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Medicaid Reform: Implications for the Health Care Safety Net

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Health care is not considered a right in the US, and health insurance coverage is not universal. In 2003, 45 million Americans were uninsured for the entire year [1] while an equally large number were uninsured for part of a year [2]. Over a 24-month period, 80 million people experienced some absence of coverage [3]. Among those with private health insurance, an estimated 10 to 25 percent are *underinsured*, meaning their insurance plan is inadequate to cover the cost of their health care needs [4]. A recent study traced 50 percent of all filed personal bankruptcies to medical care costs, and three-quarters of those filers actually had health insurance [5].

There are 2 major causes for this state of health care coverage. First, the private, primarily employment-based, health insurance system is voluntary and so costly (the annual premium for family coverage is estimated to be approximately \$10 000 in 2005) that millions cannot afford it. Second, the absence of a widely available public insurance system for those who cannot afford private coverage leaves many with no health care benefits.

Eighty percent of those who are uninsured live in families with at least 1 wage earner, and 60 percent are wage earners themselves, yet they remain uninsured because their employers offer either no coverage or no affordable coverage [6]. Medicaid, the federal-state government program, is the nation's largest insurer; it covered more than 50 million people in 2004 but that included only half of the poor and low-income individuals of working age. Adults are ineligible for Medicaid unless they have severe disabilities that prevent work. Even with coverage, millions of Medicaid beneficiaries remain medically underserved either because they live in communities without physicians or because local physicians do not accept Medicaid. Only half of all physicians report unlimited participation in Medicaid [7].

The "health care safety net" serves millions of low-income, uninsured, and publicly (ie, government) insured persons. The Institute of Medicine (IOM) has defined the health care safety net as "[t]hose providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable populations" [4]. The IOM also identified a subset of the safety net—"core" resources such as federally funded community health centers and public hospitals—which serve the aforementioned population *and* have an open door policy of offering services regardless of ability to pay. The "core safety net" includes an estimated 1300 public hospitals, 1000 community health centers, federally supported family planning clinics,

and local public health agencies whose patients are likely to be on Medicaid, uninsured, poor, and members of racial or ethnic minority groups [8, 9]. The far larger noncore safety net, comprising community and teaching hospitals, some private health professionals in office-based practices, and school-based health clinics, supplies the majority of all health care to vulnerable populations.

The core safety net depends greatly on public funding. One-third of all health center operating revenues come from Medicaid, while 38 percent of public hospital revenues are derived from Medicaid [10]. Public hospitals' and local clinics' legal obligation or rigorous mission to serve persons who cannot afford necessary health care, along with their typically heightened efforts to offer culturally appropriate care that includes patient support services such as social work, translation, and transportation, would be impossible without Medicaid revenue.

The uninsured are at risk for serious health consequences. They experience many barriers to obtaining health care, and they are more likely to delay care because of cost than are the insured [6]. Persons without health insurance tend to be sicker and more likely to die from preventable causes than those with health insurance [6]. Without the core safety net, uninsured individuals would continue to go without needed care, and millions of publicly insured persons would have no access to health care.

Yet, the safety net does much more than simply administer sporadic care for the uninsured. These health centers and other publicly supported clinics are the "neighborhood doctors" for many medically underserved communities, acting as a regular source of quality health care. Having a consistent source of care is positively associated with better and more timely access to care, better chronic disease management, fewer emergency room visits, fewer lawsuits against emergency rooms, increased utilization rates, and increased cancer screenings for women [11]. Numerous studies show that the care medically underserved populations receive in safety net settings is of high quality [4], although physicians and support staff often struggle to identify affordable sources of specialty care for their uninsured patients [1].

In some respects, support for the core safety net has never been greater. For example, President Bush has supported a major expansion of health centers, and as a result the number of patients served is expected to grow from 10 million in 2001 to more than 16 million by 2006 [2].

At the same time, as part of the federal budget for fiscal year 2006, the Bush administration and congressional supporters are calling for major cuts in the Medicaid program, deep reductions in critical grant programs that help support the safety net (eg, the National Health Service Corps), an elimination of the Preventive Health and Health Services Block Grants awarded to the states, and significant reductions in CDC preventive health programs [3].

Medicaid cuts would have the most far-reaching effects, not only because Medicaid is an essential source of revenue for physicians and clinics alike, but also because it is virtually the only source of insurance coverage for safety net patients. These proposed

reductions would further swell the ranks of the uninsured and simultaneously imperil critical funding to safety net providers when it is needed most.

In April 2005 the House of Representatives voted to cut Medicaid even more deeply than recommended by the President, while the Senate rejected all cuts. The subsequent budget resolution passed by both the House and Senate lowered Medicaid funding by \$10 billion. Regardless of how the Medicaid financial debate is eventually resolved, major reductions in smaller grant programs are inevitable. As the number of uninsured Americans continues to grow, the survival of the safety net will become an even more pressing health policy matter.

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