Hispanic individuals in this paper) are disproportionately affected.

Based on previous research, this impact is due to the structural differences in the social determinants of health caused by years of oppression and systemic racism. Racism, as defined by the American Psychological Association, permeates various levels of our institutions, manifesting internally, interpersonally, and systemically. This systemic racism has left a mark on our nation's health, influencing health policies and perpetuating disparities in healthcare access, particularly for minority communities. Moreover, the fragmented nature of the U.S. healthcare system exacerbates these disparities, leaving uninsured individuals navigating a labyrinth of inconsistent programs and inflated costs. A book by Dr. Marty Makary, *The Price We Pay - What Broke American Health Care and How To Fix It*, explores the elucidation of opaque pricing practices within the healthcare sector and exposes how uninsured individuals are further marginalized, grappling with medical debt and barriers to accessing health care.

Moreover, lobbying's influence plays a significant role in shaping healthcare policies and often perpetuates systemic inequalities. Lobbying, as a practice protected by the First Amendment, includes efforts to influence legislators and policymakers. Based on the OpenSecrets database, the health sector has been the top spender for over twenty-five years, with a total reported spending of $11,987,819,004 from 1998 to 2023 (OpenSecrets). Pharmaceutical companies, healthcare organizations, and professional associations wield significant influence through lobbying efforts, shaping legislative agendas and policy outcomes.

This paper explores the literature gap between health care access, lobbying, and minority communities. To begin, it explores the existing literature in these areas. Further, it analyzes the two legislative bills, America's Affordable Health Choices Act of 2009 (H.R. 3200) and the Patient Protection and Affordable Care Act, to assess the impact of lobbying on health care access for minority communities. Through this analysis, the paper aims to unravel the trends connecting these domains and pave the way for further scholarly research.

RESEARCH QUESTION

The Healthcare sector spends millions of dollars annually attempting to influence congressional policymakers. However, minimal changes have been observed in addressing the social determinants of health, particularly healthcare access for minority communities. This paper explores the impact of lobbying on healthcare access for minority communities.

METHODOLOGY AND LIMITATIONS

Data collection regarding racial disparities in health care access was conducted using Bryant University Krupp Library Databases, JSTOR, and Google Scholar. An independent source for health policy research, polling, and journalism, The Henry J. Kaiser Family Foundation's website (kff.org) and the Office of Disease Prevention and Health Prevention website (health.gov) were also used to assess the literature on health care access for minority communities. Additionally, articles from various medical journals, such as PubMed and the American Journal of Medicine, were used to explore this literature. The books *The Price We Pay- What Broke American Health Care and How To Fix It* by Marty Makary and *The Social Determinants of Health: Looking Upstream* by Kathryn Strother Ratcliff also used to understand the current health care landscape and the social determinants of health. While researching to understand the relations, gaps in the literature were found, with limited articles making a connection between all three subjects explored in this thesis. This contributed to the limitations of connecting health care access, minority communities, and lobbying.

The case studies' development and analysis relied on information from federal bills available via Congress.gov. America's Affordable Health Choices Act of 2009 (H.R. 3200), the first bill analyzed, was obtained via the U.S. Government Printing Office (GPO), and the summaries of this bill were found on Congressional Research Services' website (crs.gov). The second bill, The Patient Protection and Affordable Care Act (H.R. 3590), was assessed via the GOP website, and the summaries of the bill were accessed via the Kaiser Family Foundation's website. Because of the extensive length of the bills, there was a significant dependence on their summaries, which could pose a limitation to this thesis.

Lobbying disclosures were obtained from the U.S. Senate's Office of Public Records databases and the nonprofit organization OpenSecrets. The number of lobbying reports on a particular bill was collected from OpenSecrets. Then, the U.S. Senate's Office lobbying disclosure database was used to access the quarterly lobbying disclosures filed by the lobbyist on behalf of the organization lobbying or the organization itself to conduct an in-depth analysis.

The analysis of lobbying disclosures proved to be a limitation during this research. Due to the limited scope of required lobbying disclosure requirements, these reports may only comprehensively cover some aspects of lobbying activities. Additionally, it was observed that there is a minimal number of disclosures specifically for one bill. Most lobbying disclosures include all the subject matters lobbied on during the quarter, making it difficult to conclude the expenditure on a specific bill. Because of those limitations, the exchange theory from the book *Lobbying and Policymaking: The Public Pursuit of Private Interests* by Ken Godwin, Scott Ainsworth, and Erik Goodwin is used to study the relationship between the bill and the influence of lobbying. Once the relation was developed using the resource-based exchange theory, the bill's impacts were assessed concerning the health care access for minority communities.

The thesis was exempt from the Bryant University Institutional Review Board as no data was collected from human participants, and the data were publicly available.

LITERATURE REVIEW

To conduct a thorough literature review for this thesis, it would be advantageous to explore three major areas of research: systemic racism, healthcare access, and lobbying. A deeper comprehension of the intricate dynamics at work can be acquired by conducting a detailed analysis of these domains.

Systemic Racism

Our nation, the United States of America, has been built on the racist roots and systemic oppression of people of color - 336 years of slavery and legal segregation. The American Psychological Association defines *racism* as "a form of prejudice that assumes that the members of racial categories have distinctive characteristics and that these differences result in some racial groups being inferior to others" (American Psychological Association 2022). It manifests in various organizations and occurs on multiple levels: internalized (the incorporation of racist attitudes, beliefs, or ideologies into one's worldview), interpersonal (interactions between individuals), and systemic (refers to racist values deeply embedded in the systems, laws, policies (written or unwritten), established beliefs, and attitudes) (Paradies et al. 2015). Analyzing systemic racism is crucial in understanding the factors that shaped our society and how they impact the nation's health.

According to Robert W. Terry's investigation of systemic racism, the social and institutional factors are defined through power relationships. These factors of racism include power (disproportionate capacity by which dominant groups make and enforce decisions), resources (influence on the distribution of critical resources such as money, education, and political power), standards (societal standards adopted by the dominant racial groups) and problems (the incorrect analysis of issues by the dominate white groups) resulting in unequal solutions. (Byrd and Clayton 2001, 135).

In American healthcare, racism, and its mediators have plagued the system since its origins, resulting in continuous unfair treatment and discrimination against people of color. The power and resources held by the legislature and large corporations delegate the health of Americans. Medical health measures only factor for a small amount of all that affects the nation's health.

John and Sonja McKinlay conducted a study to analyze the contributions of medical measures to declining death rates for nine common infectious diseases, all of which were associated with effective vaccines or other medical measures. The analysis found that the medical measures contributed little to the overall death rate, and only 3.5 % of the total decline could be ascribed to medical measures (McKinlay and McKinlay 1977, 425). According to the World Health Organization (WHO), studies suggest that social determinants of health (SDoH) contribute more significantly to health outcomes than lifestyle choices, biology, and genetics. The social determinants account for between 30% and 55% of the nation's health.

The World Health Organization (WHO) defines *Social Determinants of Health* as "the non-medical factors that influence health outcomes…the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (Integrating Social Determinants 2023, 11). Such conditions of life are determined by how the society is built and encompass economic, social, and political influences on health outcomes. Social determinants such as poverty, unequal access to health care, lack of education, stigma, and racism are also contributing factors to the nation's health (Hacker and Houry 2022, 1050). As we discuss the SDoH further, we must understand that determinants are not standalone factors and often coincide. For instance, one's quality of housing is impacted by poverty, as "housing poor people can afford is very likely to be unsanitary and unsafe. Apartments and houses may lack adequate heating or plumbing; they tend to have unsafe stairs… cockroaches or mice." (Ratcliff 2017, 30). Moreover, due to its limitations, this paper will zoom in on healthcare access as a social determinant of health.

Healthcare Access

As a social determinant of health, the healthcare system is influenced by and influences other determinants. One of the factors that the health sector influences is access to healthcare. *Access* to healthcare is defined as "the ability to use personal health services promptly in order to attain the most favorable health results" by the National Academies of Sciences, Engineering, and Medicine (previously known as the Institute of Medicine) (Institute of Medicine (US) Committee on Monitoring Access to Personal Health Care Services1993).

Lack of access to needed healthcare services is a significant challenge many individuals and communities face due to financial and resource-related barriers.

America lacks universal healthcare, which is present in all other industrialized countries; thus, Americans have no choice but to treat medical care like a market commodity and rationalize it based on their ability to pay (Ratcliff 2017, 26). This results in most uninsured people in America being from low-income families. Almost a quarter of nonelderly adults without coverage cited that they went without needed care (such as doctor visits, dental care, and medication) due to the cost. Further, the uninsured cited the main reason for the lack of coverage was the high insurance cost (Draker et al. 2023). The out-of-pocket medical care cost often leaves the uninsured and the poorly insured with medical debt, further promoting the resistance of needed care. Individuals without health insurance are less likely to obtain preventive care for long-term health problems such as cardiovascular disease, cancer, and diabetes (Institute of Medicine 2009).

Moreover, African Americans' access to healthcare is limited by systemic racism in employment, wealth, and income, which hinders their ability to purchase health insurance. (Yearby 2018, 1121). Disparities in coverage have persisted over time, and as of 2022, uninsured rates for nonelderly Native Hawaiians and Other Pacific Islanders were 12.7%, and the rate for African Americans was 10.0%, which was higher than the rate for their White counterparts (6.6%) (Artiga et al. 2024). Due to systemic racism in employment and income, minority groups are less likely to have employer-sponsored health insurance or can pay for healthcare not covered by insurance. This causes disparities in access to healthcare for minority communities.

Additionally, the US healthcare system is not organized as an integrated system but a patchwork of inconsistent healthcare programs, providers, and facilities, which makes it difficult for the uninsured to access needed care. In Dr. Marty Makary's book, *The Price We Pay: What Broke American Health Care — and How to Fix It,* he explains the how hospital officials inflate bills in order to generate revenue and the insurance companies pay a part of the sticker price through their negotiate discounts with the hospitals. However, this makes it impossible for uninsured people to know the price they will pay or if the service is worth the price they are charged. Additionally, if the uninsured patients fail to pay the inflated price, "they get sent to collections, which means they are hassled by debt collectors and have their credit ruined" (Makary 2019, 23). The lack of transparency of actual prices of healthcare care services aids the hospital and insurance sector's agenda and raises the cost, which creates another barrier to healthcare access.

This game, described by Marty, sheds light on the limitations faced by vulnerable populations when it comes to accessing healthcare due to the policies of hospitals and insurance companies. Addressing this social determinant of health requires navigating complex political and economic systems, including understanding policies and the lack thereof. A potent tool to gain insight into the interests of these organizations and their influence on policymakers and legislatures is lobbying.

Lobbying

Lobbying is a common practice in which individuals, groups, organizations, or companies attempt to influence government officials, legislators, or policymakers. This practice is typically undertaken to shape laws, policies, regulations, or government decisions that align with the lobbying entity's interests, goals, or preferences. The Internal Revenue Service (IRS) refers to lobbying as an attempt to influence legislation. According to the IRS, "an organization will be regarded as attempting to influence legislation if it contacts, or urges the public to contact, members or employees of a legislative body for the purpose of proposing, supporting, or opposing legislation, or if the organization advocates the adoption or rejection of legislation" (Lobbying 2023). Here, legislation includes action by Congress, any state legislature, or similar governing body regarding acts, bills, resolutions, or by the public in referendum, ballot initiative, constitutional amendment, or similar procedure (Internal Revenue Service 2023). Additionally, lobbying involves various forms of advocacy, communication, and persuasion to impact decisions made by government authorities and is impeded in American democracy.

Even though lobbying is not mentioned in the U.S. Constitution, it is protected by the First Amendment, which states that "Congress shall make no law respecting… abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances." This practice has been a part of American democracy for many years and started as written petitions to local government. However, as the government has grown, it has had to address more complex economic and political issues, which has left little room for direct interaction with its constituencies. Consequently, this has led to the emergence of numerous professional lobbying firms and associations. Those firms and associations use the power of economic resources and political networks to lobby (Holman 2006, 2). Furthermore, there are two types of lobbying commonly conducted by organizations: Direct and grassroots lobbying.

Direct lobbying focuses on influencing policymakers directly and is defined as a communication with a legislator, about a specific piece of legislation that expresses a view on that legislation. This method includes meeting with any member or employee of a legislative body or government official who may participate in the formulation of legislation, providing them with information, research, and arguments, and making persuasive presentations supporting specific positions or policies ("Lobbying Definitions"). On the other hand, grassroots lobbying refers to attempts to influence the legislation by influencing public opinion of the legislation and encouraging the public to take action (writing letters) to support the interest of the enterprise. Similar to direct lobbying, communication through the public must refer to and reflect a view on specific legislation (Internal Revenue Service 2023). It is important to understand that both types of lobbying significantly influence the legislative process and are important considerations when assessing its impact.

Further, *Lobbying and Policymaking: The Public Pursuit of Private Interests* by Ken Godwin, Scott Ainsworth, and Erik Goodwin discusses two theories of group influence on policymaking: neopluralism and exchange. These theories can aid in understanding the various ways in which lobbyists and interest groups influence policymakers. Neopluralism argues that there is competition among organized interest groups, with each side having sufficient resources to lobby successfully. The exchange theory emphasizes the relationship between legislators and organized interests. It assumes that political process participants engage in interactions aiming to enhance their economic, social, and political circumstances. Based on this theory, interest groups and lobbyists represent the policymakers with resources such as money, campaign volunteers, polling services, campaign consultants, and independent spending (Godwin et al.2013, 164). Moreover, it argues that two of the most important resources are information and the ability to monitor the policymaking process, both of which come with a major financial cost, and thus, "wealthier organizations, therefore, have a considerable advantage" (Godwin et al.2013, 36). However, it is important to note that both models are not mutually exclusive, and the models' predictions can be very similar if the organizations have the same number of resources.

All active registered lobbyists must file quarterly activity reports with the Clerk of the U.S. House of Representatives and Secretary of the U.S. Senate under the Lobbying Disclosure Act of 1995. These reports do not specify the type of lobbying activities in the firm but rather report the total spending on lobbying activities (OpenSecrets). A registered lobbyist refers to anyone who is paid to lobby, makes more than one contact with government officials, or spends at least 20 percent of their time on lobbying activities. These lobbyists either work in-house for large corporations or are hired by these corporations through lobbying firms and associations to represent their interests.

The main users of lobbying are typically businesses, pressure groups, and governments. Businesses often train lobbyists to gain education and knowledge so that they can have a say in government decision-making processes. Additionally, large interest groups and groups supported by larger corporations are more likely to participate in lobbying (de Figueiredo and Richter 2014, 165). Large corporations have more resources to lobby independently, whereas smaller corporations are likely to rely on trade associations. Various healthcare organizations lobby legislatures and government officials to influence health policies that affect access to healthcare along with aspects such as licensing and oversight, research priorities, and healthcare compensation.

Lobbying in American Healthcare

According to OpenSecrets, a nonpartisan and nonprofit research organization, the top sector spending on lobbying since 1998 has been the health sector, and they have spent an estimated $12 billion. The health sector spent approximately $553 million in lobbying expenditures in 2023. Pharmaceutical and health product companies contributed the highest amount on lobbying ($285 million), followed by health services/ health maintenance organizations (HMOs) ($96 million), hospital and nursing homes ($94 million), and health professionals ($70 million). Large organizations such as Blue Cross/ Blue Shield ($22 million), Pharmaceutical Research & Manufacturers of America ($21 million), American Hospital Association ($20 million), and American Medical Association ($15 million) were amongst the top ten lobbying spenders of 2023.

Between 2005 and 2023, health-related bills such as the Patient Protection & Affordable Care Act and America's Affordable Health Choices Act of 2009 were among the most lobbied. An increased lobbying expenditure will be noted as healthcare issues become more prominent. This is due to the finding that lobbying expenditure is likely to increase when the issues are more relevant or salient or there are budgeting activities during that period (de Figueiredo and Richter 2014, 166). For instance, there was a 12% increase in healthcare lobbying from 2008 to 2009, when bills such as America's Affordable Health Choices Act of 2009 and the Patient Protection & Affordable Care Act were introduced in the House of Representatives (OpenSecrets). The lobbying on these bills has a major impact on policies, among other factors, such as political alliances, campaign contributions, and research findings.

When examining the staggering costs associated with healthcare and their effects on those without insurance, it's crucial to consider the considerable lobbying expenses of healthcare organizations. These expenses showcase the organizations' keen interest in molding healthcare laws and regulations to safeguard their financial gain. Additionally, the power held by these organizations has implications on the social determinants of health and systemic racism in American healthcare.

The primary contribution of this thesis is an initial exploration of a significant gap in the literature regarding the connection between healthcare access and lobbying, particularly in minority communities. Despite the presence of various studies examining healthcare industry lobbying and research on the social determinants of health within minority populations, there exists an absence of scholarly literature on how lobbying activities within the healthcare sector impact healthcare access within minority communities. Therefore, this thesis serves as provocative research to bridge the gap by offering an initial exploration of this complex connection between the three subjects.

CASE 1: AFFORDABLE HEALTH CHOICES ACT OF 2009

The Affordable Health Choices Act of 2009 (H.R. 3200) was introduced in the U.S. House of Representatives on July 14, 2009. It was introduced as a part of an effort of the Democratic Party to enact health care reform during the first session of the 111th Congress. The bill was referred to the Committee on Energy and Commerce and reviewed by the Committees on Ways and Means, Education and Labor, Oversight and Government Reform, and the Budget. The House passed it in November of 2009; however, it was not enacted into law. The bill's original purpose was "To provide affordable, quality health care for all Americans and reduce the growth in health care spending and for other purposes" (America's Affordable Health Choices Act of 2009, 2). This bill aimed to address the unmet healthcare needs of medically underserved areas. It was divided into three divisions, further broken into titles and subtitles.

Division A is Affordable Health Care Choices and discusses four titles: protections and standards for qualified health benefits plans, health insurance exchange and related provisions, shared responsibility, and amendments to the Internal Revenue Code of 1986. The general purpose of this division was to provide affordable, quality healthcare for all American citizens and to reduce the growing healthcare expenditures. Additionally, it aimed to build on the established healthcare system and repair the broken aspects. These broken aspects included the equal access of care, cost-of care and the discriminatory policies that restrain the quality of care of the minorities. As discussed in the literature review, these broken aspects stem from the SDoHs' disparities. The division also encouraged vital insurance market reform and initiatives to share healthcare access responsibility among workers, employers, and the government. It advocated for creating a new Health Insurance Exchange that would provide a public health insurance option, private plans, and cooperatives and would be headed by a commissioner. The Exchange was designed to be a transparent marketplace for individuals or businesses to purchase health insurance from competing private or public health plans. This would have played a vital role in helping the minority population needing assistance acquire affordable insurance knowledge. Lastly, this division also instituted health delivery system reforms to increase quality and reduce spending so that health care becomes more affordable for businesses, families, and the government. Overall, the primary objectives of Division A of H.R. 3200 include decreasing the number of uninsured individuals, restructuring the private health insurance market, establishing minimum standards for health benefits, extending financial assistance to specific individuals, and providing aid to small employers where applicable (Congressional Research Service 2009).

Division B is in regard to Medicare and Medicaid Improvements and reviews the nine titles: improving health care value, Medicare beneficiary improvements, promoting primary care, mental health services, and coordinated care, quality, Medicare graduate medical education, program integrity, Medicaid and CHIP, revenue-related provisions and miscellaneous provisions. The purpose of this division was to provide provisions related to Medicare Parts A & B, Medicare Advantage Reforms, Improvements to Medicare Part D, and Medicare Rural Access Protections. Title II focused on improving and simplifying financial assistance to low-income Medicare beneficiaries and reducing health disparities. Other purposes of the division included improving nursing home transparency, quality measurements, physician payments, sunshine provision, and public reporting on healthcare-associated infections. Furthermore, the division also focuses on increasing funding to fight waste, fraud, and abuse and advocating for Medicaid and health reform.

Division C is Public Health and Workforce Development and has five titles: community health centers, workforce, prevention and wellness, quality and surveillance, and other provisions. It contains provisions to increase primary care and public health workforce, promote preventive services, and strengthen quality measurement (Binder et al. 2009, 2). This division advocated for the creation of a public health insurance option. This option would have been available to individuals and small businesses and provided an alternative to private health insurance plans. It also advocated establishing health insurance exchanges to make it easier for individuals and small businesses to purchase coverage and set new standards for insurance companies to ensure all Americans have access to affordable and comprehensive health insurance.

Overall, H.R. 3200 was a comprehensive and ambitious attempt to improve and expand healthcare coverage in the United States—the bill aimed to improve one of the social determinants of health (healthcare access). Expanding the Medicaid coverage and creating the Exchange Marketplace program would have presented the opportunity for these communities to improve the access to care. As mentioned above, it focused on reducing the number of uninsured individuals, which would increase healthcare access for minority communities. The bill would have created a national health insurance exchange with plans available to all legal residents. Every individual in the United States would have been required to purchase insurance, and employers would be required to offer insurance to all employees, with some exceptions for smaller businesses. Throughout the case study, we will discuss the detailed implications of this bill on minority communities.

However, the bill's critics believed that H.R. 3200 would do more harm than good as it increased government involvement in the healthcare process. It faced harsh criticism from media outlets, and institutions feared it would turn to socialized medicine due to extreme government control, which could lead to healthcare rationing. The critics also worried about the potential costs associated with implementing this bill, particularly for taxpayers and the federal government. Furthermore, they believed that the bill would have negative consequences for small businesses, potentially burdening them with increased healthcare costs and regulatory requirements (Salins 2009). The opinions on the legislation varied, thus it is important to assess the attempts made to influence the legislation to tilt the healthcare reform towards the organization or the clients' interests.

Organizations that Attempted to Influence the Legislation.

Since the introduction of H.R. 3200, over a thousand organizations registered to lobby for this bill (OpenSecrets). Lobbying was critical in shaping the legislation and determining the bill's fate. Due to the lack of required reporting specifications for lobbying activities, it is unknown which organizations were for or against the bill or what they wanted included in it, or changes they wanted to make. The organizations used in this analysis are the ones that specify their opinion on H.R. 3200. These organizations include the American Hospital Association and the American Medical Association. Some associations filed more specific issue reports for this bill, such as Blue Cross/Blue Shield (43 specific issue reports); however, they are excluded from this analysis as their lobbying expenditure is not included in the healthcare sector.

American Hospital Association (AHA) is the national organization representing and serving all types of hospitals, healthcare networks, and their patients and communities. AHA was founded in 1898, and it aims to get its members' perspectives and needs heard and addressed in national health policy development legislative and regulatory debates. It mentions on its website that "AHA provides education for health care leaders and is a source of information on health care issues and trends." (About the AHA 2024) AHA is a resource-rich organization with 27 subsidiaries and has spent $525,121,249 since 1998.

The association filed 22 specific issue reports, according to the OpenSecrets database, which mentioned H.R. 3200 in 2009 and 11 in 2010. Only ten reports were filed specifically for the Affordable Health Choices Act of 2009, which created a limitation in finding the definite expenditure for this specific bill. Additionally, only a limited number specified their position on the bill. However, according to an article published on OpenSecrets, one of the reports from AHA "opposed proposal to expand Medicare under the public option… Advocated in favor of non-profit, non-governmental co-op and opposed other public options proposals including the opt-out proposals" (Mbeckel 2010). As mentioned in the literature review, according to the exchange model of group influence on policy, "organized interests 'buy' policies by providing resources to policymakers in exchange for favorable policy decisions." (Godwin et al. 2008, 25). Using this theory, the conclusion can be drawn that AHA's opposition to the expansion of Medicare could have influenced the alterations made to the H.R. 3200 by the committees responsible for this bill.

The second organization is the American Medical Association (AMA), the largest national association representing physicians and specialty medical societies in courts and legislative bodies across the nation. Its mission, as stated on its website, is "to promote the art and science of medicine and the betterment of public health" (About 2024). Along with the American Hospital Association, this organization has been a top lobbying spender since 1998 and has invested $504,434,500 in lobbying activities. This organization has five subsidiaries: California Medical Association, Massachusetts Medical Society, Florida Medical Association, Texas Medical Association, and Kentucky Medical Association.

The American Medical Association filed 12 specific issue reports in 2009 and four in 2010 regarding H.R. 3200. Again, only five bills exist with only issues about H.R. 3200. The lobbying reports do not specify the AMA's position on the bill. However, a document published by the organization, titled *AMA Support for H.R. 3200*, states that the organization supports some aspects of the bill and is working with the members of the House of Representatives to seek changes: "As is typical with very large bills, it contains many provisions that we wholeheartedly support, others that concern us, and still other provisions that we want to see changed. We plan to continue refining those elements inconsistent with our policy as the legislative process progresses" (AMA SUPPORT 2020, 1). While the AMA supported the bill, it continuously worked with the House members to amend the bill to put themselves in a favorable position. This underscored the AMA's commitment to advocating for changes aligned with the policy goals, potentially impacting minority communities. The policy goals of AMA mentioned in their report released include maintaining key insurance market reforms, reducing "regulatory burden that detract from patient care and increase costs," and ensuring "that Medicaid, Children's Health Insurance Program (CHIP) and other safety net programs are adequately funded" (Key AMA 2017). By applying the exchange theory, it becomes apparent that the resources invested by the AMA in this legislative process likely influenced the eventual changes to H.R. 3200 in a manner that aimed to benefit the organization. Their influence could have led to the bill's demise or helped shape the Patient Protection and Affordable Care Act.

In conclusion, the American Hospital Association and the American Medical Association demonstrated significant efforts to influence the Affordable Health Choices Act of 2009. These organizations aimed to advance their interests through lobbying activities and engagement with legislators. Utilizing the exchange theory of group influence, it is evident that the substantial resources invested by AHA and AMA likely played a crucial role in influencing the outcome of H.R. 3200, highlighting the relationship between organizations and the policy-making process. This influence eventually impacts the SDoHs, specifically healthcare access, for minority communities as discussed in the section below.

How does it Affect the Minority Communities?

The failure to pass H.R. 3200 had positive and negative implications for the minority community in the United States. As mentioned above, the legislation aimed to expand access to healthcare and improve affordability, which would have directly benefited many minority individuals and families who often face disproportionate barriers to healthcare access due to systemic racism in healthcare. However, there would have been individuals who would have lost their current access to healthcare due to the denial of the Medicare Advantage (MA).

One of the central components of H.R. 3200, Division D, was the proposal to broaden Medicaid eligibility, extending coverage to more individuals and families with low incomes. Such an initiative held the potential to offer crucial support to minority communities living in poverty. Based on a report by the U.S. Census Bureau released in 2022, Black individuals constituted 13.5% of the overall population. Yet, they accounted for a significantly higher proportion, 20.1%, within the poverty population. Similarly, Hispanic individuals, representing 19.3% of the total population, disproportionately comprised 28.4% of those in poverty population (Shrider and Creamer 2023, 5). This shows that despite constituting a smaller segment of the total US population, these minority communities are disproportionately affected by poverty. Thus, expanding to encompass low-income individuals and families would have been a critical step toward providing healthcare access to those affected by poverty. It would have improved one aspect of the SDoH, which impacts the minority community.

Furthermore, Division C advocated for allocating funding for prevention and public health initiatives to address disparities in chronic diseases, such as diabetes, heart disease, and cancer. Diabetes rates for Black (16%) and Hispanic (12%) individuals are higher when compared to the rates of White individuals (11%). Moreover, black (12%) adults have a higher rate of asthma compared to white (10%) adults, and black children (17%) are twice as likely to have asthma. Further, there is a higher likeliness for a black individual to die from a chronic condition: "Black people were more than twice as likely as White people to die from diabetes, and Black people were more likely than White people to die from heart disease" (Artiga et al. 2023). The initiatives outlined in H.R. 3200 were geared towards promoting healthy behaviors, expanding access to preventive services, and confronting the healthcare aspect of SDoH. By setting aside funds for these important initiatives, H.R. 3200 aimed to strengthen efforts to reduce the impact of chronic diseases on minority communities. This approach to healthcare access would have played a crucial role in providing the minority community with preventative care they currently lack.

While focusing on the negative consequences of not passing the legislation, it's essential to acknowledge that the bill could have also negatively affected minority community members. Based on a news article released by the Committee on Ways and Means, Section 1161 of H.R. 3200, only an estimated 8 million seniors could enroll in the Medicare Advantage (MA) program. The MA is a healthcare plan offered by private companies and approved by Medicare. It provides protection against high out-of-pocket costs, free preventive care, and cancer screening. In 2009, the Congressional Budget Office (CBO) indicated that the number of seniors enrolled in the plan would increase to 14 million. However, Section 1161 called for Medicare cuts, which would only allow 8 million seniors to be enrolled in these plans in 2019. This disproportionately would impact the minority community as, according to another article released by the committee, "Hispanic and African-American seniors are most likely to choose MA over the traditional Medicare program" (Democrats' H.R.3200 2009). This is due to their lower likelihood of having employer-based coverage to supplement traditional Medicare. Thus, if the bill had passed, it would have increased the disparities in healthcare access for seniors within minority communities.

Overall, H.R. 3200 aimed to expand Medicare coverage, potentially aiding the minority communities facing poverty. Census data reveals disproportionate poverty rates among Black and Hispanic individuals and families; thus, this expansion would have been favorable for minority communities. Division C of the bill also proposed funding for preventative and public health initiatives targeting prevalent chronic diseases among minorities, which would have positively impacted the community. However, Section 1161's Medicare cuts limited enrollment in the Medicare Advantage plan, which would have exacerbated the healthcare disparities and impacted them negatively. This failure to pass this bill had mixed implications for the minority community. Despite the negative impacts of this bill, it was used as a starting point for healthcare reform, and its elements of proposals were incorporated into future bills such as the Patient Protection and Affordable Care Act.

Conclusion

The Affordable Health Choices Act of 2009 aimed to expand healthcare coverage (which would improve healthcare access), control healthcare costs, and improve the quality of care. The bill proposed several key provisions, including establishing a public health insurance option, mandates for individuals to have health insurance coverage, and requirements for employers to provide health insurance to their employees or contribute to the cost of coverage. Furthermore, based on the exchange theory, the bill was heavily influenced by groups such as the American Medical Association and American Hospital Association due to the magnitude of these associations and the abundance of resources at their disposal. The impact of these associations, along with the 1037 other registered organizations, is a probable cause for the alternations made to the bill and the failure of the bill. Moreover, the failure of the bill had mixed impacts on the communities. The bill promoted the expansion of Medicare and provided funding for preventative and public health initiatives, which would have improved healthcare access for minority communities. Still, some aspects of the bill, such as Section 1161, would have negatively impacted them. Overall, the extensive lobbying on H.R. 3200 had mixed implications on healthcare access for the minority community.

CASE 2: PATIENT PROTECTION AND AFFORDABLE CARE ACT

H.R. 3590, Patient Protection and Affordable Care Act (ACA), was introduced in the House of Representatives on November 7, 2009, as H.R. 3962 under the title "Affordable Health Care for America Act." It passed the House vote with a 220-215 majority. Later, it was amended and introduced in the Senate under the title "America's Healthy Future Act" (S. 1796). After significant negotiations and revisions between the House and the Senate, a reconciled bill was passed in the House with a 219-212 vote and in the Senate with a vote of 60-39. It was signed into law by President Barack Obama on March 23, 2010. The law also became known as Obamacare.

Obamacare is a comprehensive healthcare reform law aimed at expanding access to health insurance, implementing consumer protections, and controlling healthcare costs in the United States (The Patient Protection and Affordable Care Act 2009, 2). H.R. 3590 contains ten titles addressing different aspects of healthcare reform. Titles I and II, of the ACA primarily focus on health care access, which are titled *Quality, Affordable Health Care for All Americans,* and *The Role of Public Programs,* respectively. Due to the length of ACA and the focus of this thesis on healthcare access, the above are the titles explored and analyzed.

Title I, *Quality, Affordable Health Care for All Americans,* consists of numerous sections, subsections, and parts and is central to the law's goals of expanding access to health insurance coverage, implementing consumer protection, and improving the overall quality and affordability of healthcare services in the United States. Systemic insurance market reform is one of the main goals of this title, which advocates for eliminating discriminatory practices such as pre-existing condition exclusion. The law ensures that all Americans are a part of the system and must have coverage. Additionally, tax credits were provided to individuals and families to ensure insurance affordability. The immediate improvements, supposed to be implemented in 2010, included eliminating lifetime and annual limits on benefits, assisting those uninsured because of pre-existing conditions, requiring coverage of preventative services and immunizations, developing uniform coverage documents to ensure accurate compatibility, etc. This title prohibited insurance companies from denying coverage or setting rates based on health status. Furthermore, it also required the new American Health Benefit Exchange to provide benefit options standardized for easy comparison and require one simple enrollment form. Moreover, states can establish basic health plans for lower-income individuals not enrolled in Medicaid. Refundable tax credits are available for Americans between 100 and 400 percent of the federal poverty line. However, undocumented immigrants are not ineligible for premium tax credits. Credit is also available to small businesses with fewer than 25 workers to assist with premium costs. Lastly, this title required individuals to maintain minimum essential coverage or pay a penalty. Employers also faced penalties for not offering coverage or if their offered coverage was deemed unaffordable or inadequate.

Title II, *The Role of Public Programs* and *Strengthening Quality,* of the law expands public healthcare programs, primarily Medicaid and the Children's Health Insurance Programs (CHIP), with the goal of increasing coverage for low-income individuals and families. It improves Medicaid services and provides new options for long-term services and support. It expands the eligibility criteria and funding (through federal responsibility) for these programs to provide healthcare access to those who may not otherwise be able to afford it. States could start Medicaid expansion on January 1, 2011, and were required to have a significant expansion by January 1, 2024, covering individuals with family incomes up to 133 percent of the federal poverty. For CHIP, states were required to maintain income eligibility levels through September 30, 2019, and the states would receive a 23-percentage point increase in the CHIP federal match rate. Furthermore, hospitals can provide Medicaid services during a presumptive eligibility period. The law also allowed states to offer community-based attendant services and support to those with mental disabilities who would otherwise require care in a hospital, nursing facility or intermediate care facility. Lastly, the title required the Federal Coordinated Health Care Office to integrate care under Medicare and Medicaid and provide dual eligibility for individuals enrolled in both programs.

Organizations that Attempted to Influence the Legislation.

The Patient Protection and Affordable Care Act has been amongst the top 20 most lobbied bills since 2005. One thousand two hundred forty-eight organizations have registered to lobby on this bill, and many organizations (such as Blue Cross/Blue Shield and Pharmaceutical

Research & Manufacturer of America) have filed over 50 lobbying reports concerning H.R. 3590. The organizations explored in the thesis (American Hospital Association and American Medical Association) fall closely behind the top lobbyists, with 63 lobbying reports filed between them. The American Hospital Association filed 16 lobbying reports in 2009, 23 in 2010, five in 2011, and 3 in 2013, all of which mentioned H.R 3590. The American Medical Association filled seven and five reports concerning this bill in 2009 and 2010, respectively.

According to the lobbying reports on OpenSecrets and the U.S. Senate's Office lobbying disclosure database, only nine of 47 lobbying reports filed by AHA were specifically for the issues relating to H.R. 3590. The other 38 reports mentioned several other bills, which limited the possibility of curating a specific expenditure of this bill. However, as discussed in Case 1, AHA is a resource-rich organization, and based on the exchange theory, it impacted the bill. An article by Antoon Spithoven discusses the impacts of AHA's lobbying on the bill and states that the organization had a mixed effect on the bill. The positive impact of the lobbying effort was "the expansion of Medicaid eligibility, the temporary removal of Medicare hospital payment from the mandate of the Independent Payment Advisory Board (IPAB)" (Spithoven 2016, 634). He also mentioned the negative impact on the hospitals, including Medicare spending reductions after 2019, penalties on readmissions, and bundled payments. The organization's lobbying significantly impacted the bill through exchange theory, and the implications of the legislation can be observed through Spithoven's research.

The second organization analyzed was the American Medical Association, which filed 12 lobbying disclosures that mentioned this bill. Despite the relatively fewer reports than other organizations, the AMA's lobbying effort affected various provisions of Obamacare. These included higher Medicare payments for the 'outlier' physicians, smaller reductions of Medicare enrollment fees for doctors, and revoking public opinion (Spithoven 2016, 634). AMA argued that public opinion would push private insurers out of the market, creating healthcare centralization and reducing consumer choices. Based on the AMA's advocacy for "appropriate payment to physicians under the Medicaid program" (Key AMA 2017), the best outcome for them was physicians not having to pay for the reform through reimbursement costs and the House leaders' agreement to address Medicare's growth in a separate legislation (the adoption of Public Law No.114-10 in 2015). AMA's lobbying efforts failed to address a handful of policies that the AMA opposed, which included the evaluations of alternatives to tort litigation, accountable-care organizations, and physician-quality reporting. Overall, the impact of AMA on the legislation is evident in Spithoven's research. The exchange theory can also conclude that they invested resources in the bill, which helped achieve policy changes that favored AMA and its clients' interests.

In conclusion, the Patient Protection and Affordable Care Act has been a focal point the K-street and lobbying organization since its introduction. With over a thousand organizations lobbying on this bill, it is evident that the healthcare sector has monitored and influenced the bill since its development. The American Hospital Association and the American Medical Association stand out among the top lobbyists making significant impacts on various provisions of H.R. 3590. Despite the challenges of curating specific expenditures, Spithoven's article and the exchange theory showcase these organizations' influence on the bill. Both organizations established a variety of policy goals, making an impact on the bill and, in turn, the minority communities. Overall, the exchange theory also shows the investment of resources by AHA and AMA, shaping policy changes that align with their respective interests. Due to the significant influence, it is essential to examine how the bill's provisions affect the minority communities, shedding light on the disparities and challenges they face concerning healthcare access.

How does it Affect the Minority Communities?

Since the inception of the Patient Protection and Affordable Care Act, there have been vast improvements in the states that have implemented Medicare expansion along with other provisions of the law. Early post-ACA showed positive improvement concerning the impact on healthcare access among minority communities. Based on an article published in 2016, more than 15 million individuals have enrolled in Medicaid and CHIP since the enrollment under this legislation. Moreover, based on an article released by the Obama Foundation in 2023, the coverage expanded to "approximately 4 million Latinos and 3 million Black

Americans since 2010 when the ACA was enacted" (13 Years 2023). H.R. 3590's enactment has significantly improved healthcare access for minority communities.

Various research studies have been conducted since the law's enactment to assess its impact on minority communities. This law aimed to expand healthcare coverage, which is a determinant factor in access to healthcare. An issue brief by KFF, which reviewed 65 studies examining the impacts of Medicaid expansion by race/ethnicity, shows that 24 studies found that expansion was associated with improved healthcare access for Black and Hispanic individuals (Guth et al. 2020). Moreover, the Commonwealth Fund's issue brief released in 2023 states that the uninsured rate for adults in minority communities fell after the Medicaid expansions, with rates falling for Hispanic adults by 15.7 percentage points and for Black adults by 10.9 points. The gap between white and Black adults narrowed to 5.3 percentage points in 2013 from 9.9 percentage points in 2021. The uninsured rate has decreased in states that implemented the ACA's Medicaid expansion and those that did not; however, the coverage gains were greater in the states that expanded Medicaid programs. Moreover, a study found that the coverage disparities in the private insurance sector were greater, and despite minority communities being more likely to have public insurance, there was an increase in private insurance coverage for Black and Hispanic individuals (Buchmueller et al. 2016, 1417). Overall, the increase in coverage improved the SDoH of healthcare access for minority communities and impacted them positively.

Additionally, as discussed in the literature review, cost plays a significant role for minority communities and was stated as one of the barriers to healthcare access as a quarter of the uninsured adults went without needed care due to the cost. The ACA has played a vital role in reducing cost-related access problems for Black and Hispanic individuals. Based on the Commonwealth Fund's issue brief, the percentage of Hispanic adults who said they avoided care due to the cost has dropped by 9.5 percentage points. The percentage of Black adults has dropped by 9.0 points (Baumgarter et al. 2020). The ACA improvements have not completely improved the cost-related access problems, as Black and Hispanic adults had much higher cost-related access problems. Still, it has narrowed the disparities as these groups have reported fewer cost-related problems after 2019. Black-white disparities due to cost dropped from 8.1 to 4.7 percentage points, and Hispanic-white disparities dropped from 12.7 to 8.9. Cost-related access problems have declined significantly; however, more systemic approaches can be taken to reduce the existing disparities.

Despite the ACA's efforts to reduce disparities in healthcare access for low-income individuals, it falls short in states where Medicaid expansion is not adopted. These states include Florida, Georgia, Kansas, Mississippi, South Carolina, Wisconsin, and Wyoming. In states such as Georgia, a significant portion of the population (43%) encompasses Black and Hispanic populations (Population Distribution 2023). Expanding Medicaid under ACA would help reduce the racial disparities, as seen in the states implementing it. The law falls short in such instances and fails to address the overall healthcare disparities for the minority population.

In conclusion, implementing the Patient Protection and Affordable Care Act has significantly improved healthcare access for minority communities across the United States, particularly in states that adopted Medicaid expansion and other key law provisions. Enrollment in Medicaid and CHIP has increased, with millions of Black and Hispanic Americans gaining coverage since the ACA's enactment. Research studies have highlighted the positive impacts of Medicaid expansion on healthcare access for minority communities, with declines in uninsured rates and cost-related access problems. While progress has been made in narrowing disparities, minority communities continue to face changes in states where expansion was not adopted, leaving substantial portions of the population without the benefits of improved healthcare access. Addressing these disparities will require continued efforts to expand Medicaid coverage and implement systemic approaches to reduce barriers for minority communities.

Conclusion

The goal of Obamacare was to expand healthcare coverage, improve healthcare affordability, and enhance the quality and efficiency of healthcare in the United States. The law's provisions related to healthcare access, Quality, Affordable Health Care for All Americans, and The Role of Public Programs aimed to expand access to health insurance coverage by establishing health insurance marketplaces and expanding eligibility for Medicaid in participating states. The provisions also aimed at controlling healthcare costs and providing incentives for preventative care to reduce long-term healthcare expenses. American Hospital Association and American Medical Association participated in lobbying efforts to support their interests in the legislation's provisions. They successfully achieved some of their intended goals, which altered the law in their interest. Using the exchange theory, the resources and information provided by these organizations and other major organizations determined the final law passed and enacted by President Barack Obama. The enactment of the bill into law had various positive implications in reducing the racial disparities relating to healthcare access due to insurance coverage and cost-related issues in the states that implemented it. Overall, the lobbying on H.R. 3590 had positive implications for minority communities regarding expanding Medicaid coverage and reducing problems relating to healthcare access.

CONCLUSION

Overall, both the Affordable Health Choices Act of 2009 and the enactment of the Patient Protection and Affordable Care Act (ACA), show the complex relationship between healthcare policy, lobbying efforts, and their impacts on minority communities. While the Affordable Health Choices Act aimed to expand coverage, control costs, and improve care quality, its failure highlighted the significant lobbying by organizations such as the American Medical Association (AMA) and American Hospital Association (AHA). This has mixed implications for healthcare access for minority communities. Moreover, the Affordable Health Choices Act of 2009 was a blueprint for the Patient Protection and Affordable Care Act. ACA goals of expanding coverage, improving affordability, and enhancing healthcare quality resulted in positive implications for minority communities, particularly in the states that expanded Medicaid coverage, The lobbying efforts of AMA and AHA still impacted the bills' provisions, as discussed in Case 2, however, the enactment of ACA marked progress in reducing racial disparities in healthcare access and addressing cost-related issues. Establishing a direct connection between these bills and lobbying is not possible due to the limited information disclosed regarding lobbying efforts, still, we can draw the above conclusion through the exchange theory. To address this limitation, future research could dive deeper into the lobbying landscape, regarding healthcare access for minority communities, to study the influence of various interest groups.

REFERENCES

"13 Years of the Affordable Care Act." Obama Foundation, March 25, 2023. https://www.obama.org/stories/13-years-aca/.

"About the AHA: AHA." American Hospital Association, 2024. https://www.aha.org/about.

"About." American Medical Association, 2024. https://www.ama-assn.org/about.

"Access to Health Services." Access to Health Services - Healthy People 2030. Accessed April 2, 2024. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services.

"AMA SUPPORT FOR H.R. 3200." American Academy of Sleep Medicine – Association for Sleep Clinicians and Researchers, July 20, 2020. https://aasm.org/clinical-resources/scoring-manual/.

America's Affordable Health Choices Act of 2009. Bill, The U.S. Government Printing Office (GPO) § (2009). https://www.govinfo.gov/content/pkg/BILLS-111hr3200ih/pdf/BILLS-111hr3200ih.pdf.

Artiga, Samantha, Latoya Hill, and Anthony Damico. "Health Coverage by Race and Ethnicity, 2010-2022." KFF, January 11, 2024. https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/.

Baumgarter, Jesse C., Sara R. Collins, David C. Radley, and Susan L. Hayes. "How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care." How ACA Narrowed Racial Ethnic Disparities Access to Health Care | Commonwealth Fund, January 16, 2020. https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access.

Binder, Cliff, Paulette C. Morgan, Jennifer Staman, Patricia A. Davis, and Holly Stockdale. "Medicare Program Changes in H.R. 3200, America's Affordable Health Choices Act of 2009." EveryCRSReport.com, September 11, 2009. https://www.everycrsreport.com/reports/R40804.html.

Buchmueller, Thomas C., Zachary M. Levinson, Helen G. Levy, and Barbara L. Wolfe. "Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage." American journal of public health, August 2016. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4940635/.

Byrd, W. M., and L. A. Clayton. "Race, Medicine, and Health Care in the United States: A Historical Survey." Journal of the National Medical Association, March 2001. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2593958/.

Cohen, Robin A., and Michael E. Martinez. "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–June 2023." Centers for Disease Control and Prevention, January 1, 2023. https://stacks.cdc.gov/view/cdc/134757.

Congressional Research Service, H. R. Chaikind, Private health insurance provisions of H.R. 3200 §. R40724 (2009).

Congressional Research Service, Stephen Redhead, Andrew R. Sommers, Kristen J. Colello, Ramya Sundararaman, Elayne J. Heisler, Cliff Binder, et al., public health, workforce, quality, and other provisions in H.R. 3200 §. R40745 (2009). https://crsreports.congress.gov/product/pdf/R/R40745/4.

"Democrats' H.R. 3200 Disproportionately Harms Low-Income and Minority Seniors." House Committee on Ways and Means, September 17, 2009. https://waysandmeans.house.gov/democrats-h-r-3200-disproportionately-harms-low-income-and-minority-seniors/.

"'Direct' and 'Grass Roots' Lobbying Defined." Internal Revenue Service. Accessed April 2, 2024. https://www.irs.gov/charities-non-profits/direct-and-grass-roots-lobbying-defined.

Drake, Patrick, Jennifer Tolbert, and Anthony Damico. "Key Facts about the Uninsured Population." KFF, December 18, 2023. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

Figueiredo, John M. de, and Brian Kelleher Richter. "Advancing the Empirical Research on Lobbying." *Annual Review of Political Science* 17, no. 1 (May 11, 2014): 163–85. https://doi.org/10.1146/annurev-polisci-100711-135308.

Godwin, Ken, Scott H. Ainsworth, and Erik Godwin. *Lobbying and Policymaking: The Public Pursuit of Private Interests*. Thousand Oaks, California: Sage/CQ Press, 2013.

Guth, Madeline, Samantha Artiga, and Olivia Pham. "Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care." KFF, September 30, 2020. https://www.kff.org/medicaid/issue-brief/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care/.

Hacker, Karen, and Debra Houry. "Social Needs and Social Determinants: The Role of the Centers for Disease Control and Prevention and Public Health." *Public Health Reports* 137, no. 6 (September 9, 2022): 1049–52. https://doi.org/10.1177/00333549221120244.

"Health Lobbying Profile: Lobbyists." OpenSecrets. Accessed April 2, 2024. https://www.opensecrets.org/federal-lobbying/sectors/lobbyists?cycle=2023&id=H.

Holman, Craig. "Origins, Evolution and Structure of the Lobbying Disclosure ..." Public Citizen, May 11, 2006. https://www.citizen.org/wp-content/uploads/ldaorigins.pdf.

Institute of Medicine (US) Committee on Monitoring Access to Personal Health Care Services. Edited by Michael Millman. Access to health care in America, January 1, 1993. https://doi.org/10.17226/2009.

"Integrating the Social Determinants of Health into Health Workforce Education and Training." World Health Organization, 2023. https://www.who.int/publications-detail-redirect/9789240064256.

"Key AMA Policies Related to Health Reform." American Medical Association, September 2017. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/strategic-focus/AMA-policies-health-reform.pdf.

"Lobbying Definitions, Exceptions, and Examples." Duke Government Relations. Accessed April 2, 2024. https://govrelations.duke.edu/ethics-and-compliance/lobbying-definitions-exceptions-and-examples#:~:text=Direct%20Lobbying%3A%20Any%20attempt%20to,but%20only%20if%20the%20principal.

"Lobbying." Internal Revenue Service, December 4, 2023. https://www.irs.gov/charities-non-profits/lobbying.

Makary, Marty. The Price We Pay: What broke American Health Care--and how to fix it. New York, New York: Bloomsbury Publishing, 2021.

Mbeckel. "Public Option in National Spotlight, but Rarely in Details of Lobbying Reports." OpenSecrets News, March 22, 2010. https://www.opensecrets.org/news/2010/02/public-option-in-national-spot.

McKinlay, John B., and Sonja M. McKinlay. "The Questionable Contribution of Medical Measures to the Decline of Mortality in the United States in the Twentieth Century: Milbank Quarterly." The Milbank Memorial Fund Quarterly, June 14, 2019. https://www.milbank.org/quarterly/articles/the-questionable-contribution-of-medical-measures-to-the-decline-of-mortality-in-the-united-states-in-the-twentieth-century/.

Ndugga, Nambi, Latoya Hill, and Samantha Artiga. "Key Data on Health and Health Care by Race and Ethnicity." KFF, March 15, 2023. https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/.

Paradies, Yin, Jehonathan Ben, Nida Denson, Amanuel Elias, Naomi Priest, Alex Pieterse, Arpana Gupta, Margaret Kelaher, and Gilbert Gee. "Racism as a Determinant of Health: A Systematic Review and Meta-Analysis." PLOS ONE 10, no. 9 (September 23, 2015). https://doi.org/10.1371/journal.pone.0138511.

Patient Protection and Affordable Care Act, The U.S. Government Printing Office (GPO) § (2009). https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf.

"Population Distribution by Race/Ethnicity." KFF, October 27, 2023. https://www.kff.org/other/state-indicator/distribution-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D.

"Racism, Bias, and Discrimination." American Psychological Association, November 2022. https://www.apa.org/topics/racism-bias-discrimination.

Ratcliff, Kathryn Strother. The Social Determinants of health looking upstream. Newark, New Jersey: Polity Press, 2017.

Salins, Ted. "Letters to the Editor: Many Small Businesses Don't Endorse HR 3200." Richmond Times-Dispatch, August 25, 2009. https://richmond.com/news/letters-to-the-editor-many-small-businesses-dont-endorse-hr-3200/article_0cd1bfed-ba64-52f6-8cd4-af13dc95ff27.html.

Shrider, Emily A, and John Creamer. "Poverty in the United States: 2022," September 2023.

"Social Determinants of Health." World Health Organization. Accessed April 2, 2024. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

Spithoven, Antoon. "Vested Interest's Influence over Health Care Legislation in the United States in 2009-2010." American Economic Association, January 5, 2016. https://www.tandfonline.com/doi/full/10.1080/00213624.2016.1179073.

Yearby, Ruqaiijah. "Racial Disparities in Health Status and Access to Healthcare: The Continuation of Inequality in the United States Due to Structural Racism." The American Journal of Economics and Sociology 77, no. 3–4 (May 2018): 1113–52. https://doi.org/10.1111/ajes.12230.