



*In October 2012, Linda J. Blumberg, an economist and senior fellow at the Health Policy Center of the Urban Institute, presented a seminar at IRP on “Implementation of the Affordable Care Act: Early Experiences in Ten States.” Her talk drew a large crowd of faculty and students from across campus over a range of disciplines, and sparked considerable discussion. This brief extends Blumberg’s talk to include a look at the pre-reform health care system as well as examination of the ways in which low-income families stand to benefit from the Affordable Care Act (ACA) reforms.*

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## The Affordable Care Act: What does it do for low-income families?

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A group of health economists, policy scholars, and practitioners conducted a study in 2008 that examined the approximately 10,000 low-income, uninsured adults in Oregon who were selected by lottery and given a chance to apply for public health insurance. The state had opened a previously closed waiting list for a limited number of spots in its Medicaid program for poor adults, and drew names from the 90,000 people who signed up. Known as the Oregon Health Insurance Experiment, the study presents a unique opportunity to gauge how expanding access to public health insurance affects the health care use, financial strain, and health of low-income adults using a randomized controlled design (the gold standard in social science research).<sup>1</sup>

In the year after random assignment by lottery, the treatment group (comprising those who were given the opportunity to apply for Medicaid) was about 25 percentage points more likely to have insurance than the control group (comprising those not given a chance to apply for Medicaid). The authors found increases in hospital, outpatient, and prescription drug utilization; greater compliance with recommended preventive care; and declines in exposure to substantial out-of-pocket medical expenses and medical debts. They also found evidence of better self-reported physical and mental health, perceived access to and quality of care, and improved overall well-being.<sup>2</sup>

In another study, Jack Hadley reviews health services research in an attempt to answer the question: Does having health insurance improve health? He notes that much of the debate over providing health insurance for the uninsured focuses on cost and strategy, and, while important considerations, the question of whether having health insurance actually improves health also should be considered. From a more pragmatic perspective, good health is an important part of human capital, which leads to improved educational attainment, higher productivity, and greater labor force participation. Hadley states, “As such, improved health can potentially increase incomes, increase tax revenues, and reduce government spending for disability and other health-related transfer programs.” Hadley concludes, “Health services research conducted over the past 25 years makes a compelling case that having health insurance or using more medical care would improve the health of the uninsured. Corroborating process studies find that the uninsured receive fewer preventive and diagnostic services, tend to be more severely ill when diagnosed, and receive less therapeutic care.”<sup>3</sup>

Both Hadley’s review and the Oregon experiment make a compelling case for the benefits of having health insurance, which health care reform seeks to ensure for most Americans. This brief explores how the Patient Protection and Affordable Care Act of 2010, commonly referred to as the Affordable Care Act (ACA), reforms the U.S. system of health insurance and, specifically, how it affects low-income families. It begins with a brief description of the pre-reform health care landscape, identifying those hurt most by it, and goes on to describe and assess the reform, which is grounded in private insurance coverage, encourages employer-based

## Major U.S. Efforts to Provide Health Care for the Poor Since 1900

- 1900–1935: Medical care assistance provided ad hoc by civic and religious groups, primarily to “deserving poor”
- 1935–1945: Social Security Act passed, rise of public hospitals and clinics for the poor, beginning of two-tiered system of medical care
- 1945–1965: Private insurance coverage expands, setting the stage for Medicaid
- 1965: Medicare and Medicaid implemented
- 1984–1990: Expansion of Medicaid
- 1990s: Efforts to slow Medicaid spending growth, waivers, and welfare reform
- 1997: Creation of the State Children’s Health Insurance Program (CHIP)
- Early 2000s: Efforts to control Medicaid spending growth and state experiments to expand options for poor people
- 2010: Passage of a comprehensive health care reform bill called the Patient Protection and Affordable Care Act (ACA)

**Source:** Katherine Swartz, “Health care for the poor: For whom, what care, and whose responsibility?” *Focus* 26(2): 69–74, Fall 2009; with ACA update.

insurance for non-elderly adults, and expands eligibility for public insurance for the lowest-income uninsured. The ACA affects providers, consumers, and taxpayers.

### Pre-reform health care in the United States

In their primer on the pre-reform U.S. health care system and their assessment of reform, Robert Haveman and Barbara Wolfe identify eight major problems. The pre-reform system: (1) leaves many Americans uninsured (over 18 percent of the non-elderly population); (2) constrains access to care; (3) presents problems with the private insurance system that preclude coverage; (4) has high health care costs (over 16 percent of GDP); (5) has regressive and inefficient financing arrangements; (6) provides coverage for items traditionally not insured, including dental and eye care, which drives up costs; (7) allows private insurance carriers to deny coverage to people with “pre-existing conditions” and to cap lifetime coverage; and (8) leaves areas across the nation where access to medical care is limited, typically low-income and rural areas.<sup>4</sup>

While the problems described by Haveman and Wolfe have the potential to affect everyone, regardless of income, the pre-reform health care system leaves low-income families especially vulnerable. Of the many implications of this disadvantage, perhaps the most devastating are the ways in which poor health affects the ability to work and learn. In addition, as Katherine Swartz notes, “There is no doubt that poverty is a contributing factor to poor health outcomes. Poor people have lower life expectancies, a higher prevalence of chronic illnesses and health conditions, and more unmet health needs than do people with middle-class and high incomes.” Swartz also notes that cause and effect move in both directions, with poor health being a contributing factor to low income and poverty.<sup>5</sup>

#### Who is covered?

More than half of non-elderly Americans—148.7 million individuals (55.8 percent of the total population)—obtained

health insurance through their own or a family member’s employer in 2011.<sup>6</sup> American families that lack a regular full-time worker, such as many single-parent families and those headed by elderly or disabled persons, and many employees of small firms, are not offered employer-based health insurance. Some low-income families without job-related insurance rely on Medicaid, a federally sponsored but state-based insurance program. The Children’s Health Insurance Program (CHIP) is another public program, focused on providing coverage for low-income children ineligible for Medicaid. In 2011, about 47 million Americans, including over 27 million children, received insurance under the Medicaid and CHIP programs.<sup>7</sup> However, only a portion of low-income adults are currently eligible for Medicaid. About 15 million non-elderly people who lack coverage through the workplace purchase non-group health insurance. Active duty military service members, National Guard and Reserve members, retirees, their family members and survivors, and certain former spouses receive free or federal-government-subsidized medical and dental care, most of which falls under a managed care program known as “TRICARE.”<sup>8</sup>

Individuals age 65 or older, regardless of income or medical history, receive health care coverage from the Medicare program, a federal health insurance program that was created in 1965.<sup>9</sup> In late 2011 Medicare covered 49 million Americans. In conjunction with Social Security, it helps provide financial security to seniors and younger beneficiaries with permanent disabilities. Medicare is financed by a combination of general revenues (42 percent), payroll taxes (37 percent), beneficiary premiums (13 percent), and other sources. Many people with Medicare buy supplementary insurance to cover the patient cost sharing required by the program. Most low-income elderly—21 percent of beneficiaries—are covered by a combination of Medicare and Medicaid.<sup>10</sup>

Children in low- to moderate-income families who are ineligible for Medicaid may be covered by the newest public program, the Children’s Health Insurance Program (CHIP), which, like Medicaid, is a joint state-federal program. Income eligibility guidelines for CHIP differ by state, as is the case with Medicaid. The federal government pays a higher

**Table 1**  
**Declining Rates of Employer-Sponsored Health Insurance, 2000–2010**

	2000	2010	Total Change	Change Attributable to the Economy	Change Attributable to Other Factors
Overall	69.3%	58.8%	-10.6%	-3.7%	-6.7%
Parents	75.7	65.5	-10.2	-3.4	-6.5
Childless Adults	67.3	57.6	-9.6	-3.7	-5.8
Children	66.7	55.0	-11.6	-3.3	-8.2

**Source:** Urban Institute, 2011. Based on data from the 2001–2011 Annual Social and Economic Supplement to the Current Population Surveys.

share of costs for CHIP than for Medicaid to encourage states to set more generous eligibility standards. States can also obtain waivers to cover parents under CHIP, although such coverage is at lower levels of federal matching support. In 2010, 7.7 million people were enrolled in CHIP.<sup>11</sup>

### Who is not covered?

The pre-reform health care system leaves a significant number of Americans with no health insurance at all, 18.5 percent of the population in 2010.<sup>12</sup> Non-elderly adults without dependent children who lack access to employer-sponsored health insurance (ESI) have the fewest options, since they are the least likely to be eligible for public insurance. The uninsured, especially the near poor, are at risk for high out-of-pocket medical costs that increase poverty and in extreme cases cause medical bankruptcy.<sup>13</sup>

The uninsured population has grown and diversified over the past decade—which included two recessions and saw increases in health insurance premiums that continued to outpace income growth—during which there were significant changes in both employer offer and employee take-up behavior. In a brief analyzing coverage trends overall and among parents, adults without dependent children, and children, Fredric Blavin and colleagues find that over the past decade, from 2000 to 2010, rates of ESI steadily deteriorated across these populations, with more substantial declines occurring among lower-income groups, as depicted in Table 1.<sup>14</sup>

### High out-of-pocket costs for insured and uninsured

Researchers at the Health Policy Center of the Urban Institute convened a meeting in 2005 that included actuaries, insurance industry professionals, public policy analysts, economists, representatives of high-risk pools, and representatives of advocacy groups for those with specific illnesses. In a report that includes ideas and insights shared at the meeting, Linda Blumberg and colleagues examine ways to lower financial burdens and increase health insurance coverage for persons with high medical costs.

They found substantial evidence that chronically ill individuals and others with high health costs face substantial financial burdens, even when they have health insurance. Examining out-of-pocket financial burdens of low-income adults with high medical costs, Blumberg and colleagues found that out-of-pocket payments among low-income adults accounted for

10 percent of income, 16 percent of income when proxies for health insurance premiums are included. For those with non-group coverage, out-of-pocket burdens are at least double that of those with employer-sponsored insurance. Not surprisingly, the burden on low-income uninsured individuals and families with high-cost medical conditions is greatest, with nearly 25 percent of them reporting forgone care due to financial burden.<sup>15</sup>

## The Affordable Care Act (ACA)

This brief describes the major problems with the pre-reform U.S. health care system, including lack of health insurance coverage for 18.5 percent of the non-elderly population; high premiums and copayments for the insured; and the decline in employer-sponsored insurance. These problems affect most Americans, with the most egregious consequences for low-income individuals and families. To address these and other shortcomings in the existing health care system, on March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was enacted. The ACA constitutes comprehensive reform of the U.S. health care system that will have transformative effects on public and private health insurance coverage.

Enactment of the ACA brings extraordinary opportunities for greater security, affordability, adequacy, and equity in health insurance coverage. However, it also faces very substantial hurdles in both political and practical realms. These include the challenges of implementing substantial changes to the Medicaid program, significant reforms of private health insurance market regulations, development of new systems for delivering subsidies and enrolling individuals in coverage, creating greater transparency, and promoting efficiency in the delivery of health care. States will play a vital role in the implementation of these reforms and in the design of specific aspects of the changes. The timeline below shows key features of the ACA by year.<sup>16</sup>

### How does the ACA improve access to health insurance?

The primary focus of the ACA is to increase health insurance coverage and health care access for citizens and legal immigrants. The federal law is expected to transform public and private health insurance coverage, operation of health care markets, affordability and accessibility of insurance, and fi-

nancing of medical care. Some of the reforms were effective the year of enactment, others are being phased in; all will be in place by January 1, 2014.

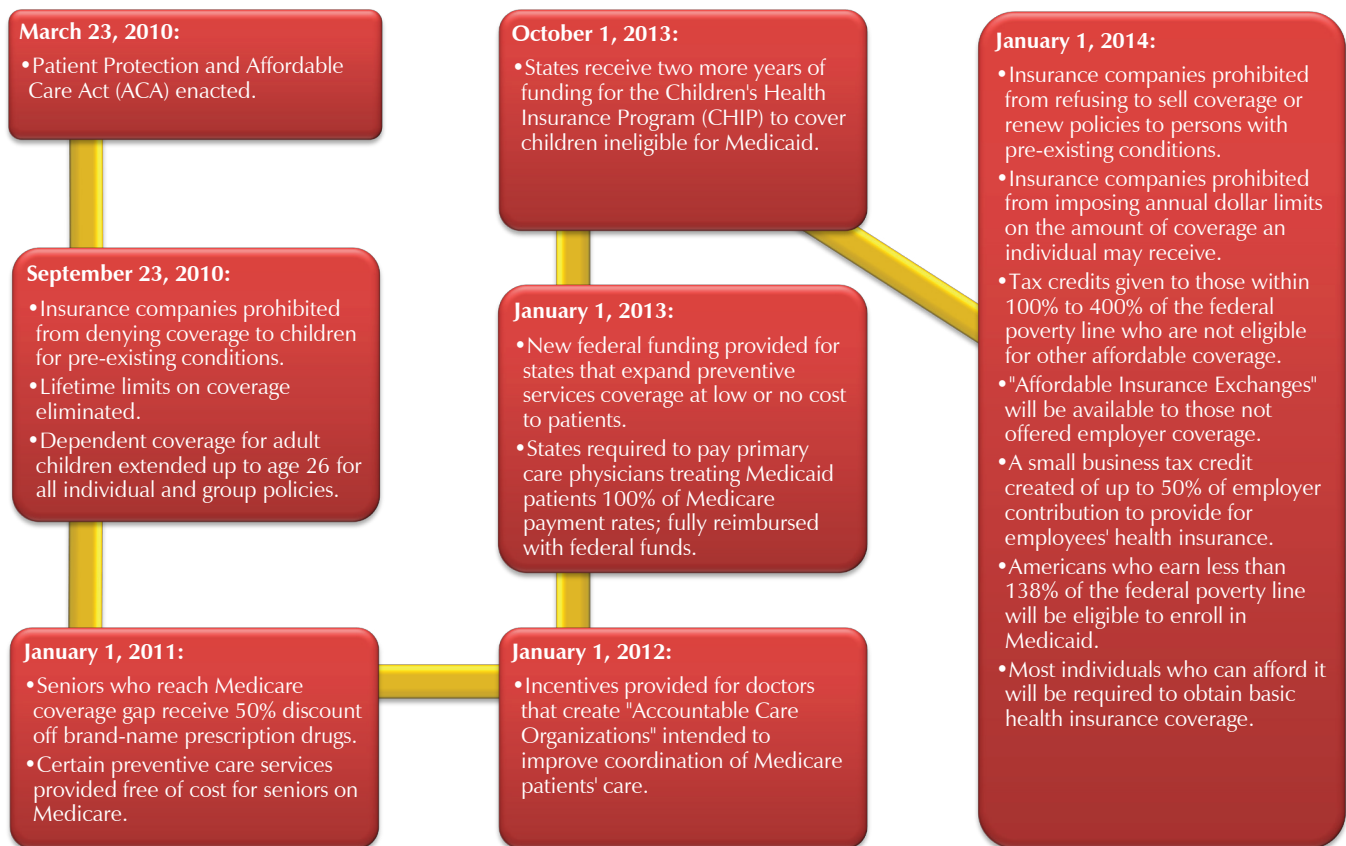
Major components of the ACA include:

- Extensive private health insurance regulatory reforms, particularly in the small group and non-group markets;
- Tax credits to the smallest lowest-wage employers for the purchase of health insurance;
- Reductions in cost-sharing associated with recommended preventive care;
- Establishment of health insurance exchanges for the purchase of private coverage plus subsidies for the individual purchase of exchange-based coverage and for the cost-sharing of the modest income;
- Expansion of eligibility for the Medicaid program to all non-elderly with incomes up to 138 percent of the federal poverty level (\$23,000 to \$32,000 for a family of four in 2012) starting in 2014;<sup>17</sup>
- Phasing out of the Medicare prescription drug benefit coverage gap, a.k.a. the “doughnut hole”;
- A requirement for non-elderly individuals to enroll in qualified health insurance coverage with tax penalties imposed on some of those that do not comply;

- Financial requirements imposed on large- and medium-sized employers in cases where an employer’s full-time worker obtains subsidized coverage through a health insurance exchange due to the employer not offering coverage or not offering coverage deemed adequate or affordable to that worker;
- An array of initiatives for reducing costs in the Medicare program;
- Creation of incentives to establish cost-efficient health care systems, such as accountable care organizations and quality improvement initiatives; and
- Tax changes that will generate revenue to help finance the new programs.<sup>18</sup>

### Medicaid expansion

The law included an expansion of Medicaid eligibility to all those with incomes up to 138 percent of the poverty line, regardless of family status or place of residence. However, the Supreme Court decision made this expansion optional for states, and it is currently not known how many states will take up the option. For those states choosing to participate, the costs of the expansion population will be financed completely by the federal government for the first three years, thereafter phasing down to 90 percent federal and 10 percent state funding. The Congressional Budget Office estimates



### Timeline of Key Affordable Care Act Features.

Source: U.S. government health care reform website, HealthCare.gov, at <http://www.healthcare.gov/law/timeline/full.html#2012>.



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that the ACA's Medicaid expansion would cover some 17 million uninsured, low-income Americans.

### ***Private insurance reforms***

The ACA's private insurance reforms eliminate lifetime dollar limits (currently in effect) and annual dollar limits (completely eliminated in 2014, with minimum coverage phasing up as we approach 2014); include first dollar coverage of many preventive services (currently in place); extend dependent coverage on parents' private insurance policies to adult children up to age 26 (currently in place); and include a prohibition on "pre-existing condition" exclusions (currently in effect for children, to include adults in 2014). Further, in small group and non-group markets, the law prohibits premium rating differences by gender, health status, past claims experience, industry; and limits premium variation by age and tobacco use (beginning in 2014 these two become the only allowable rating factors in these markets aside from geography and whether coverage is for an individual versus a family).

The ACA guarantees issue and renewal of policies and limits waiting periods for insurance coverage to no more than 90 days. Further, essential health benefits (as defined in the law and through regulations) must be covered by small group and non-group plans, which also must be structured to fit into actuarial value tiers (60 percent, 70 percent, 80 percent, 90 percent). In addition, there is a young adult policy that some will be eligible for (those below maximum age and those without affordable access to another source of coverage). These more standardized levels of coverage can be bought in the non-group and small group markets both in and outside of the exchanges.

### ***Health insurance exchanges***

Health insurance exchanges, which must be operating by October 2013 and able to enroll people for coverage that will begin on January 1, 2014, are intended to provide an organized marketplace for the purchase of health insurance set up as a governmental, quasigovernmental, or nonprofit entity to help insurers comply with consumer protections, compete in cost-efficient ways, and to facilitate the expansion of insurance coverage to more people. They are a central component of the small group and individual health insurance market reforms in the ACA. Exchanges do not bear risk themselves—they are not insurers—but rather they contract with private insurers to cover specified populations (such as those obtaining coverage through small employers and those without employer coverage). There will be tax subsidies for the smallest lowest-wage employers on a time-limited basis.

The law provides each state with the option of developing its own health insurance exchange, but, if the state is unwilling or unable to do so, the law provides for the federal government to establish an exchange in that state instead. The federal government has also made provisions to develop exchanges in partnership with states that are unable to develop exchanges independently but which want to participate in

the process. As of this writing, 17 states have passed laws or have governors that have issued executive orders establishing state based exchanges.

Ideally, an exchange would promote insurance transparency and accountability, facilitate enrollment and the delivery of subsidies, while also playing roles in spreading risk (i.e., ensuring that the costs associated with those with high medical need are shared broadly) and containing costs.

### ***Closing Medicare prescription-drug-benefit gap***

As of January 1, 2011, seniors who reach the prescription drug coverage gap in Medicare receive a 50 percent discount when buying Medicare Part D-covered brand-name prescription drugs. Over the next ten years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed in 2020.

### ***Basic health insurance option***

Finally, the ACA gives states the option to implement the Basic Health Program (BHP), which gives states 95 percent of what the federal government would have spent on tax credits and subsidies for out-of-pocket costs for two groups: adults between 138 and 200 percent of the federal poverty level, and legally resident immigrants with incomes below 138 percent FPL whose immigration status disqualifies them from federally matched Medicaid. This is seen by many as an attractive option for low-income workers and their family members who do not have access to adequate or affordable employer-based insurance. Placing such low-income workers in a program similar to Medicaid could allow this group to obtain coverage at lower premiums and with lower out-of-pocket costs than would be the case through exchanges.

### ***ACA's progressive financing***

The progressive financing of the ACA embraces the core principle that everybody should have some basic security when it comes to their health care. It aims to directly address the inability of many people to afford medical care after they lose a job or get sick. And it would do so in large measure by lifting payroll taxes on households making more than \$250,000 and reducing Medicare subsidies for private insurers. The benefits, meanwhile, flow mostly to households making less than four times the poverty level—\$90,000 for a family of four. It also will reduce the gap in the economic well-being between the sick and the healthy at every income level.

## ***ACA challenge and Supreme Court decision***

On the day the ACA was signed into law, it was challenged. In a case known as *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court considered the constitutionality of two major ACA provisions: the individual mandate that requires most people to maintain a minimum level of health insurance coverage for themselves

and their tax dependents in each month beginning in 2014, and the Medicaid expansion. A majority of the Court upheld the individual mandate and left the Medicaid expansion intact; however, the enforcement authority of the Secretary of Health and Human Services to withhold a state's existing Medicaid funding for failure to comply with the ACA's Medicaid expansion was circumscribed.<sup>19</sup>

At this writing, 12 state governors have affirmatively stated that they will expand the program, and many more are expected to do so, given that 100 percent of the cost will be covered by the federal government for the first three years, and then fall to 90 percent federal and 10 percent state when fully phased in. States will pay a small share of the costs for the additional coverage, but will save money in other areas because they will no longer need to fund indigent care programs or support hospitals and other health care providers who provide uncompensated care to the uninsured.<sup>20</sup>

## Conclusion

After more than a century of efforts to establish a national health insurance system in which all Americans have access to affordable care, comprehensive reform was passed by the U.S. Congress and signed into law by President Obama in March 2010. The Affordable Care Act introduces monumental changes to increase access, reduce inequities, control costs, increase quality, and realign incentives. By 2014, the deadline for full implementation, health care consumers, insurers, and taxpayers will all be affected. Some 32 million additional Americans will have health insurance coverage once the effects of the reforms are fully phased in, reducing the uninsured from 18 percent to 6 percent of the population. Pre-existing conditions exclusions, outright denials of coverage, and higher premium rates for those with health problems will be prohibited, and financial help in obtaining coverage will be provided, increasing access to medically necessary care, thus saving lives as well as family resources. ■

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<sup>1</sup>Amy Finkelstein and colleagues, "The Oregon Health Insurance Experiment: Evidence from the First Year," NBER Working Paper 17190, National Bureau of Economic Research: Washington, DC, 2011. Available at <http://www.nber.org/papers/w17190>.

<sup>2</sup>Finkelstein and colleagues, "The Oregon Health Insurance Experiment."

<sup>3</sup>Jack Hadley, "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review* 60, No. 2 (2003): 3S–75S. doi:10.1177/1077558703254101

<sup>4</sup>Robert Haveman and Barbara Wolfe, "U.S. Health Care Reform: A Primer and an Assessment," *CESifo DICE Report: Journal for Institutional Comparisons*, 8(3): Autumn 2010. Available at <http://www.cesifo-group.de/portal/pls/portal/docs/1/1192792.PDF>.

<sup>5</sup>Katherine Swartz, "Health Care for the Poor: For Whom, What Care, and Whose Responsibility?" in *Changing Poverty, Changing Policies*, eds. Maria Cancian and Sheldon Danziger (New York: Russell Sage Foundation, 2009), 330–363.

<sup>6</sup>[http://www.kff.org/uninsured/upload/7451-08-Data\\_Tables.pdf](http://www.kff.org/uninsured/upload/7451-08-Data_Tables.pdf)

<sup>7</sup>Ibid.

<sup>8</sup>See <http://tricare.mil/mybenefit/ProfileFilter.do?puri=%2FHome%2Foverview%2FWhatIsTRICARE>.

<sup>9</sup>Those age 65 and above are eligible for Medicare if they or their spouse is eligible for Social Security and have made payroll tax contributions for at least 10 years.

<sup>10</sup>Kaiser Family Foundation, Medicare Policy Fact Sheet, "Medicare at a Glance," November 2011. Available at <http://www.kff.org/medicare/upload/1066-14.pdf>.

<sup>11</sup>See U.S. Census Bureau, *Statistical Abstract of the United States: 2012*, "CHIP Enrollment and Expenditures." Available at [http://www.census.gov/compendia/statab/cats/health\\_nutrition/medicare\\_medicaid.html](http://www.census.gov/compendia/statab/cats/health_nutrition/medicare_medicaid.html).

<sup>12</sup>Fredric Blavin, John Holahan, Genevieve Kenney, and Vicki Chen, *A Decade of Coverage Losses: Implications for the Affordable Care Act*, research report, Urban Institute and Robert Wood Johnson Foundation, February 2012. Available at <http://www.urban.org/UploadedPDF/412514-Implications-for-the-Affordable-Care-Act.pdf>.

<sup>13</sup>Linda J. Blumberg, Lisa Clemans-Cope, and Fredric Blavin, Health Policy Center, "Lowering Financial Burdens and Increasing Health Insurance Coverage for Those with High Medical Costs," December 19, 2005, Urban Institute. Available at [http://www.urban.org/health\\_policy/url.cfm?ID=311261](http://www.urban.org/health_policy/url.cfm?ID=311261).

<sup>14</sup>Blavin and colleagues, *A Decade of Coverage Losses*.

<sup>15</sup>HPC estimates were computed using a three-year merged file of the Medical Expenditure Panel Survey—Household Component, 2000–2002, comprising data that are nationally representative of the U.S. population. The Survey collects data on demographic characteristics, health conditions, health status, use of medical services, charges and payments, health insurance coverage, income and assets, and employment. See [http://meps.ahrq.gov/mepsweb/about\\_meps/survey\\_back.jsp](http://meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp).

<sup>16</sup>See Urban Institute, Health Policy Center, "Health Care Reform" at [http://www.urban.org/health\\_policy/health\\_care\\_reform/index.cfm](http://www.urban.org/health_policy/health_care_reform/index.cfm). For more about state implementation of the ACA, see Linda J. Blumberg and Shanna Rifkin, "State Progress in Implementing Health Insurance Exchanges: Results from 10 State Analyses," September 10, 2012, Urban Institute; and Sabrina Corlette, Kevin Lucia, and Katie Keith, "Monitoring State Implementation of the ACA in 10 States: Rate Review"; and Kevin Lucia, Sabrina Corlette, and Katie Keith, "Monitoring State Implementation of the ACA in 10 States: Early Market Reforms" September 10, 2012. All available at [http://www.urban.org/health\\_policy/health\\_care\\_reform/long-term\\_care-pubs.cfm](http://www.urban.org/health_policy/health_care_reform/long-term_care-pubs.cfm).

<sup>17</sup>The U.S. Supreme Court considered the constitutionality of two major provisions of the ACA, the individual mandate to purchase health insurance and the Medicaid expansion. A majority of the Court upheld the individual mandate and made the Medicaid expansion voluntary for states. See Kaiser Family Foundation Focus on Health Reform, "A Guide to the Supreme Court's Affordable Care Act Decision," July 2012. Available at <http://www.kff.org/healthreform/upload/8332.pdf>.

<sup>18</sup>See "Health Care Reform," Urban Institute Health Policy Center, [http://www.urban.org/health\\_policy/health\\_care\\_reform/index.cfm](http://www.urban.org/health_policy/health_care_reform/index.cfm)

<sup>19</sup>Kaiser Family Foundation, "A Guide to the Supreme Court's Affordable Care Act Decision," *Focus on Health Reform*, July 2012. Available at <http://www.kff.org/healthreform/upload/8332.pdf>.

<sup>20</sup><http://www.urban.org/UploadedPDF/412628-Considerations-in-Assessing-State-Specific-Fiscal-Effects-of-the-ACAs-Medicaid-Expansion.pdf>

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