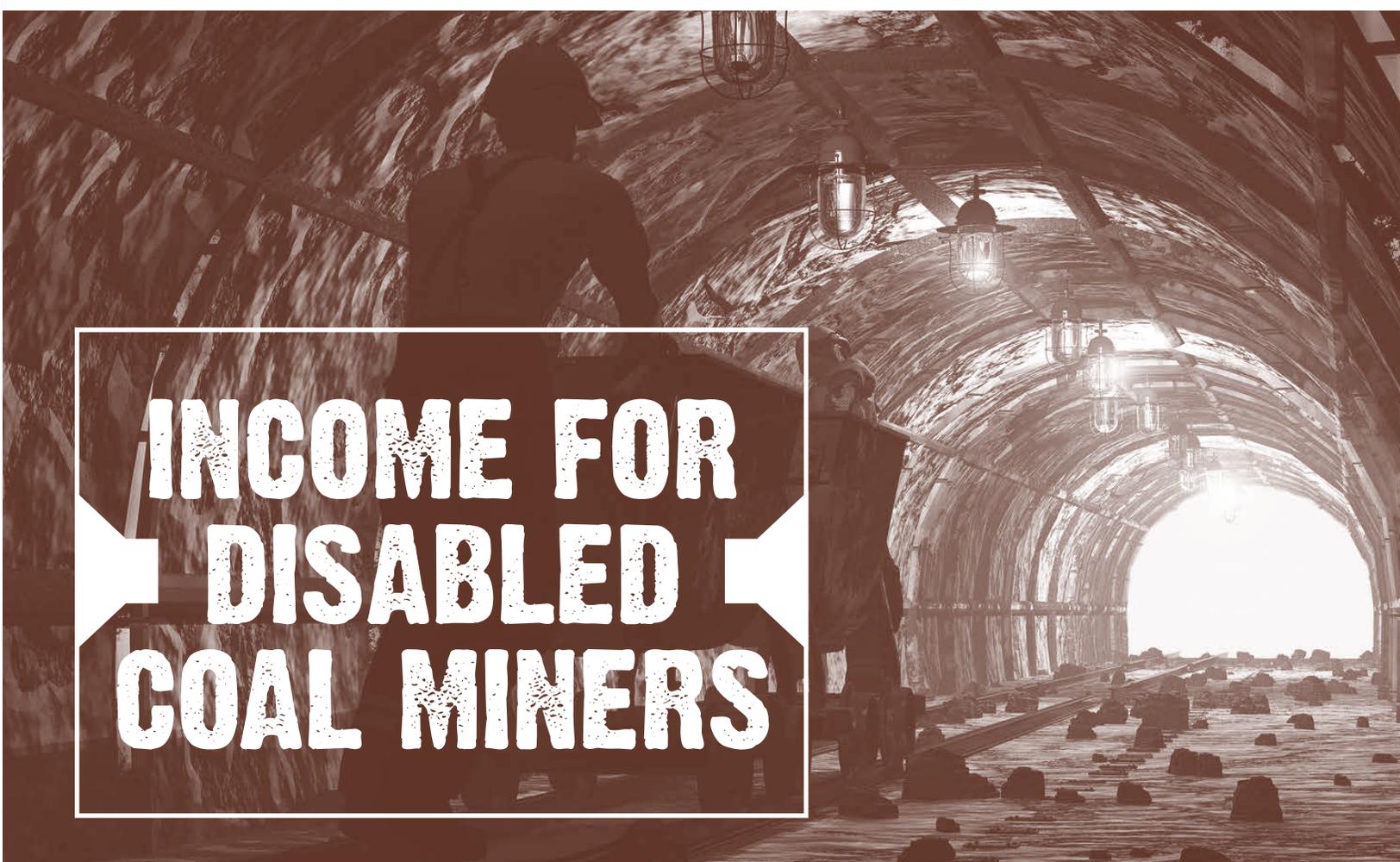


# Clearinghouse REVIEW

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# THE AFFORDABLE CARE ACT

## AN EFFECTIVE ASSET-BUILDING POLICY

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**T**he Patient Protection and Affordable Care Act of 2010 is the most significant health care law since the establishment of Medicaid and Medicare in 1965.<sup>1</sup> While the Act focuses on health care and health insurance access, it can also be viewed as an asset-building policy.

The lack of financial security is a major and growing problem in the United States. Sixty million people in the United States are estimated to be living in asset poverty.<sup>2</sup> Having insufficient funds to meet one's needs for three months if all income were to disappear for those three months is asset poverty. Thus, while income poverty may measure whether one has enough to get by, asset poverty measures whether one has enough to get ahead.

The U.S. government has long recognized the distinction between income and assets. To achieve success and the economic mobility of the American Dream, generating income, as well as translating such income into assets, is necessary. Throughout its history the federal government therefore has designed and implemented policies and programs to help families build assets.<sup>3</sup> Here we explain how the Affordable Care Act can be viewed as another example of effective asset-building policy by the federal government.

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<sup>1</sup>Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

<sup>2</sup>Caroline Ratcliffe & Sisi Zhang, Urban Institute, U.S. Asset Poverty and the Great Recession 1 (Oct. 2012), <http://bit.ly/TLfcif>.

<sup>3</sup>See generally Lilian G. Woo et al., Corporation for Enterprise Development, Hidden in Plain Sight: A Look at the \$335 Billion Federal Asset-Building Budget (2004), <http://bit.ly/ZHNZRq>. In the 2013 fiscal year the federal government will spend, through both direct outlays and tax deductions and credits, nearly \$548 billion on asset-building policies (Reid Cramer et al., New America Foundation, The Assets Report 2012: An Assessment of the Federal "Asset-Building" Budget (April 2012), <http://bit.ly/11uluGz>).

### Asset-Building Policy Must Consider Both Individuals and Institutions

An effective asset-building policy must consider both individual and institutional constructs and how they affect savings and investments.<sup>4</sup> Conditions that are put in place by institutions affect saving behavior. Institutions operating in the free market are not always incentivized to act in the best interest of the people they affect; this is why asset-building policy often focuses on modifying the conditions that are put in place by institutions. The minimum wage law, occupational safety laws, and consumer protection laws are all examples of enacted public policies that altered institutional behavior for the benefit of people affected by institutions. However, an effective asset-building policy cannot focus solely on institutions because savings outcomes are related to individual behavior and choices.

Behavioral economics research shows that people tend to make poor financial decisions, do not have complete financial education, and do not always learn from their mistakes.<sup>5</sup> Behavioral economics research also reveals that when people are faced with financial decisions, many experience inertia and make no decision at all—even when inaction is against their best financial interests.<sup>6</sup> Thus an effective asset-building policy on individual behavior might focus on imparting financial education as well as incentivizing long-term savings through some type of matching program.

The Affordable Care Act's provisions are an example of an asset-building policy that attempts to take on both institutional and individual asset-building behavior. The individual mandate, which requires all people to acquire a minimum standard of health insurance, for example, is based on the assumption that without such a requirement many young

healthy individuals would not purchase health insurance, even though failing to do so goes against their best interests.<sup>7</sup> It is also based on the assumption that if such a mandate to purchase insurance lacked a minimum benefit standard, many people would act against their own financial interests by purchasing low-cost, low-benefit insurance products to save money in the short term but wind up having higher medical expenses in the long term. In other words, intrinsic to the Act's individual mandate provisions is the assumption that when left to their own devices, people tend to make poor financial choices.

The Affordable Care Act is also filled with provisions directed toward institutional change. For example, under the Act insurance companies will no longer be able to deny health insurance to people with preexisting health conditions.<sup>8</sup> While, in a free market, coverage denials make financial sense for insurance companies, such denials are not in the best interests of society because they create a segment of sick individuals who must rely on public health care programs because they cannot obtain private medical insurance. To modify this self-serving behavior, the Act creates public policies that alter insurance companies' behavior for the benefit of people who need health care coverage.

Thus the Affordable Care Act, consisting of provisions founded in the constructs of individual and institutional financial behavior with the goal of health promotion, has an impact on asset-building efforts as well. We discuss in more detail how specific provisions of the Act promote asset building and to health outcomes.

### Access to Health Insurance Promotes Asset Building

One of the major problems that the Affordable Care Act tries to solve is the high

<sup>4</sup>Sondra Beverly et al., Urban Institute et al., *Determinants of Asset Building* (March 2008), <http://bit.ly/XymJR7>.

<sup>5</sup>*Id.* at 6–8.

<sup>6</sup>*Id.*

<sup>7</sup>Affordable Care Act §§ 1501 & 10106.

<sup>8</sup>*Id.* § 1101.

rate of uninsured Americans.<sup>9</sup> In 2011 the Census Bureau reported that 48.6 million Americans were uninsured.<sup>10</sup> Being uninsured is a major financial burden for those who require medical care. Without health insurance, out-of-pocket health care costs are too high for most people to afford. According to the 2010 U.S. Census, in 2009 the average cost of a hospital stay was \$10,379.<sup>11</sup> Worse yet, hospitals generally charge uninsured individuals higher prices than the prices they have negotiated with insurance companies.<sup>12</sup> When individuals are unable to pay such high costs, their cases are sent to collection agencies, thereby diminishing their credit scores and further hampering asset building.<sup>13</sup> All of this evidence points to having health insurance as being essential for attaining financial stability and economic mobility.

The Affordable Care Act works to expand access to health insurance through provisions aimed primarily at institutional changes. First, the Act provides that all states must open Medicaid eligibility to any adult earning below 133 percent of the federal poverty level.<sup>14</sup> A second provision creates health insurance exchanges.<sup>15</sup> These health insurance exchanges are new marketplaces for buying private health

insurance by paying premiums based on income. Beginning in 2014, exchanges will serve primarily individuals buying insurance on their own and small businesses with up to a hundred employees, although states may choose later to include larger employers. Originally the Act required states to set up such exchanges or face elimination of federal funding for their Medicaid programs. However, the U.S. Supreme Court's decision on the constitutionality of the Act held that threatening to withhold federal Medicaid funding was unconstitutional.<sup>16</sup> As a result, states now may decide whether to establish exchanges.<sup>17</sup> So far twenty-five states have indicated that they will not establish them and will rely instead on a federally created exchange.<sup>18</sup> The Act requires that exchanges give people private insurance plan options that would be categorized into four levels of quality: platinum, gold, silver, and bronze.<sup>19</sup> Tax credits would be granted to people who earn below 400 percent of the federal poverty level and choose to purchase insurance through the exchange system.<sup>20</sup>

Besides creating structural changes in Medicaid and developing a new health insurance exchange system, the Affordable Care Act sets new requirements for

<sup>9</sup>Gordon Bonnyman, *Helping Hope and History Rhyme: Why and How Every Advocate Can Help Realize Health Care Reform*, 46 CLEARINGHOUSE REVIEW 308 (Nov.–Dec. 2012); Sarah Somers & Jane Perkins, *The Affordable Care Act: A Giant Step Toward Insurance Coverage for All Americans*, 44 *id.* 330 (Nov.–Dec. 2010).

<sup>10</sup>Carmen DeNavas-Walt et al., U.S. Census Bureau, *Current Population Reports: Income, Poverty, and Health Insurance Coverage in the United States: 2011*, at 21 (Sept. 2012), <http://1.usa.gov/W4ohRF>.

<sup>11</sup>U.S. Census Bureau, *Statistical Abstract of the United States: 2012, Health and Nutrition, Table 173: Average Cost to Community Hospitals Per Patient: 1990 to 2009*, at 120 (2012), <http://1.usa.gov/Ulo5Wr>.

<sup>12</sup>Catherine New, *Health Insurance Costs: Two-Tiered Medical Billing for Insured and Uninsured Frustrates Hospital Patients*, HUFFINGTON POST (May 30, 2012), <http://huff.to/WOMUyN>.

<sup>13</sup>Alan Weil, *A Health Plan to Reduce Poverty*, 17 FUTURE OF CHILDREN 2, 97, 99 (Fall 2007), <http://bit.ly/Vlvud7>.

<sup>14</sup>Affordable Care Act § 2001. How many states will expand their Medicaid programs is unclear since, the U.S. Supreme Court ruled, states are not required to comply with this provision of the Affordable Care Act (*National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012)). While nineteen states and the District of Columbia have already submitted blueprints for their state exchanges for approval as required by the Act, many other states have indicated that they will not establish exchanges (National Conference of State Legislators, *State Actions to Address Health Insurance Exchanges* (Jan. 4, 2013), <http://bit.ly/110U1bT>; Advisory Board Corporation, *Where Each State Stands on ACA's Medicaid Expansion: A Roundup of What Each State's Leadership Has Said About Their Medicaid Plans* (Nov. 29, 2012), <http://bit.ly/Y7OGDE>).

<sup>15</sup>Affordable Care Act § 1311.

<sup>16</sup>*National Federation of Independent Business*, 132 S. Ct. 2566.

<sup>17</sup>Editorial, *Scorecard on Health Insurance Exchanges*, NEW YORK TIMES, Jan. 6, 2013, <http://nyti.ms/TYCOjv>.

<sup>18</sup>National Conference of State Legislators, *supra* note 14.

<sup>19</sup>Affordable Care Act § 1311.

<sup>20</sup>Henry J. Kaiser Family Foundation, *Explaining Health Care Reform: Questions About Health Insurance Subsidies* (July 2012), <http://bit.ly/Wl8Ddl>.

employer-based health insurance. All employers with more than two hundred employees will be required to enroll employees automatically, and, beginning in 2014, employers that have more than fifty employees and do not offer health insurance coverage will be subject to a fine of \$2,000 per full-time employee.<sup>21</sup> Employer coverage must cover at least 60 percent of all medical costs, while the enrollee is responsible for, at most, 40 percent of medical costs.<sup>22</sup> If employees opt out of employer plans because their shares of premiums exceed 9.5 percent of family income, the employer must pay \$3,000 for each full-time employee who purchases health insurance on the exchange.<sup>23</sup> Employees earning under 400 percent of the federal poverty level and whose share of the premiums is between 8 percent and 9.8 percent will have the option to purchase insurance on an exchange, and employers will be required to provide employees with a voucher equal to what the employer would have paid under the employer plan.<sup>24</sup>

The final institutional change aimed at increasing health insurance access is the prohibition against coverage denials due to preexisting conditions.<sup>25</sup> This practice of selecting only healthy risk-pool enrollees and denying coverage to those with preexisting conditions was pervasive because it is in health insurance companies' best interest to avoid covering the sick. Under the Affordable Care Act insurance companies are required to cover all people who apply for coverage even if they are potentially expensive enrollees. In order to ensure that this provision does

not significantly negatively affect insurance companies' bottom line, the Act also includes the individual mandate.<sup>26</sup> The individual mandate ensures that enough healthy people will enroll in health insurance plans to offset the cost of the potential influx of sick people caused by the preexisting-condition provision. To have a functional health insurance risk pool there must be a balance between healthy and sick participants. And to incentivize the so-called young invincibles to purchase health insurance, the law requires everyone to purchase it. However, beyond benefiting health insurance companies, the individual mandate should benefit individuals by encouraging people to acquire health insurance.

Approximately 95 percent of the total population will not be required to purchase new health insurance or pay a fine, and for those who are required to purchase insurance the law puts measures in place that will lessen this burden.<sup>27</sup> Such measures include the new insurance requirements on employers, the expansion of Medicaid eligibility, and the creation of health insurance exchanges. The law requires individuals to purchase health insurance only if they are able to afford the costs.<sup>28</sup> Overall the individual mandate is beneficial both for individuals and for the country as a whole since it allows for more people to have access to health insurance.

While a patient's health insurance status is well known to be related to the patient's health outcomes, a patient's health insurance status is less well known to affect the patient's asset-building efforts also.<sup>29</sup>

<sup>21</sup>Affordable Care Act § 1511.

<sup>22</sup>*Id.*

<sup>23</sup>*Id.*

<sup>24</sup>*Id.*

<sup>25</sup>*Id.* § 1101.

<sup>26</sup>*Id.* § 1501.

<sup>27</sup>Linda J. Blumberg et al., Urban Institute, *The Individual Mandate in Perspective: Timely Analysis of Immediate Health Policy Issues 1* (March 2012), <http://bit.ly/RYYA73>.

<sup>28</sup>Henry J. Kaiser Family Foundation, *The Requirement to Buy Coverage Under the Affordable Care Act Beginning in 2014* (n.d.), <http://bit.ly/Wld48f>.

<sup>29</sup>Families USA, *Dying for Coverage: The Deadly Consequences of Being Uninsured* (June 2012), <http://bit.ly/ZUjq6p> (effect of being uninsured on health care outcomes); Rachel Banov, Center for Social Development, Washington University in St. Louis, *The Effect of Health Insurance on Savings Outcomes in Individual Development Accounts* (2005), <http://bit.ly/V2PF3f> (effect of being uninsured on saving rates).

According to studies, health insurance operates as a significant mediator for savings and asset accumulation.<sup>30</sup> One study examined how health insurance status affected Individual Development Account program participants' success in savings.<sup>31</sup> The study found that people with health insurance were less likely than uninsured people to drop out of the Investment Development Account program and more likely to make an asset purchase with program funds.<sup>32</sup> This trend might have been because people who had health insurance were healthier and therefore were able to be more productive workers. It could have been due also to the differences in mind-sets among individuals with and without health insurance. Uninsured people might have felt their future was less secure and therefore did not see as great a value in saving money. Whatever the reason for these results, people with health insurance appear to have a greater disposition toward saving money. Another study showed that, among families receiving Temporary Assistance for Needy Families (TANF), those who had health insurance were significantly less likely to continue receiving TANF benefits after three months compared to those who were uninsured.<sup>33</sup> Again, the underlying reasons for these results are unclear, but the lesson seems to be that those with health insurance are more able to grow their assets.

Along with demonstrating a direct correlation between asset building and health insurance status, researchers note the cyclical nature of poverty and the lack of access to health care. According

to a review of more than nine thousand research papers on the link between poverty and health outcomes, people without health insurance are at greater risk for breast cancer, lung cancer, cardiovascular disease, and death when compared to insured individuals.<sup>34</sup> This research also confirms that poor health reduces income by between 10 percent and 28 percent and reduces educational attainment, in turn reducing income.<sup>35</sup> This cyclical nature extends not only to individuals and families but to neighborhoods as well. Studies find that where there is a concentration of poverty, there is often a concentration of uninsured people; and, in neighborhoods with high rates of uninsured people, health care providers lack incentives to serve the community.<sup>36</sup> Health care providers abandon these poor neighborhoods, and such communities are left lacking both the means to pay for health care and the providers themselves.

By providing financial incentives to both insurance companies and individuals to purchase health insurance, the Affordable Care Act not only helps improve individuals' and the nation's health outcomes but also creates asset-building opportunities for such individuals.

### Promoting Health and Well-Being Promotes Asset Building

The Affordable Care Act not only promotes wellness by expanding access to health care and health insurance but also contains provisions that directly promote health outcomes and well-being. These provisions can also be viewed as promot-

<sup>30</sup>Banov, *supra* note 29, at 1.

<sup>31</sup>*Id.* Individual development accounts are matched savings accounts that help low- and moderate-income individuals save toward the purchase of a lifelong asset. For every dollar saved in an individual development account, savers receive a corresponding match that serves as both a reward and an incentive to increase savings. Savers agree to complete financial education classes and use their savings for an asset-building purpose—typically for postsecondary education or job training, home purchase, or to capitalize a small business (Corporation for Enterprise Development, *IDA Basics: How IDAs Work* (2012), <http://bit.ly/V7fu60>).

<sup>32</sup>Banov, *supra* note 29, at 1.

<sup>33</sup>Pamela Loprest, Urban Institute, *Who Returns to Welfare?* (Sept. 2002), <http://bit.ly/Y7XYQ1>.

<sup>34</sup>Henry J. Kaiser Family Foundation, *Kaiser Commission on Medicaid and the Uninsured, Sicker and Poorer: The Consequences of Being Uninsured* (May 2002), <http://bit.ly/W4ykGw>.

<sup>35</sup>*Id.*

<sup>36</sup>INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *A SHARED DESTINY: COMMUNITY EFFECTS OF UNINSURANCE 3* (2003), <http://bit.ly/W5LORC>.

ing asset building since research shows that people who are healthier tend to be more financially stable and have more assets than those who are less healthy.

A 2009 study by the National Bureau of Economic Research found that in 2006, for two-person households between the ages of 56 and 61, the ratio of household assets in the top health quintile to the household assets in the bottom health quintile was 2.2.<sup>37</sup> In other words, healthier households had, on average, over twice the assets of unhealthy households. This same research team also examined the health status and asset accumulation of a group of people in 1992 and that same group of people again in 2008.<sup>38</sup> Among people within a certain range of assets in 1992, when that same group of people was reexamined in 2008, the people in the top third of the latent health distribution accumulated, on average, at least 50 percent more assets than people in the bottom third of the health distribution.<sup>39</sup> In other words, the study showed that people with health problems accumulated fewer assets than people with good health. Similarly, a 2011 U.S. Department of Health and Human Services report examined the relationship between health outcomes and socioeconomic position.<sup>40</sup> The report showed repeatedly that lower-income individuals were more likely to experience negative health outcomes than higher-income individuals.<sup>41</sup> Those who were uninsured or in the lower-income brackets were more likely to have a lower

health status. For instance, between 2005 and 2010, for adults earning between 100 percent and 200 percent of the federal poverty level, one in ten had depression, while among adults earning below the federal poverty level the prevalence of depression was almost double (17 percent).<sup>42</sup> Similarly, for adults earning between 100 percent and 200 percent of the federal poverty level, nearly one in four had two or more selected chronic health conditions (heart disease, high blood pressure, asthma, chronic bronchitis, or kidney disease) compared to about one in three adults earning below the federal poverty level.<sup>43</sup>

As we established earlier, poverty and poor health outcomes go hand in hand. Sometimes poverty leads to negative health outcomes, and sometimes negative health outcomes lead to poverty. While the directionality of this relationship is not consistent across all people, poor health outcomes are known to place additional burdens on low-income people and act as a barrier for moving out of poverty. Improving health outcomes is therefore an asset-building tool.

That a higher level of preventive care is associated with more favorable health outcomes is well established in the public health and medical community.<sup>44</sup> The Affordable Care Act expands health insurance and health care access, which is directly correlated with improved health outcomes.<sup>45</sup> The Act also has several provisions that directly promote health

<sup>37</sup>James M. Poterba et al., *Family Status Transitions, Latent Health, and the Post-Retirement Evolution of Assets 1* (National Bureau of Economic Research, Working Paper No. 15789, Feb. 2010), <http://bit.ly/W9JKIT>.

<sup>38</sup>James M. Poterba et al., *The Asset Cost of Poor Health 1* (National Bureau of Economic Research, Working Paper No. 16389, Sept. 2010), <http://bit.ly/W9KKN1>.

<sup>39</sup>*Id.*

<sup>40</sup>National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, *Health, United States, 2011: With Special Feature on Socioeconomic Status and Health* (2012), <http://1.usa.gov/UQLeJ0>.

<sup>41</sup>Approximately 42 percent of adults earning below 200 percent of the federal poverty level were uninsured in 2011, compared to 21 percent of adults earning between 200 percent and 400 percent of the federal poverty level and about 6 percent of adults earning above 400 percent of the federal poverty level (*id.* at 17).

<sup>42</sup>*Id.* at 38.

<sup>43</sup>*Id.* at 40.

<sup>44</sup>Chiang-Hua Chang et al., *Primary Care Physician Workforce and Medicare Beneficiaries' Health Outcomes*, 305 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 2096–2104 (May 2011), <http://bit.ly/14o0bHw>.

<sup>45</sup>Jill Bernstein et al., *Mathematica Policy Research, How Does Insurance Coverage Improve Health Outcomes?* (April 2010), <http://bit.ly/141cXeP>.

outcomes which translate into helping people build assets. Title IV of the Act, for instance, focuses on preventive medicine.<sup>46</sup> This section of the law establishes the National Prevention, Health Promotion, and Public Health Council chaired by the surgeon general with the purpose of developing coordinated strategies for preventive health measures.<sup>47</sup> In its June 2012 plan for implementing the national prevention strategy, the council included topics such as tobacco-free living, healthy eating, active living, injury and violence-free living, reproductive and sexual health, and mental and emotional well-being.<sup>48</sup> Title IV also provides for an education and outreach campaign about the importance of utilizing preventive health measures.<sup>49</sup> Specifically the law encourages people to utilize preventive health services by prohibiting health insurance companies from imposing any cost-sharing requirements for preventive health services approved by the U.S. Preventive Service Task Force.<sup>50</sup>

Prohibiting cost-sharing for preventive care, the Affordable Care Act also attempts to improve health outcomes by requiring that all health insurance plans provide certain essential health benefits including, but not limited to, doctor visits and outpatient services, emergency services, hospitalization, maternity and newborn care, mental health and substance disorder services, prescription drugs, rehabilitation services, laboratory services, preventive services, and pediatric services such as oral and vision care.<sup>51</sup> In order to promote health outcomes for Medicaid enrollees, the law increases

reimbursement for primary care doctors who treat Medicaid patients, thereby incentivizing doctors to provide basic primary health care to Medicaid patients.<sup>52</sup> With people having more access to primary and preventive care, health outcomes should improve, and this, as indicated by the aforementioned research, should improve asset-building efforts.

### Reducing Medical Bankruptcies and Debt Promotes Asset Building

Unaffordable out-of-pocket medical costs are a well-known driver of asset poverty, and much of the Affordable Care Act is dedicated to reducing the financial burden that individuals face when consuming health care. A well-known study published in the *American Journal of Medicine* in 2007 examined the total number of bankruptcies filed in the United States and determined that 62.1 percent of all bankruptcy filings could be attributed to medical debt.<sup>53</sup> Among those who filed for bankruptcy due to medical debt, 92 percent had medical debts greater than \$5,000.<sup>54</sup> The Act provides measures that aim to prevent people from filing for bankruptcy in order to meet overwhelming costs of health care and health insurance.

Before the Affordable Care Act was passed, annual or lifetime benefit limits were pervasive insurance company practices. Once a person's annual or lifetime benefit limit was reached, the enrollee would be responsible for all health costs incurred. The Act's provisions help protect consumers' assets by making sure that deductibles and out-of-pocket costs are capped.

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<sup>46</sup>Affordable Care Act tit. IV.

<sup>47</sup>*Id.* § 4101.

<sup>48</sup>National Prevention, Health Promotion, and Public Health Council, National Prevention Council Action Plan: Implementing the National Prevention Strategy (June 2012), <http://1.usa.gov/1445J98>.

<sup>49</sup>Affordable Care Act § 4004.

<sup>50</sup>*Id.* § 2713; HealthCare.gov, Preventive Services Covered Under the Affordable Care Act (Sept. 27, 2012), <http://1.usa.gov/T05IGb>.

<sup>51</sup>HealthCare.gov, Essential Health Benefits: HHS Information Bulletin (Feb. 24, 2012), <http://1.usa.gov/10PtHHK>.

<sup>52</sup>Press Release, U.S. Department of Health and Human Services, Health Care Law Increases Payments to Doctors for Primary Care (May 9, 2012), <http://1.usa.gov/VRaJes>.

<sup>53</sup>David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 *AMERICAN JOURNAL OF MEDICINE* 741 (2009), <http://bit.ly/376D0o>.

<sup>54</sup>*Id.* at 1.

First, the Affordable Care Act bars deductibles from exceeding \$2,000 for individuals and \$4,000 for families.<sup>55</sup> Individuals and small businesses that use the exchange system will have cost-sharing maximums laid out based on the level of insurance plans: bronze plan enrollees pay no more than 40 percent out-of-pocket, silver plan enrollees pay no more than 30 percent out-of-pocket, gold plan enrollees pay no more than 20 percent out-of-pocket, and platinum plan enrollees pay no more than 10 percent out-of-pocket expenses.<sup>56</sup> Out-of-pocket maximums are also capped. Out-of-pocket limits are based on the Internal Revenue Service's limits on health savings account contributions.<sup>57</sup>

Upon deciding what type of health insurance they would like to purchase, all consumers earning under 400 percent of the federal poverty level will also qualify for premium tax credits based on a sliding income scale.<sup>58</sup> In other words, those earning less than 400 percent of the federal poverty level will receive tax credits equal to the amount that premiums exceed a percentage of their income.<sup>59</sup> Thus people earning between 133 percent and 150 percent of the federal poverty level are eligible for tax credits equal to the amount of their premiums above 3 percent to 4 percent of their income.<sup>60</sup> The tax credit for people earning between 150 percent and 200 percent of the federal poverty level is based on premium costs above 4 percent to 6.3 percent of their

income. The tax credit for people earning between 200 percent and 250 percent of the federal poverty level is based on premium costs above 6.3 percent and 8.05 percent of income. And the tax credit for people earning between 250 percent and 400 percent of the federal poverty level is based on premium costs exceeding 8.05 percent to 9.5 percent of total income.<sup>61</sup> These tax credits will further offset the amount of out-of-pocket expenses that an individual will spend.

Protecting people from exorbitant out-of-pocket health care-related expenses, the Affordable Care Act also contains a provision to make sure that insurance companies use their premium revenue in an efficient manner. The Act prohibits group market health insurance companies from spending more than 20 percent of total health care premiums on non-health benefit costs.<sup>62</sup> For individual plans, that limit is 25 percent.<sup>63</sup> Examples of non-health benefit claims would be internal administrative costs and salaries and bonuses for insurance company executives. If an insurance company exceeds this limit, it must refund to each enrollee, on a pro rata basis, the amount by which non-health benefit costs exceeded 20 percent of premium revenue. This provision was implemented in 2011, and there are already data showing its direct impact: 31 percent of individual market enrollees, 28 percent of small-group market enrollees, and 19 percent of large-group market enrollees are expected to receive rebates this year.<sup>64</sup>

<sup>55</sup>Affordable Care Act § 1302 (c)(2).

<sup>56</sup>*Id.* § 1302 (d)(1).

<sup>57</sup>Thus, for people earning between 100 percent and 200 percent of the federal poverty level, the limit would be one-third of the health savings account limit; for people earning between 200 percent and 300 percent of the federal poverty level, the limit would be one-half of the health savings account limit; for people earning between 300 percent and 400 percent of the federal poverty level, the limit would be two-thirds of the health savings account limit; and those earning 400 percent of the federal poverty level or more would have a limit of 100 percent of the health savings account limit (*id.*) (see generally Community Catalyst & Georgetown University Health Policy Institute, Health Insurance 101: Federal Subsidies: Helping People Afford Health Care (2011), <http://bit.ly/XUYhKa>).

<sup>58</sup>Community Catalyst & Georgetown University Health Policy Institute, *supra* note 57.

<sup>59</sup>*Id.*

<sup>60</sup>*Id.*

<sup>61</sup>*Id.*

<sup>62</sup>Affordable Care Act § 2718 (b)(1).

<sup>63</sup>*Id.*

<sup>64</sup>Henry J. Kaiser Family Foundation, Focus on Health Reform: Insurer Rebates Under the Medical Loss Ratio: 2012 Estimates 2–3 (April 2012), <http://bit.ly/112KxT5>.

The direct consumer benefits from rebates are important, but the indirect benefits from the premium-limit provision are arguably more important, especially in asset building. For example, insurance companies are incentivized to avoid these rebates by investing in their enrollees. Such investing can be made in the form of lower premiums or more comprehensive benefits. Lower premiums and more comprehensive benefits will likely mean greater financial security for enrollees compared to cash rebates, which in 2012 will average out to \$127 per individual-market enrollee, \$21 per small-group enrollee, and \$14 per large-group enrollee.<sup>65</sup> While more research must be done to quantify the indirect benefits of this provision, there will likely be a reduction in overall premium amounts as companies compete with one another and try to control their own costs to meet these thresholds.

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Besides regulating insurance companies, the Affordable Care Act requires hospitals to have written forms explaining their financial assistance policies, such as eligibility for reduced cost or free medical care.<sup>66</sup> Thus low-income people who cannot afford health care will learn which hospitals provide charity care and how to qualify for and access such care. The new law also prohibits hospitals from engaging in “extraordinary collections actions” against patients before determining if such patients are eligible for financial assistance.<sup>67</sup> By increasing the visibility and accessibility of charity and reduced-price care, the Act helps ease the financial burden of medical care. This is the last line of protections for people who have fallen through the cracks. People who are left with unaffordable hospital bills and were unable to take advantage of the Act’s other provisions will have the opportunity to utilize the hospital charity or reduced-price care program.

While the Affordable Care Act contains many provisions that aim to reduce financial burdens related to health care, the efficacy of such provisions will have to be evaluated. The aforementioned 2007 study showed that medical bankruptcy is the leading cause of bankruptcy nationally.<sup>68</sup> In 2009, three years after Massachusetts’ health care reform was passed, the same research team conducted a Massachusetts-specific study.<sup>69</sup> The results showed that there was not a significant reduction of medical-related bankruptcies in Massachusetts postimplementation compared to preimplementation. This suggests that Massachusetts’ health care reform did not implement effective provisions to prevent health care-related bankruptcies. Because Massachusetts’ health care reform is so similar to the Act, the Act arguably does not go far enough in reducing medical bankruptcies.



Although the Affordable Care Act is commonly thought to be solely related to health care, here we show that it also affects people’s financial security. Health and poverty are so deeply intertwined that one cannot be taken up without the other. Health insurance, health outcomes, and medical out-of-pocket costs all affect asset-accumulation efforts. The Act employs an effective asset-building policy by focusing primarily on institutional changes while keeping in mind individual behavioral changes. As the Act is implemented, its asset-building effects must be evaluated. Moreover, while the Act focuses on many of the institutional problems within the health care system, there are many other industries and sectors that still present barriers to individual asset-building efforts and many institutions that ignore people’s asset-building needs. These problems also need to be solved in a comprehensive manner using effective asset-building strategies.

<sup>65</sup>*Id.*

<sup>66</sup>Affordable Care Act § 9007(a)(4).

<sup>67</sup>*Id.* § 9007(a)(6).

<sup>68</sup>Himmelstein et al., *supra* note 53.

<sup>69</sup>David U. Himmelstein et al., *Medical Bankruptcy in Massachusetts: Has Health Reform Made a Difference?*, 124 AMERICAN JOURNAL OF MEDICINE 224 (2011), <http://bit.ly/WdJATn>.



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