

## **Introduction:**

The United States boasts great national wealth as well as advanced medical technology. Yet, international health indicators show that American citizens suffer poor health compared to other industrialized nations with particularly poor outcomes amongst low-income and minority populations. Over forty one million Americans lack health insurance and an untold number are underinsured. Financial barriers prove the greatest obstacle to access, with one third of uninsured deemed poor or near poor according to federal guidelines (Poltizer 2003; 296). Measured healthcare need demonstrated by self-assessed health status, chronic illness, and annual disability days is not the most important determinant of whether health services were sought out. This demonstrates that low-income citizens suffer inequitable access and not simply a preference for less health services typified in lower utilization rates. These barriers are long-established. Data from 1977 shows that privately insured citizens received fifty four percent more ambulatory care and ninety percent more inpatient hospital care than persons without insurance coverage. Race and geographic location contribute to this disparity, though not as potently as income status (Davis 1991; 261).

Inequitable access correlates with lower life expectancies, greater frequencies of chronic illness, and greater instances of infant mortality amongst these disadvantaged groups (Poltizer 2003; 296-7). Poltizer and colleagues, in a 2003 paper, estimated that United States healthcare professionals could reduce preventable mortality in this country by ten to fifteen percent through better availability and quality of healthcare obtained by uninsured populations (Poltizer 2003; 297).

Research indicates that community health centers, free clinics, emergency rooms, hospital outpatient departments and primary care physicians are primary means through which the uninsured access care (Olson 1994; Davis 1991). I intend to focus on the methods that these organizations use to serve uninsured populations as well as the cost of this service to the organization and to the uninsured. An additional concern is underinsured and at-risk populations. The underinsured are those whose insurance fails to secure purchasers access to needed care in two ways. Insufficient reimbursement rates for participating physicians constrict the type and quality of physician and severely limit

covered services. At-risk populations are considered underinsured for these individuals may soon lose their insurance coverage due to precarious financial situations.

Hospitals, clinics, and physicians that care for the uninsured and underinsured face specific challenges. These organizations are understaffed or ill-equipped to serve patients with greater-than-average health needs. Often, patients must endure deferred appointments, long waits in the provider's office, lack of amenities that insured patients' enjoy, and inflexible or absent referrals to specialty physicians. These organizations must provide care (including medications) at severely reduced costs. They must expend greater time and energy to enroll patients in charity care, indigent care, and other free service providing programs. This problem aggravates the high administrative costs associated with these organizations. In particular, emergency rooms, free clinics and health centers suffer from capital costs in the form of billing systems, insurance documentation and information technology systems. Also, as better medical technologies facilitate health improvements amongst privately insured patients, the medical community sets higher, resource-intensive, standards for treatment and care of all patients. These standards are difficult to achieve with the limited or dated treatments provided by health centers. Nor are these resources frequently utilized in ER's or specialty physician's offices due to a patient's inability to pay. For this reason, uninsured patients may be denied treatment in tertiary care facilities and specialty physicians' offices. Or, they must wait months for needed services through an indigent care program (Schiff 2003; 310).

Contemporary means of healthcare for both the uninsured and underinsured lead to insufficient access to medical resources and disproportionately poor health outcomes for both groups. Current obstacles to access include temporal, spatial, and educational impediments in addition to the obvious financial concerns. Consequently, healthcare policy reforms must address all of the current access impediments to remove the harmful consequences of the current, multi-operational system called the healthcare "safety net."

### **Hospital Outpatient Departments and Emergency Rooms**

Hospitals, like all healthcare providers, face enormous cost pressures stemming from insurer and government cost-cutting measures. Hospitals that unsuccessfully combat

these demands risk financial disaster. Inappropriate use of emergency care services for primary care purposes, particularly by low-income citizens, present significant expense to many hospitals. Emergency departments are built, staffed and maintained to treat persons in need of urgent care and are extremely expensive to operate. Consequently, use of emergency rooms as primary care clinics for the indigent presents huge cost inefficiencies. Hospitals have long since born a significant portion of the burden of care for the nation's uninsured. In a 1991 internal study of emergency rooms in California, researchers found that thirty-nine percent of emergency room patients presented with non-urgent medical needs- problems that do not require treatment within three hours (Olson 1994; 453). The remaining forty-four percent required treatment within twenty minutes to three hours of arrival. This number doubles the seventeen percent of that year's patients whose ailments constituted emergencies. To appreciate the role of hospitals and emergency rooms as members of the healthcare safety net, we must examine the means by which these organizations routinely finance the care provided to low-income patients.

Emergency rooms and hospitals often categorize patients according to insured status and income brackets. Once characterized as "low income" or "uninsured," the hospital bears the cost of caring for these patients through two means: charity care or bad debt. Through charity care programs, lower income patients are afforded discounts using income-based sliding scales. Charity or free care includes multiple levels of discounts provided that patients meet financial eligibility qualifications determined by individual hospitals with certain state regulations in mind (Kane 2000; 191). The patient is never billed, nor does the hospital attempt to collect any sort of reimbursement for services rendered to charity care patients. Charity care contrasts with patients whose lack of payment results in "bad debt". Bad debt is care for which the patient is billed and the hospital is unable to collect. Up to fifty percent of a hospital's bad debt is generated by patients who would qualify for charity care if the proper financial information could have been collected prior to administration of care (Kane 2000; 191). The income-based qualifications for charitable care are in many instances at the discretion of the hospital board but they are most often expressed as income percentages above or below poverty line (e.g. 150% of the poverty line).

According to a study published in 2000, the total amount of uncompensated care provided by hospitals (charity care and bad-debt) exceeded eighteen billion in 1996 (Kane 2000; 186). The degree of participation in charitable programs varies amongst hospitals according to institutional status. For instance, for-profit hospitals face great economic and institutional pressure to contain costs and maximize revenue. This competitive force leads them, on average, to serve fewer uninsured in charitable programs (Davis 1991; 265). Hospitals engage in many cost containment strategies to retain lost income. Many of these measures adversely affect access for the uninsured to hospital services, particularly high-cost and high discretion procedures (Davis 1991; 266).

For example, in non-critical cases, hospitals can shuttle patients to community providers such as community health centers or free clinics. “Patient dumping” prevents hospitals from incurring costs associated with treating uninsured patients. This method aligns with the hospital’s strong financial incentives not to treat poor and publicly insured patients who bring, on average, a 2,539 dollar loss with each visit to the hospital (Olson 1994; 465). The Arizona Supreme Court developed the legality behind this shuffling process. Previous legislation resulted in legal obligations for all hospitals to contain emergency departments and treat all those that sought care in them. A later verdict from *Thompson v. Sun City Community Hospital* provided clarification. ER’s are not required to care for all. Instead, only for whom care was “medically indicated” as urgent. So long as the patient would not suffer harm resulting from delays in care and transportation, patients financially prohibited from paying the cost care would incur may be legally transferred to another appropriate hospital or clinic (Olson 1994; 454). Wisconsin, New York, Illinois and Pennsylvania fashioned policies after Arizona’s model. Since this ruling, regulatory legislation prohibiting inappropriate transfers of low-income patients attempts to curtail the disproportionate impact of *Thompson* on low-income and minority patients. Sanctions include 50,000 dollar fines for the doctor and potential loss of Medicare contracts. States have proscribed prior proof of ability to pay before filling transfer paperwork (Olson 1994; 456-7). The former penalty is potentially ruinous to hospitals. The extensive capital costs in the form of equipment and staffing associated with ERs inflate annual fixed costs. For though Medicare’s reimbursement rates fail to

cover costs, Medicaid contracts are imperative to narrowing the difference between marginal and average costs (Olson 1994; 462).

Legislative contradictions leave hospitals in the middle of a legal and moral battle. Hospitals risk financial ruin treating every low-income patient. The government pressures hospitals to provide care to the uninsured. Demand increases as the number of uninsured patients rises. Yet, the market suffers from a reduced supply of hospitals. Between 1965 and 1990, annual emergency room visits grew from thirty million to ninety-two million while the number of hospitals dropped from 7,123 to 6,649 (Olson 1994; 465). This alarming trend results in overcrowding, budget crises, and threatens the general population's access to emergency services.

Hospitals often attempt to recoup losses associated with uninsured or underinsured patients by inflating costs for paying patients, a process called cost-shifting. ProPAC, the Prospective Payment Assessment Commission calculated that cost shifting to privately insured and self-paying patients generated over twelve billion in revenue in the early nineties. Funds used to pay for the increasing number of services rendered to uninsured (Kane 2000). However, the efficacy of cost shifting to pay patient-generated bad debt has been noticeably limited in the past ten years as private payers and insurance companies actively pursue cost containing measures such as participation in health management organizations (HMOs). Finally, a hospital's ability to raise costs is proportionate to the number of paying customers it serves. Nonprofit hospitals and those serving a disproportionate number of uninsured are forced to cost shift to a smaller number of paying clients.

Despite varying efficacy of cost shifting across hospitals, this method remains one of the most effective means of debt containment. Hospitals charge commercially insured patients 154 percent of the expense to offset losses associated with uninsured and publically insured patients. Accordingly, just over thirty percent of emergency room visits generate ninety percent of the average hospital's surplus income (Olson 1994; 469). Treatment and admission of just a few uninsured or publically insured patients can quickly consume any revenue the hospital generates. A 1994 study of California hospitals demonstrated that admittance of two additional publically insured patients (Medcal plan) and one uninsured patient in a single month consumes approximately nine

percent of the hospital's annual net profits. Hospitals reasonably conclude that although "outpatient visits are very costly; inpatient treatments are potentially disastrous" (Olson 1994; 475). Current financial and legal burdens force hospitals to make a choice between serving their communities and staying competitive. Overcrowding, cost shifting, and hospital closings exacerbate barriers to access. Thrusting the burden of care for the uninsured on hospitals requires them to serve a population in a manner they are neither designed nor capable of serving. Emergency room's and outpatient departments are prevalent providers within the healthcare safety net. Yet, financial pressures jeopardize their continued contribution to positive health outcomes for even the general population.

### **Community Agencies (Free Clinics and Health Centers)**

Within the national healthcare safety net, community-based primary care clinics play a critical role in remedying income-based healthcare disparities. The nation's 3,500 community health centers and free primary care clinics confront problems of health disparities, resource accessibility, and financial concerns directly. Unlike other hospital-based modes of care, primary care clinics are less expensive and more responsive to the general health needs of uninsured persons. Furthermore, consistent use of physicians for preventative care reduces delayed diagnoses that contribute to minority and low-income health disparities. By providing consistent access to physicians and basic services, primary care clinics help to alleviate the adverse impact of low-income status on population health (Politzer 2003; 297).

Free clinics and health centers are institutions designed specifically to serve the unique preventative and primary care needs of these most vulnerable populations in a community setting. Health centers are federally supported clinics that serve the uninsured and underinsured (including those that have Medicaid and Medicare) based on a sliding scale. Health centers served nearly five million patients in 2006, a fifty percent increase in only five years, with only 1.7 billion of federal funding (NACHC 2007). Free clinics differ in that they receive little or no government funding. They instead rely upon local support, donations, volunteers, and partnerships with local health providers. A Community focus allows clinics to diversify and specialize based on the prevalent needs of their patients (NAFC 2007). The service missions of free clinics and health centers

coalesce. Both emphasize prevention, early intervention, education, and direct care to promote good health amongst the underserved through provision of comprehensive primary care, dental services, patient education, and mental health/substance abuse services.

In 2001, community agencies provided healthcare to one-fifth of the nation's uninsured and underserved (Politzer 2003; 299, 302). Demand for these services has risen dramatically with growing numbers of uninsured. Yet, the number of community providers has remained essentially stagnant since 2001. Community providers directly attack racial and income disparities by providing healthcare to populations in greatest need of consistent, high-quality services. Furthermore, free clinics ameliorate several non-financial barriers to access by providing transportation to and from appointments, childcare, case management, outreach, health education, and referrals to specialty physicians in charity care settings (Politzer 2003; 299).

Politzer and colleagues outline some of the positive contributions of community agencies to health outcomes of low-income, minority, and uninsured populations. African American mothers who are patients of community health centers give birth to low-birth weight babies at a rate twenty percent below the average rate for African American women. Free clinics have been particularly successful in rural settings. Here, clinics have reduced birth weight differences by two-thirds (Politzer 2003; 300). Utilization of obstetrical services correlates with long-term positive outcomes for both mother and child via long-term health seeking behaviors such as childhood immunizations and annual check-ups.

Free clinic patients perceive their care-giving environment and providers to be high in quality. In part, due to physician familiarity that continuity of care provides. Patient satisfaction ratings are near 96 percent for free clinics. Clients describe their agencies as community-oriented, culturally competent, and enabling. Out-patient departments and emergency rooms do not receive such positive appraisals (Politzer 2003; 302). These results support the argument for expansion of this mode of care, thus allowing free clinics and health centers to facilitate better long-term health outcomes amongst more uninsured populations.

The issue yet to be determined is that of quality. For, though community providers are effective primary care sources, they alone cannot solve all problems associated with the healthcare safety net. For example, increasing the number of free clinics does not improve access to tertiary or specialized care for those that cannot pay. The solution available to clinics is continued enrollments of greater numbers of patients in already taxed charity care programs. Community agencies solve only certain aspects of the healthcare crisis. These organizations have an important role in future healthcare policy reforms. New agencies will provide low-income citizens access to consistent, culturally competent, and enabling primary care in their communities as part of improved and integrated healthcare system rather than as a last and only resort of the safety net.

### **Physicians**

Income-based healthcare access disparities are arguably most severe in this aspect of the safety net. Privately insured patients receive all levels of care (primary, emergent, tertiary, etc.) from their choice of physician. The uninsured do not. In fact, the proportion of a physician's patient pool that is uninsured is significantly below the percentage of the general population that lack health insurance. This is particularly true of self-employed physicians (Blumenthal 1991; 502). Physicians may determine to what degree they include uninsured or underinsured patients in their practice. Certain factors influence a physician's willingness to provide care. These play a significant role in patient access to physician services.

The first and most obvious motive is charitable. The parameters of charitable motives are difficult to define and unique to each physician. This may lead a physician to constitute half of his patient base with uninsured patients. Alternatively, the physician may satisfy his charitable motives through services to Medicaid patients. Physicians that choose the later option benefit from a lower default risk (Blumenthal 1991; 503). They also receive at least partial reimbursement (not without great administrative effort) for the cost of services for Medicaid reimbursement rates are often significantly below typical physician charges. For decades physicians have chosen the former option, to provide free-of-charge charity care. In 1982, charitable care reduced physician billings by eight percent (Blumenthal 1991; 505). However, the amount of charity care provided is



heavily influenced by the number of competing physicians who threaten, particularly self-employed, doctors' incomes. A competition that gets fiercer as the ascension of HMOs constricts the physician's ability to be a price-maker. Levels of charity care are also influenced by the Medicaid reimbursement rate. As the value of the reimbursements fall in comparison to the cost of services as well as administrative costs accrued to collect payment, treatment of Medicaid patients becomes increasingly altruistic. Finally, the charitable motive is affected by patient demand. Physicians, such as group practice physicians, that benefit from excess demand may respond to strong financial incentives by treating only privately-insured and low default risk patients. Conversely, physicians experiencing lower demand for their services may supplement their practice with Medicaid patients or fill free time with charity care (Blumenthal 1991; 509).

Several factors such as physician age, specialty, and practice characteristics predict involvement with uninsured patients. For example, female physicians participated with more Medicaid patients but less with uninsured patients. The type of practice and specialty also has specific correlations with uninsured involvement. Self-employed physicians display greater autonomy in deciding whom they serve, yet, are paid on a per-service-rendered basis. Whereas employed physicians earn an annual salary and face alternative incentives such as administrative pressures, institutional norms, or administrative sanctions (Blumenthal 1991; 509). A 1986 study found that incentive structures associated with practices result in divergent involvement with uninsured patients. Uninsured patients constituted approximately ten percent of the average self-employed physician's patient load. Whereas the average employed physician filled approximately 16 percent of his patient load with uninsured patients. The average physician's uninsured patient load was roughly eleven percent (Blumenthal 1991; 510). This trend should indicate improved access as the prevalence of group and hospital-associated physicians has increased since 1980. However, competitive pressures and cost-cutting measures have counteracted this trend leaving uninsured patients even less likely to utilize physician services of any practice type than in 1980.

There are significant variations in uninsured involvement based upon physician specialty. Psychiatrists' provision of indigent care was significantly above average at 17.4 percent followed by pediatricians (15.7 percent) and family physicians or general

practitioners (14.2 percent). More specialized physicians such as surgeons and specialized internists had the least involvement with the uninsured at 8.7 and 6.6 percent respectively (Blumenthal 1991; 510). Additionally, physician age and years practice experience are significant predictors. Physicians with less than ten years and greater than thirty years of experience serve considerably more low-income patients (Blumenthal 1991; 511). Perhaps, physicians at prime practice years are better able to attract paying customers and take on more privately insured patients. Younger physicians may not experience the same demand as their more experienced colleagues and serve more low-income patients in response. This fails to explain why the most experienced physicians serve the greatest numbers of non-paying patients. Possibly, charitable motives are greater amongst these doctors. This trend has implications for uninsured patients' quality of care. The fact that certain physicians in certain practice settings are ten percent more likely to care for an uninsured individual speaks to the lack of demand their services may garner in the private market.

Charitable and institutional factors effect physician involvement with uninsured patients. These incentives can be enhanced or ameliorated by public policy to promote more equitable access of the uninsured to physicians of all practice types and specialties. Sixteen percent of the general population was uninsured in 2006 (NCMM 2007). Yet, only eleven percent of the average physician's caseload is uninsured, a disparity more severe amongst specialty physicians. These differences do not reflect of divergent medical needs of low-income groups, for if this was true, indigent persons would need surgery at one-half the rate of the insured population (Blumenthal 1991; 515). The likelihood of this scenario is negated by the documented poor health indicators of low-income groups compared to their more affluent peers. Patient demographics vary by physician gender and years of experience, demonstrating physician's ability to choose his or her caseload. Policy makers can use this liberty to provide incentives for physicians to treat the uninsured in a practice setting.

### **Current Policy Initiatives and Implications:**

The Bush administration declared war on health inequalities setting the lofty goal of "eliminating racial and ethnic disparities in health by the year 2010" (Schiff 2003;

307). The current administration has used tax exemptions, community health agencies, and government-sponsored health plans to meet this goal. Evaluations of these initiatives are made with the goal of consistent, equitable access to high quality, affordable primary care and measurable progress in domestic health assessments in mind. These measures fail to reach stated goals of equity amongst privately insured and publicly or uninsured groups. None rectify the inequitable allocation of health resources domestically. Hence, it falls upon future administrations to succeed. Successful policy initiatives must consider the unique infrastructure of the healthcare safety net, specifically, cost inefficiencies, the unique disease burden of the uninsured, as well as the financial and non-financial barriers to access.

### **Tax exemptions to Non-Profit Hospitals**

The federal government currently uses grants to support non-profit hospitals that serve a disproportionate number of uninsured and Medicaid patients. These funds totaled fourteen billion dollars in 1995 (Kane 2000; 186). However, this funding is not distributed evenly amongst hospitals or the states. Grant distribution is biased towards hospitals that serve the most elderly patients, specifically those eligible for SSI and Medicaid. The sum is focused in eleven states whose resident hospitals meet service criterion. In the remaining thirty-nine states, funding does not cover the cost of care for the average uninsured individual (Kane 2000; 186). This policy fails to recognize what is a national and age-unbiased problem. Distribution favoring elderly persons with mediocre coverage does not help hospitals caring for many persons with no health insurance at all. Hospitals' uncompensated care expenditures are more appropriate appraisals of costs associated with the uninsured for nonprofit hospitals caring for disproportionately needy populations.

Kane and Wubbenhorst propose an alternative delivery method using a redistributed tax exemption. Here, hospitals that serve a disproportionate number of non-paying or underinsured patients are favored. In their plan, nonprofit hospitals receive exemptions that cover annual uncompensated care costs. A state-wide redistribution policy reallocates excess tax revenue from hospitals that do not provide sufficient services to

match the value of the exemption to hospitals that require surplus benefits to cover costs of uninsured patient pools (Kane 2000; 188).

The authors used a set of core variables to calculate the value of uncompensated care and, subsequently, the value of the tax exemption for these hospitals (Kane 2000; 197). The variables include costs of federal and state income taxes, sales taxes, property taxes, free care, and bad debts incurred by the hospital annually. The authors showed that if these hospitals were tax exempt, then the saved tax revenue would cover the cost of charitable care as well as seventy-five percent bad debt costs for most of the hospitals. Even with the total annual cost of bad debt included, one-third of hospitals retained excess tax benefits (Kane 2000; 199). This trend has severe geographic bias, however. Counties containing the highest percentage of low-income patients often spent all of their tax benefits on free care alone. No income is left to offset bad debt. Counties with fewer low-income patients had hospitals whose tax exemptions covered the total cost of uncompensated care (Kane 2000; 203). In efforts to eliminate the geographic bias, the authors include a redistribution mechanism. However, not only the geographic concentration of impoverished patients needed be counteracted in the policy.

Remaining to be addressed was the serious and persisting problem associated with care of indigent patients. That is, the inherent lack of profit in providing healthcare to the poor. Tax benefits are proportional to each institution's profitability, the higher a hospital's annual income the greater their exemption. Hospitals serving more charitable and defaulting patients have less sizeable profit margins. Consequently, the hospital has less sizeable tax benefits with which to serve the health needs of the low-income community. Additionally, low-income patients still suffer spatial disparity as they are often concentrated in neighborhoods away from these more gainful hospitals. Further problematic is that this reform aids only one aspect of the healthcare safety net. Many of the uninsured do not seek primary care in hospitals. Nor could the current number of nonprofit hospitals meet all of the primary care needs of the nation's uninsured. If all 3,000 of the nation's nonprofit hospitals provided care to the full value of their exemptions, the available dollar value of care to each uninsured individual would total less than one hundred dollars annually (Kane 2000; 208-9). Then why consider this reform at all, if its value is so little in the grander scheme? The program securely fits

within the current bureaucratic structure of the healthcare system. It also ameliorates pressure from hospitals greatly burdened by their low-income populations. Further the reform has potential to expand as the number of nonprofit hospitals grows. Finally, and most importantly, it removes the hospital's disincentive to provide care to potentially defaulting patients.

### **The Role of Community Agencies: Free Clinics and Health Centers**

Kane and Wubbenhorst's policy proves that to solve the problem of equitable access, one must look beyond nonprofit and even for-profit hospitals. Successful reform will require multi-tiered efforts that incorporate all aspects of the healthcare safety net. Community agencies have been recognized as critical and successful providers to low-income groups. Current policy initiatives reflect this achievement. The current administration approved further investment in health centers at increases of thirteen percent each year (Schiff 2003; 308). With luck, this increase would allow successful health centers to expand their client base. While simultaneously providing incentives for the establishment of new health centers utilizing previous successful models. Unfortunately, 2003 data demonstrates that annual funding increases barely surpassed current medical inflation rates. Furthermore, health centers must apply for the special funds. Only one in four health centers that applied received the grant. With this modest support, community health centers cannot grow at a sufficient rate to care for the growing number of uninsured, at risk, and underserved populations whose numbers near 50 million (WHO 2007).

In 2003, this plan allocated 1.5 billion dollars to community health centers. That amounts to a mere thirty-six dollars per uninsured person per year (Schiff 2003; 308). The policy initiative fails in three ways. An individual healthcare budget of thirty-six dollars fails to provide comprehensive coverage for current uninsured persons. Nor, does the funding prevent other at-risk populations, those with inadequate insurance and those who are intermittently insured, from losing coverage completely. Finally, the plan does not eliminate income-based health disparities amongst disadvantaged groups for this would require equity in access and spending. The uninsured and at-risk groups have unique health needs that manifest in greater than average illness burdens. This plan asks

community centers to provide equitable care for citizens more often chronically afflicted, mentally ill, and substance abusing with less resources, specifically, two percent of the dollars that each privately insured enrollee spends annually (Schiff 2003; 308). This policy fails to address the goals specified by the administration. More financial and structural support is required for both free clinics and health centers to grow along with the needs of the low-income patients they serve; support that hospitals could provide. Hospitals are often required to provide non-urgent primary care to uninsured patients. Care better suited for a clinic environment.

A 1994 article by Erik Olson for the *Stanford Law Review* outlined such a potential partnership. Tax credits would fund hospitals' financial and structural support of previously established community clinics or those established by the hospital. Olson described the benefits of this plan from the hospital's point of view. Associated community clinics would give hospitals an appropriate venue to treat the thirty-nine percent of patients who do not require emergent care. Reduced patient load, particularly of low-income patients, would reduce overhead costs. Outpatient departments would not have to staff these clinics with the same number of emergency care doctors, nurses, surgeons, orderlies, clerks, administrative workers, and life saving equipment. Clinics require fewer resources to meet primary care needs of patients. Emergency rooms would not only save revenue, but would become much more profitable if their non-urgent patients were treated in relatively low cost facility.

As we have seen, community agencies are successful and appropriate means for low-income patients to achieve consistent access to primary care physicians. Patient familiarity and provider consistency add efficiency to the clinic model. Clinics also facilitate access to tertiary and specialized care in a hospital setting through established relationships with a referral hospital. Clinics can assist clients' enrollment in various charitable care programs so that patients may access acute hospital care without threat of bad debt.

This relationship between two pivotal players in the healthcare safety net will reduce many cost inefficiencies associated with the nation's multi-tiered system. However, this proposal is not ideal. Many hospitals may object to the plan because they are still burdened (though less directly now) with patients they may feel are the responsibility of

the government. Clinics are also ill-equipped to take on the full burden of the uninsured at present cared for by hospitals. The current number of clinics and health centers capacity would be exceeded by this plan. The policy must include additional incentives for hospitals to build and staff their own clinics. Patients may still inappropriately seek non-urgent care in emergency rooms. To prevent this, the hospital will have to market and advertise the clinic's services, which the patient may still choose not to use. This reform is still discriminatory. Uninsured and publicly insured patients are still discouraged from using the same medical resources privately insured patients have rights to. Consequently, this plan maintains the multi-tiered system, rather than promoting a "universal" and equitable model. Further, community agencies would remain an indefinite financial burden upon their peer hospital. Clinics are costly and so an additional problem of sustainable financing remains. Finally, the plan does not prevent further deterioration of insurance status for the general population. If today's uninsured have no potential of obtaining insurance that reimburses at rates equitable to commercial insurance plans, reforms such as these only serve as band aids on an increasingly large wound.

## Washington and Lee University

### **Expanding Medicaid Managed Care**

The founding goal of Medicaid was one of equity. Legislators hoped to provide low-income recipients with equitable access to healthcare resources. Medicaid did not meet this goal. Instead, its service to select portions of the low-income population affects the integrity of the health care safety net, the only means of healthcare access for the remaining uninsured groups. Medicaid does not serve all low-income persons. Typical recipients of Medicaid include members of single-parent families, elderly, and disabled falling within state-determined income ranges. This patient pool excludes greater than forty percent of nonelderly poor and uninsured citizens (HLR 1997; 753). Despite restricted qualifications, states face severe cost pressures to finance their portion of Medicaid. As the number qualifying individuals grows with each year so does the cost of providing coverage under current healthcare inflation rates. States are turning to Health Management Organizations to solve their budget concerns. Use of these organizations bloomed in the early nineties as they became recognized, principally by employers, as the

most effective private means to curb growth in health insurance premiums (HLR 1997; 753). However, use of the HMO model results in more limited means of access for uninsured populations.

HMO's depress premium costs by several means. The most effective are capitation payment plans and contract negotiations with providers. Capitation contrasts with the traditional fee-for-service payment plan for Medicaid HMO's reimburse by a fixed-fee basis. Physicians within this system face financial losses from providing unnecessary and ineffective services. Secondly, HMO's negotiate discounts for their patients. The HMO promises providers exclusive access to a patient pool. In return, the HMO receives discounts on services so that fees are far below that of typical fee-for-service rates expected by physicians (HLR 1997; 754). This negotiating power has led to prevalence of HMOs within states' Medicaid systems. As early as 1995, twenty three percent of all Medicaid enrollees were involved in managed care; fifty four percent of this group was a part of HMOs specifically (HLR 1997; 755).

Medicaid managed care organizations are even more influential than other HMOs for their ability to draw competitive bidding for their clients. Medicaid participants provide instant market share to HMO's and healthcare providers due to sizeable, previously enrolled, patient groups. It would otherwise take years of marketing and advertising for organizations to accumulate such a client base. Medicaid's subsequent bargaining power has saved states millions each year. Arizona's state government saved fifty-two million in acute care costs in 1991 alone (HLR 1997; 756). Though these savings appear laudable, they do not address financial concerns associated with affording healthcare to the non-elderly poor. Seventy-five percent of Medicaid expenditures compensate care for elderly and disabled populations, a group that constitutes less than a quarter of Medicaid's national enrollment (HLR 1997; 757). Their medical services, often associated with a nursing home, are paid in a traditional fee-for-service structure ninety nine percent of the time. Medicaid managed care has yet to ameliorate financial pressures associated with providing care to the current Medicaid group. Expansions of the Medicaid managed care system, therefore, have little potential to provide a cost-contained means for all indigent populations to access care.



The exclusive rights of certain providers to Medicaid patients threaten the integrity of the healthcare safety net for the uninsured population. Healthcare providers use Medicaid to cross-subsidize services (HRL 1997; 760). If “rights” to serve Medicaid patients are negotiated to other, more competitive, providers, community agencies and hospitals would lose the primary revenue source they use to afford uncompensated services to non-paying patients. Managed care alters patient demographics of public hospital and community clinics. In just three years, public hospitals lost twelve percent of Medicaid-generated income with revenues falling from 45.5 percent to thirty four percent; incredible considering that Medicaid reimburses at approximately sixty to seventy percent of inpatient costs (HLR 1997; 761). Without Medicaid revenues, hospitals and community health centers primary revenue source becomes state and federal subsidies which, on average, constitute thirty five percent of health center funding and eighteen percent of public hospital revenue (HLR 1997; 762). Medicaid revenue is critical to the maintenance of these vital aspects of the healthcare safety net. Public hospitals and clinics have neither the infrastructure nor competitive power to negotiate these critical patients from private, managed care organizations. An unmitigated effort to contain costs affects the health outcomes of other disadvantaged groups. Individuals unwilling to forego the cost sparing managed care model look to expand Medicaid HMOs. One author laments the state of ailing public hospitals:

As state funds dry up and eligibility criteria for Medicaid tighten, even more people will become uninsured. Given this trend and the shrinking support for care of the indigent, the outlook for the poor and uninsured appears dismal. . . Unfortunately, any semblance of planning. . . has been set aside in favor for an ill-considered laissez-faire strategy (Kassirer HRL 1997; 767).

To prevent the realization of the author’s admonition, conscious political initiative is required to preserve the role of community clinics and nonprofit hospitals in the safety net.

We could implement incentives that encourage HMOs to contract with local nonprofit hospitals and community clinics or provide a certain dollar value of charity care each year. Additionally, states could put limitations upon Medicaid managed care contracts requiring HMOs to subsidize public hospitals to improve the infrastructure of

these community agencies. Medicaid managed care contracts are worth billions of dollars and so reasonable requirements like those suggested above would not deter managed care organizations from enrolling Medicaid patients. However, this plan requires states to have a concerted plan not limited to cost containment. Further, to be truly successful in eradicating health differences between poor and more affluent citizens, Medicaid would have to expand enrollment to all indigent groups and raise reimbursement rates to equal those of private insurance plans. As it stands, reimbursement rates for Medicaid make affording care to the uninsured fiscally prohibitive for many physicians. Medicaid serves forty five percent of non-elderly poor citizens. This leaves nearly twenty six million without access to primary care. Expanding coverage to these citizens is an endeavor that is considerably disfavored by the voting population.

### **Conclusions:**

The over forty million uninsured and underinsured American citizens access healthcare through a myriad of providers that compromise the healthcare safety net. These providers include physicians in hospital, clinic, and practice settings. Care is afforded to these groups through federal and state funding and charitable means. All of these providers are critical part of the safety net that operates in an interdependent manner. The imperative nature of each group is reflected by reforms that focus on individual players in the provider network. Each outlined reform, even if expanded, could not hope to meet the healthcare needs of the uninsured alone.

This interconnectedness must be considered in future, more efficacious, reforms. The uninsured face barriers to access that include financial, special, educational, and temporal impediments. This is why the uninsured access healthcare in sporadic, unique, and often cost inefficient ways. These access disparities can be removed in part by eliminating the largest hindrance the uninsured face- financial constraints. Universal healthcare in the form of a single payer system could help remove this barrier. If this reform was enacted in the United States, the healthcare safety net will remain in place. Though funded through alternative means, the clinics, community agencies, hospitals, and physicians compromising the healthcare safety net today will remain the primary care

providers for low-income patients in a Universal healthcare system. The temporal, special, racial and remaining financial disparities that currently determine health status in the US will continue to effect means of access if such a reform was made law. Hence, broad understandings of the healthcare safety nets remains applicable in the face of proposed sweeping financial restructuring. The appreciation of the unique healthcare experience of the uninsured today will produce better understanding of the effects of major reforms such as Universal systems.

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