

April 2001

**NATIONAL
HEALTH
POLICY
FORUM**

The Health Care
Safety Net in a Time
of Fiscal Pressures

The
George
Washington
University
WASHINGTON DC

■
A background paper prepared by
Richard E. Hegner

Overview—For a variety of reasons—some related to the nation’s lack of universal health care coverage, others related to basic barriers to access—the uninsured, underinsured, and others lacking access to health care have come to depend on a loosely woven safety net of providers committed to seeing that they receive medical attention. This background paper serves as the foundation for three upcoming National Health Policy Forum meetings on the difficulties confronting this safety net. Against the backdrop of last year’s report issued by the Institute of Medicine (IOM), America’s Health Care Safety Net: Intact but Endangered, the paper reviews the recurrent choice in U.S. health care policy between underwriting public insurance coverage and subsidizing direct provision of health care. After noting reasons for direct federal interest in the safety net and the major findings of the IOM report, the paper looks at the distinction between core safety-net providers and other health care providers offering safety-net services as well as at local variation in the safety net. The paper then turns to what is known about uninsured Americans and the determinants, dynamics, and medical consequences of uninsurance. Also reviewed are the financial underpinnings of the safety net, including Medicaid (its major source of funding), Medicare, and the intricate system of cross-subsidies that allow safety-net providers to offer uncompensated care. Referencing the principal threats that confront the safety net, such as managed care and competition for insured patients, possible cuts in direct and indirect subsidies, and growth in the numbers of uninsured Americans, the paper goes on to examine the particular jeopardy facing hospital emergency rooms.

Inevitably, in discussions of proposals for expanding health insurance coverage in this country, the point is made that no American has to go without health care simply because he or she lacks adequate insurance coverage or cannot afford to pay for treatment. This assertion implicitly refers to the nation’s safety-net providers, who have committed—to a greater or lesser degree—to provide health care to people, regardless of their ability to pay. Safety-net providers include certain hospitals (such as public and some community facilities), community and migrant health centers, rural health clinics, local health departments, nurse-managed centers, most teaching hospitals, many physicians and other individual practitioners, and numerous other providers who care for a disproportionate percentage of patients who are uninsured, underinsured, or covered by Medicaid

or who face special conditions such as AIDS, serious mental illness, or homelessness. (The uninsured population alone totaled 42.6 million in 1999—about one in six Americans.)

While few would question the crucial role played by the health care safety net in the United States, there is disagreement over its adequacy and sufficiency—and over its capacity to withstand current trends in third-party reimbursement and in the general market for health care. Certainly, the strength, depth, and composition of the safety net varies greatly from region to region, state to state, and locality to locality. Moreover, the safety net has some evident holes—for example, it is more likely to provide care for serious illnesses than offer preventive services and more likely to attend to acute than chronic illnesses.

James Mongan, president of the Massachusetts General Hospital, commented in a *Washington Post* op-ed piece last October:

Many Americans do not understand, or choose not to understand, the impact of being uninsured. Many assume that the uninsured get help when they need it, and in a sense they are right—but also very wrong. For some acute, visible episodes such as childbirth or a broken leg, almost everybody does get treatment. What is not well understood is that the uninsured often do not receive care for many serious illnesses, such as cancer, diabetes, and hypertension, and in many instances defer care until their illness has reached an advanced stage.¹

Nevertheless, there does seem to be a consensus that the health care safety net plays an important auxiliary

BACKGROUND PAPER

National Health Policy Forum

2131 K Street, NW, Suite 500
Washington, DC 20037

202/872-1390

202/862-9837 (fax)

nHPF@gwu.edu (e-mail)

www.nHPF.org (Web site)

Judith Miller Jones, Director
Karen Matherlee, Co-Director
Judith D. Moore, Co-Director
Michele Black, Publications Director

NHPF is a nonpartisan education and information exchange for federal health policymakers.

role in health care delivery. In its report on the safety net issued last year, *America's Health Care Safety Net: Intact but Endangered*, the Institute of Medicine (IOM) concluded: "In the absence of universal comprehensive coverage, the health care safety net has served as the default system for caring for many of the nation's uninsured and vulnerable populations."²

Given the demise of the Clinton health reform proposal of 1993–1994, most observers seem to agree that universal coverage is not going to materialize in the foreseeable future. A reexamination of the safety net as a means of providing health care to those with no other recourse therefore seems in order.

Such an examination is timely because of the Bush administration's commitment during the 2000 presidential campaign to add 1,200 community health centers over the next five years. In addition, the 107th Congress has already shown interest in the safety net, in part because a number of federal safety net programs, including community and migrant health centers, are up for reauthorization.³ Furthermore, the National Governors' Association has proposed a radical restructuring of the Medicaid program, which would allow it to cover a larger portion of the indigent population with a less rich benefit package, potentially relieving some of the pressures on safety-net providers.⁴ Yet, Medicaid is becoming increasingly vulnerable in many states; according to data from the National Conference of State Legislatures for early March 2001, 23 states and the District of Columbia are experiencing Medicaid cost overruns.⁵

While the safety net is primarily defined at the local level across the country, there are numerous reasons for federal interest in safety-net policy, among them:

- Medicaid is the single largest source of safety-net patient revenue.
- Federal statute governs patient treatment in hospital emergency rooms (ERs) across the United States.
- To varying degrees, federal tax laws and entitlement programs have an impact on who has access to health insurance coverage and who is left out.
- If the safety net were to fail, there would be major public health consequences for all residents of the United States.

Even if there were near universal coverage, arguably there would also be a residual role for safety-net providers, who offer the accessibility, cultural competence, and other consumer-friendly features that many main-

stream providers do not. As Julius Richmond and Rashi Fein pointed out in a commentary they published in the *Journal of the American Medical Association* over six years ago: "Important as universal insurance is, it is access that we seek."⁶ In other words, insurance alone does not guarantee an individual access to health care; obstacles such as shortages of providers, difficulties in enrollment, geographic distances, and language and other cultural differences can still impede access.

BACKGROUND

While the very title of the IOM's recent report—*America's Health Care Safety Net: Intact but Endangered*—suggests a somewhat unprecedented crisis, the text of the report indicates that the problems are chronic: "The funding and organization of the safety net have always been tenuous and subject to the changing tides of politics, available resources, and public policies." It is instead the timing and the nature of the financial threats facing the safety net that are unprecedented. A simultaneous combination of what has been called "our nation's uninsurance epidemic,"⁷ expansion of managed care in both the public and private sectors, threats to public subsidies for the safety net, escalating costs, and increased general competition has brought extraordinary pressures to bear on safety-net providers.

One of the basic features of the safety net is that its providers are essentially the providers of last resort. In a *New York Times* interview, the medical director of the nation's oldest public hospital, Bellevue Hospital in Manhattan, observed: "When you're at Bellevue, there is no elsewhere."⁸ Without alternatives, he had nowhere else to refer patients—it was his physicians who treated them and the hospital that absorbed the cost of their care.

Furthermore, the populations served by safety-net providers are generally both difficult and expensive. Raymond Baxter, a member of the IOM safety-net committee, and Robert Mechanic, co-authors of a recent *Health Affairs* article, observe:

[These safety-net patients] range from the uninsured and Medicaid populations to a broader array of vulnerable populations, including persons with acquired immunodeficiency syndrome (AIDS), substance abusers, the frail elderly, low-income children, and pregnant women, the homeless, and the mentally ill.⁹

Quite literally, this is a patient load like that faced by no other set of providers.

In their study of the rise and fall of the Clinton health reform proposal, *The System*, Haynes Johnson

and David Broder graphically describe the two-level system of health care that those with coverage and those without coverage confront—in the context of metropolitan Los Angeles:

“If you have insurance, you go to Cedars[-Sinai Medical Center],” [a local hospital association official] said. “If you don’t, you go to L.A. County [Medical Center], where you wait for hours, days, and months to get your health care.” . . . We have a shadow system called the public system. Because that system has been inadequately funded and faces excess demands on its services, public hospitals and clinics have been forced to subsidize the care they provide by paying low salaries and hiring people who are either willing to accept a lower salary or who cannot be hired anyplace else. Without reform of the entire system, they were now at the additional disadvantage of having to be competitive in the private marketplace without the resources to compete in it.¹⁰

While the point Johnson and Broder make is not valid for all safety-net providers, there are concerns about how core safety-net providers can sustain quality without adequate resources.

The safety net in rural America faces its own set of special challenges. In some rural locales, virtually every provider is a safety-net provider. Recruitment and retention pose special difficulties in rural settings. Geographic distances, combined with poor, if not nonexistent, public transportation, make access to care difficult. Both poverty and uninsurance levels are generally much higher—and typically increase the farther away people reside from urban areas. And the challenges to maintaining the financial viability of all types of providers from individual practitioners to community hospitals are especially daunting, given their small-scale operations. All of these factors combine to make the rural safety net especially susceptible to the threats that confront safety-net providers in urban and suburban settings across the country.

Insurance Coverage vs. Subsidized Access: Recurring Choices in American Health Policy

Over the past half century, federal health policy makers have repeatedly faced the choice between covering Americans through some sort of subsidized health insurance program and offering subsidies for the direct provision of health care, typically through institution-based health care providers. After World War II, during the Truman administration, the choice was between the Wagner-Murphy-Dingell bill, which offered universal health insurance coverage, and what became the Hill-Burton Act, which provided federal subsidies for hospital

construction in underserved areas; Congress chose the latter option.¹¹ In 1965, when Lyndon Johnson was president, Congress enacted less-than-universal coverage in Medicare and Medicaid but augmented it through a program of neighborhood health centers in low-income areas. The National Health Services Corps helped to fund a network of practitioners in areas with shortages of individual health providers.

Karen Davis and Cathy Schoen capture some of the thinking during the 1960s that went into the neighborhood health center program, which eventually evolved into today’s community and migrant health centers:

[Federal] planners argued persuasively that only a health center, as opposed to health insurance, could, in addition to financing services, simultaneously treat a variety of causes of deficient medical care common to poverty areas such as the scarcity of physicians and health facilities; inadequate transportation to areas with more abundant resources; crowded facilities with long waits and care that was frequently impersonal or minimal; physicians who, pressed for time, seldom undertook extensive workups, provided counseling, or explained fully the nature and importance of a prescribed treatment; and discriminatory practices that restricted the access of minority groups to sources of care open to whites.¹²

Moreover, it is important to remember that even existing public benefit programs, such as Medicaid itself and the more recently enacted State Children’s Health Insurance Program (SCHIP), have never succeeded in enrolling all those eligible for their services, despite sizable recent appropriations for outreach and enhanced flexibility.¹³ Larry Gage, president of the National Association of Public Hospitals and Health Systems (NAPH), suggests: “Based on our failure thus far to sign up millions of people who are already eligible for Medicaid, the State Children’s Health Insurance Program . . . , and other public coverage, any . . . health care reform efforts must be augmented by support for institutional safety-net providers.” In other words, it is not a matter of *either* public insurance coverage *or* subsidies for access through safety-net providers—but of *both*. Moreover, insurance coverage does not guarantee access to care.

Others note that, for a variety of reasons, certain populations may never be covered by public insurance programs. These include groups such as homeless people and Americans with serious and persistent mental illness, who may elude coverage to which they are entitled. These people are often difficult to enroll and may be easier to serve in safety-net settings. They also include groups such as certain legal or illegal

immigrants, whom federal lawmakers may as a matter of public policy choose not to make eligible for comprehensive coverage. Yet, simply as a matter of protecting the public health, it may be desirable to provide some minimum level of treatment, even to people who reside illegally in the United States. Some would suggest that the most efficient way of doing that is through safety-net providers.

Finally, some observers point out that subsidies to public providers do not always assure access to the whole range of needed services. For example, while many community and migrant health centers have arranged specialty and subspecialty referral networks, many others complain that they cannot get their indigent patients seen when their needs warrant more than attention by primary practitioners. This is obviously a lesser problem for safety-net patients whose medical homes are hospitals of last resort, ERs, and/or tertiary care institutions whose staffs are likely to include specialists and subspecialists. But where such gaps are likely to occur—especially in primary care safety-net settings—patients are likely to experience repeated visits for recurring complaints.

The Direct Federal Interest in the Safety Net

Because the health care safety net varies according to local circumstances, no one can really speak of a national safety net. As the IOM report notes:

The nation's health care safety net is . . . a patchwork of institutions, financing, and programs that vary dramatically across the country as a result of a broad range of economic, political, and structural factors. These factors include the strength and configuration of the local economy, the numbers and concentration of poor and uninsured individuals, the structure of the local tax base, the depth and breadth of a State's Medicaid eligibility and benefits, and the community's historic commitment to care for the uninsured and other vulnerable populations.

Nevertheless, there are a number of reasons why federal policymakers have a direct interest in the strength of the safety net:

- ***The Medicaid program is the major source of revenue for safety-net providers.*** The IOM report underscores the central importance of Medicaid to funding the safety net:

Over the years, **Medicaid has become the financial underpinning of the safety net** [emphasis added]. Historically, Medicaid has furnished the majority of insured patients for most safety net providers and has subsidized a substantial portion

of care for the uninsured through such programs as disproportionate share hospital (DSH) payments and cost-based reimbursement for federally qualified health centers [FQHCs].

No other funding source approximates Medicaid in importance for the safety net.

- ***A number of other federal grant-in-aid programs also provide financial support for the safety net.***

The Section 330 program authorized under the Public Health Service Act subsidizes community and migrant health centers, the largest formal federal component of the safety net outside of Medicaid; approximately 700 health centers with nearly 3,000 clinics and a network of 6,500 primary care clinicians provide services to more than 9 million people.¹⁴ The Indian Health Service currently serves some 1.5 million American Indians and Alaska Natives in 34 states through a system that includes 37 hospitals, 64 health centers, 50 health stations, and five school health centers. The Department of Health and Human Services' Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration (HRSA), has spurred the development of nurse-managed care centers. The Ryan White program for people with HIV/AIDS and the Stuart McKinney program for the homeless also help support safety-net providers. In addition, the Medicare program, through its direct payments to providers as well as its DSH payments for Medicare and low-income patients and its support for graduate medical education (GME)—especially its IME (indirect medical education) component—helps fund safety-net providers. Some health workforce initiatives also support the safety net; for example, the National Health Service Corps has traditionally supplied physicians to inner-city and rural community health centers and other facilities.

- ***Federal law requires hospital emergency rooms across the country to treat patients regardless of their ability to pay.*** The Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) guarantees everyone residing in the United States hospital-based emergency treatment for severe illnesses and injuries. In essence, it is an unfunded mandate whose incidence is heaviest on hospitals who choose to staff emergency rooms, particularly those located in certain urban and rural areas, where the concentration of uninsured patients is the highest. Hospitals that fail to comply with EMTALA will lose their Medicare provider status—and hence their ability to collect the Medicare

revenues on which virtually all hospitals depend for their existence.

- ***To some extent, federal income tax law and the eligibility provisions for such federal entitlement programs as Medicare and Medicaid combine to determine who is uninsured or underinsured in the United States.*** Employers' health insurance premiums are fully deductible from their federal income and social security payroll taxes. Almost two-thirds of Americans receive health insurance coverage because their employer (or a family member's employer) utilizes this tax-advantaged form of supplementary remuneration. A sizable portion of the remainder of the population receives its coverage through either the federal Medicare or Medicaid programs. Thus, to the extent that people are uninsured or underinsured and dependent on the safety net, it is largely because they do not have access to this tax-subsidized system and public programs such as Medicare and Medicaid.
- ***If the safety net were to fail in its mission, there would be public health consequences for all Americans.*** One of the many roles of the safety net is to contain the spread of contagious diseases and thereby protect the general population. Insofar as the safety net is unable to meet this challenge, the public health would be jeopardized, and the need for government intervention on a broader scale than local government would grow. Otherwise, threats to the population as a whole, such as multidrug-resistant tuberculosis, sexually transmitted diseases (including HIV/AIDS), hanta virus, measles, and influenza—none of which respects state or local boundaries—might ultimately require federal-level attention, ultimately through the Centers for Disease Control and Prevention (CDC). Similarly, insofar as the safety-net services, such as emergency departments, shock trauma care, neonatal intensive care, and burn units, that are offered to the general public are jeopardized because of their linkage to the financial well-being of the safety-net providers, the welfare of the general population itself may be threatened.

The Safety Net Over Time

Echoing the biblical "ye have the poor always with you," one of the co-editors of the IOM report, Stuart Altman, and Uwe Reinhardt and Alexandra Shields, his co-editors of another recent volume, observe:

The phenomenon of the uninsured and the underinsured in the United States is not new. It has been a permanent

feature of the American health system. The number [of uninsured] stood at close to one-third of the U.S. population before the introduction of Medicare and Medicaid in the mid-1960s. Thereafter, it gradually fell to about 12 percent of the population in the late 1970s. Since that time, it has risen steadily, reaching the current proportion of more than 15 percent. . . . In many parts of the United States—for example, in California—it already exceeds 25 percent.¹⁵

Over the years, America's health care safety net has metamorphosed from a system composed primarily of charity hospitals and clinics, backed up by some private practitioners who offered charity medicine, to a system after World War II that also included community hospitals, which gradually assumed varying degrees of safety-net responsibility. Then, with the advent of the "Great Society," came the enactment of Medicare and Medicaid in 1965, which offered, respectively, near-universal coverage for the elderly and disabled and limited coverage for the primarily welfare-related indigent population. Even these programs have had their shortcomings. Gage points out:

Many thought that the enactment of the Medicare and Medicaid programs would eliminate the need for public charity hospitals. But that just didn't happen. From the outset, the Medicaid program never covered all of the population living in poverty, and after a few years of early growth, Medicaid coverage declined dramatically. From a 1976 high-water mark of 65 percent of all individuals living in poverty or near poverty, Medicaid covered fewer than 45 percent by the early 1980s.¹⁶

Despite some expansion in coverage in the late 1980s for children and pregnant women, the proportion of poor Americans covered by Medicaid in 1999 stood at 40.9 percent. Even Medicare, though it covers all but a small percentage of Americans over 65, provides coverage for a shrinking portion of the total cost of their care. HCFA estimates that the program now covers less than half of the total medical expenses of the elderly and that the average older person spends 18 percent of his or her after-tax income on health care, up from 10 percent in 1972.

Despite serious consideration of several intervening universal coverage proposals, culminating in the Clinton administration's abortive national health insurance proposal of 1993-1994, the emphasis of legislation enacted in recent years has been on incremental change. In the late 1980s and early 1990s, the scope of income eligibility of the Medicaid program was expanded to encompass an increasing percentage of the indigent population. Then, in the years 1995 to 1997, a bipartisan consensus developed that a larger

group of low-income uninsured children should receive federally subsidized coverage. The enactment of the State Children's Health Insurance Program in August 1997 ensued. By early 2001, SCHIP had succeeded in enrolling a total of 3.3 million children. In 1996, Medicaid eligibility had been delinked from eligibility for a new program, Temporary Assistance for Needy Families (TANF), which was enacted to succeed Aid to Families with Dependent Children (AFDC) as part of welfare reform. To some extent, this delinking led to an initial decline in the number of Medicaid enrollees; between June 1997 and June 1998, Medicaid enrollment dropped from 31.3 million to 30.7 million. However, it then rebounded to 30.9 million in December 1998, to 31.4 million in June 1999, and to 32.0 million in December 1999.¹⁷ There is evidence that outreach for the SCHIP program helped boost Medicaid enrollment.

The IOM Report

Issued in March 2000, *America's Health Care Safety Net: Intact but Endangered* was commissioned by HRSA

to examine the impact of Medicaid managed care and other changes in health care coverage on the future integrity and viability of safety-net providers, particularly core safety-net providers such as community health centers, public hospitals, and local health departments.

Even before enumerating its findings, the IOM committee noted that it "was struck by the dearth of reliable and consistent data that can be used to accurately assess, measure, or compare the changing status of safety-net systems across the country."

The IOM committee went on to conclude:

- The shift to Medicaid managed care can have adverse effects on core safety-net providers and the uninsured and other vulnerable populations who rely on them.
- Managed care principles offer significant potential for improved health care for Medicaid patients [served by safety-net providers], but implementation problems can undermine this potential.
- The financial viability of core safety-net providers is even more at risk today than in the past because of the combined effects of three major dynamics: (1) the rising number of uninsured individuals; (2) the full impact of mandated Medicaid managed care in a more competitive health care marketplace; and (3) the erosion and uncertainty of major direct and indirect subsidies that have helped support safety-net functions.

- The . . . availability of care for the uninsured and other vulnerable populations increasingly depends on where they live.
- The committee found that most safety-net providers have thus far been able to adapt to the changing environment. Even for these providers, however, the stresses of these changes have made it increasingly difficult for them to maintain their missions while protecting their financial margins.

The IOM report has been criticized by some because it focuses primarily on HRSA-funded community and migrant health centers and other core safety-net providers and pays relatively little attention to other safety-net providers, such as community hospitals and emergency rooms, even though such providers, in aggregate, play a larger role in providing care to the uninsured, underinsured, Medicaid beneficiaries, and special populations. Some critics have pointed out that it focuses more heavily on public than private safety-net providers, despite evidence of the growing importance of the latter.

Some have also criticized the IOM report as a bit too oriented to maintaining the current array of safety-net providers, especially those constituting the core safety net. For example, Thomas Chapman, president and chief executive officer of the Health Services for Children Foundation, commented soon after the report appeared:

The challenge the IOM report presents is to simultaneously boost access to primary care while reducing excess capacity. What's needed is a dedicated redesign strategy that doesn't try to maintain the status quo by simply spending new healthcare dollars the same way.¹⁸

THE SAFETY NET AND ITS COMPONENT PROVIDERS

The IOM report defines the safety net as "those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable populations." Baxter and Mechanic posit a slightly different definition: "the institutions, programs, and professionals devoting substantial resources to serving the uninsured or socially disadvantaged." This background paper also includes mention of the underinsured and those who experience difficulty obtaining health care from non-safety-net providers.

The Core Safety Net and the Broader Universe of Health Care Providers

Most discussions of the safety net distinguish between the "core safety-net" and other health care

providers that may assume safety-net functions. According to the IOM, core safety-net providers have two basic characteristics:

- Either by legal mandate or explicitly adopted mission they maintain an “open door,” offering access to services for patients regardless of their ability to pay.
- A substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.

Core safety-net providers are those who recognize a principal role or mission in treating the uninsured, underinsured, or vulnerable patients and do not shun them because they have no coverage, are expensive or difficult to treat, and/or are less desirable patients. Non-safety-net providers often choose to avoid these populations for reasons related to their own economic viability. With the exception of the EMTALA mandate, the safety net is strictly a voluntary system. Yet even safety-net providers can ultimately approach a financial “tipping point” beyond which they cannot accept patients without coverage or personal financial resources. That is why some have made the comment: “no margin, no mission.” Among those typically considered core safety-net providers are public hospitals, community and migrant health centers (also known as FQHCs), and local health departments; in some communities, they may also include teaching hospitals and rural community hospitals. In most communities, smaller special service programs, including school-based health programs, nursing centers, rural health clinics, Ryan White AIDS programs, and family planning programs, are also considered core safety-net components.

It is not unusual in many communities for other providers to assume a substantial safety-net role, too. These may include community hospitals or religiously affiliated institutions with missions to serve the indigent, as well as private physicians committed to offering a substantial amount of “charity care.” Some have referred to these providers as the “invisible safety net,” since they often receive less public attention. The amount of such charity or uncompensated care is likely to vary a great deal from area to area, however, and to depend, among other things, on the size and strength of the core safety net. In addition, at least 14 states have “community benefits” laws or regulations which require certain hospitals and/or managed care organizations (MCOs) to offer some sort of public goods, including charity care.¹⁹ It is perhaps useful to conceptualize the core safety net and other health care providers in a given locality as a series of concentric circles. (As noted above, in some rural areas, virtually every provider assumes some safety-net role.)

Local Variation in Safety Nets

As noted above, there is no national health care safety net, but rather a collection of regional or local safety nets. Baxter and Mechanic observe:

The overwhelming evidence is that safety nets are local. There is no one “safety net” that an observer can point to. The interaction of composition, concentration, financing, and community context defines each local safety net. Thus it is difficult to talk about whether “the safety net is in crisis,” since there is little consistency across communities. . . . Ultimately, it is local factors, played out in the context of state policies and regional economic trends against the backdrop of federal policy, that determines the nature of local safety nets and their stability or vulnerability.

A number of factors contribute to the relative strength or weakness of a local safety net. These include elements as basic as the political culture of a community as reflected in its predisposition to assist the indigent and the uninsured. The adequacy of employer-based health insurance and the comprehensiveness of state Medicaid and SCHIP coverage as well as any other available publicly subsidized coverage obviously affect the level of demand placed on local safety-net providers. The components of the local economy and the local unemployment rate are also factors in this equation. A number of characteristics of the local population—including its per capita income, the concentration of immigrants, and its racial and ethnic composition—also contribute to the demands it places on the safety net. Finally, payment rates are key, with the penetration of managed care and the competitiveness of health care markets locally affecting the ability of local providers to cross-subsidize those without any or without adequate insurance coverage.

There are two major private and one major public demonstration grant program predicated on a recognition of the essentially local nature of the safety net:

- *The W. K. Kellogg Foundation’s Community Voices Program.* Launched in August 1998 to help ensure the survival of safety-net providers and to strengthen community support services, this initiative seeks to help reduce the number of people without health care coverage and utilize community-based resources to reach those who most often slip through the holes in the safety net. Five-year grants were made to assist “local laboratories” in 13 different sites.
- *The Robert Wood Johnson Foundation’s Communities in Charge Program.* One-year organization and planning grants were awarded to 20 communities in January 2000. These grants allowed communities to

research their uninsured problems, develop strong community-wide consortia, review potential solutions, and begin to design delivery and financing systems. Recently, the foundation announced that three-year Phase II grants of \$700,000 each were awarded to 14 of these communities to implement plans to put the programs into action.

- *The Health Resources Services Administration's Community Access Program (CAP)*. According to a recent press release, "the CAP initiative seeks to expand access for the uninsured by increasing the effectiveness and capacity of the nation's health care safety net at the community level." Following a highly competitive bidding process, HRSA announced its first round of 23 awards under the CAP program to local entities in 22 states on September 7, 2000; the awards totaled \$22,020,954 and averaged \$957,433. On February 4, 2001, HRSA announced the availability of \$40 million in additional fiscal year (FY) 2001 funds under CAP for new grantees on a competitive basis. (\$56 million in FY 2001 funds were also made available to fund 53 FY 2000 applicants that were recommended for approval by HRSA but not funded previously because of budget constraints.)²⁰

The common strengths of these three programs include a willingness to respect local decision-making processes and to allow communities to do local problem-solving. Local business, health care, and community leaders have contributed innovative ideas about how to use funds already in the health care system more effectively, while cutting down on duplication and waste in the interests of serving more people.

TARGET POPULATION: THE UNINSURED

While safety-net providers serve a broader population than the uninsured—including the underinsured, Medicaid beneficiaries, and all those who experience difficulty in obtaining health care, regardless of their insurance status—several factors argue for focusing attention on the uninsured. As the IOM report points out, it is the growing numbers of uninsured Americans that has put unusual pressure on safety-net providers. In addition, many of the factors that cause uninsurance also appear to contribute to difficulties in the access to health care of other populations. Finally, far better data are available on the phenomenon of uninsurance than on underinsurance.

In 1999, 42.6 million Americans—or 15.5 percent of the population—lacked health insurance. This was the equivalent of slightly more than the combined populations of the states of New York, Pennsylvania, New Jersey, and Connecticut. Because the uninsured are heavily concentrated in the below-poverty income group, with few resources to pay for medical expenses out-of-pocket, they are heavily dependent on safety-net providers. Although the uninsured are a heterogeneous group, making it difficult to generalize about them, they share some major characteristics.

Uninsurance and Employment

Paul Fronstin of the Employee Benefit Research Institute points out the salience of one particular factor:

Employment status is the most important determinant of health insurance coverage. Almost two-thirds of the nonelderly population have employment-based coverage. This coverage can be obtained either directly through one's employer/union or previous employer or indirectly through an employed person in one's family.²¹

Ironically, however, as a *Washington Post* reporter noted last fall: "Among people below the poverty line . . . working actually reduced a person's chance of having health insurance. About 60 percent of the non-working poor were insured, compared with 53 percent of those who had jobs."²² As much as anything, this relates to the poor fringe benefits available to low-wage workers. Charles Kahn and Ronald Pollack describe the dilemma of such workers as follows:

Low-wage workers experience a "triple whammy": They are less likely to be offered coverage by their employers, they have to pay considerably more for coverage when employers do offer it, and they have the least discretionary income available to pay for it.²³

Uninsurance and Poverty

In general, those with household incomes below the poverty line are more likely to be uninsured, as demonstrated in Table 1 (see page 10).

Despite the existence of public health insurance programs targeted to indigent Americans, it is important to remember that none of the nation's public programs—not even Medicaid—pretends to cover all Americans below the federal poverty line. Fronstin points out that

although many individuals in poor families are covered by public health plans, that coverage is far from universal. In 1999, 43.8 percent of the nonelderly with family incomes below the poverty line were covered by a public plan—40.9 percent by Medicaid.

Table 1
Uninsurance Rate of Nonelderly,
by Poverty Level, 1998

| Federal Poverty Level | Uninsurance Rate |
|-----------------------|------------------|
| <100% | 36% |
| 100%–199% | 31% |
| 200%–299% | 19% |
| 300%+ | 9% |

Source: Kaiser Commission on Medicaid and the Uninsured, *Uninsured in America: A Chart Book, 2nd ed.* (Washington, D.C.: Henry J. Kaiser Family Foundation, May 2000).

Furthermore, part of the problem is enrolling people who are indeed eligible. Research from the Center on Budget and Policy Priorities issued in December 2000 found the following:

A recent analysis of Census data . . . finds that 94 percent of all uninsured children with family incomes below twice the poverty line—currently \$28,300 for a family of three—qualify for Medicaid or a separate child health insurance program supported by SCHIP funds. [This translates into 6.7 million of 7.1 million uninsured children at this income level.] . . . The notable exception [is] certain immigrant children.²⁴

The biggest gap in Medicaid coverage is for low-income nonaged adults. A recent article in *Health Affairs* noted:

Although states have the option to include parents in Medicaid, in thirty-two states uninsured working parents are ineligible for Medicaid if they work full time at the minimum wage (\$5.15 per hour). Equally important, low-income childless parents, no matter how poor, are ineligible for coverage under federal law unless they qualify as disabled. Without changes in federal law, Medicaid is unlikely to reach the bulk of uninsured adults—the vast majority of the low-income uninsured.²⁵

Uninsurance and Age

With the exception of those over age 65, there is some relationship between an individual's age and his or her likelihood of being uninsured. (Because of the existence of the Medicare program, almost everyone over age 65—about 96 percent—has at least some health insurance coverage.)

Among American children—those age 18 and under—about 10 million, or just under 14 percent, were uninsured in 1999. These figures represented a decline from 11.1 million, or 15.4 percent, in 1998.²⁶

The 1999 Commonwealth Fund National Survey of Workers' Health Insurance found that nearly one of five adults aged 18 to 64 was uninsured.²⁷ Fronstin reports, "Individuals ages 45–54 were less likely to be uninsured (13.4 percent), and individuals ages 21–24 were more likely to be uninsured (33.4 percent), than those in all other age groups in 1999."²⁸

Race, Ethnicity, Place of Birth, Citizenship Status, and Uninsurance

Another important correlate of uninsurance is an individual's race or ethnic background. About 14 percent of white Americans are uninsured, but the percentage for Americans of color is considerably higher.

- While Latinos represent about 12 percent of the total population of the U.S., they constitute one-quarter of the nation's uninsured. Almost 40 percent of Latinos are uninsured, the highest rate for any racial or ethnic group.²⁹
- Twenty-three percent of African Americans are uninsured. That rate is more than 1.5 times that among whites, primarily because of differences in employer-based coverage.³⁰
- Roughly 21 percent of Asian Americans and Pacific Islanders are uninsured, again because of lesser likelihood of having job-based insurance coverage.³¹
- Over 27 percent of American Indians and Alaska Natives are uninsured, nearly twice the rate of whites.³²

Place of birth and immigrant status are also closely related to uninsurance status:

- The foreign-born population was more likely than the native population to be uninsured, 33.4 percent versus 13.5 percent.
- With respect to immigrant status, Fronstin reports:

Citizenship is a primary factor in the likelihood of an individual having coverage and in the source of that coverage. . . . More than 45 percent of nonelderly respondents indicating that they were noncitizens were uninsured in 1999, compared with 16.5 percent of citizens. . . . High uninsured rates may be due in part to the fact that a higher proportion of noncitizens were in low-income families, were likely to be nonworkers, or were likely to work in small firms.

Major Reasons for Uninsurance

The Kaiser chart book also presents some revealing data on the single most important reason that individuals cite for uninsurance (Table 2).

Table 2
Most Important Reason for Not Having Health Insurance*

| | |
|---|-----|
| It is too expensive | 47% |
| Your job doesn't offer coverage | 15% |
| You are between jobs or unemployed | 15% |
| You can't get coverage or were refused | 5% |
| You don't think you need it | 3% |
| Other | 15% |

*Reported by uninsured adults.

Source: *The NewsHour with Jim Lehrer/Kaiser Family Foundation National Survey on the Uninsured 2000.*

ACCESS: THE CONSEQUENCES OF UNINSURANCE

Not surprisingly, uninsurance—and related conditions, such as underinsurance and irregular connections with health care providers—have adverse consequences for individuals' health status, especially if these individuals are confronted by episodes of serious illness. As in so much of the picture, the best available evidence is for uninsurance, where the situation is the starkest.

Altman, Reinhardt, and Shields report a noteworthy statistic, based on a 1993 Congressional Budget Office report:

It is known from prior research that, after adjusting for other socio-economic factors such as income, family status, and geographic residence, uninsured Americans receive on average only about 60 percent of the health services received by insured Americans.

A variety of factors account for this disparity. For example, Kaiser Commission data indicate that, while 9 percent of insured Americans could not identify a regular source of health care, 36 percent of uninsured Americans could not do so—a fourfold difference.

A number of sources document barriers to care confronted by the uninsured; again and again, these seem to boil down primarily to insufficient financial resources. In 1997, unpaid medical debts were the fourth most often mentioned reason for personal bankruptcy in the United States.³³ A recent Commonwealth Fund report, *Can't Afford to Get Sick: A Reality for Millions of Working Americans*, documents what the combination of precarious personal financial circumstances and uninsurance does to access to care:

- Uninsured adults were [almost] three times as likely as insured adults to have gone without a needed doctor visit, not filled a prescription, or not followed up on a recommended medical test or treatment in the past year because of an inability to pay (49% vs. 18%).
- Nearly one of four (24%) adults said they had not visited a doctor when sick, had not followed up on a recommended medical test or treatment, or had not filled a prescription in the past year because of the cost.

The Kaiser Commission provides additional evidence of the deleterious effects of lack of insurance on access:

- The chances of uninsured children who are injured receiving medical attention are 30 percent less than children who have insurance.
- Uninsured adults often forego even recommended treatment. At least 30 percent did not fill a prescription or skipped a medical test or treatment in the past year because of its cost.
- Problems with access to care are worse for those with the greatest medical needs—those not in good health. For example, two-thirds of uninsured adults in fair or poor health have problems getting medical care.
- The majority of uninsured pregnant women do not begin their prenatal care in the first trimester as recommended. They are more than twice as likely not to receive the standard number of visits before delivery. Contrary to a belief that uninsured people are able to get care when they truly need it, 15 percent of uninsured mothers have prenatal care refused them when looking for a provider.

Perhaps most striking of all is evidence on how some conditions worsen because of the lack of timely medical attention, resulting in both needless suffering to individual patients and avoidable costs to the medical system. The Kaiser Commission reports: “The uninsured are hospitalized at least 50 percent more often than the insured for ‘avoidable hospital conditions’ like pneumonia and uncontrolled diabetes.”

A revealing piece of research showing how lack of health insurance coverage affects individual families was reported by Nancy Vuckovic of the Kaiser Permanente Center for Health Research in the July/August 2000 issue of *Health Affairs*.³⁴ In a study of 18 uninsured women and their families in southern Arizona, she sought answers to the following questions:

What strategies do . . . families [without health insurance] use in their daily efforts to maintain health and respond to illness? . . . What priorities do they set?

What risks—both to their own health and to the public’s health—do they take in attempting to treat themselves?

Among Vuckovic’s principal findings were that

caring for their own health and that of family members was a time-intensive task that required ingenuity and persistence. As one woman put it: “You have to be so damn creative when you don’t have medical benefits.” When it was necessary to allocate limited financial resources to health care, women used strategies for triaging and responding to illness that included finding information and health care resources “through the grapevine,” setting priorities for who gets care, and treating illnesses with pharmaceuticals that they could borrow, stockpile, or get from “under-the-counter” sources.

The women found that “social networks” offered an important resource for information and advice in general, as well as a means of financial and social support and a source of medications and information about how to obtain free or reduced-cost medical care. They lived under continual stress as a result of the threat of illness or accident, compounded by the day-to-day problem of securing health care for themselves and their families.

Vuckovic’s conclusions have potential implications beyond the scope of her study:

For the women I interviewed, being without health insurance magnified their health concerns and prompted them to take a very active role in their health care. While their self-reliant attempts to “do what you can do” in response to illness are laudable, we cannot ignore the health hazards that accompany lack of access to resources or appropriate information. Risks associated with drug interaction, side effects, treating conditions in insufficient ways, and lack of monitoring of medication use can have a detrimental effect on personal health. These behaviors may also have wider-ranging effects on public health, such as drug resistance and masked but uncured contagious diseases. These risks are typically absent from discussions about the personal and health system costs resulting from lack of insurance.

While some of these concerns might have been obviated by linking these women and their families with safety-net providers, this may have been difficult in southern Arizona.

FINANCIAL SUPPORT FOR THE SAFETY NET

As noted above, the safety net derives revenue from a number of sources, both direct and indirect. These

include public funds such as Medicaid and Medicare, special federal grant-in-aid programs, state and local subsidies, private insurance payments, and cross-subsidies from various payers.

Medicaid

Medicaid revenues flow to safety-net providers through a number of channels—as direct payments for patient care, as capitation or case management payments under managed care arrangements, or as indirect subsidies such as DSH payments or GME payments. Furthermore, federal law has stipulated requirements for Medicaid payments to certain types of safety-net providers—in particular, FQHCs, which include community and migrant health centers and similar clinics.

Because of the salience of Medicaid revenues in their budgets, safety-net providers have been especially vigilant about any threats to their Medicaid funds. Since 1989, state Medicaid programs have been required to pay community and migrant health centers and other FQHCs under a cost-based reimbursement mandate. (Prior to the enactment of the mandate, state Medicaid agencies could pay these providers no differently than other providers—typically discounted reimbursement.) Medicaid now represents about one-third of health centers’ total revenues. When the Balanced Budget Act (BBA) of 1997 included provisions to phase out cost-based reimbursement, these safety-net providers mobilized to prevent any changes. First, the Balanced Budget Recovery Act (BBRA) of 1999 provided some relief, delaying implementation of the phase-out and mandating a study to determine how FQHCs should be paid in the future. Then, in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, FQHCs were able to get a Medicaid prospective payment system that offers them reimbursement levels no lower than those they previously received under full-cost reimbursement. This victory on the part of FQHCs is noteworthy, however, for its uniqueness; no other safety-net providers have been able to attain similar accommodations within the Medicaid program, although some, such as nursing centers, continue to seek it. Over time, cost-based reimbursement has been a sore point with many state Medicaid agencies, who have felt that the special provision was unwarranted in relation to other providers.

Another special Medicaid reimbursement mechanism for safety-net providers, the DSH program, was initially intended to subsidize hospitals that provided high volumes of care to indigent patients not eligible for

Medicaid. Some states have distributed the funds over a broader set of hospitals than those that really belong to the safety net under even the broadest definition. At best, the DSH program has had a rather checkered history, since many states once used it as a vehicle to channel the flow of increased federal revenues into state coffers without increasing state outlays. Congress then limited this practice through the enactment of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991.³⁵ Further DSH budget cuts were enacted in subsequent years, including those in the BBA in 1997, which were partially restored by BIPA of 2000. The Medicaid DSH program's funding is no longer open-ended. Nonetheless, many safety-net providers depend heavily on the DSH program for support; for example, 34 percent of unreimbursed care at NAPH hospitals in 1998 was funded from Medicaid DSH funds, the second most important source after state-local subsidies (39 percent).³⁶ According to the Congressional Budget Office, DSH spending is projected to represent about 6.5 percent of total FY 2001 federal Medicaid spending.

Another indirect Medicaid subsidy is GME payments. A survey conducted under the aegis of the National Conference of State Legislatures found that all but five states paid for GME through Medicaid in 1998 and that these Medicaid GME payments totaled \$2.4 billion.³⁷

Medicare

Under the Comprehensive Omnibus Budget Reconciliation Act of 1985, provision was made for special payments to hospitals that served a high percentage of Medicare and low-income patients—the Medicare DSH adjustment. The legislation amended the 1983 statute that established the Medicare prospective payment system. According to the Congressional Budget Office, however, Medicare DSH payments are proportionately much less important to safety-net hospitals than are Medicaid DSH payments. In 1997, Medicare DSH payments totaled approximately \$4.5 billion, while Medicaid DSH payments equaled \$16 billion.

Under the Medicare inpatient hospital PPS system, teaching hospitals—which typically play an important safety-net role—are also given allowances for direct and indirect graduate medical education expenses. The IME portion helps underwrite their charity care. In FY 1996, IME payments totaling \$4.3 billion went to 1,061 teaching hospitals.

Cross-Subsidies and Uncompensated Care

One of the basic elements of the financial viability of the health care safety net is providers' ability to cross-

subsidize the care of those who lack health insurance coverage and/or the ability to pay for their care. They accomplish this cross-subsidy by charging the cost of that care to the surpluses that accrue from care charged to other third-party payers, principally private insurers. The term for this form of financial alchemy is “uncompensated care” or “charity care,” and the concept has a dual purpose in discussions of the safety net:

Uncompensated care—the amount of care written off by hospitals or other providers—is generally taken as a measure of both the need for care among persons unable to pay and the willingness and ability of health care providers to make such care available. Although uncompensated care is far from a perfect indicator of access, it has become a standard measure for tracking provision of care for the medically indigent.³⁸

To some degree, all types of health care providers offer uncompensated care. However, the most reliable data on uncompensated care are available for hospitals. A number of recent studies rank hospitals according to the relative amount of uncompensated care they provide. In doing so, they offer a measure of the extent to which safety-net responsibilities are concentrated or dispersed among general hospitals.

In a July/August 1997 article in *Health Affairs*, Linda Fishman, then associate vice president for governmental relations at the American Association of Medical Colleges (AAMC), ranked 5,229 community hospitals by deciles according to the relative amount of uncompensated care they provided in 1994. Among her findings are the following:

- Many hospitals claim to be part of the safety net. . . . However, there is substantial dispersion in the concentration and dispersion of responsibility for indigent care and graduate medical education [which often serves as a proxy for indigent care].
- A substantial percentage of private hospitals, which includes church-sponsored and private hospitals that probably receive little funding from state and local governments, maintains a relatively heavy uncompensated care burden.
- Hospitals with the highest concentration of uncompensated care had more Medicaid inpatient days (31 percent of all days) and fewer Medicare inpatient days (33 percent) than did hospitals in the other nine deciles (19 percent and 46 percent respectively).
- Despite public financial support structures for uncompensated care, such as disproportionate share payments in both the Medicare and Medicaid programs and other support from state and local governments,

the 523 hospitals that carried a particularly large uncompensated care burden relative to their operations were in a worse financial position in 1994 than other hospitals were. This raises questions about how well the current support structures are working.³⁹

The latter point seems to confirm concerns raised by the IOM report.

Other researchers have looked at different measures than uncompensated care as proxies for safety-net linkage or membership. In 1996, Georgetown University's Institute for Health Care Research and Policy estimated the existence of some 369 "urban safety-net hospitals" in the nation, using HCFA's definition of Medicaid patient volume of more than one standard deviation above the mean. (Of these 369, 33 percent were public, 57 percent private nonprofit, and 10 percent investor-owned.) As an alternative, the Lewin Group suggested that there were 696 hospitals that met the optional Medicaid definition of a greater than 25-percent "low-income utilization rate."⁴⁰

A paper published by the Johns Hopkins Center for Hospital Finance and Management in August 1998 suggested that the major share of hospital uncompensated care has shifted from public to private hospitals for a number of reasons. These include a decline in state and local subsidies to public hospitals for uncompensated care as well as the greater availability of DSH subsidies and uncompensated care pools to private hospitals.⁴¹ It is important to note, too, that some hospitals have switched from public to community ownership in order to have greater governance and management flexibility.

At the same time, the spread of various managed care arrangements and attention to controlling outlays—among both private and public third-party payers—are undoubtedly constraining safety-net providers' ability to shift costs to allow them to provide uncompensated care.

THREATS CONFRONTING THE SAFETY NET

As noted above, the IOM report identified three major challenges confronting the health care safety net:

- The impact of Medicaid managed care in a more competitive health care marketplace.
- The erosion and uncertainty of major direct and indirect subsidies that have helped support safety-net functions.

- The rising number of uninsured Americans.

As the IOM report notes, the particular difficulty of these challenges is that they are confronting safety-net providers concurrently. However, even in the relatively short time since the release of the IOM report in March 2000, some of the landscape affecting the safety net has changed.

Looking at the situation from a longer-term perspective, it is perhaps worth remembering that its component providers have seldom been in a comfortable financial position. In a paper published by the Urban Institute in September 1998, Stephen Norton and Debra Lipson observed: "Ultimately, the safety net is never fully supported, as the institutions are not fully compensated for care to the uninsured. Thus, no matter how high or low the level of pressure they experience, these institutions will be under some stress."⁴²

The question, then, is less one of whether the safety net is in a state of crisis—it seems perpetually so—than one of how serious the difficulties are and how likely the safety net is to withstand them. What Linda Fishman and James Bentley, then at the AAMC, had to say about hospitals in general applies equally to safety-net providers of all kinds:

Now the health care system is transforming from one based on a delicate web of confusing cross-subsidies to a system based on price competition in which both private and public purchasers want to pay only for the cost of the services their enrollees receive. Pressure to curb the rate of growth in state and federal health care spending threatens to erode the existing public support mechanisms for uncompensated care and GME. The question in the current competitive environment is whether, how, and to what extent society will continue to support the additional roles of hospitals that now are funded with patient care revenue.⁴³

Managed Care and Competition

While the IOM report zeroes in on Medicaid managed care as a particular threat to the safety net, certainly the larger phenomenon of managed care in both the private and public sectors threatens the ability of safety-net providers to shift costs among providers and thereby fund uncompensated care. This problem, which transcends Medicaid, is characterized by the American College of Emergency Physicians' (ACEPs') Wesley Fields as follows: "The price elasticity of the fee-for-service era that allowed community facilities to perform safety-net functions is largely eliminated by MCOs' efforts to control their own costs."⁴⁴

But it is managed care under Medicaid that poses the greatest threat for safety-net providers. Among the immediate results the IOM report highlights are a decline in Medicaid revenues related to the diversion of Medicaid patients to other providers and lower payments by Medicaid managed care plans. Many critics contend that state Medicaid agencies have been so narrowly bottom-line-oriented that they have made inadequate provisions for safety-net providers; one laments: “The trend has been to implement managed care first and iron out the kinks later.” He and others point out, for example, the ill effects of TennCare on the Regional Medical Center in Memphis and on Meharry Medical College in Nashville as examples of Medicaid managed care run amok. Others suggest that TennCare is an extreme example and that a number of states have made special provisions for incorporating safety-net providers into their Medicaid managed care programs.

Focusing primarily on hospitals, Fishman and Bentley observe:

The shift of Medicare and Medicaid enrollees to managed care distorts the integrity of the current fee-for-service support mechanisms. . . . The rates that the plan negotiates with the hospital do not necessarily include the DSH, DGME [direct general medical education], or IME [indirect medical education] payments that would be made to the hospital if the beneficiary remained in the fee-for-service system. Alternatively, the risk plan may direct patients away from the teaching or DSH hospital to a lower-cost site of care because the plan receives the same capitation rate regardless of the provider with whom it has a contract.

In some states, there is some very preliminary evidence that Medicaid managed care is unraveling, as a combination of states’ ratcheting down on the rates that they pay health plans and the associated withdrawal of managed care organizations—especially private plans—may mark the commencement of a new phase of Medicaid payment and organization.⁴⁵ What remains to be seen, however, is how the timing of these changes will affect safety-net providers.

Similarly, capitated managed care may have reached its zenith among private purchasers as well. As part of the general “managed care backlash,” both private employers and their employees seem to be turning away from traditional HMOs in favor of preferred provider organizations, point-of-service plans, and more or less strongly managed indemnity arrangements. It may be that the day of rigorously gatekept, closed panel, shared risk managed care has come and gone. If so, some of the threat to safety-net providers may be subsiding.

Related to the managed care phenomenon is the unusually competitive health care environment in many localities where, for the first time, hospital inpatient and outpatient departments have actually been competing for Medicaid patients—often to the detriment of safety-net providers, who in the process lose these patients and the associated Medicaid revenues on which they depend. In its article on Bellevue Hospital, for which one of the hospital’s registration clerks was interviewed, the *New York Times Magazine* reported:

In 1975, Bellevue was the dump for indigent Medicaid patients that voluntary hospitals would not treat. Now, however, facing rising costs and empty beds, the same voluntary hospitals have become insurance blind. The result is brutal competition for Medicaid patients, whom [the clerk] follows the way a bookie follows the races. . . . As voluntary hospitals and managed care siphon off Medicaid patients, Bellevue winds up with the uninsured no one else wants to treat—and less and less income to offset the cost. “We are begging for Medicaid patients,” [the clerk] said.

Gage indicates that NAPH member hospitals have seen a dramatic decline in the number of babies delivered, since private hospitals have increasingly sought to compete for Medicaid patients. Between 1990 and 1997, the number of births declined by more than 36 percent (or nearly 1,800) at the average NAPH member hospital.

An important piece of the Medicaid equation is the significant amount of churning that occurs in the Medicaid population over time, as a sizable number of people go on and off Medicaid eligibility rolls. As the IOM report points out, safety-net providers have been in a unique position to accommodate this factor while assuring continuity of care; whether commercial managed care organizations participating in Medicaid can do so seems open to question:

The categorical and episodic nature of Medicaid eligibility means that individuals tend to cycle on and off insurance, often with long spells of no insurance. Under the traditional Medicaid program, low-income individuals and families who lost Medicaid coverage would continue to see safety-net providers without much interruption. Private managed care organizations have no legal responsibility or mission to continue to support the care of patients when they become uninsured.

Threats to Direct and Indirect Subsidies

Although the passage of BIPA in 2000 was a victory for FQHCs, there remain threats to funding for other safety-net providers. Already, Medicaid budgets in a number of states seen to be going into deficit, partly

because of rising pharmaceutical expenses. In a paper published in February 2001, Brian Bruen and John Holahan of the Urban Institute issued the following cautionary note:

Careful monitoring of Medicaid spending is very important because it is a large part of federal and state budgets. . . . Some studies suggest that Medicaid expenditures grew faster after 1998. Growth rates of Medicaid expenditures in the 10 percent range could easily occur in the near future because of growth in health care costs (particularly prescription drugs), the eroding impact of Medicaid managed care, wage pressures in the long term care sector, the use of supplemental payment programs, and enrollment increases. Growth rates at these levels have potentially serious fiscal implications for both federal and state governments and unfortunately could affect willingness of either to pursue expansions of eligibility.⁴⁶

Further signs of poor prospects for state subsidies for safety-net providers, both in Medicaid and in general revenue support, are evidenced in a recent *Wall Street Journal* report that as many as 11 states are showing signs of recessionary conditions. These include Alabama, Indiana, Ohio, Michigan, Mississippi, North Carolina, North Dakota, Oregon, South Dakota, Tennessee, and West Virginia.⁴⁷

The NGA proposal for radical restructuring of the Medicaid program is yet another variable to consider; by extending eligibility to a broader range of the population, it may help the safety net, but this is by no means a foregone conclusion. The restoration of cost-based reimbursement for FQHCs may only worsen the plight of some other safety-net providers because states, constrained by a tendency to zero-sum Medicaid budgeting, may be less willing to reimburse other safety-net providers at reasonable levels.

Growth in the Uninsured

From 1987, when the U.S. Census Bureau first began collecting data on health insurance status, through 1998, the number of uninsured Americans increased steadily. During this period, the number of uninsured nonelderly individuals grew from 31.8 million to 43.9 million, or from 14.8 percent to 18.4 percent of the population. In 1999, primarily because of the strength of the national economy, the total number of uninsured nonelderly Americans declined to 42.1 million individuals or 17.5 percent of the population. As Fronstin points out, however: "Even if the United States experiences five more years of declines in the uninsured similar to that in 1999, 34 million Americans would still be uninsured in 2005." Such sustained

reductions in the numbers of uninsured Americans seem unlikely, however.

Several factors must be considered when projecting trends in the size of the uninsured population. Major economic and political variables, including the strength and growth of the national economy, trends in the prices of private health insurance, and federal and state legislation affecting such public benefit programs as Medicaid and Medicare all play a role.

The reduction in the total number of uninsured Americans from 1998 to 1999 seems anomalous, in that it coincides with an increase in the costs of employer-sponsored health benefits. In 2000, the 8.1 percent rise in health benefits costs marks the third straight year of growth at more than double the rate of general inflation.⁴⁸ Coupled with growing concerns about weakness in the economy, such as increased unemployment or reduced consumer confidence, such a sustained increase in health benefits costs might mark the beginning of a renewed upturn in uninsurance.

On December 14, 2000, the Health Insurance Association of America released a study by the Center for Risk Management and Insurance Research which projects the level of uninsured Americans through the year 2009 under three different scenarios:⁴⁹

- An assumption of sustained economic growth and higher but moderate health care cost inflation would result in a projection of more than 48 million uninsured.
- Employing an assumption of rapid economic growth but of even more rapid economic cost inflation would yield a projection of about 55 million uninsured.
- Assuming a recession on the order of that experienced in the early 1990s, there would be more than 61 million uninsured.

Thus, depending on the assumptions used, the numbers of uninsured could vary by some 13 million individuals, with major implications for safety-net providers. Fronstin suggests: "Should a severe downturn in the economy occur, causing the uninsured to represent 25 percent of the nonelderly population, 63 million Americans would be uninsured [in 2005]." Assuring that the safety net has the capacity to accommodate numbers of this magnitude would obviously represent a major challenge.

Problems Affecting Emergency Rooms

Emergency rooms are often the provider of first resort for the uninsured. As the authors of a paper recently

published by the American College of Emergency Physicians (ACEP) observe: “Emergency departments [EDs] are the only element of the health care safety net whose function has been defined by federal law, the EMTALA, which mandates that all EDs provide screening, stabilization, and/or appropriate transfers to all patients with any medical condition.”⁵⁰

They further point out:

In contrast to other safety-net providers, EDs define their mission in terms of unlimited access regardless of citizenship, insurance status, ability to pay, day of the week, or time of day. . . . The ED is the only source of care available for certain populations. The 1996 welfare reform legislation severed the link between Medicaid and Aid to Families with Dependent Children, legal immigrant status, and disability due to substance abuse. This had a significant impact on health care for the poor and immigrant populations. . . . EDs were exempted from these restrictions.

Last October, the *New York Times* ran a front-page article entitled “Emergency Room, to Many, Remains the Doctor’s Office.” In it, the author reported:

Visits to ERs grew about 3 percent a year from 1997 to 1999 and have risen 6 to 8 percent in the last year. . . . The reasons are similar to those behind other problems in health care: the lack of access to primary care doctors among the poorest Americans and a large number of Americans who are without insurance, often because of higher premiums.⁵¹

At the same time, a number of hospitals are closing their ERs, largely because of financial pressures. Looking at trends over a longer period, the ACEP’s Fields notes:

Between 1988 and 1996, ED patient visits rose from 81.3 to 93.1 million, an increase of 14 percent. During the same period, the number of EDs decreased from 5,210 to 4,740, with ED closures outstripping the rate of facility closures by 28 percent. . . . The average annual ED census increased 25.6 percent, from 15,600 in 1988 to 19,600 in 1996.⁵²

The closure of these EDs and the increased volumes at the remaining EDs threaten the access of those patients who must rely on the EDs that remain in operation, while imposing new pressures on the quality of care at those institutions.

The evidence of financial pressures on individual hospitals is striking. In an article on Florida ERs last November, the *Wall Street Journal* reported: “Statewide, hospitals swallowed \$1.1 billion in medical bills for patients who couldn’t pay in 1997, the latest year available. That was a 13% jump in write-offs from five years earlier.”⁵³

Another *New York Times* article, published in December, gives evidence of even more increased pressures on emergency rooms:

For years it was all but unheard of in most cities for a hospital to regularly hang out a “No Vacancy” sign for ambulance crews. But in recent months, in cities from Boston to San Francisco, Phoenix to Denver, it has become common to the alarm of doctors, paramedics and patients. . . . Those voicing their concern most loudly . . . do worry openly that patient care suffers because of the extra minutes spent in ambulances and because of the emergency room crowding that causes the diversions in the first place.⁵⁴

There are a variety of reasons why ERs are overcrowded and ambulances must sometimes be diverted. Some health plans blame the “prudent layperson” laws enacted in 33 states, requiring them to pay ER bills if patients are in great pain and believe that they are in a medical emergency. The BBA also obligates Medicare and Medicaid to follow a prudent layperson standard. In addition, some health plans have abandoned prior authorization requirements for emergency care. Other observers assert that patients are experiencing greater difficulty in getting appointments with primary care physicians, forcing them to rely on ERs to a greater extent.⁵⁵

But one contributing factor is the safety-net role that ERs must play. According to a recent Commonwealth Fund study, in New York City, nearly 75 percent of all visits to an ER that do not result in admissions are for nonemergencies, reflecting to some degree poor access to primary care.⁵⁶ This has highlighted a question of whether relieving ERs of some of this responsibility might allow them to better fulfill their emergency roles. The *Times* article seems to suggest that the problem is both widespread and unprecedented:

Diversions have become a year-round problem in Denver, in Las Vegas, even in smaller cities like Newport News, Virginia. San Francisco General Hospital was on diversion 39 percent of the time in October, and is averaging 31 percent for this year, compared with 19 percent at this time last year. . . . And in Massachusetts, the state public health commissioner, Dr. Howard Koh, said, “This past year we saw diversions in the summer and the fall for the first time in memory.”

Previously, diversions had been experienced primarily during the winter flu season.

The implications for quality of care are troublesome, according to a warning contained in the January 2000 issue of *Annals of Emergency Medicine*: “Unless the problem is solved in the near future, the general public

may no longer be able to rely on EDs for quality and timely emergency care, placing the people of this country at risk."⁵⁷

THE SAFETY NET IN A LONGER-TERM CONTEXT

For those who rely on the safety net and for those who believe it needs to be strengthened, there may be some signs of positive action. Congress and the administration have begun to consider ways of strengthening safety net capacities. These include support for more community health centers and extension of the National Health Service Corps. Moreover, proposals to increase levels of insurance coverage are gaining some currency. These have been buttressed by discussion about ways to use current surpluses; some also argue there will be savings realized through improved access to appropriate care and through more efficient coordination of providers and services. Finally, exemplary efforts at the local and state level are showing that, because of regional variation, solutions may lie as much in partnerships between the public and the private sector as in relationships between the federal government and the states. But how these deliberations will play out and the level of funding that might be made available is still very uncertain. Only time will tell if these incremental efforts, made during yet another cyclical period of attention, will lead to more meaningful resolution of the safety net's operational and funding dilemmas.

The author gratefully acknowledges the helpful comments of the following reviewers: Mary Lou Andersen; Eric Baumgartner, M.D.; Christine Caputo Burch; Catherine Dunham; Lynn Etheredge; Robert Hurley; Wilhelmine Miller; Victor Miller; Susan Nestor Levy; Trish Riley; and Andy Schneider. Any errors of fact or interpretation are solely the responsibility of the author.

ENDNOTES

1. James J. Mongan, "The Forgotten Uninsured," *Washington Post*, October 10, 2000, A25.
2. Marion Ein Lewin and Stuart Altman, eds., *America's Health Care Safety Net: Intact but Endangered*, National Science Foundation, Institute of Medicine (Washington, D.C.: National Academy Press, 2000), 2.

3. "Congress to Expand Access Focus to Include Safety Net Programs," *BNA Health Care Policy Report*, February 19, 2001, 246.

4. Robert Pear, "Governors Offer 'Radical' Revision of Medicaid Plan," *New York Times*, February 26, 2001, A1, A12.

The National Governors' Association is proposing radical changes in Medicaid that would allow states to provide health insurance to millions of additional people, but the benefits would be less generous than those now guaranteed to poor people. . . . Many governors want to help provide coverage to people who are uninsured. . . . The new policy . . . would still guarantee a comprehensive package of benefits for the poorest families, thus "maintaining the health care safety net for vulnerable populations."

5. National Conference of State Legislatures, *State Fiscal Outlook for 2001: February Update*, posted February 28, 2001, updated March 8, 2001; accessed March 30, 2001, at <http://www.ncsl.org/programs/fiscal/sfo2001.htm>. These states were Arizona, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Missouri, Montana, New Mexico, North Carolina, Ohio, Oklahoma, Texas, Vermont, Virginia, and Washington.

6. Julius B. Richmond and Rashi Fein, "Caring for the Uninsured and Underinsured: The Health Care Mess," *Journal of the American Medical Association*, 273, no. 1 (January 4, 1995): 71.

7. Charles N. Kahn III and Ronald F. Pollack, "Building a Consensus for Expanding Health Coverage," *Health Affairs*, January/February 2001, 40.

8. Katherine Eban Finkelstein, "Bellevue's Emergency," *New York Times Magazine*, February 11, 1996, 52.

9. Raymond J. Baxter and Robert E. Mechanic, "The Status of Local Health Care Safety Nets," *Health Affairs*, July/August 1997, 9.

10. Haynes Johnson and Davis S. Broder, *The System: The American Way of Politics at the Breaking Point* (Boston: Little, Brown, and Co., 1996), 536, 539.

11. For a time, beginning in 1972, voluntary hospitals which had received Hill-Burton funding were required by federal regulation to expend 5 percent of their estimated patient revenues for charity care. See Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), 314-315, 345.

12. Karen Davis and Kathy Schoen, "A New Approach to Health Care Delivery," in *Health and the War on Poverty: A Ten-Year Appraisal* (Washington, D.C.: The Brookings Institution, 1978), 165.

13. See Judith D. Moore, "SCHIP in the Formative Years: An Update," National Health Policy Forum Issue Brief No. 759, September 21, 2000, and "CHIP and Medicaid Outreach and Enrollment: A Hands-On Look at Marketing and Applica-

tions,” NHPF Issue Brief No. 748, October 19, 1999.

14. U.S. Department of Health and Human Services, Health Resources Services Administration. Bureau of Primary Health Care, Division of Community and Migrant Health, *Experts with Experience: Community and Migrant Health Centers: Highlighting a Decade of Service, 1990-2000* (no date).

15. Stuart H. Altman, Uwe E. Reinhardt, and Alexandra E. Shields, “Healthcare for the Poor and Uninsured: An Uncertain Future,” in *The Future U.S. Health Care System: Who Will Care for the Poor and Uninsured?* ed. Stuart H. Altman, Uwe E. Reinhardt, and Alexandra E. Shields (Chicago: Health Administration Press, 1998), 7.

16. Gage, “Safety Net Hospitals,” 126.

17. Eileen R. Ellis, Vernon K. Smith, and David M. Rousseau, *Medicaid Enrollment in 50 States, June 1997 to December 1999*, Kaiser Commission on Medicaid and the Uninsured, October 2000.

18. Thomas Chapman, “It’s Time to Strengthen the Safety Net,” *Modern Healthcare*, June 19, 2000, 28.

19. Natalie Seto and Bess Karger Weiskopf, *Community Benefits: The Need for Action, an Opportunity for Healthcare Change, A Workbook for Grassroots Leaders and Community Organizations* (Boston, MA: The Access Project, 2000), page 94; accessed March 21, 2001 at <http://www.accessproject.org/publications.htm>. The states are California, Connecticut, Georgia, Idaho, Indiana, Massachusetts, Minnesota, New Hampshire, New York, Pennsylvania, Rhode Island, Texas, Utah, and West Virginia.

20. The CAP program had single-year appropriations in FY 2000 and FY 2001. As of this writing, it has been zeroed out of the proposed FY 2002 budget.

21. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2000 Current Population Survey*, Employee Benefit Research Institute Issue Brief No. 228, December 2000, 7.

22. David Brown, “Percentage of Uninsured Dropped in 1999,” *Washington Post*, September 29, 2000, A5.

23. Kahn and Pollack, “Building a Consensus,” 44.

24. Matthew Broaddus and Leighton Ku, *Nearly 95 Percent of Low-Income Uninsured Children Now Are Eligible for Medicaid or SCHIP: Measures Need to Increase Enrollment Among Eligible but Uninsured Children*, Center on Budget and Policy Priorities, December 6, 2000; accessed on March 2, 2001 at <http://www.cbpp.org/12-6-00schip.htm>.

25. Judith Feder et al., “Covering the Low-Income Uninsured: The Case for Expanding Public Programs,” *Health Affairs*, January/February 2001, 22.

26. Since they affect state allocations under the SCHIP program, data on the number of uninsured children have been a source of particular contention.

27. John Budetti et al., *Can’t Afford to Get Sick: A Reality for Millions of Working Americans* (New York: Commonwealth Fund, September 1999), 1.

28. Among the reasons that younger people tend to be uninsured is that they reject available employer-sponsored insurance because they believe they are less prone to illness.

29. Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage and Access to Care Among Latinos*, Key Facts, June 2000. Among nonelderly Latinos, the uninsurance rate, by area of origin, varied as follows: Central and South American, 42 percent; Mexican, 39 percent; Cuban, 21 percent; Puerto Rican, 21 percent, and Total Hispanics, 37 percent. See Kaiser Commission on Medicaid and the Uninsured, *Uninsured in America: A Chart Book*, 2nd ed. (Washington, D.C.: Henry J. Kaiser Family Foundation, May 2000), 21.

30. Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage and Access to Care Among African Americans*, Key Facts, June 2000.

31. Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage and Access to Care Among Asian Americans and Pacific Islanders*. Key Facts, June 2000.

32. U.S. Bureau of the Census, *Health Insurance Coverage: 1999*, September 28, 2000.

33. John D. Banja, “The Improbable Future of Employment-Based Insurance,” *Hastings Center Report* 30, no. 3 (May-June 2000): 22.

34. Nancy Vuckovic, “Self-Care Among the Uninsured: ‘You Do What You Can Do,’” *Health Affairs*, July/August 2000, 197-199.

35. See Karen R. Matherlee, “The Federal-State Medicaid Match: An Ongoing Tug-of-War over Practice and Policy,” National Health Policy Forum Issue Brief No. 760, December 15, 2000.

36. National Association of Public Hospitals and Health Systems, *How Are Safety Net Hospitals Financed? Who Pays for “Free Care”?* NAPH Issue Brief, February 2001.

37. Tim H. Henderson, “Medicaid’s Role in Financing Graduate Medical Education,” *Health Affairs*, January/February 2000, 221-229. Only 16 states and the District of Columbia carve out Medicaid GME payments from their capitated rates paid to managed care plans and rechannel them directly to teaching programs.

38. Graham Atkinson, W. David Helms, and Jack Needleman, “State Trends in Hospital Uncompensated Care,” *Health Affairs*, July/August 1997, 233.

39. Linda E. Fishman, “What Types of Hospitals Form the Safety Net?” *Health Affairs* July/August 1997, 215, 218, 219, 221.

40. Gage, “Safety Net Hospitals,” 126.

41. Johns Hopkins Medical Institutions, Center for Hospital Finance and Management, *Discovering the Healthcare Safety Net*, August 18, 1998.
42. Stephen A. Norton and Debra J. Lipson, *Public Policy, Market Forces, and the Viability of Safety Net Providers*, Occasional Paper 13, Urban Institute, September 1998, 2; accessed October 10, 2000 at <http://newfederalism.urban.org/html/occa13.html>.
43. Linda E. Fishman and James D. Bentley, "The Evolution of Support for Safety-Net Hospitals," *Health Affairs*, July/August 1997, 31.
44. Wesley Fields, "Defining America's Safety Net," in *Defending America's Safety Net*, ed. Wesley Fields (Dallas: American College of Emergency Physicians, 1999), 9.
45. See, for example, Robert Cunningham, "The Uninsured: Local Efforts in State, Federal, Global Contexts," *Medicine & Health Perspectives*, February 21, 2000, 1-4, which reports on research on the exit of commercial plans in 1997 and 1998. See also Michael J. McCue et al., "Reversal of Fortune: Commercial HMOs in the Medicaid Market," *Health Affairs*, January/February 1999, 223-230.
46. Brian Bruen and John Holahan, *Medicaid Spending Growth Remained Modest in 1998, But Likely Headed Upward*, Issue Paper, Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., February 2001, 15.
47. Ken Gepfert, "Cross Country: For Some States, Recession May Be Here," *Wall Street Journal*, March 7, 2001; accessed March 29, 2001, at <http://www.wsj.com>.
48. "Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans," *Medical Benefits*, January 30, 2001, 1.
49. William S. Custer and Pat Ketsche, *The Changing Sources of Health Insurance* (Washington, D.C.: Health Insurance Association of America, no date).
50. Patrick M. O'Brien et al., "The Emergency Department as a Public Safety Net," in *Defending America's Safety Net*, ed. Wesley Fields (Dallas: American College of Emergency Physicians, 1999), 19-21.
51. Jennifer Steinhauer, "Emergency Room, to Many, Remains the Doctor's Office," *New York Times*, October 25, 2000, A1, A25.
52. Wesley Fields, "Executive Summary," in *Defending America's Safety Net*, ed. Wesley Fields (Dallas: American College of Emergency Physicians, 1999), 2.
53. Trebor Banstetter, "Group Mulls Big Changes to Help ERs," *Wall Street Journal*, November 8, 2000, F1.
54. Carey Goldberg, "Emergency Crews Worry as Hospitals Say, 'No Vacancy,'" *New York Times*, December 17, 2000, A27.
55. See Leigh Page, "Patients Bypassing Doctors for Emergency Care," *American Medical News*, February 12, 2001, 1-2.
56. John Billings, Nina Parikh, and Tod Mijanovich, *Emergency Department Use: The New York Story*, Commonwealth Fund Issue Brief, November 2000.
57. Robert W. Derlet and John R. Richards, "Overcrowding in the Nation's Emergency Departments: Complex Causes and Disturbing Effects," *Annals of Emergency Medicine*, January 2000, 63. Some ERs across the country have instituted special triage programs that allow them to transfer less seriously ill patients to affiliate primary care clinics to relieve some of the pressure on the ER while assuring that these patients receive timely attention for their medical complaints.