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://bit.ly/1OiUtOW).

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/1M3diky). 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/1McBILs). 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." ■

The JAMA Forum

A Healthy Living Wage

Andrew Bindman, MD

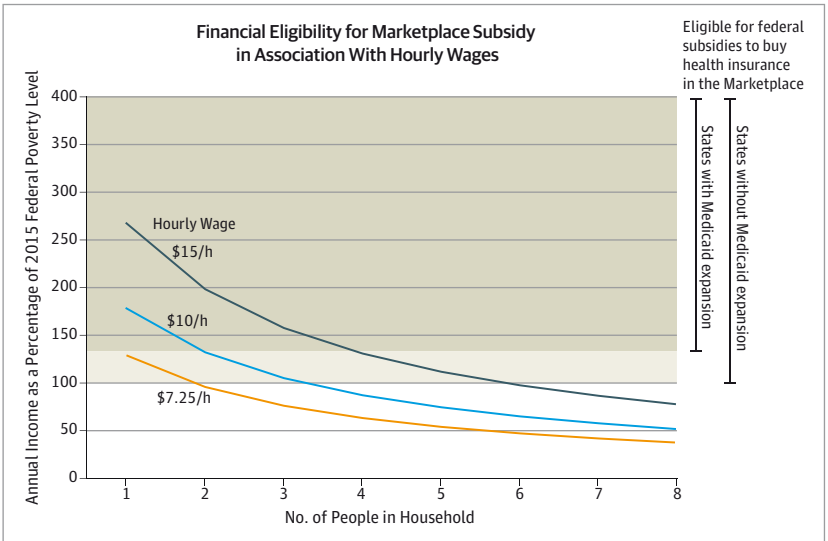
During the next year of presidential campaigning, candidates' positions on their support of or opposition to the Affordable Care Act (ACA) will become shorthand for their health care policy. Ever since the ACA's passage without any Republican votes in either chamber of Congress, the law has been a lightning 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/1RIq3Vp) 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



Annual incomes for each wage level were calculated based on working 40 hours per week and 52 weeks per year. Dollar values of 2015 Federal Poverty Levels are available at http://obamacarefacts.com/federal-poverty-level.

the law, there are signs that it will be difficult to achieve the original estimate that the ACA would expand coverage to 32 million uninsured Americans (http://1.usa.gov/1M609aE).

One barrier is the 20 states that have refused to expand Medicaid. This leaves an estimated 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 individuals are not pursuing insurance for themselves and their family members through either a marketplace or by accepting employer-based coverage. There were 7.1 million uninsured individuals who did not take advantage of federal subsidies to purchase health insurance through a marketplace in 2015 (http://kaiserf.am/1OiOwoq), and federal officials do not anticipate significant growth in coverage through marketplaces 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 insurance, but the Kaiser Family Foundation estimates that 4.9 million uninsured individuals did not accept the option of coverage from an employer in 2015. The decision to forego employer-sponsored coverage or to purchase coverage through a marketplace is highly related to a worker's income level.

More than 80% of uninsured individuals (http://kaiserf.am/19BJGeq) are in families with at least 1 working adult, but the income in the majority of these uninsured households is less than 200% of the FPL because the workers are being paid at or near the federal minimum wage. A 40-hour per week job for 52 weeks at the current minimum wage of $7.25 results in an annual income 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 promoted raising the minimum wage to a level that can enable working families to achieve a safe and decent style of living independent of the complex matrix of public assistance programs (http://bit.ly/1MBaAsm). An increasing number of cities are recognizing the importance of ensuring that workers are paid a living wage and are taking steps to increase the minimum wage, sometimes quite substantially, above the federal requirement. For example, Birmingham, Alabama; Chicago, Illinois; Los Angeles, California; San Francisco, California; Santa Fe, New Mexico; and Seattle, Washington, have already implemented minimum wage requirements of $10 per hour or more (http://bit.ly/1M60zhp). 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/1WszObQ) 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 coverage and where a disproportionate number 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/VFm6KJ), 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 under the current hourly federal minimum wage of $7.25 may end up paying more for coverage through employer-sponsored insurance or through an insurance marketplace. But they are still likely to come out ahead with a raise in the minimum wage (http://bit.ly/1PfoYVY), even after paying some additional amount for coverage.

Socioeconomic Status and Health

Independent of its effect on health care coverage, a higher socioeconomic status is positively 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 illness. These health benefits of raising the minimum wage would also contribute to preventing the premature deaths of hundreds of lower-income Californians each year (http://bit.ly/1MaXsYI).

The main argument of critics who oppose raising the minimum wage is that it will hinder job growth. They argue that businesses 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/1RIrS4x), but even if true, one has to ask whether growing 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/1LOl3y3). Democratic candidates appear to be leaning toward raising it, whereas Republican candidates look to maintain the status quo or eliminate the requirement altogether. The election's outcome 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 improvements in health. ■

Author Affiliation: Professor of medicine, health policy, epidemiology and biostatistics at University of California, San Francisco (UCSF). He is the founder and director of the University of California Medicaid Research Institute, a multicampus research program that supports the translation of research into policy, and a member of the National Academy of Medicine.

Corresponding Author: Andrew B. Bindman, MD (abindman@medsfgh.ucsf.edu)

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