HEALTH POLICY

The Mission of Safety Net Organizations Following National Insurance Reform

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National health insurance reform will pose considerable challenges to the core missions of safety net organizations that serve the uninsured. Those who currently donate money or time will, rightly or wrongly, view uninsured recipients as less deserving on the whole. Nevertheless, safety net organizations can serve several critical functions that continue to justify their existence and support. One important mission is to maintain access for low-income uninsured until all elements of insurance reform are fully in place. Second, once the reform is implemented, people will need a great deal of assistance and encouragement to determine what they are supposed to do and where they are supposed to sign up. Third, substantial portions of the remaining uninsured will continue to lack affordable insurance options, and large numbers of people eligible for coverage will unavoidably undergo temporary gaps in coverage as their family and financial circumstances change. Finally, not all people with insurance will have affordable access to all needed care. Market conditions will continue pushing higher levels of patient cost-sharing through deductibles and co-payments. To serve these multiple needs, safety net organizations should consider adapting their missions and business models so that they accept both insured and uninsured patients under a sliding fee scale that varies charges according to ability to pay.

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THE MISSION OF SAFETY NET ORGANIZATIONS FOLLOWING NATIONAL INSURANCE REFORM

Challenges

When national health insurance reforms are fully implemented, safety net organizations that serve the uninsured will confront a variety of challenges and opportunities.[1–3] These organizations include free clinics, community health centers (CHCs), public and academic medical centers, and various community access programs.[4] From one perspective, insurance reform will be a boon. Expansion of Medicaid and private insurance coverage will greatly reduce the collective burden of uncompensated care for the uninsured. And, increased funding and payment rates for CHCs and primary care physicians will greatly assist with meeting the increased demand for service among those who previously were underserved. The Affordable Care Act allocates $11 billion for expansion of federally qualified health centers (FQHCs) and requires private insurers that sell through the new insurance exchanges to contract with FQHCs at the higher government rates that reflect their all-inclusive services.[5]

Insurance reforms, however, also pose considerable challenges to core missions of safety net organizations. These organizations have justified much of their support by improving access to low-income uninsured, but starting in 2014 most low-income legal residents will be eligible for Medicaid or highly subsidized private insurance.[6] The majority of those who remain uninsured will be either illegal immigrants, or people who fail to comply with the reform law's "individual mandate" (which requires coverage if the individual cost is less than 8% of household income). According to estimates by the Urban Institute, using its sophisticated microsimulation model, if the Affordable Care Act were fully implemented now (in 2011), we could expect to have 18.6 million uninsured adults, which is about 10% of the nonelderly adult population.[6] Over one-third of these would be Medicaid eligible, 25% undocumented immigrants, and only 16% exempt from the mandate for failing to have an affordable option (Table 1).

Anticipating reductions in the uninsured population, the ACA calls for "disproportionate share hospital" (DSH) payments to be cut by 75% under Medicare and 20% under Medicaid. At the same time, hospitals can expect their Medicaid patient load to roughly double, and the ACA does nothing to require or encourage states to increase their current hospital payment rates under Medicaid. These rates average roughly 10% below hospitals' costs and one-third less than private insurer rates, with rates in some states considerably lower. Unlike physicians,

Table 1. Composition of Uninsured Adults Under the ACA

Demographic	Percentage
Eligible for Medicaid	36.5%
Undocumented immigrants	24.5%
Not able to afford insurance	16.2%
Others	22.8%
Total	100.0%

Notes: Estimated by Urban Institute using its Health Insurance Policy Simulation Model,[6] projecting the impact of the ACA as if it were fully implemented in 2011

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hospitals have no realistic option to refuse Medicaid, especially if they are tax exempt, but their ability to make up for Medicaid shortfalls will not increase commensurate with their increasing Medicaid patient load.

Also in a quandary will be free clinics and programs that refer needy patients for specialty care at no cost. The reduced need for these volunteer programs will be a relief, but the shifting public sympathies for those who remain uninsured could make it difficult to maintain even a reduced scope of operations. If health insurance reform works as intended, it is more likely that those who currently donate money or time will, rightly or wrongly, view uninsured recipients as less deserving on the whole.

Opportunities

Reflecting on these challenges, safety net organizations have identified a variety of potential responses, geared to doing the most good under an imperfectly reformed system.

The Glide Path to Insurance Reform. One important mission for safety net organizations is to maintain access for low-income uninsured until all elements of insurance reform are fully in place. The major elements do not start until 2014, and it may take until 2015 or later to work out all the kinks. Moreover, there are serious threats to the reform law's surviving intact until it has a chance to function. Courts could strike down major components as unconstitutional, the shift of power in Congress could threaten to hold up key funding, and a change in the Presidency could result in repeal or major amendment of the entire Act.[7] Were any of those threatened events to occur, existing safety net support would remain as critical as ever.

Setting aside these doomsday scenarios and looking optimistically to implementation, there is good reason to believe that safety net organizations will have a major role to play in helping people navigate the complex and changing system in 2014. The insurance exchanges and subsidy structures will be new and unfamiliar. Medicaid eligibility will be substantially revamped. The information needed to determine which route to follow may not be available readily to eligible people. And some people will be distressed about the tax penalty consequences for noncompliance.

Therefore, a great deal of assistance and encouragement will be necessary to help people know what they are supposed to do and where they are supposed to sign up. Many safety net organizations already are adept at screening people for Medicaid or other public program eligibility.[8] This puts them in an excellent position to facilitate eligibility screening and enrollment under the ACA, and function that the ACA provides to funding to support.

Serving this screening and facilitation function could help to secure a larger base of insured patients for safety net organizations that accept Medicaid and private insurance. Willingness to accept patients regardless of source of payment allows programs that previously focused mainly on the uninsured to now offer membership and a medical home to all low-income patients, many of whom will become paying patients starting in 2014. However, screening for the ACA's full complement of income, family status, and citizenship criteria is more complex, and this more detailed screening could deter some vulnerable patients from seeking care, which creates a tension between maintaining access and increasing enrollment.

Access for the Remaining Uninsured and Underinsured. Despite the reduced size and changed composition of the uninsured, those who continue to lack insurance will not be wholly *un*-deserving. Approximately 2 million (according to Urban Institute estimates)[6] will be middle-income people whose insurance remains unaffordable, because they are not eligible for employer-sponsored or subsidized coverage. Although subsidies will not phase out until 400% of the federal poverty level, which is above the median household income, some people who qualify for subsidies will still face unaffordable premiums due to various quirks in how premiums and subsidies are calculated, for individuals and families.[6] Moreover, for those above 400% of poverty, while average premiums might be affordable, insurers are allowed to charge near-elderly subscribers as much as three times what they charge young adults. Many of these unaffordably uninsured people will have significant unmet needs.

For undocumented immigrants, social attitudes are deeply divided,[9,10] but most people believe that, as a matter of basic human rights, everyone deserves access to at least some level of care—such as in true emergencies. This humanitarian instinct can be fortified with the need to guard against infectious disease, and the better cost-efficiency of primary care that avoids expensive emergency treatment. Moreover, excluding people without legal residence requires that everyone, including citizens, document their legitimacy. Therefore, programs that serve all segments of society have good reason to minimize documentation burdens.

Finally, not all people with insurance will have affordable access to all needed care. Market conditions will continue pushing higher levels of patient cost-sharing in the form of deductibles and co-payments. The ACA subsidizes cost-sharing for people below 250% of the federal poverty level, but even some of these people can still face "catastrophic" levels of expense, relative to their modest incomes. And, certainly this will be true for people above 250% of poverty. Many analysts view 10% of income as a rough gauge for affordability.[11,12] The Urban Institute estimates that, for people above 300% of poverty, the most costly decile covered by non-group insurance will incur costs that exceed *twice* this affordability threshold—20% of household income.[13] This is because the insurance premium people must pay at or above 250% of poverty is itself 8% to 9.5% of household income for each covered person; thus, the added cost of their out-of-pocket payments can easily reach or exceed 20% of income.

Adapting to Change. Safety net organizations should consider how best to structure their policies and programs to meet the needs of these diverse segments of legitimately uninsured and underinsured people. Principally, this will require adopting a sliding scale approach to payment that varies charges according to ability to pay. Sliding fee schedules have substantial precedent among safety net organizations.[3] This is the basis on which FQHCs operate, and even some "free" clinics charge "nominal" copayments such as $10 per visit.[14] But charging any fee is a major shift for some organizations, and may threaten their current philanthropic support. Also, their state-law immunity from tort suits may depend on providing only free services. More

complex partnership and "wrap-around" program structures are conceivable that could separate but coordinate components of service that are virtually free versus substantially paid.[15] Therefore, as long as service is not denied on account of inability to pay at the point of service, charging for service should not necessarily undermine a safety net organization's claim to charitable support.

Insurance Continuity over Time and Within Families. Another critical function safety net organizations can serve under the ACA is to mitigate the inevitable discontinuities that will arise in insurance coverage, both over time and within families. At a given point in time, many families will have a mix of insured and uninsured members. This is because insurance eligibility depends on three factors that vary within families: 1) age; 2) citizenship (or legal residence); and 3) availability of affordable employer-sponsored coverage. Only legal residents are eligible for subsidies and are subject to the individual mandate. Coverage that employers offer may be affordable for the worker but not for the family. And individuals required to purchase their own coverage are more likely to face unaffordable premiums if they are older.

Coverage will also vary over time, as individual or family income changes. Especially problematic will be people whose eligibility for private insurance subsidies shifts from time to time, based on fluctuating income. Enrolling in private insurance is not an instantaneous process. Unlike Medicaid, which can take effect on any day and sometimes even retroactively, private insurance typically begins only on the first of the month, and only after all paperwork is completed and the first month's premium is prepaid. Also, the ACA still allows employers to subject newly employed people to a three-month probationary waiting period. All of this means that many eligible people unavoidably will experience temporary gaps in coverage and/or changes in their managed care networks.[16] Half of people below 200% of poverty each year have a shift in income that would change their eligibility for Medicaid or private insurance,[16] and roughly a fifth of working people change jobs each year (varying widely by sector). These changes in insurance can disrupt continuity of care.

Safety net organizations can help minimize these discontinuities in two ways. First, they can arrange for access to care during unavoidable periods of uninsurance. Second, they can arrange for places of care that maintain access for the entire family regardless of type of insurance or ability to pay. Community health centers are a prime example. Not only do they accept all patients regardless of insurance, they have emerged as a leading exemplar of the medical home model that elsewhere is elusive.[17,18] Another encouraging example are public hospitals in some municipalities, such as Boston and Denver, that maintain coordinated full-service access programs for the uninsured using the same provider networks as their Medicaid managed care plans.[19,20] They established these seamless access systems a decade or so ago, when Medicaid first moved to managed care, in order to avoid losing the paying portion of their traditional patient base.

Similarly, other safety net organizations can now consider business models that mix reimbursing patients with uninsured patients as a way to attract and serve the full complement of lower-income people, regardless of presence or type of insurance. Seamless safety net access is facilitated by a provision in the ACA that requires health insurers who want to sell through the new insurance exchanges to include in their provider networks any clinics or disproportionate share hospitals willing to accept the insurer's standard rates. Activating this provision for "any-willing safety-net provider" will be an important step to addressing discontinuity problems.

The Holy Grail of Universal Access. The need for these various safety net functions will vary considerably from state to state, and within different parts of each state, according to demographic and economic conditions.[11,21] According to Urban Institute estimates, the proportion of anticipated uninsured adults that will have no affordable insurance option ranges from 14% to 25% among regions of the country, and those who will be undocumented immigrants ranges from 12% to 32%.[6]

Despite this diversity of conditions, it is possible to foresee safety net organizations in some communities complementing the ACA in a way that achieves truly universal access: by focusing both on enrolling those who are newly eligible and on access for those who legitimately remain uninsured. Without safety net support, the ACA is expected to fall short of universal access, leaving about 8% of residents and 6% of citizens without insurance coverage. Many of these will be eligible for Medicaid or highly subsidized private coverage, and, therefore will mainly need assistance with enrolling. Some portion will decline affordable coverage until the need arises, but they too will be eligible during open enrollment periods.

Those who continue to face unaffordable premiums or inevitable gaps in coverage could be sufficiently manageable in number that more dedicated communities and organizations might find it possible to provide adequate access to a fairly full range of services. Currently, some model programs enroll low-income uninsured people with a primary care medical home and arrange for sliding scale access to prescription drugs, specialists, diagnostic testing and hospitalization as needed.[22] This form of direct-access safety-net care can be at least minimally adequate compared with access through insurance.[23] Following these models, a well-structured safety net access program, coupled with insurance reform, could bring us at least within sight of the Holy Grail of universal access to decent *care*, even if we still fall short of universal *insurance*.

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