

Health Care Reform and Low-Income Families: New Costs, Lower Burdens

By Barbara L. Wolfe, Institute for Research on Poverty, University of Wisconsin-Madison

Last year's health care reform legislation, the Patient Protection and Affordable Care Act (PPACA) raises two important questions with regard to low-income people:

1. Does PPACA increase coverage and access?
2. What is the cost to taxpayers of increasing care?

Before this bill, there were two ways that poor, nonelderly individuals could secure health care coverage.

First, families could be eligible for either Medicaid or the Children's Health Insurance Program, as determined by federal mandates and the state in which they reside.

Second, individuals who were sufficiently disabled could be covered by Supplementary Security Income, and hence eligible for Medicaid. Low-income persons who were disabled could also have been covered by Medicare with co-payments covered by Medicaid.

Individuals living in poverty who did not qualify for such coverage could access care through community health centers, where bills are based on ability to pay, or through hospital emergency rooms and outpatient facilities, where billing reflects the going rate for services. Many of these bills are not paid in full and the cost of care is born by others.

Even with coverage, many people had trouble accessing health care services. Providers generally avoid low-income areas where they face lower compensation and less attractive working conditions; low-income earners often have inflexible work schedules and lack reliable transportation. Language barriers also impede access for those poor who are not native English speakers.

PPACA will improve this situation for many of the poor in the following ways:

- Coverage will become more uniform across states
- It will no longer be legal for private insurance companies to discriminate against individuals with preexisting conditions
- Resources will be increased for community health centers.

Access is also likely to improve because PPACA contains incentives to attract new professionals to practice in community health centers and other underserved areas, such as low-income rural and urban communities. Also, under PPACA, the fee schedule used by Medicaid to reimburse for primary care services is set to increase to the level of the Medicare fee schedule.

The question about cost may lead taxpayers to ask whether providing care to the poor is too expensive, especially during this period of fiscal stress in which the government is looking to decrease expenditures.

There are several reasons to believe it is not.

First, we are paying for health care for the poor now, often indirectly and awkwardly. For those under age 65 in the lowest quintile, total health care expenditures per capita over the period 2001-2005 were \$2,428 (in 2005 dollars). That's higher than the expenditures of those in the second and middle quintiles, according to Gary Burtless of the [Brookings Institution](#).

spotlight on
POVERTY and OPPORTUNITY
THE SOURCE FOR NEWS, IDEAS AND ACTION

Much of this cost is borne through uncompensated care—services for which patients are either unable or unwilling to pay. Because individuals in low-income households are far more likely to be uninsured and require assistance to pay for their care, reform should reduce public expenditures for uncompensated care by extending coverage to low-income individuals and families. In Massachusetts, during the year following their reform in 2008, state expenses paid for uncompensated care were reduced by nearly [35 percent](#).

Second, increased access, prevention, and early detection of disease will reduce medical care spending. Oral health care, treatment for certain cancers, vaccinations, the new nursing home visiting program, and diabetes care are just a few of the health care reform programs that will reduce costs over time.

Third, health reform will save money by encouraging chronically ill poor individuals to receive primary care from medical homes, an approach to providing comprehensive primary care by facilitating partnerships between patients and their physicians. These homes are likely to save unnecessary and duplicative care and reduce avoidable hospital admissions for those with diseases such as asthma and diabetes.

Fourth, PPACA creates incentives to improve the quality of care, which should limit costs and help to reduce medical errors overall and particularly for the poor. For example, under the law, if a patient with public coverage is re-admitted to a hospital for a “preventable reason,” which includes hospital acquired infection, the hospital will be paid little or nothing for fixing the mistake. This is a substantial change to the current fee-for-all-service payments to most hospitals.

Perhaps more important are the longer run gains to the economy. Existing evidence suggests that poor pregnant women and new mothers who are served by visiting nurses tend to smoke less and improve their nutrition, and therefore their children will be healthier and do better in the long run. Poor persons with conditions such as hypertension will fare better and be more productive while poor persons with acute myocardial infarctions will be less likely to die prematurely.

While many ask whether providing care to the poor is too expensive, the real question remains: can we afford not to provide coverage to the poor?

Barbara Wolfe is Professor of Economics, Population Health Sciences, and Public Affairs and Faculty Affiliate at the Institute for Research on Poverty at the University of Wisconsin-Madison.