they incorporated some aspects of holistic review into the admissions process. Beyond rethinking admissions policies, cultural competency training for faculty may also help colleges better serve black male students who are preparing for medical careers. Such training, which teaches faculty members to understand and appreciate cultural differences, has been recognized as an important tool in helping minority male students achieve their educational goals (http://1.usa.gov/1RIq3Vp).

**Need for Diversity in Medicine**

Increasing the racial and ethnic diversity of students entering medical school is important for 2 reasons, Nivet said. First, as the country becomes more racially diverse, it will become more important to have a physician workforce that mirrors the US population (http://1.usa.gov/IM3diky). In fact, ensuring cultural sensitivity of the health care workforce is one of the objectives listed in the federal Healthy People 2020 initiative to help eliminate health disparities (http://1.usa.gov/IMcBIIy). That’s because nonwhite and poor individuals are more likely to have health conditions such as diabetes and cardiovascular disease, and minority physicians more often opt than their white peers to care for racial and ethnic minority patients in medically underserved areas, noted a Health and Human Services report (http://1.usa.gov/1tfOAoW). In fact, 54.6% of black medical school students plan to practice in underserved areas compared with 36% of Latino students, 21.4% of white students, and 19.4% of Asian students, according to the AAMC’s 2012 report on diversity in medical education (http://bit.ly/1PgFOiC).

“Sometimes patients want a provider who looks like them, understands them, and may have grown up in a similar neighborhood,” Nivet said.

Second, it’s also important not to waste the talents of black men, Nivet noted. “We can’t afford to have any large segment of the population not reaching their full potential.”

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**The JAMA Forum**

**A Healthy Living Wage**

Andrew Bindman, MD

During the next year of presidential campaigning, candidates’ positions on their support of or opposition to the Affordable Care Act (ACA) will become shorthand for their health care policy. Ever since the ACA’s passage without any Republican votes in either chamber of Congress, the law has been a lightning rod of partisan politics and a political dividing line. But the candidates’ minimum wage policies may actually have a more substantial effect than their support of the ACA on the rates of health insurance coverage and population health during their time in office.

**Expanding Coverage**

The ACA has already had an enormous effect on expanding health insurance coverage, with an estimated 17.6 million people (http://1.usa.gov/1RIq9fH) gaining coverage as a result of its passage. This has occurred primarily through an expansion of Medicaid coverage and the establishment of state and federal health insurance exchanges, or marketplaces.

In the 30 states that have expanded Medicaid, individuals with incomes below 133% of the Federal Poverty Level (FPL) qualify for Medicaid coverage. In 2015, this corresponds to an annual income of less than $15,556 for an individual (http://bit.ly/1RIq9fH). Federal subsidies are also available in all states to support eligible individuals with incomes up to 400% of the FPL to purchase health insurance coverage through marketplaces. In the Medicaid expansion states, a person with an income above the Medicaid eligibility threshold and less than 400% of the FPL qualifies for these subsidies. In states that have not expanded Medicaid, federal subsidies to purchase insurance through a marketplace are available for those with incomes above 100% of the FPL ($11,670 in 2015).

Even with the federal financial support for coverage expansion as a part of the ACA, more than 30 million Americans still lack health insurance. Although the Congressional Budget Office anticipated that it would take time to fully implement...
the law, there are signs that it will be diffi-
cult to achieve the original estimate that the
ACA would expand coverage to 32 mil-
on uninsured Americans (http://1.usa.gov
/1M609aE).

One barrier is the 20 states that have re-
fused to expand Medicaid. This leaves an es-
timated 3 million individuals, 43% of whom
reside in Texas and Florida, living in poverty
without the benefit of Medicaid coverage
(http://kaiserf.am/1FUROTX).

Another concern is that many eligible in-
dividuals are not pursuing insurance for
themselves and their family members
through either a marketplace or by accept-
ing employer-based coverage. There were 71
million uninsured individuals who did not
take advantage of federal subsidies to pur-
case health insurance through a market-
place in 2015 (http://kaiserf.am/1OI0w0q),
and federal officials do not anticipate signifi-
cant growth in coverage through market-
places in the year ahead (http://1.usa.gov
/1VUvhp7).

Wages and Employer-Sponsored
Coverage
Employer-based coverage is the main way
that most Americans obtain health insur-
ance, but the Kaiser Family Foundation
estimates that 4.9 million uninsured indi-
viduals did not accept the option of cover-
age from an employer in 2015. The deci-
sion to forego employer-sponsored
coverage or to purchase coverage through
a marketplace is highly related to a work-
er’s income level.

More than 80% of uninsured individu-
als (http://kaiserf.am/19BJGeq) are in fami-
lies with at least 1 working adult, but the in-
come in the majority of these uninsured households is less than 200% of the FPL be-
cause the workers are being paid at or near
the federal minimum wage. A 40-hour per
week job for 52 weeks at the current mini-
num wage of $7.25 results in an annual in-
come of $15,080, which corresponds to
129% of the FPL for an individual and only
63% of the FPL for a family of 4.

Advocates for a living wage have pro-
moted raising the minimum wage to a level
that can enable working families to achieve
a safe and decent style of living indepen-
dent of the complex matrix of public assis-
tance programs (http://bit.ly/1M8aAsm). An
increasing number of cities are recognizing
the importance of ensuring that workers are
paid a living wage and are taking steps to in-
crease the minimum wage, sometimes quite
substantially, above the federal require-
ment. For example, Birmingham, Alabama;
Chicago, Illinois; Los Angeles, California;
San Francisco, California; Santa Fe, New
Mexico; and Seattle, Washington, have al-
ready implemented minimum wage require-
ments of $10 per hour or more (http://bit.ly
/1M602hp). Expanding this local policy
approach to a national level through a
change in the federal minimum wage could
have a substantial effect on health care
coverage.

Based on national estimates, raising the
hourly minimum wage from $7.25 to
$10 would increase a full-time employee’s
annual salary by approximately $5000
(http://bit.ly/1Wz0QBq) and increase the
likelihood that the employee would accept
employer-sponsored coverage from 37% to
58%. Raising the hourly minimum wage to
$15, as Los Angeles plans to do by 2020,
will increase the annual income of a full-
time employee to more than $31,000 and
the likelihood to 77% that the employee
will elect to accept employer-sponsored
insurance.

A higher minimum wage will also make it
possible, depending on household size, for
a greater number of individuals who are not
offered employer-based coverage to earn
enough to qualify for subsidies to purchase
coverage through a marketplace (Figure).
This is particularly important in southern
states that have not expanded Medicaid cov-
verage and where a disproportionate num-
ber of the working poor reside.

The shift in coverage from Medicaid to
the marketplace would tend to reduce a
state’s contribution toward the costs of
health care coverage for its residents. For
example, California’s planned statewide
increase in the minimum hourly wage to
$10 is estimated to result in state-related
Medicaid savings of $200 million per year
(http://bit.ly/1Fm6KJ), and a proposal to
increase the statewide minimum hourly
wage to $13 would result in state-related
Medicaid savings of $600 million per year.

Individuals who qualify for Medicaid un-
der the current hourly federal minimum
wage of $7.25 may end up paying more for
coverage through employer-sponsored in-
surance or through an insurance market-
place. But they are still likely to come out
ahead with a raise in the minimum wage
(http://bit.ly/1PfoYYy), even after paying
some additional amount for coverage.

Socioeconomic Status and Health
Independent of its effect on health care cov-
verage, a higher socioeconomic status is posi-
tively associated with health benefits. An
analysis of the proposal to raise California’s
minimum wage to $13 per hour suggested
that it would reduce smoking, obesity, and
related chronic diseases, as well as lead to
lower rates of depression and bipolar ill-
ness. These health benefits of raising the
minimum wage would also contribute to pre-
venting the premature deaths of hundreds
of lower-income Californians each year (http:
//bit.ly/1MaXsYi).

The main argument of critics who op-
pose raising the minimum wage is that it will
hinder job growth. They argue that busi-
nesses may be more reluctant to hire new
employees at a minimum wage higher than
the current one. The data suggest this may
not be the case (http://bit.ly/1RlrS4x), but
even if true, one has to ask whether grow-
ing jobs at the current federal minimum
wage is a healthy long-term strategy for our
population.

During the upcoming election cycle,
candidates will offer differing opinions on the
merit of raising the minimum wage (http:
//huff.to/1LOi3y3). Democratic candidates
appear to be leaning toward raising it, whereas
Republican candidates look to maintain the status quo or eliminate the re-
quirement altogether. The election’s out-
come will affect whether the country moves
from a minimum wage toward a living wage
that can provide financial security against
health care costs and deliver improve-
ments in health.

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