Approaching Universal Coverage with Better Safety-Net Programs for the Uninsured

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The Patient Protection and Affordable Care Act (PPACA) will extend public and private insurance to about thirty million people, which will cover more than half of those who currently are uninsured.[1] This is a monumental achievement, but it still will leave more than twenty million residents uninsured—or about 8% of the nonelderly population.[2] Therefore, the United States will continue to lag well behind peer industrialized nations in providing nearly universal access to a decent level of care. To approach universal coverage, additional efforts will be required to improve access to care for those who continue to lack insurance coverage. Insurance, after all, is not an end in itself; it is the best means of access to affordable care. But, if other means to minimally acceptable access exist, they may provide a form of non-insurance, direct-access coverage that helps to fill the remaining coverage gap for the uninsured.

Sources of care for the uninsured are referred to loosely as the health care "safety net."[3] In general, health insurance obviously provides better access to care than is available to the uninsured. However, the uninsured do not have zero access.[4] Those with resources can pay for at least some care out-of-pocket at

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1. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Representative Nancy Pelosi, Speaker, U.S. House of Representatives (Mar. 18, 2010), *available at* http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf.

2. *Id.*

3. *See, e.g.*, ALISON SNOW JONES & PARSA S. SAJID, ROBERT WOOD JOHNSON FOUND., A PRIMER ON HEALTH CARE SAFETY NETS (2009), *available at* http://www.rwjf.org/files/research/49869.pdf.

4. Joseph D. Freeman et al., *The Causal Effect of Health Insurance on Utilization and Outcomes in Adults: A Systematic Review of US Studies*, 46 MED. CARE 1023 (2008) (comparing medical utilization of the insured versus uninsured); Caroline Roan Gresenz, Jeannette Rogowski & José J. Escarce, *Health Care Markets, the Safety Net, and Utilization of Care Among the Uninsured*, 42 HEALTH SERV. RES. 239, 240 (2007); Jack Hadley & Peter Cunningham, *Availability of Safety Net Providers and Access to Care of Uninsured Persons*, 39 HEALTH SERVICES RES. 1527, 1527 (2004) ("[U]ninsured persons can often obtain health services from providers who treat patients regardless of their ability to pay."); Joseph S. Ross, Elizabeth H. Bradley & Susan H. Busch, *Use of Health Care Services by Lower-Income and Higher-Income Uninsured Adults*, 295

market rates as the need arises. Hospitals must screen patients who come to the emergency room and treat those who urgently need care regardless of their ability to pay.[5] Moreover, in many communities, government and nonprofit hospitals and community health centers will treat some low-income uninsured patients for free or for deeply discounted sliding-scale fees.[6]

Nevertheless, the inadequacy of safety-net access[7] is a major justification for Congress' recent expansion of public and private insurance coverage and for earlier efforts by Massachusetts and other states. Nationwide, the uninsured face substantially increased chances of death, disability, or impairment due to reduced access to care.[8] The exact magnitude of these health deficits is subject to dispute.[9] But the basic fact remains that, overall, the uninsured in this country have inadequate access to care.

What is generally true for the uninsured nationwide is not necessarily true, however, for each community. Some communities have gone to considerable lengths to improve access to care for the uninsured.[10] In various ways, they have constructed and funded programs that each provides tens of thousands of patients a primary care medical home and coordinates access as needed to prescription drugs, specialist referrals, and hospital services. This Essay argues that if all safety-net systems were to perform at the level of these well-structured model programs, then the uninsured would have a level of access that approximates that provided by conventional insurance coverage. It then points to various provisions in the new law that might facilitate the development of programs like these that

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JAMA 2027, 2027 (2006).

5. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2006).

6. *See* MARION EIN LEWIN & STUART ALTMAN, AMERICA'S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED 47-70 (2000) (discussing the role of core safety-net providers in offering discounted care).

7. *See* J. Michael McWilliams, *Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications*, 87 MILBANK Q. 443 (2009); Andrew P. Wilper et al., *Health Insurance and Mortality in US Adults*, AM. J. PUB. HEALTH 2289 (2009).

8. COMM. ON HEALTH INS. STATUS & ITS CONSEQUENCES, INST. OF MED., AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 116 (2009).

9. Richard Kronick, *Health Insurance Coverage and Mortality Revisited*, 44 HEALTH SERVICES RES. 1211, 1227 (2009); Helen Levy & David Meltzer, *The Impact of Health Insurance on Health*, 29 ANN. REV. PUB. HEALTH 399, 406 (2008).

10. *See, e.g.*, CHRISTINA MOYLAN, NAT'L ASS'N OF PUB. HOSPS. & HEALTH SYS., MANAGING CARE FOR UNINSURED PATIENTS 1 (2005), *available at* http://naph.org/Publications/managingcareforuninsuredpatients.aspx; Lynn A. Blewett, Jeanette Ziegenfuss & Michael E. Davern, *Local Access to Care Programs (LACPs): New Developments in the Access to Care for the Uninsured*, 86 MILBANK Q. 459, 461 (2008); Lawrence D. Brown & Beth Stevens, *Charge of the Right Brigade? Communities, Coverage, and Care for the Uninsured*, 25 HEALTH AFF. W150, w150-51 (2006); Stephen L. Isaacs & Paul Jellinek, *Is There a (Volunteer) Doctor in the House? Free Clinics and Volunteer Physician Referral Networks in the United States*, 26 HEALTH AFF. 871, 872 (2007).

meet at least a standard of minimal adequacy.

I. MODEL SAFETY-NET PROGRAMS FOR THE UNINSURED

For the sake of brevity, this Essay discusses only two safety-net prototypes. The first uses traditional safety-net providers, namely, public hospitals connected with medical schools and community health centers. This traditional model is found mainly in large cities or major metropolitan areas[11] such as Albuquerque,[12] Boston,[13] Dallas,[14] Denver,[15] Indianapolis,[16] New Orleans,[17] New York,[18] and the San Francisco Bay Area.[19] A second model is more adaptable to different community types since it pays or recruits volunteer providers throughout and is therefore suited for communities of any size with a full-service hospital. Examples can be found in places as diverse as Asheville, North Carolina;[20]

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11. *See, e.g.*, MOYLAN, *supra* note 10; MARSHA REGENSTEIN ET AL., URGENT MATTERS, WALKING A TIGHTROPE: THE STATE OF THE SAFETY NET IN TEN U.S. COMMUNITIES 3 (2004), *available at* http://urgentmatters.org/media/file/UrgentMatters_Walking_A_Tightrope.pdf.

12. Arthur Kaufman et al., *Managed Care for Uninsured Patients at an Academic Health Center: A Case Study*, 75 ACAD. MED. 323, 323 (2000).

13. MARK A. HALL, ROBERT WOOD JOHNSON FOUND., THE COSTS AND ADEQUACY OF SAFETY NET ACCESS FOR THE UNINSURED: BOSTON, MASSACHUSETTS 7 (2010), *available at* http://www.rwjf.org/files/research/safetynetmass201006.pdf.

14. MOYLAN, *supra* note 10, at 42.

15. MARK A. HALL, THE COSTS AND ADEQUACY OF SAFETY NET ACCESS FOR THE UNINSURED: DENVER, COLORADO (2010), *available at* http://www.rwjf.org/files/research/safetynetdenver201006.pdf.

16. MOYLAN, *supra* note 10, at 28.

17. MICHELLE M. DOTY ET. AL., THE COMMONWEALTH FUND, COMING OUT OF CRISIS: PATIENT EXPERIENCES IN PRIMARY CARE IN NEW ORLEANS, FOUR YEARS POST-KATRINA ix (2010), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jan/Coming%20Out%20of%20Crisis/1354_Doty_coming_out_of_crisis_new_orleans_clinics.pdf.

18. DOUGLAS MCCARTHY & KIMBERLY MUELLER, THE COMMONWEALTH FUND, THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION: TRANSFORMING A PUBLIC SAFETY NET DELIVERY SYSTEM TO ACHIEVE HIGHER PERFORMANCE vii (2008), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2008/Oct/The%20New%20York%20City%20Health%20and%20Hospitals%20Corporation%20%20Transforming%20a%20Public%20Safety%20Net%20Delivery%20System/McCarthy_nychlthospitalscorpcasestudy_1154%20pdf.pdf; Eve Weiss, Kathryn Haslanger & Joel C. Cantor, *Accessibility of Primary Care Services in Safety Net Clinics in New York City*, 91 AM. J. PUB. HEALTH 1240, 1240 (2001).

19. EMBRY M. HOWELL ET AL., THE URBAN INST., A REPORT ON THE SECOND YEAR OF THE SAN MATEO COUNTY ADULT COVERAGE INITIATIVE AND SYSTEMS REDESIGN FOR ADULT MEDICINE CLINIC CARE 2 (2010), *available at* http://www.urban.org/UploadedPDF/412103-san-mateo-clinic-care.pdf; Mitchell H. Katz, *Golden Gate to Health Care for All? San Francisco's New Universal-Access Program*, 358 NEW ENG. J. MED. 327, 327 (2008).

20. *See* MARK A. HALL & WENKE HWANG, ROBERT WOOD JOHNSON FOUND., THE COSTS AND ADEQUACY OF SAFETY NET ACCESS FOR THE UNINSURED: BUNCOMBE COUNTY (ASHEVILLE), NORTH

Hollywood, Florida;[21] Lansing, Michigan;[22] and Portland, Maine.[23] Several communities have programs that combine elements of each model.

In either model, uninsured individuals are screened for eligibility, given a membership card good for six to twelve months, and assigned a primary care medical home. Care managers help coordinate care and educate patients, especially those with chronic or recurring ailments. Prescription drugs, diagnostic testing, specialist referrals, and hospitalization are available as needed. However, members have little or no choice of providers, and there may be strict medical necessity controls for services that are covered. Also, some services may not be covered, such as routine dental care, specialized behavioral health, and expensive medical equipment.

Importantly, these programs usually do not commit to providing a specified level of service. Instead, they typically disavow any notion of providing insurance coverage, and they often qualify the range of services and providers offered as being subject to change or limitation based on fluctuations in funding and availability of providers. In short, the notion is one of *eligibility* for limited resources rather than an *entitlement* to a defined standard of care. An entitlement connotes individually enforceable rights arising from a legal commitment created by contract or statute. Safety-net eligibility arises from screening a person as qualified to receive available services, and so it is more of a social understanding than a legal standard.

This absence of an individually enforceable legal guarantee does not, by itself, negate a notion of minimally decent coverage. Similar constraints on legal entitlements exist in major European countries that fund their health care systems through fixed budgets or block grants for direct service, rather than through insurance. Under these countries' legal regimes, rights to health care and guarantees of access often are non-justiciable as individual claims since any meaningful adjudication requires balancing one individual's need for a particular service against the collection of expected needs from all other patients

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CAROLINA (2010), *available at* http://www.rwjf.org/files/research/safetynetnc201006.pdf.

21. *See* MEMORIAL HEALTHCARE SYS., ANNUAL REPORT (2009), *available at* http://www.mhs.net/pdf/AnnualReport_2009.pdf.

22. *See* TERESA COUGHLIN ET AL., THE URBAN INST., THE MEDICAID DSH PROGRAM AND PROVIDING HEALTH CARE SERVICES TO THE UNINSURED: A LOOK AT FIVE PROGRAMS 29-38, 51 (2001), *available at* http://www.urban.org/UploadedPDF/410976_ASPEIDSH.pdf; Erin Fries Taylor, Peter Cunningham & Kelly McKenzie, *Community Approaches to Providing Care for the Uninsured*, 25 HEALTH AFF. (WEB EXCLUSIVE) w173, w175 (2006), *available at* http://content.healthaffairs.org/cgi/reprint/25/3/w173.

23. *See* MARK A. HALL, ROBERT WOOD JOHNSON FOUND., THE COST AND ADEQUACY OF SAFETY NET ACCESS FOR THE UNINSURED: SOUTH COASTAL MAINE (CARE PARTNERS) (2010), *available at* http://www.rwjf.org/files/research/49869maine.pdf; Jeffrey T. Kullgren, Erin Fries Taylor & Catherine G. McLaughlin, *Donated Care Programs: A Stopgap Measure or a Long-Run Alternative to Health Insurance?*, 16 J. HEALTH CARE FOR POOR & UNDERSERVED 421, 422 (2005).

throughout the remainder of the funding period. Therefore, constitutional or statutory commitments to provide coverage are often characterized in Europe as creating only social rights that are vindicated mainly through political institutions.[24] Nevertheless, these systems are regarded as providing universal coverage.

In the United States, some structured safety-net programs provide care that is virtually free, but others use sliding fee scales to charge significant amounts to patients who are not indigent. The programs that are virtually free typically cover people with incomes only up to 200% of the federal poverty level (FPL), but sliding scale programs go up to 300% FPL or more.[25]

When patients pay, the critical distinction is that they pay only for specific services received and usually not for membership in the program. Along with the absence of explicit guarantees of access, this explains why these programs do not constitute insurance. When membership fees are charged, they are only modest amounts covering administrative expenses, not prospective payment for expected services.

II. PROGRAM ADEQUACY AND COST

Many studies profile the structure and funding of the safety net generally,[26] but prior research has done little to document the costs and adequacy of care provided by model programs. To help fill this void, I have reported elsewhere five in-depth studies of model programs in Asheville, Boston, Denver, Flint, and San Antonio.[27] Based on a variety of indicators, these studies conclude that these programs provide access to care that is similar to that provided by conventional insurance.[28] From a structural perspective, these programs enroll members in a

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24. Uwe E. Reinhardt, *Reforming the Health Care System: The Universal Dilemma*, 19 AM. J. L. & MED. 21, 22 (1993).

25. Mark A. Hall, *Rethinking Safety-Net Access for the Uninsured*, NEW ENG. J. MED. (forthcoming 2010) (manuscript at 5, on file with author).

26. DENNIS ANDRULIS & MICHAEL GUSMANO, N.Y. ACAD. OF MED., COMMUNITY INITIATIVES FOR THE UNINSURED: HOW FAR CAN INNOVATIVE PARTNERSHIPS TAKE US? (2000); LYNN QUINCY ET AL., MATHEMATICA POLICY RESEARCH, DESIGNING SUBSIDIZED HEALTH COVERAGE PROGRAMS TO ATTRACT ENROLLMENT: A REVIEW OF THE LITERATURE AND A SYNTHESIS OF STAKEHOLDER VIEWS (2008), *available at* http://aspe.hhs.gov/health/reports/08/subenroll/report.pdf; Lynn A. Blewett & Timothy J. Beebe, *State Efforts To Measure the Health Care Safety Net*, 119 PUB. HEALTH REP. 125 (2004); Peter J. Cunningham, *The Healthcare Safety Net: What Is It, What Good Does It Do, and Will It Still Be There When We Need It?*, HARV. HEALTH POL'Y REV., Fall 2007, at 5; Sheldon M. Retchin, Sheryl L. Garland & Emmanuel A. Anum, *The Transfer of Uninsured Patients from Academic to Community Primary Care Settings*, 15 AM. J. MANAGED CARE 245 (2009).

27. Mark A. Hall, Alison Snow Jones & Parsa S. Sajid, *Health Care Safety Nets*, http://www.rwjf.org/healthpolicy/product.jsp?id=49869 (follow links to second through fifth publications on left sidebar).

28. Mark A. Hall, Access to Care Provided by Better Safety Net Systems for the Uninsured:

coordinated system that offers the basic range of services and providers that one expects from insurance. Program members use physicians with frequencies similar to insured groups. However, there is less use of hospitals than expected in the two programs (Flint and Asheville) that rely on uncompensated hospital charity care.

Also, these programs are not able to show improvements in the population-wide measures of access that commonly are used in national or state surveys. These measures include: having a usual source of care; an ability to receive care when needed; and having at least one medical visit each year.[29] Uninsured populations in most of the five study communities fare no better under these population-wide measures of access than uninsured elsewhere in the state or the nation, and they usually fare worse than people with insurance. However, these surveys fail to assess the exact target group of people who are both low-income and uninsured; instead, results typically are shown for uninsured at all income levels or for all low-income, including those on Medicaid.

Moreover, respondents may consider enrollment in a well-structured safety-net program to be equivalent to insurance. If so, population surveys may be *least* accurate in assessing uninsured rates within the target population in the very communities that have the *best* safety-net programs. In fact, there is evidence of underreporting of uninsured status in most of the case studies, which itself is an indicator of these programs' basic adequacy, since it means that some members do not even realize they are without coverage.

Measuring the value of the care received in terms of its institutional costs of delivery, these studies also estimated that, in 2008, the institutional costs of the services provided by these programs ranged from $141 to $200 a month for adults.[30] This was roughly one-quarter to one-half less than the estimated cost to cover these same populations with Medicaid or private insurance, even if that insurance were restricted to the same general range of benefits and the same set of providers.[31] Therefore, these programs are a more affordable means to increase coverage than expanding insurance.

These findings are not unique to these communities. Similar successes also have been documented in other communities,[32] and for federal programs that

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Measuring and Conceptualizing Adequacy (Aug. 30, 2010) (unpublished manuscript) (on file with author).

29. Jill Eden, *Measuring Access to Care Through Population-Based Surveys: Where Are We Now?*, 33 HEALTH SERVICES RES. 685, 699 (1998).

30. Mark A. Hall, Wenke Hwang & Alison Snow Jones, The Costs of Caring for the Uninsured Under Well-Structured Safety Net Systems (Aug. 30, 2010) (unpublished manuscript) (on file with author).

31. *Id.* at 20.

32. *See supra* notes 11-23; *see also* ALLISON COOK & BARBARA A. ORMOND, THE URBAN INST., WHO HAS INSURANCE AND WHO DOES NOT IN THE DISTRICT OF COLUMBIA? 3 (2007), *available at* http://www.urban.org/UploadedPDF/411589_insurance_dc.pdf.

serve safety-net functions for veterans and for Native Americans. The Veterans Health Administration (VA) is widely regarded as a successful direct care system.[33] The most thorough and sophisticated study to date concluded that it would have cost Medicare about 20% more if it had paid for the services that the VA provided in 1999.[34]

The Indian Health Service (IHS) provides direct care to tribal members on or near reservations.[35] The level of access they report is similar to that for insured groups. The leading study (which used 1997-1999 data), found that Native Americans "with only IHS access fared . . . as well as insured Whites for key measures" such as having a usual source of care and having had a medical or dental visit in the past year.[36] According to the government's actuarial estimates, the IHS current spending provides roughly half of what it would cost to increase IHS coverage to its core population to the level of federal employees, adjusting for differences in demographics, health characteristics, and covered services.[37] IHS funding is widely regarded as inadequate for patients who require referral for advanced hospital and specialist services that are not immediately available from IHS providers.[38] But if funding for these outside referrals were increased to levels that program advocates testified are needed,[39] IHS costs would still be about 40% less than commercial insurance.[40]

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33. *See* CONG. BUDGET OFFICE, THE HEALTH CARE SYSTEM FOR VETERANS: AN INTERIM REPORT (2007), *available at* http://www.cbo.gov/ftpdocs/88xx/doc8892/12-21-VA_Healthcare.pdf; PHILLIP LONGMAN, BEST CARE ANYWHERE: WHY VA HEALTH CARE IS BETTER THAN YOURS (2010); Anne E. Sales, *The Veterans Health Administration in the Context of Health Insurance Reform*, 46 MED. CARE 1020 (2008).

34. Gary N. Nugent et al., *Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices*, 61 MED. CARE RES. REV. 495, 502 (2004).

35. INDIAN HEALTH SERV., THE FIRST 50 YEARS OF THE INDIAN HEALTH SERVICE: CARING & CURING 15 (2006).

36. Stephen Zuckerman et al., *Health Service Access, Use, and Insurance Coverage Among American Indians/Alaska Natives and Whites: What Role Does the Indian Health Service Play?*, 94 AM. J. PUB. HEALTH 53, 53, 56 (2004).

37. ROGER WALKE, INDIAN HEALTH SERVICE: HEALTH CARE DELIVERY, STATUS, FUNDING, AND LEGISLATIVE ISSUES 14-16, 19-21 (2008).

38. *See* U.S. GOV'T ACCOUNTABILITY OFFICE, INDIAN HEALTH SERVICE: HEALTH CARE SERVICES ARE NOT ALWAYS AVAILABLE TO NATIVE AMERICANS 18 (2005), *available at* http://www.gao.gov/new.items/d05789.pdf.

39. *See Access to Contract Health Services in Indian Country: Hearing Before the S. Comm. on Indian Affairs*, 110th Cong. 1-7 (2008) (statement of Hon. Byron L. Dorgan, Chairman, S. Comm. on Indian Affairs).

40. According to Senator Dorgan, outside referral services are "funded at about $580 million at this point" and that "$1.3 billion would be necessary to meet the current need." *Id.* at 2. This infers that IHS is about 40% less than commercial insurance.

III. SAFETY-NET PROGRAMS AFTER HEALTH INSURANCE REFORM

Recognizing that safety-net programs can provide the uninsured adequate access at reasonable costs, it remains to be seen how these programs can be adapted to fit the components of the population that will remain uninsured. Starting in 2014, many of the people safety-net programs have served will become eligible for Medicaid or highly subsidized private insurance. Nevertheless, substantial segments of uninsured will remain.

First, the reform law's subsidies are not available to undocumented immigrants.[41] These non-citizen residents will constitute roughly one-third of the remaining uninsured.[42] It is notable that most of the model safety-net programs profiled above are open to non-citizen residents. They adopt inclusive policies not only because undocumented immigrants are a major component of the needy population in some communities, but also as a matter of convenience to legal residents. Excluding illegal immigrants would require identifying them, which entails insisting that all applicants verify their legitimacy. Many citizens find it offensive and difficult to prove their legitimacy using birth records and the like. Thus, the more acceptable policy for everyone concerned is often simply to dispense with any documentation requirements other than showing local residence (such as with a utility bill).

Second, the reform law requires legal residents to purchase insurance only if they have decent coverage available to them that costs less than 8% of their income. Insurance subsidies that reduce premiums to approximately this level phase out at 400% of the federal poverty level. Some upper-middle-income people will face insurance premiums greater than the mandate threshold, especially older people for whom insurers may vary rates threefold based on age.[43] Legally, these higher-income people may decide to drop or avoid health insurance without penalty.

Also not subject to a mandate penalty are people who are uninsured for only three months or less. Observing the similar reform measures in Massachusetts, we learn that gaps in coverage are difficult to avoid when people switch from public to private coverage.[44] This is because private insurance, even when highly

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41. Nathan Cortez, Embracing the New Geography of Health Care: A Novel Way To Cover Those Left out of Health Reform 7 (Aug. 30, 2010) (unpublished manuscript) (on file with author).

42. Mark A. Hall, *The Mission of Safety Net Organizations Following National Insurance Reform*, J. GEN. INTERNAL MED. (forthcoming 2010) (manuscript at 4, on file with author).

43. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 300gg) [hereinafter PPACA].

44. *See* HEALTH CONNECTOR, REPORT TO THE MASSACHUSETTS LEGISLATURE: IMPLEMENTATION OF HEALTH CARE REFORM FISCAL YEAR 2009 (2009), *available at* https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Executive%2520Director%2520Message/Connector%2520Annual%2520Report%25202009.pdf; Sharon K. Long & Karen Stockley, *Sustaining Health Reform In*

subsidized, is not designed for immediate or retroactive enrollment. Instead, the process of filling out forms and paying the first month's premium in advance will usually entail a delay. Also, once the new insurance exchanges are operational, it is entirely possible that open enrollment will not be continuously available, but will instead be limited to certain times of the year. Insurance gaps caused by these transitions from public to private coverage will be fairly common, since the reform law requires that this switch occur each time a person's income increases above 133% FPL.[45]

A structured access system that allows the legally uninsured to pay for care as needed under a sliding fee scale would provide an alternative form of coverage. The programs in Denver and San Antonio are two notable examples of this approach.[46] If these sliding scale service payments are capped at a reasonable percent of income or assets, they may provide affordable access to a decent range of services.

The remaining component of the uninsured will consist of people who illegally forgo coverage, despite having an insurance option that costs less than 8% of income. A large portion of this group will be eligible for Medicaid,[47] which allows enrollment for free at the point people need treatment (or even retroactively in some circumstances). Therefore, people eligible for Medicaid will have virtual coverage when needed, even if they are not actually enrolled. This leaves only about a quarter of the uninsured (about 2% of the population) that safety nets will need to exclude.[48] In order to avoid "crowding out" the legal mandate to purchase insurance when it is affordable,[49] safety-net programs should not accept middle-income people (above, say, 250% FPL) who have subsidized or employer-sponsored insurance options that cost less than 8% of

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A Recession: An Update on Massachusetts as of Fall 2009, 29 HEALTH AFF. 1234 (2010).

45. *See* PAMELA FARLEY SHORT ET AL., COMMONWEALTH FUND, IMPLEMENTING NATIONAL HEALTH INSURANCE REFORMS: MAINTAINING AFFORDABILITY, SHARED RESPONSIBILITY, AND CONTINUITY WHEN LIFE CHANGES (forthcoming 2011) (manuscript on file with author).

46. MARK A. HALL, ROBERT WOOD JOHNSON FOUND., THE COSTS AND ADEQUACY OF SAFETY NET ACCESS FOR THE UNINSURED: BEXAR COUNTY (SAN ANTONIO), TEXAS 4 (2010), *available at* http://www.rwjf.org/files/research/safetynettexas201006.pdf. *See* HALL, *supra* note 15, at 5.

47. *See* RAND CORP, ANALYSIS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (H.R. 3950) 11 (2010), *available at* http://www.rand.org/pubs/research_briefs/2010/RAND_RB9514.pdf.

48. *See* Hall, *supra* note 25.

49. *See generally* GESTUR DAVIDSON, LYNN A. BLEWETT & KATHLEEN THIEDE CALL, ROBERT WOOD JOHNSON FOUND., PUBLIC PROGRAM CROWD-OUT OF PRIVATE COVERAGE: WHAT ARE THE ISSUES? (2004), *available at* http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no5_researchreport.pdf; M. Susan Marquis & Stephen H. Long, *Public Insurance Expansions and Crowd Out of Private Coverage*, MED. CARE 344 (2003); ROBERT WOOD JOHNSON FOUND., UNDERSTANDING THE DYNAMICS OF "CROWD-OUT": DEFINING PUBLIC/PRIVATE COVERAGE SUBSTITUTION FOR POLICY AND RESEARCH (2001), *available at* http://www.allhealth.org/briefingmaterials/hcfo-845.pdf.

income. This portion hopefully will be small enough that, in theory, a comprehensive safety-net program for the legally uninsured would be capable of bringing us to nearly universal access.

IV. POLICY INITIATIVES FOR IMPROVING ACCESS FOR THE UNINSURED

It is wishful thinking, of course, to hope that model safety-net access programs will soon spread nationwide to encompass all of these major swaths of the legally uninsured. An important funding source for insurance expansion is to reduce and redirect funds previously aimed at safety-net care for the uninsured under the logic that there will be substantially fewer uninsured people.[50] Nevertheless, the potential for safety-net improvements exists in several critical pieces of this comprehensive legislation, even with the redirection of safety-net funds.

First, $11 billion in new funding is directed to federally qualified community health centers (FQHCs),[51] which is expected to roughly double their capacity.[52] Second, although PPACA cuts existing federal payments to hospitals that serve a disproportionate share of uninsured and low-income patients, it does not eliminate these payments altogether. Instead, the reform law calls on the Secretary of Health and Human Services to devise a fairer approach to allocating Medicaid disproportionate share funds.[53] Rather than basing these payments entirely on hospital services, the new allocation criteria could give greater weight to investments in primary care delivery for the uninsured. Also, the allocation could favor hospitals that require specialist physicians on their medical staff to accept a fair allotment of uninsured safety-net patients at discounted rates.[54] Finally, the reform law provides for a series of demonstration projects or waiver programs that could support developing better safety-net access programs.[55]

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50. JOHN HOLAHAN & BOWEN GARRETT, THE COST OF UNCOMPENSATED CARE WITH AND WITHOUT HEALTH REFORM 1 (2010), *available at* http://www.urban.org/UploadedPDF/412045_cost_of_uncompensated.pdf.

51. PPACA, Pub. L. No. 111-148, § 10503, 124 Stat. 119, 1004 (2010) (to be codified at 42 U.S.C. § 254b-2).

52. KAISER COMM'N ON MEDICAID & THE UNINSURED, COMMUNITY HEALTH CENTERS: OPPORTUNITIES AND CHALLENGES OF HEALTH REFORM 7 (Aug. 2010), *available at* http://www.kff.org/uninsured/upload/8098.pdf.

53. § 2551, 124 Stat. at 313-14, *modified by* § 10201(f) (to be codified at 42 U.S.C. § 1396r-4 note).

54. *See* COUGHLIN ET AL., *supra* note 23, at iii. The reform law also requires increased transparency and scrutiny of the charity care policies and practices that justify nonprofit hospitals' tax exempt status, § 9007, 124 Stat. at 855-57, *modified by* § 10903 (to be codified at 26 U.S.C. § 501). This is another leverage point to encourage community hospitals to help coordinate more comprehensive safety-net access for the uninsured.

55. The PPACA states the option to establish a "basic health program," § 1331(a)(1), 124 Stat. at 199 (to be codified at 42 U.S.C. § 18051), for low-income people (up to 200% FPL) who are not

States and communities need not wait for federal support, however, to construct better safety-net access for the uninsured. The changing composition of the uninsured will require safety-net programs to be reconfigured in any event. Some current funding sources might diminish, but others, such as local property taxes or philanthropy, remain largely intact. In addition, Medicaid's expansion to 133% of poverty will free up existing funds by eliminating much of the need to serve truly indigent people. Finally, free care programs might consider adopting sliding scale fee schedules for middle-income people in need, which would generate new resources.

With this combination of support and through careful crafting, well-structured safety-net programs could be tailored to fit the major population segments that, legally, will remain uninsured. We may scoff at the phrase "Mission Accomplished." But reasonable insurance coverage for most of us and a decent safety net for the rest could at least allow the United States to hold its head higher among peer industrialized nations. Although decent safety-net access is inferior to comprehensive insurance, further expansions of insurance are highly unlikely any time soon. To refuse safety-net improvements out of compunction over ideal social equity is to hold the lives and welfare of the least advantaged among us hostage to the unachievable ransom demands of those who might prefer single-payer insurance for all. If good-enough safety-net programs were in place, no longer would we be the only advanced society that fails to provide decent access to care for almost all its people. That would be a remarkable accomplishment indeed.

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eligible for Medicaid, including legal immigrants who have not met Medicaid's five-year waiting period, § 1331(e)(1), 124 Stat. at 202-03, *modified by* § 10104(o) (to be codified at 42 U.S.C. § 18051). Through these basic health programs, states may contract directly with providers for discounted rates, creating in essence a state version of the much-debated public option that was rejected at the federal level. States that opt for this approach will receive 95% of the tax credits and cost-sharing reductions that the federal government would have paid for individuals enrolled in exchange-based health plans. *Id.* Somewhat more tentatively, sections 10333 and 10504 authorize, but do not appropriate, funds for two special programs related to better-structured safety-net programs. The first is for a "community-based collaborative care network program" that provides "comprehensive coordinated and integrated health care services" for low-income populations. § 10333, 124 Stat. at 970 (to be codified at 42 U.S.C. § 256i). These networks must include at least one hospital and all FQHCs in their area, and funding priority is given to networks with public hospitals or clinics. *Id.* The second special program is a three-year demonstration project authorized for up to ten "[s]tate-based, nonprofit, public-private partnership[s]" that provide "access to comprehensive health care services to the uninsured at reduced fees." § 10504, 124 Stat. at 1004 (to be codified at 42 U.S.C. § 256 note).