

The Impact of the Affordable Care Act on the Safety Net

April 2011

Genesis of this Brief

This policy brief is drawn, in part, from a panel discussion on the same topic held on February 7, 2011, at AcademyHealth's National Health Policy Conference in Washington, D.C. Panelists were Patricia Gabow, M.D., chief executive officer, Denver Health; Mitchell Katz, M.D., director, Los Angeles Department of Health Services; Sara Rosenbaum, J.D., Hirsh Professor and chair, Department of Health Policy, The George Washington University; and Bruce Siegel, M.D., M.P.H., president, National Association of Public Hospitals. Winston Wong, M.D., M.S., medical director, Community Benefit, Kaiser Permanente, moderated the discussion.

Summary

The passage of the Patient Protection and Affordable Care Act (ACA) presents both opportunities and significant challenges for the safety net, a system of health care providers that primarily serve patients who otherwise cannot afford or gain access to care. In 2014, the ACA will extend health insurance coverage to more than 30 million currently uninsured people. The law also promises some significant investments to build provider capacity and help deliver care in a more coordinated manner. However, safety net providers are concerned that changes in the ACA regarding health care financing may affect the availability of adequate and sustainable funding as they continue to care for the most vulnerable consumers, particularly the millions who will still lack insurance.

Safety net providers note that the successes of health reform and of the safety net are bound together as the health of the nation will not improve unless providers are available to deliver care. All providers recognize the need to plan strategically in anticipation of major changes in the health care system, but safety net providers also face the immediate challenge of responding to a significant increase in the demand for services that accompanied the recent recession. At the same time, cuts in Medicaid, the largest single revenue source for safety net providers, have occurred in states that face large budget deficits. Safety net providers must focus on sustaining current services while planning for the major changes to come in 2014.

The ACA gives federal agencies the discretion to define critical terms and concepts in the law. The manner in which they are interpreted can have a profound impact on the viability of the safety net.

Introduction

In a landmark report issued in 2000, the Institute of Medicine defined the essential characteristics of safety net providers: they offer care to patients regardless of their ability to pay for services; and a substantial share of their patient mix are uninsured, Medicaid, and other vulnerable patients.¹ Certain types of health care providers such as public hospitals, community health centers, rural clinics, and local health departments are generally viewed as “core” safety net providers. Specialized programs, such as AIDS and school-based clinics, are also considered to be core providers. In addition, the majority of private, office-based physicians report that they provide some charity care and virtually all hospitals provide some level of uncompensated care.²

The safety net is not as uniform, comprehensive, or well organized as its name might imply. Access to safety net providers varies geographically, with residents of rural areas particularly affected by a shortage of providers.³ And though primary care services are generally available from safety net providers, patients may have difficulty finding more specialized care.

The safety net not only comprises a variety of health care providers, but also relies on many different financing sources. Local, state, and federal economic circumstances and politics can affect how robust and effective the safety net is. Some communities have well organized integrated systems of care; in others, providers may be available, but loosely connected and do not function as part of a more comprehensive system of care. Among safety net providers, some are very large, sophisticated organizations, well integrated with a larger health care community, and some are small isolated facilities. Researchers and policymakers have noted a growing disparity between top-tier, economically viable safety net providers and smaller, less successful ones.⁴ For example, some small entities whose mission has always been to serve the neediest have not engaged in strategic planning or become part of larger systems. With the passage of the ACA, all safety net providers are anticipating major changes in health service payment and delivery policies.

Current Challenges

The immediate challenge for all safety net providers is to respond to a significant increase in the demand for services that accompanied the recent recession and has continued. Almost 51 million people were uninsured in 2009.⁵ The decline in employer-sponsored health insurance coverage, as well as the loss of jobs during the recent recession and the accompanying loss of health insurance, has swelled the ranks of the uninsured and others who rely on the safety net. The National Association of Community Health Centers (NACHC) reported a 14 percent increase in visits between June 2008 and June 2009, compared to a just a 6 percent increase for a comparable period the year prior to the recession.⁶ Health centers in some communities reported in 2009 that they were at full capacity and, therefore, had limited ability to accept new patients. As a result, patients were experiencing longer waits for care.⁷

The National Association of Public Hospitals and Health Systems (NAPH) reports that the demand for services increased steadily from 2000 to 2009 for all hospitals, but the increase was significantly greater for public hospitals compared to all acute care hospitals. Inpatient discharges increased by 17 percent and 9 percent respectively. Capacity at public hospitals did not keep pace with demand during this period.⁸ Since the beginning of the recent recession, public hospital systems have had substantial increases in the amount of uncompensated care provided—including emergency room care—and increases in the numbers of both uninsured and Medicaid patients seeking care.⁹ The amount of uncompensated care that Denver Health, an integrated safety net provider, delivered to uninsured patients increased from \$275 million to \$338 million from 2007 to 2010.¹⁰

Safety net providers are coping not only with an increase in demand for services, but also with diminished resources. The Medicaid program is the largest single revenue source for safety net providers; but, in light of major budget deficits, states and the federal government are considering how to control Medicaid spending. In the fall of 2010, 39 states had implemented a provider rate cut or freeze for that year and 37 states planned spending cuts for fiscal year 2011. States have also narrowed the scope of Medicaid benefit packages. In fiscal year 2010, 20 states implemented benefit restrictions and 14 states planned benefit restrictions for fiscal year 2011.¹¹ These cuts have occurred even as states have had some relief from a temporary increase in the federal Medicaid matching rate since October 2008, but that is due to expire at the end of June 2011.¹² A February 2011 letter from the secretary of the U.S. Department of Health and Human Services (HHS), which acknowledges states' struggles to balance budgets, suggests strategies for potential cost saving including benefit modification for optional services.¹³ The current harsh fiscal reality means that providers must focus on ensuring their current solvency even as they contemplate their role in a changing environment.

Looking Ahead: Key Considerations for Maintaining a Strong Safety Net

Like others in the health care system, safety net providers are anticipating major changes in the delivery of health care services as reimbursement processes change and more than 30 million people obtain health insurance.¹⁴ The newly insured will be more likely to seek care than they were in the past. All providers face uncertainty about how many provisions of the law will be interpreted and implemented. Federal agencies have a great deal of authority to define critical terms and concepts. Thus, providers must maintain some flexibility as they plan for anticipated changes.

Seizing new opportunities

The ACA provides some significant investments for the safety net. New funding totaling \$11 billion over five years is authorized for health centers. The NACHC estimates that those funds will enable health centers to double their current capacity and serve 40 million patients by 2015.¹⁵ The law contains new authorizations for nurse-managed health centers and school-based health centers. The Prevention and Public Health Fund, to be administered by the secretary of HHS, is authorized to spend \$15 billion over 10 years beginning with fiscal year 2010. Financial incentives available through Medicaid and Medicare to encourage the use of electronic medical records are another source of funds that can help improve service delivery and quality among safety net providers. The law encourages the formation of innovative delivery systems such as accountable care organizations (ACOs), patient-centered medical home demonstrations, and community-based collaborative care networks. Safety net providers can be important participants in these new arrangements, but their participation is not assured. As providers of primary care services they are logical partners, but many are at a disadvantage because they have very limited access to capital and few resources to devote to planning for new opportunities or developing new business strategies. Safety net providers that are already part of integrated systems—providers that are aligned with physicians by employment or contract, that own or operate health plans, or that are actively developing and using health information technology—are more likely to succeed. Others that do not have those competitive advantages will face more challenges. Safety net providers imbedded in city or county governments may have limited flexibility to make the types of changes encouraged by the ACA.

Maintaining and expanding the patient base

A positive consequence for safety net providers of the anticipated health care coverage expansions is that they will have a new payment source for many patients who were formerly uninsured. The Medicaid program will expand to cover people under age 65 with incomes up to 133 percent of the federal poverty level (FPL). Premium and cost-sharing subsidies will be available to families with incomes between 100 and 400 percent FPL to help them purchase insurance.

Safety net providers have considerable experience serving the population that will be newly insured. Currently, more than half of the uninsured are people of color.¹⁶ Many providers tailor services, taking language and culture into account and making patients feel welcome regardless of their circumstances. Safety net providers will continue to be essential in a reformed system as the need for providers who can anchor and customize care will persist. Safety net

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providers are also beginning to think about whether they should try to attract the newly insured group that includes more middle and upper-middle class patients who may have different expectations about their health care. The challenge for some safety net providers will be how to continue to be welcoming to the most vulnerable patients who have come to rely on them, but also to change their image from a place of last resort in order to attract a new group of patients. However, safety net providers may also face competition for newly insured patients from other providers.

Continuing to care for the uninsured

If everyone were insured with comprehensive coverage, the need for the safety net would be markedly diminished. But, safety net providers are acutely aware that in 2014 they will still be treating a substantial number of patients who do not have insurance.

An estimated 23 million people will remain uninsured under the ACA.¹⁷ Some of the uninsured will be exempt from the individual mandate.¹⁸ Others may conclude that health insurance is unaffordable even with subsidies and may choose to pay a penalty instead of purchasing insurance. In the new system, undocumented immigrants will remain uninsured. Also, gaps in coverage are anticipated. People may be uninsured temporarily if their employment or financial status changes and accompanying changes in the subsidy or coverage status do not occur immediately or seamlessly. Individuals are exempt from the coverage mandate if they have been uninsured for less than three months. In Massachusetts, which passed comprehensive health reform legislation in 2006, some 15 percent of tax-filing uninsured adults were exempt from the state's individual mandate in 2008 because they did not have an affordable option. An additional 18 percent were uninsured and penalized because they did not comply with the mandate, and 17 percent were uninsured for up to three months.¹⁹

Regardless of the reason for the lack of insurance, safety net providers—like public hospitals—anticipate that they will continue to be the providers of choice for the uninsured. The NACHC estimates that 22 percent of health center patients will be uninsured in 2015, a reduction from the 39 percent in 2010, but still a substantial portion.²⁰ Under the Emergency Medical Treatment and Labor Act (EMTALA) passed in 1986, hospitals will still be required to treat anyone needing emergency care, regardless of citizenship or ability to pay.

Assuring adequate reimbursement

An overriding concern for safety net providers is that funds they currently receive through grants, Medicaid reimbursement, or specific programs may be diverted to help pay for insurance expansions. As a consequence, they do not know whether there will be ongoing and sustainable funding to adequately support their operations, particularly as they continue to care for the uninsured

and provide services that have historically been partially subsidized by Medicaid payments. Safety net providers have voiced concerns that with continuing financial pressures in states, efforts to control Medicaid spending may involve more provider rate cuts. They note that they will be expected to continue to provide certain services, even when Medicaid reimbursement is not available as it has been in the past.²¹

The Medicaid Disproportionate Share Hospital (DSH) program, which provides funding to states to subsidize certain hospitals for the unreimbursed costs they incur treating uninsured and Medicaid patients, will be phased out beginning in 2014. DSH covers the cost of care for those who are not able to pay and it fills the gap between the cost of care and payments from Medicaid. The expectation among lawmakers is that with fewer uninsured patients in a reformed system there will be fewer uncompensated costs and, therefore, less need for DSH payments.

However, safety net providers worry that reductions in DSH payments may not comport with reductions in uncompensated care costs. They may lose more in DSH payments than they will gain in other revenue. Thus, they will still provide uncompensated care, but without the subsidies.

Safety net providers already play an important role in the development of the health care workforce, and expect to continue to play a critical role in training the next generation of health workers. They have the advantage of being able to prepare workers for changing demographics, but they fear losing the resources to support the training.

The ACA directs the secretary of HHS to develop a new method to reduce DSH funds from 2014 to 2020. Currently, the levels of DSH funding and the purposes for which it is used differ considerably among states. Presumably, in developing a reduction methodology, HHS will study the current distribution and use of funds. Some providers have suggested that rather than cutting DSH payments on the assumption that revenue will increase, the reductions should occur only after a decline in the demand for uncompensated costs can be measured and verified.²²

Assuring that coverage is comprehensive

All states have some discretion to limit the amount, duration, and scope of services covered by Medicaid. They may also apply to HHS for waivers that include redesigned benefit packages. Safety net providers point out that consumers will continue to need the same services; but, if the benefit packages states offer in the future are less robust than the current packages, providers will be at greater financial risk for the services they deliver.

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The type of coverage offered by health insurance plans that will be available through the health insurance exchanges that each state must establish will also affect the safety net. The ACA sets a minimum standard of coverage and requires that the secretary of HHS define “essential benefits” that plans in the individual and small group health insurance markets must offer. Plans may offer additional benefits. The law provides some direction for the development of the essential benefit definition, but HHS has considerable discretion and decisions that it makes will affect providers. If patients need services beyond what their policies cover, safety net providers may be at financial risk.

Participating in plans

The extent to which safety net providers are considered “essential community providers” will have a major impact on their viability. Consumers will only receive premium subsidies if they buy “qualified health plans” offered through exchanges, and qualified health plans must contract with “essential community providers” as defined by HHS. If the agency adopts a narrow definition, certain safety net providers may be excluded and, therefore, not assured of being able to participate in the qualified plans. Safety net providers also point out that if health insurance plans offered outside the exchanges were also obliged to contract with them, then individuals whose subsidy status or insurance coverage changes could continue to receive continuous covered care from safety net providers such as community health centers.

Participating in networks

Many safety net providers are already part of integrated delivery systems. They are well positioned to participate in ACOs, medical home demonstrations, and other collaborative service delivery arrangements. Others, such as local health departments, could enhance networks, but they may have difficulty competing with providers who have more experience or established relationships.

Historically, different facilities have been established in response to specific needs, where safety net providers may be working in close proximity, but not working in a systematic way. Safety net providers in some areas view each other as competitors. The *Healthy San Francisco* program is one example of an effort that promotes integration among safety net providers. The program provides comprehensive care through 29 clinics and five local hospitals. Prior to the implementation of the program, these entities provided care but did not function as a system. Because the program now uses a common eligibility and record-of-care system, it is possible to determine where patients are assigned for care if they come into the emergency room. Thus, care can be less fragmented. New patients can choose providers based on where appointments are available and the system helps with referrals to specialists. With the system in place, the city is also able to determine how many people are using the safety net.

New arrangements involving both safety net and other providers have the potential to appeal to a broad group of consumers and to enhance the delivery of care. ACOs could help build a better safety net if they include safety net providers, but ACO policy could also drive inequity if providers gather profitable parts of the health system and exclude the safety net. Regulations regarding the formation and operation of ACOs, as well as state and local rules, circumstances, and providers’ abilities to negotiate partnerships, will influence the way care is delivered.

Building capacity

The dearth of primary care providers is an issue across the health care system, but it can be particularly difficult for safety net providers to attract primary care personnel. The ACA specifies Medicaid primary care provider payment enhancements, a federally funded increase to bring rates for primary care providers to Medicare rates, but only for a two-year period. Other policies are also needed to increase the pool of primary care providers and help assure that the safety net will have the capacity to respond to an increased demand for services. Some safety net providers suggest, for example, that states should consider expanding scopes of practice for non-physician providers such as nurse practitioners and physician assistants.

Access to specialty services is already problematic for the population that relies on safety net providers. Gaining access to mental health services is a particular problem.²³ People who have put off care because they could not pay may enter care with untreated issues along with social and medical needs; more health problems that need follow-up treatment will be identified. Safety net hospitals expect that the increased demand for specialty services will strain their capacity to provide care, unless adequate financing is available. Public hospitals already provide substantially more non-emergency outpatient visits that other acute care hospitals and more than half of the outpatient visits – 56 percent in 2009 – are for specialty care services.²⁴

Responding to new requirements

Safety net providers note that the regulatory burdens will grow with the implementation of the ACA and they are being asked to take on new responsibilities and risks. For example, the ACA includes requirements that nonprofit hospitals must fulfill in order to maintain tax-exempt status. They must perform community health needs assessments at least every three years, make the results of the assessment available to the public, and then develop strategies to meet the needs. Anticipated regulations from the Internal Revenue Service (IRS) will help hospitals understand just what their obligations will be, but the current concern is that the requirement may be burdensome. Although the law does not require that local public health departments be involved in the process, they are logical partners for hospitals’ community needs assessment activities. However, they may not be in a position to perform this new task without additional resources.²⁵

The ACA's emphasis on quality improvement is welcome, but safety net providers question whether resources for data collection, reporting, and use will be available. Without support, they view these as additional tasks that must be accomplished with already limited funds. Safety net hospitals are concerned in particular about requirements for payment reductions that could occur if certain standards are not met. For example, financial penalties will be imposed if certain patients are readmitted to the hospital. This is problematic for hospitals that serve populations such as the homeless or chronically mentally ill that are more likely to be re-admitted. Similarly, these populations may be more susceptible to hospital acquired conditions such as pressure ulcers when they enter the hospital because of ongoing poor nutrition or skin care. Safety net providers suggest that the nature of the patient population should be considered in developing quality measures and associated penalties.

About the Author

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