Chapter 3

Financing and Organization of Health Care for Vulnerable Populations

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Objectives

- Describe the core functions of health-care financing.
- Explain how health-care financing may be tailored to address the challenges that vulnerable populations face.
- Describe the provisions in the Affordable Care Act and how they affect the financing and organization of health care.
- Describe the types of providers that constitute the safety net.
- Explain why the organization and financing of the health-care safety net does not adequately meet all the health needs of vulnerable populations.
- Articulate the arguments for increasing the numbers of primary care safety net providers to improve the access for vulnerable populations.

INTRODUCTION

John Walsh is a 56-year-old man with essential hypertension and type 2 diabetes. Since being laid off from full-time work, Mr. Walsh and his dependents, a wife and two children, were left without insurance. Neither of his part-time jobs, as a security guard and a deliveryman, offered any health insurance benefits.

Mr. Walsh and his family members have slipped through the cracks of a fragmented system of health-care insurance coverage. The United States has lagged behind almost all developed nations in establishing universal health-care coverage. In 2013, there were approximately 40 million uninsured people in the United States.[1] The majority of the uninsured live in households with at least one full-time working adult.[2] Absence of insurance creates obstacles to obtaining health care in a timely way. Without a means to pay, patients forgo necessary health services resulting in worsening health.

In 2010, President Obama signed into law the Affordable Care Act (ACA). The ACA establishes an individual mandate for health insurance coverage and has numerous provisions to assist low-income individuals with financing to obtain health insurance. Nonetheless, the ACA has not removed all barriers to health care, nor has it resulted in universal coverage for Americans. The high costs of care and the dearth of providers serving vulnerable populations are persistent and substantial challenges.

A *safety net* system exists to care for those who face barriers in access to care, such as Mr. Walsh. The safety net is a geographically variable patchwork of providers available to care for individuals with barriers to care, such as a lack of insurance or those residing in a community that is medically underserved because of an inadequate supply of practitioners. Individuals with low family income, minority status, rural residence, limited English proficiency, and

poor health status are more vulnerable to not receiving needed health care, and when they do obtain care, they are more likely to receive it from safety net providers. Even in nations with universal financial coverage, safety net programs often exist to address the needs of populations with special access challenges, such as the homeless, recent immigrants, and residents of remote rural regions.

The financing and organization of the health system are the starting points for understanding how health care is delivered to populations. No health system has enough resources to meet the demands of every patient served, not even the United States, which spends close to 18% of its gross domestic product on health. The ways in which health care is financed and organized represent choices about who will receive what services under which conditions.[3]

This chapter describes the financing of health care in the United States, changes in the financing of health insurance coverage related to the ACA, and the architecture of the safety net available to care for vulnerable populations.

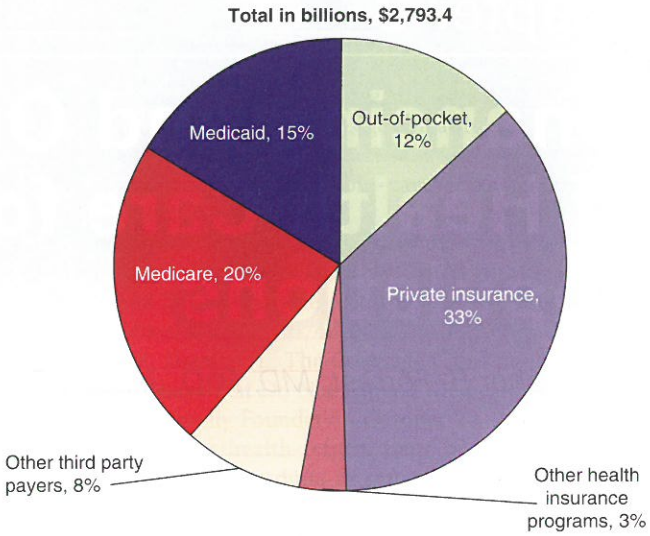

Figure 3-1. National health-care source of funds, 2012. (*Source:* Centers for Medicare and Medicaid Services, 2012 National Health Expenditure Data [Online]. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.)

HEALTH SYSTEM FINANCING

Financing of health systems can be characterized by the sources of health system funds and by how the collected funds are structured, whether by pooling to spread risk and ensure financial security of individuals and families or requiring patients who lack insurance coverage to pay directly in order to receive services.

REVENUE COLLECTION

Revenue collection refers to where the money to pay for health care comes from (i.e., the funding sources) and how these resources are obtained (i.e., contribution mechanisms). Nearly all health system revenue in developed nations comes from individuals—as workers, as tax payers, and as patients. In the United States, public funds are raised as taxes on workers, such as the Medicare wage tax, or from federal and state income taxes, and a limited amount from corporate and other types of taxes. Private sector funds come from insurance premium contributions that employees and their employers make. Employers consider their portion of the premium payment to be part of their employee's total compensation package; so, in fact, it is the employee who actually pays both their own and their employer's contributions.

Out-of-pocket payments that insured patients incur when they use health services are the second source of private sector funding. An out-of-pocket payment may be made in the form of *deductibles* (a fixed amount of money that a patient is responsible for paying before the insurer also pays), *coinsurance* (a percentage of health-care costs that a patient pays up to a maximum out-of-pocket limit), and *copayments* (a fee paid at the time of every visit). These three types of payments are forms of cost sharing, and are used by insurers to reduce utilization and shift costs to individuals using services. For low-income families, cost sharing can be so burdensome that they forgo necessary care with inimical effects on their health.[4]

A second type of out-of-pocket payment results from *direct payments* made to providers by patients with no insurance. Direct payments offer no financial protection and can be very burdensome for vulnerable populations.

The distribution of the various sources of health system revenue in the United States is shown in Figure 3-1. Note that health system revenue in the United States is collected in approximately equal proportions using public and private sector mechanisms. This pluralistic mix of revenue contributions to the health system is one of the many obstacles in the United States to achieving a system of universal coverage.

RISK POOLING

When revenue is collected on a prepaid basis (rather than at the time care is received), and aggregated across many individuals, an insurance risk pool is formed. Protecting individuals from the financial impact of health-care costs is best achieved with prepayment and risk pooling. At the individual level, health-care events are largely unpredictable and, when they occur, can be costly. By pooling resources, health insurers, whether they are private plans or government-sponsored insurers, spread the risk of

financial loss due to health care across the all contributors. This provides a level of financial security to a given individual that cannot be achieved without risk pooling. To sustain themselves, risk pools require large numbers of healthy individuals who in effect cover the costs of those who are sick and require more resources. Individuals are willing to participate in risk pools because of the uncertainty of illness at the individual level.

Low-income individuals may not have the financial means to participate in a health insurance risk pool. Individuals with no health insurance coverage must pay for services entirely out of pocket, rendering low-income individuals in general and those with high health-care needs in particular susceptible to financial hardship, because they are not part of a financing pool that shares financial risk.

UNDERINSURANCE

Even when insured, many individuals may have plans with high amounts of cost sharing that cause financial hardship. Having insurance with high levels of cost sharing is a form of underinsurance, which can pose as large a financial barrier to care as having no insurance at all. Underinsurance refers to insurance that does not provide adequate financial coverage to address an individual or family's health needs. High-deductible health plans are an example of insurance that provides coverage for expensive care, but requires patients to cover the first several thousand dollars of health-care costs on an annual basis. One-third of low-income insured individuals are actually underinsured.[5] When enrolled in high-deductible health plans, low-income families and individuals with chronic conditions are at increased risk for delaying or forgoing needed health care, including physician visits and medications.[6]

The ill effects of being uninsured extend beyond delaying care: poor health that results from lack of insurance reduces income by an estimated 15–30%, and people with lower incomes are less likely to have health insurance.[7,8] Costs associated with illness and injury in the United States are the most common reason to declare personal bankruptcy,[9] and many of these bankruptcies have been among insured patients with insufficiently comprehensive benefits.

Health Insurance

Most industrialized and many developing nations provide health-care coverage to their populations as a form of social security. In the United Kingdom, the National Health Service is funded by general taxes, whereas in Germany, sickness funds are sponsored by worker payroll taxes and government contributions. The ACA, signed into law in 2010, is intended to move the United States closer to universal coverage through a combination of private insurance regulatory changes and increased availability and affordability of insurance for low-income persons.

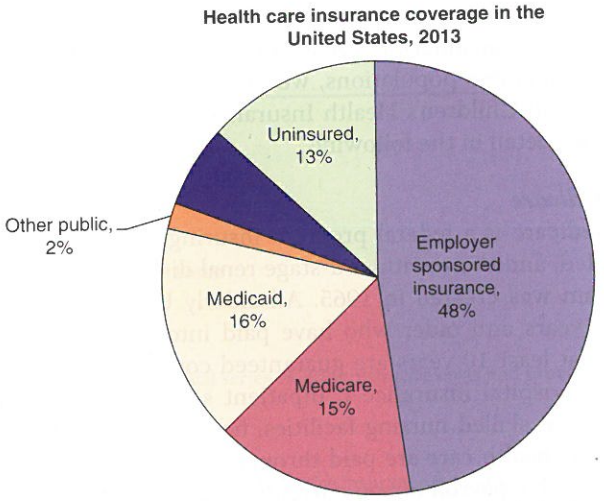

Figure 3-2. Health-care insurance coverage in the United States, 2013. Categories are mutually exclusive; persons cannot be in more than one insurance category. The "Other Public" insurance category includes nonelderly Medicaid enrollees as well as individuals covered through the military or Veterans Administration. (*Source:* Kaiser Family Foundation, 2014 estimates. Available at http://kff.org/other/state-indicator/total-population/.)

The major provisions to expand health insurance coverage as a part of the ACA were implemented in 2014. In 2013, 13% of Americans reported that they were uninsured; 48% reported that they obtained coverage through a voluntary system of employer-sponsored health-care insurance benefits, 6% purchased individual private insurance policies, and most of the remainder were covered by two major public insurance programs, Medicare and Medicaid (Figure 3-2). For low-income persons younger than 65 years, just 10% received employer-sponsored health insurance, 8% purchased it as individuals, and 27% were uninsured (the balance got their coverage from publicly sponsored programs).[10,11]

Publicly Sponsored Health Insurance

Health-care policy in the United States focused on improving insurance coverage rates and has largely developed via an "incrementalist" approach in which government confers health benefits to defined categories of the population.[12] Medicare, the Indian Health Service, and the Veterans Administration's (VA) medical system are programs sponsored by the federal government, and are entitlements where, respectively, all US citizens aged 65 years and older, Native American/Alaskan natives, and veterans are guaranteed insurance coverage. These three programs contrast with Medicaid, which is a means-tested publicly sponsored insurance benefit that, prior to

implementation of the ACA, limited eligibility to a subset of poor individuals. Because of their size and importance to vulnerable populations, we discuss Medicare, Medicaid, and Children's Health Insurance Program (CHIP) in more detail in the following.

Medicare

Medicare is a federal program insuring the elderly, disabled, and those with end-stage renal disease.[13] The program was created in 1965. All elderly US citizens aged 65 years and older who have paid into Social Security for at least 10 years are guaranteed coverage under Part A ("hospital insurance"). Inpatient services, short-term stays at skilled nursing facilities, hospice care, and some home health care are paid through this program, funded through a payroll tax on currently employed workers.

Medicare Part B ("medical insurance") provides limited coverage of outpatient services and requires beneficiaries to pay a monthly premium. Many elderly individuals without sufficient incomes to pay for Part B premiums are eligible to have state Medicaid programs pay their Part B premiums, as well as some of their other out-of-pocket costs. Individuals who receive both Medicare and Medicaid coverage are termed "dual-eligibles."

The 1997 Balanced Budget Act instituted Medicare Part C, called Medicare + Choice, to allow beneficiaries to opt into managed care plans in lieu of enrolling in Medicare Part A and Part B. In 2014, 30% of Medicare beneficiaries were enrolled in a Medicare Advantage plan.[14]

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 added Medicare Part D, a voluntary prescription drug benefit.[15]

Medicaid

Medicaid was also created in 1965, but unlike Medicare, which is funded from federal and beneficiary funds, Medicaid is funded by federal and state revenues with no beneficiary premiums. The amount of federal matching funds a state receives reflects the economic status of a state as well as the size and eligibility profile of a state's vulnerable populations. Federal guidelines govern the administration of the programs but allow for substantial flexibility in coverage and implementation, rendering each state's Medicaid program unique.

Medicaid beneficiaries must meet the residency standards of the state and federal immigration standards, and prior to the ACA, be a member of a population eligible for coverage (e.g., pregnant women, children, and disabled persons), and satisfy income and asset requirements. As a result of these "categorical" eligibility criteria, the main classes of Medicaid beneficiaries are low-income children and their parents, pregnant women, low-income disabled individuals (who must first meet state requirements for Supplemental Security Income, SSI), and low-income elderly with Medicare coverage.

The ACA attempted to standardize Medicaid eligibility by requiring all states to expand eligibility to people with incomes up to 133% of the federal poverty level and eliminating categorical eligibility criteria; this expansion is 100% funded by the federal government for 2014–2016, decreasing to 90% federal contribution by 2020 and beyond. The Supreme Court later ruled that requiring states to change their Medicaid eligibility rules was unconstitutional, and that these policy reforms must be voluntary for states instead of mandatory. By the end of 2015, 30 states and the District of Columbia have opted to participate in the ACA's expanded Medicaid program.

Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) was created in 1997. Under this legislation, states were offered new funds to expand Medicaid or set up new programs to cover children above Medicaid income thresholds but below 200% of poverty level. Some states have chosen to extend this program beyond children to include the uninsured parents of eligible children. CHIP benefits are generally similar to those of Medicaid. Over the past decade, expansions in Medicaid eligibility and enactment of CHIP have reduced rates of uninsurance for children. The ACA requires states to maintain current income eligibility levels for children in CHIP until 2019.

AFFORDABLE CARE ACT

The Affordable Care Act (ACA) is the most significant change to the US health-care delivery system since the creation of Medicare and Medicaid in 1965. Table 3-1 provides a summary of the key provisions of the ACA related to health care for vulnerable populations.

One of the most important elements of the ACA is the prohibition to exclude individuals with preexisting conditions from purchasing health coverage. Before the ACA, insurers could charge individuals with preexisting health conditions, such as heart disease, diabetes, and arthritis, much higher premiums, decide not to cover costs related to the treatment of a specific condition, or deny coverage completely. The ACA requires health plans to *guarantee issue*—that is, cover all applicants with a minimum standard benefit package and offer the same rates regardless of preexisting conditions or gender.

For guaranteed issue to be workable, everyone needs to be covered, both healthy and sick, so the risk can be spread across a larger pool of enrollees. This is the reason why the ACA also created an individual mandate, which, beginning in 2014, requires individuals to obtain insurance, either through their employer, in the Marketplace (health insurance exchange), or via a public program. Those individuals not obtaining coverage face a financial penalty for lack of compliance.

Table 3-1. Summary of ACA Implications for Vulnerable Populations

I. Improvement and Expansion of Health Insurance Coverage

Overall improvements to health insurance coverage

Guaranteed issue
- Prohibit the exclusion of individuals with preexisting conditions

Individual mandate
- Requires most US citizens to have health insurance

Coverage of prevention
- Eliminate cost sharing for preventive services recommended by the US Preventive Services Task Force

Changes to private insurance
- Provide coverage for dependent children up to age 26
- Prohibit lifetime and annual limits on dollar value of coverage
- Medical loss ratio: Require health plans to report the proportion of premium dollars spent on clinical series vs. administrative costs and provide rebates to consumers if that amount is less than 85%

Employer-sponsored plans
- Require employers with more than 50 employees to provide health coverage for full-time employees
- Provide small employers (less than 50 employees and average annual wages less than $50,000) that purchase health insurance for employees with a tax credit

Individual/Small group market
- Create state-based exchanges (Marketplaces) through which individuals and small businesses (up to 100 employees) can purchase coverage
- Provide premium credits for eligible individuals and families with incomes between 133% and 400% FPL
- Provide cost-sharing subsidies for eligible individuals and families with incomes between 133% and 400% FPL

Changes to public-sponsored coverage

Medicaid
- Expand Medicaid to cover eligible individuals with incomes up to 133% of FPL. Supreme Court later ruled this optional for states
- Create Medicaid Health Home option for chronically ill
- Provide states with new option for home and community-based services
- Temporary increase Medicaid payments for primary care providers to 100% of Medicare rates.
- Establish the community first choice option to allow states to provide home and community-based attendant services to Medicaid enrollees with disabilities

CHIP
- Require states to maintain current income eligibility levels until 2019 and extend funding through 2015

Medicare
- Phase down the coinsurance rate for prescription drugs in Medicare Part D from 100% to 25% (AKA Doughnut hole)
- Provide time-limited 10% bonus payment to primary care physicians

II. Noninsurance elements to improve care for vulnerable populations

Workforce
- Expand National Health Service Corps
- Provide 10% bonus payment to primary care providers and general surgeons practicing in HPSAs

PCORI
- Support comparative effectiveness research by establishing nonprofit Patient-Centered Outcomes Research Institute

Duals office within CMS
- Improve care coordination for beneficiaries covered dually by both Medicare and Medicaid by creating the Federal Coordinated Health-Care Office.

Innovation center within CMS
- Authority and funding to test, evaluate, and expand new models of care delivery and payment reform that will reduce expenditures while maintaining or improving quality of care

The ACA provides financial assistance to help low-income individuals comply with the individual mandate. In addition to providing federal support to states to expand Medicaid eligibility to all non-elderly individuals below 133% of the federal poverty level, the ACA provides affordability credits on a sliding scale for individuals between 133% and 400% of the federal poverty level to purchase health insurance through a Marketplace.

It is estimated that more than 18 million Americans have gained coverage since implementation of the ACA.[16] Even without all states electing to expand Medicaid, the Congressional Budget Office anticipates that within a few years more than 25 million Americans who otherwise would have been uninsured will have gained coverage as a result of the ACA.[17] However, millions of individuals in the United States will remain uninsured, including nearly 4 million residents living in states who have chosen not to expand Medicaid,[18] individuals eligible for Medicaid or subsidized private coverage who do not enroll,[19] and undocumented residents who remain ineligible for Medicaid and for the affordability credits to purchase health insurance through a Marketplace.

In addition to its impact on expanding health insurance coverage, the ACA reduces the risk of underinsurance by prohibiting health plans from placing lifetime and annual

limits on the amount of coverage and by preventing insurers from rescinding coverage after a patient is diagnosed with an expensive medical condition.

ORGANIZATION OF THE HEALTH-CARE SAFETY NET

In order for health insurance coverage to translate into improvements in health, it must facilitate access to care. While financial barriers to care are reduced by the availability of coverage, there are other barriers that challenge vulnerable populations' ability to use health-care coverage to receive health-care services. One major barrier is the availability of providers willing to accept a patient's form of coverage. Many of the same geographical areas where there are likely to be some of the largest expansions of health insurance coverage related to the ACA are also areas that have traditionally been underserved by health professionals. While the expansion of coverage will potentially provide patients from vulnerable groups with new options for where they might seek care, many either by choice or due to limited alternatives will continue to depend on the safety net for their care. Safety net providers are experienced in caring for vulnerable population groups and often have resources not found in other settings to support the provision of culturally competent care.

SAFETY NET PROVIDERS: WHO ARE THEY?

The US health-care safety net is a complex mix of primary care and specialty services (e.g., renal dialysis and care for persons with HIV-AIDS), hospital-based clinics and programs, community health centers, and other health-care providers that deliver services to vulnerable patients.

The composition of providers in a safety net varies greatly between communities and depends on factors such as a state's Medicaid policies, the socioeconomic composition of a community, the competitiveness of the local health-care market, and the existence of other programs for the poor and uninsured or special needs populations.[21-23] A diverse groups of practitioners, physician organizations, and hospitals provide services to vulnerable populations and can range from pharmaceutical programs for indigent patients to private physicians serving Medicaid patients to community health centers, free clinics, and hospitals providing uncompensated care. In most communities, the health-care safety net is not a formalized network of coordinated services.

CORE SAFETY NET PROVIDERS AND THEIR FUNDING

The Institute of Medicine report coined the phrase "core safety net providers" to refer to practitioners and health-care organizations that care for a substantial share of uninsured, Medicaid beneficiaries, and other vulnerable populations among the patients they serve.[22] Also called "providers of last resort," core safety net providers have organizational missions that mandate serving vulnerable populations within their communities or they are legally required to serve patients regardless of ability to pay. As a result, these providers tend to bear a disproportionate share of the burden in caring for those who are uninsured or covered by public insurance.[22]

Several government programs provide financial support for care to safety net providers as a supplement to what is reimbursed for the hospital care of specific patients covered by those programs. In 2013, providers' uncompensated care costs totaled $80 billion, with two-thirds ($53 billion) offset by government payments (Figure 3-3). The most significant of these special streams of payments is Disproportionate Share Hospital (DSH) Payments, provided separately by Medicaid and Medicare. Hospitals receive Medicaid DSH funds when they exceed a designated threshold of hospital bed days for Medicaid and uninsured patients and Medicare DSH funds when they exceed a designated threshold for low-income Medicare beneficiaries dually covered by Medicaid. Medicare also contributes supplemental funds to safety net teaching

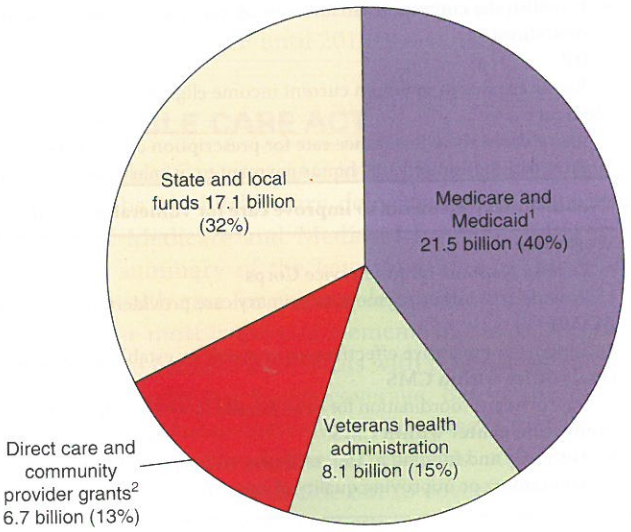

Figure 3-3. Distribution of government expenditure on $53.3 billion in caring for the unreimbursed, 2013.

[1]Payments made primarily through Medicaid DSH (both Medicaid and Medicare), upper payment limit (Medicaid), and IME (Medicare) mechanisms. Medicare and Medicaid DSH (disproportionate hospital share payments) are payments made to hospitals serving a disproportionately large share of the low-income and uninsured patients. Medicare IME payments are made to teaching hospitals and their residency programs in recognition for the role of teaching hospitals as core safety net providers.

[2]Federal monies at the Indian Health Service, Community Health Centers, Ryan White CARE Act, and MCH Title V Block Grant.

(*Source:* Coughlin TA, Holahan J, Caswell K, McGrath M. Uncompensated Care for the Uninsured in 2013: A Detailed Examination. Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2014. Available at http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/.)

hospitals through indirect medical education (IME) funds. Anticipating that the amount of uncompensated hospital care will decrease as health insurance coverage under the ACA expands, the ACA is scheduled to reduce DSH payments to hospitals over time.

The other major governmental sources of safety net funds come from state and local government, the VA, and grants including those provided by the Indian Health Service and by the Health Resources and Services Administration to support community health centers.

Uncompensated care that is not covered by government sources may be partially subsidized by providers shifting excess payments relative to actual costs available from patients covered by private insurance to underwrite the expenses of uninsured or underinsured patients unable to fully cover the costs of their care. Providers may also receive philanthropic contributions or the in-kind contributions of volunteer health-care workers who can help furnish services to uninsured and underinsured patients.

Safety Net Hospitals

Public hospitals and some nonprofit hospitals serve as the backbone of the safety net hospitals that provide a disproportionate share of the care to vulnerable populations. Among the approximately 5700 registered hospitals in the United States, approximately 1000 are public hospitals.[24] The public hospital commitment to caring for all persons is a key attribute that makes them such an integral part of the US health-care safety net.

Many nonprofit hospitals also contribute to the care of vulnerable populations. In urban areas, nonprofit teaching hospitals are often the only providers of certain types of specialized care that typically do not generate revenues to cover their cost, such as trauma care and burn units. In rural areas, nonprofit hospitals often serve as the primary source for both ambulatory and acute care for their communities.

Current market forces are increasing the fragility of the financial sustainability of safety net hospitals. Many safety net hospitals, in fact, are operating in the red, incurring more expenses than revenue received. Some analysts have raised concerns that the new insurance payments that result from the ACA reforms will not be enough to offset the DSH reductions.[25] This will place new strain on safety net hospitals' finances and many will struggle to maintain their mission of providing high-quality hospital services to all.

Community Health Centers

The Federally Qualified Health Center (FQHC) program is the main federal policy initiative which supports the furnishing of primary care services for vulnerable populations. FQHCs are nonprofit, free-standing clinics, located in medically underserved areas, providing primary care regardless of ability to pay, and governed by a community board. FQHCs provide enabling services such as on-site availability of medications, transportation, translation services, or in-house lab testing in order to lower access barriers to care. Community health centers, migrant health centers, health care for the homeless programs, and the public housing[26] primary care programs all fall under the FQHC designation.

In 2012, a total of 1200 FQHCs served 22 million patients.[27] More than 90% of patients were from low-income families, 36% were uninsured, 39% were Medicaid recipients, and 73% were from racial/ethnic minorities. ACA and the American Recovery and Reinvestment Act (ARRA) 2 years prior provided significant funding for both FQHC organization expansion and capital funding—through 2015. By this time, it was expected that most of FQHC patients would be covered either by Marketplace plans or the mandated Medicaid expansion. FQHCs in states not opting to expand Medicaid coverage will face significant financial threats without an additional funding source.

Emergency Departments

Emergency departments (EDs) are often the provider of last resort for vulnerable populations with limited to or no access to primary care physicians and specialists. ED visits account for 10% of ambulatory care in the United States.[28]

The Emergency Medical Treatment and Active Labor Act of 1985 (EMTALA) guarantees screening and stabilizing treatment in the ED regardless of the patient's ability to pay (see Chapter 4). The requirements under EMTALA in combination with inadequate access to primary care in many communities contribute to higher use of the ED as the site of care by vulnerable patients. In 2012, the percentage of individuals with at least one ED visit was 40% among adult Medicaid beneficiaries and 25% among children covered by Medicaid as compared with 20% among uninsured adults, 16% among uninsured children, 15% among privately insured adults, and 13% among privately insured children.[29]

After losing health insurance sponsored by his employer, Mr. Walsh purchases a new insurance plan on the health insurance exchange (healthcare.gov) and receives a tax credit to defray the costs of his premium. His diabetes and hypertension did not increase the cost of the premium, because the ACA precludes insurers from increasing rates due to preexisting conditions. He and his family take advantage of the preventive care benefits in their new insurance policy and obtain flu shots and cancer screening tests, such as Mr. Walsh's colonoscopy. His primary care physician based at a community health center identifies that Mr. Walsh has proteinuria and renal insufficiency. He refers Mr. Walsh to a nephrologist, but the wait for a new appointment is 7 months. The primary care physician believes Mr. Walsh needs to be seen more urgently, but there are no other nephrologists in his local community who agree to see him any sooner.

Health Workforce

The National Health Service Corps (NHSC)[30] is one of the main federal programs recruiting providers to work in medically underserved communities by providing direct financial incentives. The NHSC aims to attract these providers through two programs: a loan repayment program and a scholarship program, both of which provide financial aid to students or practitioners of primary care disciplines in exchange for terms of service in a Health Professional Shortage Area (HPSA). Currently, there are approximately 9200 NHSC clinicians consisting of allopathic or osteopathic physicians, dentists, mental health professionals, nurse practitioners, nurse midwives, and physician assistants.[30] NHSC received significant funding increases through the ACA and ARRA. However, there are many more sites requesting NHSC clinicians, and many more clinicians applying for NHSC loan repayment, than positions funded by the NHSC.

Private physicians contribute to safety net care by providing charity care or volunteering in safety net clinics. Private physicians' offices receive no direct subsidies for unreimbursed care. Charity care in private physicians' offices is not necessarily available for all patients. Although most primary care physicians are willing to accept uninsured patients, their payment policies vary widely and may make care inaccessible. Some physicians are unwilling to accept patients with Medicaid insurance, citing low reimbursement, paperwork burden, and the medical and social complexity of cases as primary reasons. Approximately half of generalists and specialists in one survey cited additional risk of being sued as a factor in the decision to not serve uninsured and Medicaid patients,[31] although low-income patients are not in fact more likely to file malpractice claims.

Not surprisingly, physicians find it difficult to refer uninsured and Medicaid-eligible patients to specialists. Both general internists with private offices and providers at FQHCs say it is very difficult to obtain needed medical services beyond what can be provided at the office visit for their uninsured patients. Many physicians believe they must rely upon personal relationships as opposed to formal processes to connect the uninsured to needed specialty care.[32,33] Also, a quarter of the physician faculty members at US academic health centers report that they were rarely able to provide nonurgent admissions for their uninsured patients, and for some respondents, there were formal policies limiting care to uninsured patients at their institutions.[34]

CONCLUSION

The organization and financing of health care for vulnerable populations is characterized by complexity and fragility. The United States lacks a coordinated system to pay for and provide health-care services to all its residents, which leaves those most vulnerable to lack of health care in a precarious position if they lose insurance coverage or need to obtain specialized services. Although the ACA is reducing the number of uninsured Americans, it is unlikely to completely eliminate uninsurance as a problem, particularly if states choose not to expand their Medicaid programs. Moreover, low-income individuals' insurance benefits may provide protection against catastrophic loss but may not provide adequate coverage for routine and lower cost services, which leads to delays in obtaining needed care.

Safety net providers will benefit from the ACA's effects on increasing rates of insurance coverage, but only if those newly insured have policies that provide adequate reimbursement to providers. Many public hospitals are at risk of closure because of dwindling revenue sources. Despite expansion of the federal community health center program and the NHSC, there are not enough primary care safety net providers in this country to address all health needs of vulnerable populations. Because of their hands-on experience in health care, health professionals are in a unique position to advocate for strategies that will bolster the safety net and address the needs of the most vulnerable in our society.

KEY CONCEPTS

Health System Financing
- Risk pooling is required to protect individuals from the unpredictability of severe illness
- Differs based on revenue source

Insurance Programs differ based on sources of revenue and eligibility
- Employer-sponsored insurance
- Individually purchased insurance
- Health insurance exchanges (Marketplaces)
- Medicare
- Medicaid
- CHIP

The Accountable Care Act
- Expands the risk pool through the individual mandate that requires everyone to participate in some system of insurance or pay a fine.
- Prohibits excluding patients from purchasing insurance on the basis of gender or health status (pre-existing conditions).

Safety Net Is Composed of
- Core safety net providers
- Public hospitals
- Teaching hospitals
- Federally qualified health centers
- NHSC
- Unreimbursed care
- Disproportionate share payments

CORE COMPETENCY: UNDERSTANDING COVERAGE OPTIONS

Health Insurance Marketplace

- No eligibility restrictions
- Four levels of plans: bronze, silver, gold, platinum
- Tax credits available for low- and moderate-income individuals and families to lower premiums
- Other subsidies available for lowest income enrollees

Medicaid

- All states cover low-income:
  - Children under 18
  - Pregnant women
  - Working parents
  - Patients with severe physical and mental disabilities
  - Elderly low-income Medicare beneficiaries
  - Beneficiaries who receive SSI cash benefits
  - Limited eligibility for those who would otherwise be eligible (low-income pregnant women or children) but who are undocumented persons or short-term (<5 years) residents
  - Median maximum income is 50% of federal poverty line for those without employer-sponsored or privately purchased health insurance

DISCUSSION QUESTIONS

1. As a primary care practitioner, if Mr. Walsh were your patient who became newly uninsured, what would you do? How would you advocate for his need for a specialty consultation?
2. Who are the safety net providers in your community? What local funds or programs exist to support your safety net providers?
3. As providers, one of the ways to help your vulnerable patients is to get involved in advocacy. What safety net related issues can a provider be involved in at the organizational, city/county, state, or federal levels?

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