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The Health Care Reform Dialogue: Key Questions about Coverage and Access

Safety net health systems are committed to providing high quality health care to their communities—now and in the future. Today, safety net health systems rely heavily on Medicaid disproportionate share hospital (DSH) payments to fulfill their missions of: 1) treating a disproportionate number of Medicaid and uninsured patients; 2) training physicians; and 3) ensuring that essential health care services such as trauma and burn centers are available throughout the country.

As the economic crisis continues, safety net health systems are more necessary than ever—with rising unemployment rates, the number of uninsured and under-insured continues to grow. Safety net hospitals are meeting Americans' health care needs and will collaborate with policymakers to ensure a strong safety net system during the economic crisis that guarantees patient access to care.

Over the longer term, safety net hospitals are eager to be full participants in the national dialogue on how to improve health care delivery, lower costs and expand health coverage. During that discussion, policymakers must give careful consideration to the full range of essential patient care, public health, medical education and community-wide services that are supported by DSH payments. By addressing the following questions, policymakers will help ensure that the goals of expanded health coverage and access are achieved for patients in national health reform.

1. IS DSH FUNDING ADEQUATE TO MEET PATIENT NEEDS AS HEALTH REFORM IS DEBATED AND IMPLEMENTED?

When Congress imposed caps on individual states' DSH allotments in the early nineties, the size of the allotments were not based on need at the time, but rather on historical program spending levels dating back to 1991. Thus, states that had implemented large DSH programs prior to 1991 were granted relatively large DSH allotments but were not permitted to increase their DSH spending, while those with smaller programs were allowed to let them grow by modest amounts that still did not address inequities across states. In 1997, Congress imposed deep cuts in DSH spending as part of the Balanced Budget Act. After the devastating effects of such cuts became clear, Congress halted and ultimately reversed the cuts with a one-time 16 percent increase in DSH allotments in 2004. Since then, DSH allotments for all but 16 "low DSH" states have been frozen until this year, when most states received an inflation-related increase in their 2009 allotments provided for under current law, and the 2009 American Recovery and Reinvestment Act provided a temporary DSH allotment increase of 2.5 percent. Generally though, DSH allotments have not changed based on fluctuating patient need for safety net services. Safety net hospitals that serve a disproportionate share of Medicaid and uninsured patients have had to manage around these inadequate funding streams, all the while coping with ever-growing costs and meeting ever-growing needs.

The number of uninsured Americans reached 46 million in 2007 (up from 42 million in 2002), and the number of Medicaid recipients reached 38 million (up from 33 million in 2002). During the same time period, prices for medical care services increased by 26 percent.[1] Medicaid DSH spending by the federal and state governments did not keep pace—$17.15 billion in

2006 (up from $15.9 billion in 2002 but down from $17.5 billion in 1992). Current DSH funding levels, and how this money is distributed across the country, are critical issues especially during the economic crisis—for states that have arbitrarily low DSH allotments, the challenge of meeting patient care needs is particularly difficult. Depending on the speed of national health reform discussions, policymakers may find it necessary to assess whether DSH funding levels are adequate to meet existing patient needs and those expected in the economic crisis.

2. SHOULD DSH FUNDS BE USED TO EXPAND HEALTH CARE COVERAGE?

Some have suggested diverting DSH funds to pay for expanded health coverage, reasoning that as the number of uninsured decline, so too will the financial burden on safety net hospitals. While it may seem logical to assume that safety net hospitals will experience reductions in uncompensated care as coverage expands, it is important to recognize that paying for uninsured care is only one aim of DSH spending. Using DSH to "pre-pay" for health insurance coverage will dismantle the nation's safety net. In health reform policy discussions, the following should be considered:

- Even if a goal of health reform is to achieve universal coverage, large numbers of patients are likely to continue to fall through the cracks, remaining uninsured and under-insured even with universal coverage.
- A significant portion of current Medicaid DSH spending is targeted to make up for payment shortfalls for Medicaid patients. It is unlikely that payment levels for such patients would improve under health reform, and newly covered individuals may also generate uncompensated costs.
- DSH payments ensure that safety net facilities are able to deliver essential community-wide health care services, including medical education, trauma and burn services, surge capacity and emergency readiness.

Total federal spending on DSH—$9.6 billion in FY 2006, of which only $7.6 billion is directed to safety net hospitals—while essential to safety net providers, would pay for only a small portion of the total cost of health reform. DSH financing should only be redirected for coverage after a demonstrated decline in demand for uninsured and under-insured services, not in anticipation of a decline in demand. Furthermore, addressing the uses of Medicaid DSH funds beyond financing uninsured care—including covering losses on Medicaid patients and the cost of "public goods" like medical education and specialized, high-cost services like trauma and burn care—is necessary before funds are redirected.

3. WITH "UNIVERSAL COVERAGE," HOW SHOULD THE NATION PLAN FOR PATIENTS LIKELY TO REMAIN UNINSURED AND UNDER-INSURED?

Universal coverage is a critical goal in the overall effort to reform U.S. health care. Yet, even with the goal of universal coverage, policymakers should anticipate, and plan for, the needs of those individuals who will remain uninsured and under-insured. Addressing the following questions allows policymakers to scenario-plan and fund safety net health systems accordingly to provide uninsured and under-insured care.

- **Who will remain uninsured?** Recent state coverage initiatives demonstrate that, no matter how ambitious, coverage expansions will not reach all individuals. For example, in Massachusetts, newcomers who have been in the state for less than six months and undocumented immigrants are categorically ineligible for coverage. In Vermont, individuals who were insured at any point during the past 12 months are categorically ineligible. And in Indiana, individuals who were insured at any point during the past 180 days or earn more than 200 percent of the Federal Poverty Guidelines are categorically ineligible to qualify for the Healthy Indiana Plan.

  In addition to individuals who are categorically ineligible for coverage, state coverage initiatives have demonstrated that certain individuals will simply choose not to participate in coverage programs—in Massachusetts, despite a coverage mandate, the statewide uninsured rate remains 2.6 percent.[2] Additionally, we have learned from Massachusetts that individuals may cycle on and off

insurance coverage due to eligibility determination processes.

- **How long will it take for individuals to secure health coverage?** As demonstrated by state coverage initiatives, it takes time for individuals to gain health insurance coverage. Allowing adequate time for coverage policies to take effect is critical—as is ensuring that the safety net is funded to provide patient care during this critical transition period.

For example, in Massachusetts, while over 400,000 individuals gained coverage one year after health reform implementation, 340,000 people remained uninsured. In Vermont, one year after health reform implementation, only 5,000 of the state's estimated 60,000 uninsured individuals were enrolled. In Maine, one and a half years after health reform implementation, over 100,000 individuals remained uninsured. And in Tennessee, not only did 256,000 people remain uninsured four years after the state implemented TennCare, more than 170,000 people lost coverage in 2005 when TennCare was restructured due to budget overruns and financial difficulties. To reduce the impact of changes on these newly uninsured individuals, Tennessee put money back into the state's safety net providers and programs. This infusion of funding was necessary because funds targeted to the safety net prior to TennCare were used to finance coverage expansions that proved not as effective as policymakers hoped.

- **Will the coverage benefits be sufficient?** Expanding health care coverage requires careful decisions about patient benefit packages. The scope of the benefit package may reveal key health care needs that may be uncovered or unmet in the future—these unmet patient needs are typically tended to by safety net health systems. While coverage initiatives should include a comprehensive benefit package, to the extent that this is not achievable, policymakers must make allowances for ongoing care to "under-insured" patients.

A look at various states reveals that coverage initiative benefits vary considerably. On one end of the spectrum, Massachusetts, Maine and Vermont offer robust health care benefits for enrollees—with primary care, hospital services and prescription drug coverage. On the other hand, Indiana's benefit package covers preventive care and requires that remaining health care be covered through a high-deductible plan ($1,100 annually)—as a result, most health care costs are shifted to the individual or their health care provider if costs are not covered. In Indiana, a patient's annual deductible is paid using a health-savings-like account, which is funded jointly by the enrollee, state, and federal government based on family income levels.[3] Similarly, Utah and Arkansas offer limited benefit plans. Utah's limited benefit plan for low-income working adults covers primary and preventive care, limited prescription drug benefits, and no hospitalization or specialty care.[4] Arkansas's Safety Net Benefit program covers seven inpatient days, two major outpatient services and six physician office visits per year; and two prescriptions per month.[5]

- **Will publicly insured patients be able to access health care providers?** Securing public or private health insurance does not necessarily mean that an individual can access the care they need. Several factors can inhibit access to care and, when this happens, patients turn disproportionately to safety net hospitals. As we have seen in the Medicaid and Medicare programs, low payment rates can provide a disincentive for health care providers to treat publicly-insured patients—in 2006, Medicaid covered, on average, 86 percent of hospital costs, and Medicare paid 91 percent of hospital costs.[6] Similarly, physicians struggle to cover the costs of treating Medicaid and Medicare patients—in 2006, Medicaid covered, on average, 60 percent of costs, and Medicare paid 89 percent of costs.[7] Inadequate payment rates for hospitals and physicians mean that patients cannot always access the primary care or, more often, specialized health care services, such as orthopedic care, that they need. Recently, this has proven to be particularly challenging in Massachusetts following implementation of statewide health reform.

In Massachusetts, safety net providers

are paid significantly less than the cost of caring for both Medicaid and Commonwealth Care patients (the new public insurance program). Because DSH funds were utilized to finance, in part, the expansion of health insurance in MA, they are no longer available to supplement insufficient Medicaid payment rates.

Moreover, policymakers should consider the nationwide capacity of health care workers and health care organizations to meet patient needs. In Massachusetts, the shortage of primary care providers has created challenges for patients who have recently gained health care coverage. In 2008, the Massachusetts Medical Society reported that the primary care specialties of internal medicine and family medicine have been facing critically stressed labor markets since 2005.[8] Demand for both types of physicians has outstripped supply and with the continued implementation of health reform efforts, these labor shortages face even greater stress.

4. WILL KEY "PUBLIC GOODS" BE SACRIFICED IF DSH FUNDS ARE ELIMINATED?

States have considerable flexibility in directing DSH funds—many have chosen to support unprofitable "public goods" that are essential to communities, yet difficult for health care providers to deliver in a competitive market. These public goods include physician training, where DSH funds can help defray both the direct education costs and the productivity sacrifices in hospitals that prepare the next generation of medical professionals. Additionally, DSH funding helps safety net health systems finance essential community-wide health services such as emergency preparedness activities, surge capacity, trauma care, and burn units that must be available 24/7. Assessing how these public goods will be funded is essential in the health reform dialogue, to ensure that key public health services are not lost in the transition to a new health care system.

The Health Reform Dialogue: Addressing Coverage and Access

Health reform must establish a clear path to expanded health care coverage and access. To get there, policymakers must assess coverage policies, project uninsured and under-insured volumes, and gauge how quickly or slowly these volumes will change based on new federal policies. We believe the questions above will aid in that assessment. Understanding the volume of individuals who will either temporarily or permanently lack health care access allows policymakers to support alternative vehicles for their care—the largest portion of which will be delivered through safety net health systems.

If you have questions about this issue or would like more information, contact the National Association of Public Hospitals and Health Systems. ■

Notes

1. NAPH analysis of U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index for Medical Care, 2002–2007.

2. Massachusetts Division for Health Care Finance and Policy

3. Kaiser Family Foundation, Kaiser Commission on Medicaid Facts, *Summary of Healthy Indiana Plan: Key Facts and Issues*, June 2008.

4. Utah Department of Health, *Primary Care Network Member Guide*, May 2008, available at http://health.utah.gov/pcn/pdf/PCNMemberGuideEng.pdf.

5. Arkansas Department of Human Services, ARHealthNetworks: what does *ARHealthNetworks cover?*, December 2008, available at www.arhealthnetworks.com/benefits.

6. American Hospital Association and Avalere Health, Avalere Health analysis of 2006 American Hospital Association Annual Survey data, for community hospitals, Trendwatch Chartbook 2008, Trends Affecting Hospitals and Health Systems, April 2008, Table 4.4, p. A-35.

7. Milliman, "Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid and Commercial Payers," December 2008.

8. Massachusetts Medical Society, *Physician Workforce Study*, October 2008.