FACSIMILE

From the Immediate Office of the Secretary
Executive Secretariat

To: CHRIS JENNINGS / DAN MENDELSON

Fax#: 456-5557 / 395-5631

Re:

Date: 12/9/98

Pages: including this cover sheet 11

From the desk of:

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- [ ] Sandy Bart
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- [ ] Martina Varnado
- [ ] Ann White
- [ ] Melvin Whitfield
- [ ] Other

Comments:

JOHN PODESTA RECEIVED THE ORIGINAL YESTERDAY.

U.S. Department of Health and Human Services
Immediate Office of the Secretary- Executive Secretariat

200 Independence Avenue SW
Washington, DC 20201
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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

DEC 8 1998

MEMORANDUM FOR THE WHITE HOUSE CHIEF OF STAFF

Subject: Characteristics of Uninsured Low-Income Adults

At our meeting a few days ago, you asked for additional information on the characteristics of the uninsured adult population. Below you will find information that discusses low income, uninsured adults focusing on demographic characteristics, work status, availability of coverage at work, and access to care. Our response focuses on uninsured, low-income adults because over the last several years we have taken several large steps to address the needs of uninsured children. While about 11 million children remain uninsured, the Medicaid expansions and the new Children's Health Insurance Program give most uninsured children access to coverage. Reducing the number of uninsured children is now largely a matter of improving the effectiveness of existing programs.

Of the 43 million people without health insurance coverage in the United States, roughly 32 million are adults between the ages of 19 and 64. Among uninsured adults, 53 percent or 17 million have incomes below 200 percent of poverty. Not only is health insurance difficult to afford, but at this income level needed health care may also be too expensive.

The information presented below is drawn from several sources, so there are some differences in terms of the estimated number of adults and the age groups studied. However, in general, lower income (under 200 percent of poverty) uninsured adults:

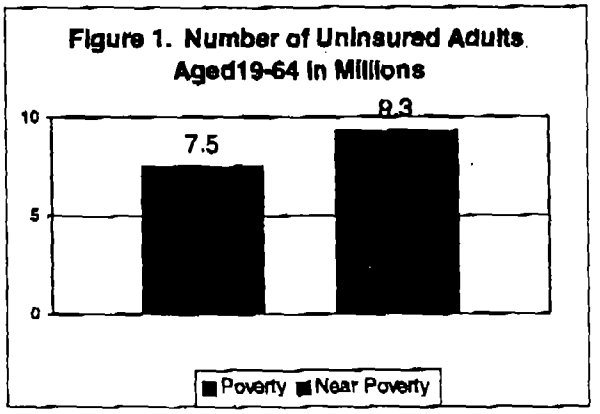
- are likely to be employed at least part time;
- are likely to be white, although they are also disproportionately likely to be Hispanic;
- are more likely to live in the South or West; and
- are disproportionately noncitizens (23 percent lack citizenship).

More detailed characteristics of low income uninsured adults are discussed below.

Donna E. Shalala

Income

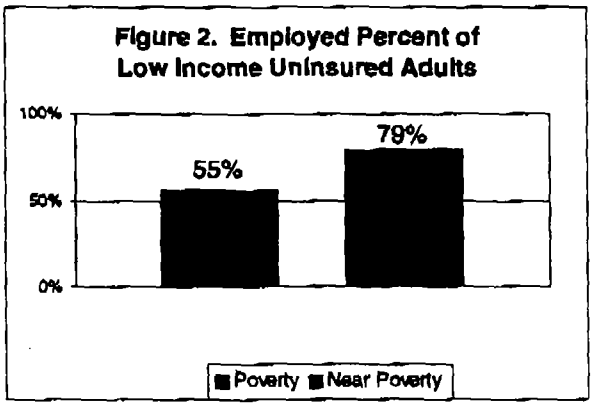
Of approximately 17 million low income uninsured adults, about 7.5 million have incomes below poverty, while the remaining 9.3 million have incomes between 100 and 200 percent of poverty. (Figure 1)



Source: ASPE tabulation of the March 1998 Current Population Survey. "Near Poverty" means between poverty and twice poverty.

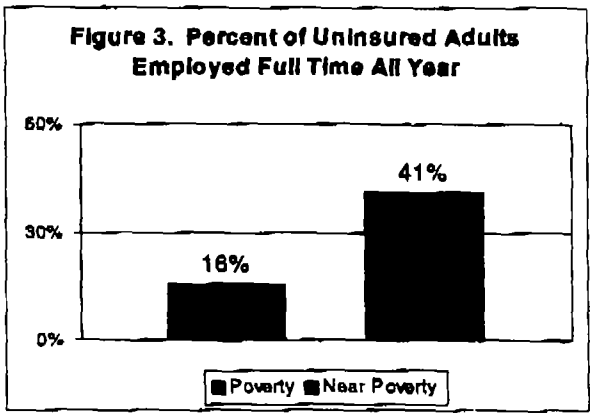
Work Status

While many uninsured adults have low income, most work at least part time. Sixty-eight percent of uninsured low income adults are employed. Among low income uninsured adults, 55 percent of the uninsured below poverty work, while 79 percent of those between 100 and 200 percent of poverty work. (Figure 2)



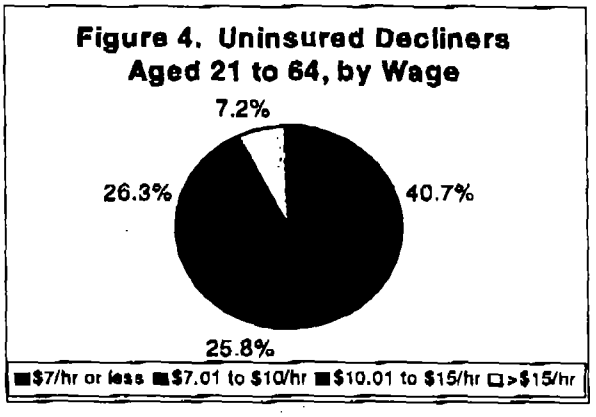
Source: ASPE tabulation of the March 1998 Current Population Survey. "Near Poverty" means between poverty and twice poverty.

Over half of the employed near poor adults work full time, all year, while almost 30 percent of those who are employed and living in poverty work full time, all year. (Figure 3)



Source: ASPE tabulation of the March 1998 Current Population Survey. "Near Poverty" means between poverty and twice poverty.

Many uninsured workers are not offered health insurance through their employers; however, 13 percent of uninsured adults who are offered insurance decline to accept it. Roughly 40 percent of those who decline coverage and remain uninsured earn $7 an hour or less in wages. (Figure 4)

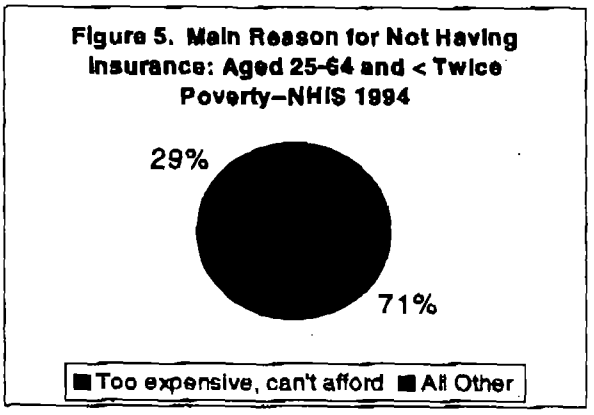


Source: ASPE tabulation of the 1996 Medical Expenditure Panel Survey (MEPS).

While purchasing health insurance through an employer is much more affordable than trying to purchase insurance as an individual, it can still be very expensive for low income adults. For example, a 1993 employer survey found that nearly a third of workers earning less than $14,000 per year were asked to pay over 50 percent of the cost of their insurance. In 1997 terms, a worker who contributed 50 percent of the cost of their insurance for single coverage would pay about $1150. For a person with income at the 1997 poverty line, this would represent 15 percent

of their annual income. If the same worker purchased family coverage for a family of four, the cost would be about $3015 or 19 percent of the annual income for a family of four at the poverty line.

Among workers and nonworkers asked the main reason for not having health insurance in 1994, 71 percent of adults below 200 percent of poverty said it was too expensive and they couldn't afford it. (Figure 5)

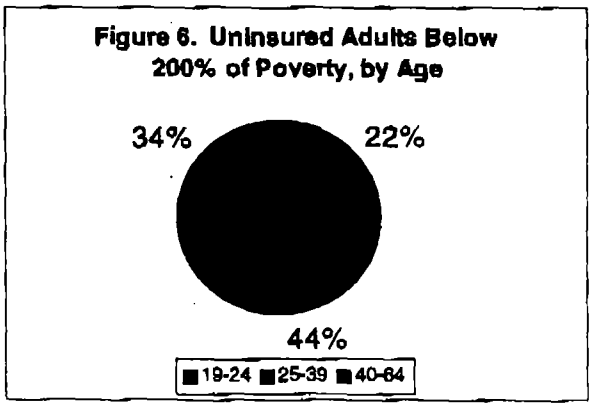


Source: ASPE tabulation of the March 1998 Current Population Survey.

Age

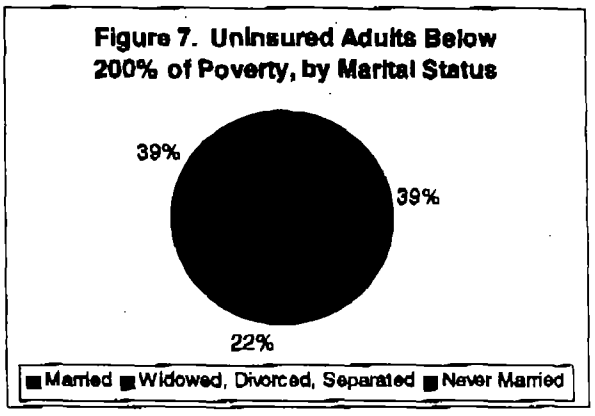
Understanding the composition of the low income uninsured adult population by age is important for understanding what type of health services the uninsured need most. About 44 percent of uninsured low income adults are between the ages of 25 and 39, about 34 percent are between 40 and 64 and the remaining 22 percent are between the ages of 19 and 24. (Figure 6)

Source: ASPE tabulation of the March 1998 Current Population Survey.



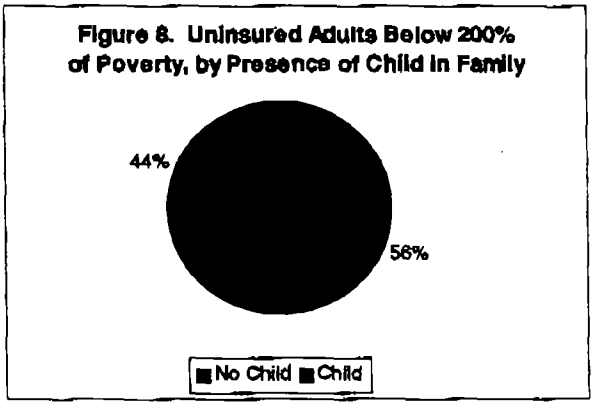
Family Composition

Marital status and the presence of dependent children can make a difference in the resources available to purchase health insurance or medical services. Among uninsured low income adults, 39 percent are married, 22 percent are widowed, divorced or separated, and the remaining 39 percent have never married. (Figure 7)



Source: ASPE tabulation of the March 1998 Current Population Survey.

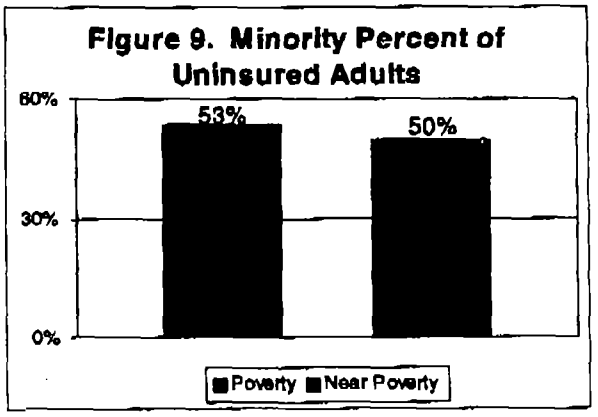
Regardless of marital status, 44 percent of uninsured low income adults have at least one dependent child. (Figure 8)



Source: ASPE tabulation of the March 1998 Current Population Survey.

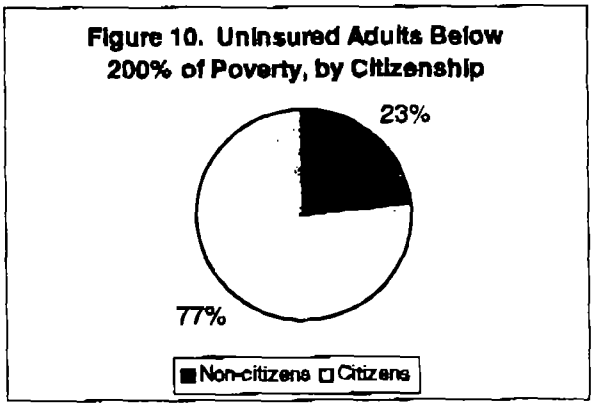
Race/Ethnicity

Slightly less than half (44 percent) of all uninsured adults are non-white. Among low income adults however, 53 percent of the uninsured below poverty and 50 percent of those between 100 and 200 percent of poverty are non-white. (Figure 9)



Source: ASPE tabulation of the March 1998 Current Population Survey. "Near Poverty" means between poverty and twice poverty.

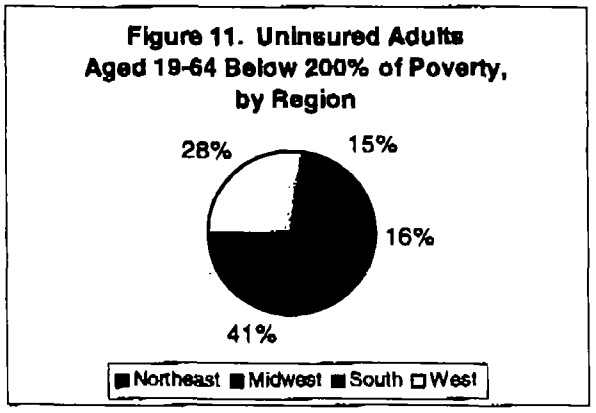
Nearly 4.8 million or 29 percent of low income uninsured adults are Hispanic. Nearly one quarter of adults with income below 200 percent of poverty lack citizenship. (Figure 10)



Source: ASPE tabulation of the March 1998 Current Population Survey.

Region

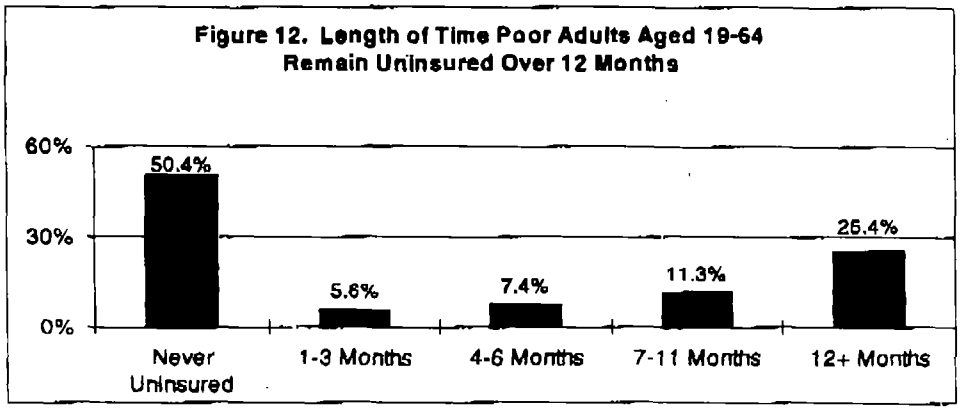
Understanding where low income uninsured adults live is important when considering options to address their health care needs. Most -- 41 percent or 6.7 million--low income uninsured adults live in the South compared to 28 percent in the West, 15 percent in the Northeast and 16 percent in the Midwest. (Figure 11)



Source: ASPE tabulation of the March 1998 Current Population Survey.

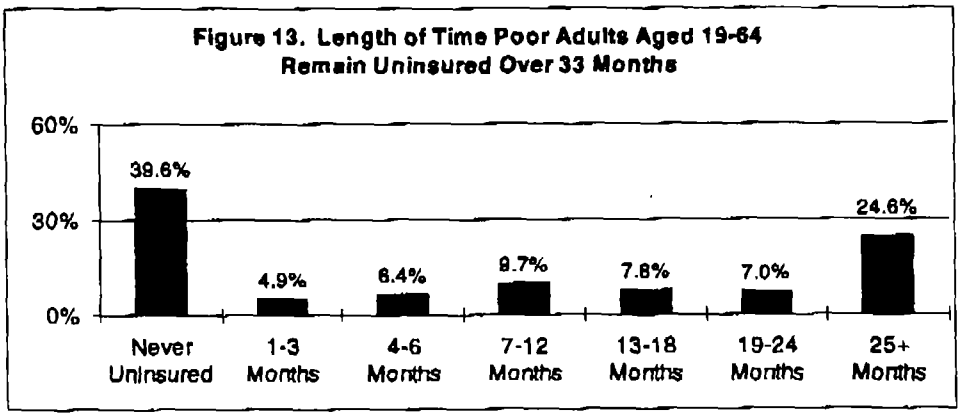
Length of time uninsured

Another important distinction among uninsured adults is between those who experience short terms gaps in coverage and those who are chronically uninsured. Studies that track health insurance coverage over several years have shown that most low income adults experience some gap in coverage and a significant proportion--one quarter-- lack coverage for more than one year. Among poor adults who were uninsured at any time during a twelve month period, roughly half were uninsured for 12 months or more, while one quarter were uninsured for six months or less. (Figure 12)



Source: ASPE tabulation of 1992-1994 SIPP data.

When followed over 33 months, only 40 percent of poor adults experienced no gaps in coverage, while 11 percent were uninsured for six months or less, 25 percent for 7 to 24 months and 25 percent for 25 months or more. (Figure 13)

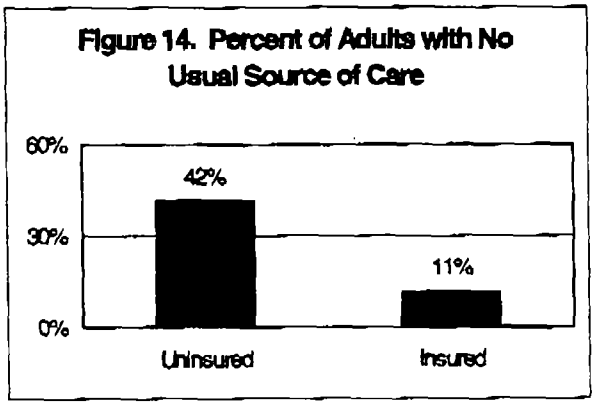


Source: ASPE tabulation of 1992-1994 SIPP data.

Among all persons, those most likely to experience longer gaps in coverage include: those living below poverty, Hispanics, persons aged 25 to 44 years, those without a high school diploma, and those living in the South or in central cities.

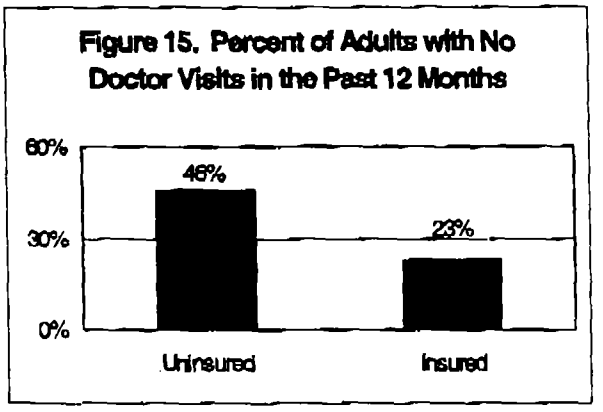
Getting Needed Care

One indicator of receiving adequate health care is knowing who to call or see when you have a medical problem. A recent survey that asked people about their usual source of care found that 42 percent of uninsured adults had no usual source of care compared to 11 percent of adults with health insurance. (Figure 14)



Source: ASPE tabulation of the 1995-1996 National Health Interview Survey (NHIS).

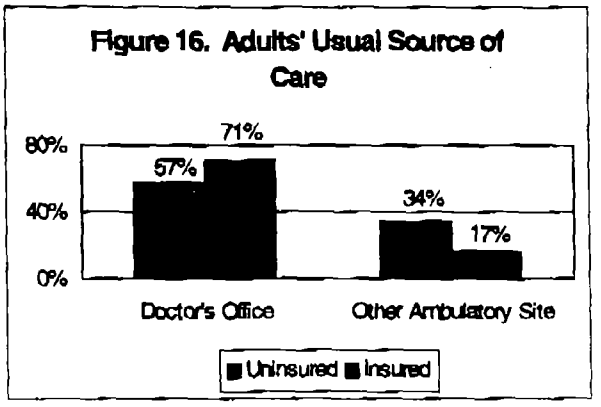
Twice as many uninsured adults (46 percent) reported no doctor visits in the past 12 months compared to insured adults. (Figure 15)



Source: ASPE tabulation of the 1995-1996 National Health Interview Survey (NHIS).

Unfortunately, fewer doctor visits do not mean that uninsured adults are healthier than insured adults--11 percent of uninsured workers report being in fair or poor health compared to 6 percent of insured workers.

When seeking health care, the uninsured are also more likely to get care somewhere other than a doctor's office. Of those who identified a usual source of care or reported a doctor visit within the past year, 34 percent of uninsured adults identified a hospital outpatient department, clinic, urgent care center or emergency room as the site of care compared to only 17 percent of insured adults. (Figure 16)



Source: ASPE tabulation of the 1995-1996 National Health Interview Survey (NHIS). "Other Ambulatory Site" includes hospital outpatient department, clinic, urgent care center, or emergency room.

Conclusion

The above information demonstrates that a substantial number of poor adults remain uninsured and use much less health care than similar people with insurance. Low income adults have less access to affordable employer based coverage and, when they become uninsured, they tend to be uninsured for long periods of time. There is a demonstrated need to develop programs to address both the health insurance and health care needs of this population.

Components of general outlines
need more capacity w/in safety
net service system.
mechanism for $ ⟶ States.

· Links w/ existing grant programs.

Safety Net (1)

Dan: grant prog of $7B that relate to this problem. Can we use this as an opportunity to improve the level of accountability? Concurs that new $ is necessary, but wants to make sure that acc is part of it

Gary: delicate balance; need to get people interested in something new but not make them defensive about what's already there.
acc → grant conditional on srcs coordination; need to document inputs

Peggy: report card of standardized data, $ that's already there.

Gary: release grant funds only to extent that it's not being bled away.

Dan: CHC explicitly?

Gary: explore politics; long run doesn't make complete sense

Dan: creation of super CHCs acc full range of svcs. some function in that way

network under new entity that's not CHCs, they're subsumed.

need to demonstrate that this works before we comm put more strings on block grants

Dennis: ① encourage w/ $ to create

② make $ contingent

Dan: make explicit that we would continue to go there.

Dennis & Dan disagree.

Safety Net (2)

Peggy: how much $ in this?

Dan: answer dependant on what we're trying to create here. new funding stream to fill in the holes, that different from fully acc. local org @ local level.

Gary: end up being the same thing

Dan: have to subsume local funding streams.

Gary: agrees but Dennis.

Dan: hard to figure out what existing holes are. no one knows!

trends not where you want

<u>Gary</u>: hosp walking away
more defined expression of need.

<u>Dan</u>: weaning out of nonfunctioning CHCs

<u>Dennis</u>: failure defining weaning out.

<u>Dan</u>: need to address the out years.

<u>Gary</u>:

prog ramp up to certain amt of #

at least .5 on structure
after all is a.c. funded
shift .25 structure
.75 on service.
primary care, mental health, dental, prenatal

Dan: each of those areas have their own directed funding stream

2000 coordination for new svcs for old

Dan: prioritize $ for care vs. $ for model?

Gary: set in grant criteria through approp $

Dan: more for structure

Gary: POTUS wanted $ ~~$~~ of people

Peggy: low hanging fruit quickly shift into new model

Dan: funding for mental health thru new svcs.

Richard: here or other funding streams.

POTUS: SOTU for FY2000

Dan: pressure for svcs not on for 2000. verify w/ Chris.

Dennis: see 5-year plan. emphasis on svcs.

Richard: we already to (?) assistance on state level.

CDC infrast. $80 M

SAMHSA 5% set aside g block grant

MH: infrastructure support

currently being carried on mandatory side

~~#s~~ being nailed down by end of the week.

Who's proposal on this conf call on Wed.

Richard leg drafting

Dan would we need leg for this?

Yes

Gary

PHS 301 as authority.

Dan SOTU question for Rich & John; maybe just do it through PHS.

reconvene on Wed to discuss paper (8:30) Teresa

③

Pre[illegible]: NGA & NCSL

Ashley: can we learn from EZ-EC process? outrageous process low, coordination process is unnatural.

Dan: outreach $ how do we prioritize

next steps for Budget

① FY 2000

② ~~Ex~~ process for out years.

disc doc today
HHS rec? tomorrow
final budget for Wed.

NATIONAL
New York Region
The New York Times ON THE WEB

December 23, 1998

City Hospitals Lose Funds in Pataki Video

By JENNIFER STEINHAUER

Gov. George E. Pataki vetoed a bill Tuesday that sought to give New York City's public hospital system $100 million to help pay for its swelling ranks of uninsured patients.

The veto of the bill, which was approved unanimously by the State Legislature in June, was a huge blow to the city's Health and Hospitals Corporation, which is struggling to come up with a plan to pay for treating uninsured patients.

In his veto message, Governor Pataki said that while he was "sensitive to the corporation's mission to provide indigent care and the financial demands the corporation experiences as a result of that mission," he nonetheless killed the bill, which would have added to the existing $470 million the corporation receives in charity funds.

The bill would not have required additional state financing. Instead, it would have lifted a cap legislators had imposed on the Health and Hospitals Corporation, which prevented it from applying for its full share of Federal **Medicaid** money for hospitals that treat very sick and uninsured people. The bill could have translated into $50 million more from Washington, to be matched by $50 million already pledged by the Giuliani administration.

Yet Governor Pataki said he feared that the bill would break the budget already set aside by the Federal Government. He said he was also concerned that it could endanger the state's ability to transform its **Medicaid** program into one in which recipients are required to enroll in managed care, a plan that must pass muster with Federal officials.

The bill's sponsors and H.H.C. officials questioned the Governor's logic, noting that the bill had numerous provisions to assure that it would get Federal approval.

"I am completely mystified as to why he would veto this," said Richard N. Gottfried, chairman of the Assembly Health Committee. "At the time we were considering this, I didn't see this issue being raised by the Assembly fiscal people or even from the executive branch."

In a June letter to the president of the corporation, Dr. Luis R. Marcos, Federal officials wrote that while they had yet to form a firm opinion on the bill, "we have observed, nevertheless, that the draft legislation appears to include many safeguards to prevent its enactment from causing the state to exceed any federally imposed limits."

The corporation is in desperate need of fresh money to cover the uninsured. The number of its patients who do not have insurance has risen by 39 percent since 1995, and is expected to grow more this year due to a variety of factors,

including welfare reform legislation that decreased **Medicaid** coverage for many people and the increasing number of businesses that are not offering insurance. Of the city's uninsured population, 71 percent seek care in its public hospitals.

Further complicating the corporation's fiscal problems are decreased revenues from **Medicaid** as more recipients move to managed care. As a rule, managed care programs have lower reimbursement rates than the traditional fee-for-service **Medicaid** programs. Further, under managed care, **Medicaid** recipients have more choices of where to get care, and many are opting for competitors of the public hospitals.

"For us, this is a very big deal," Dr. Marcos said. "Our costs are increasing by the day as our **Medicaid** numbers decrease. We are very disappointed that the state government did not recognize the need to support health services for the men and women without insurance."

How to pay for the uninsured will almost certainly be an important legislative issue next year, and the corporation and its allies will most likely be back with new proposals.

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BACKGROUND ON THE SAFETY NET

Pressure on the safety net is increasing. Regional safety net systems face high demand for services. Approximately 43.4 million people in the United States were without health insurance coverage during the entire 1997 calendar year, and the number of uninsured is increasing rapidly, up 1.7 million from 1996. Although CHIP and Medicaid can potentially provide coverage to many of the 11 million uninsured children, roughly 32 million adults remain uninsured. Over half of those have incomes below 200 percent of the poverty level. Since the majority of Medicaid programs do not provide coverage to adults unless they are significantly below the poverty level, these individuals have no option but to rely on the safety net for care.

The safety net is financially unstable. The implicit cross subsidy of care for the uninsured is eroding as a result of the Federal, State, and private industry efforts to provide low cost care for a defined population that excludes the uninsured. States are increasingly enrolling their Medicaid beneficiaries in managed care plans in order to cut costs, forcing safety net providers to compete with other local providers to serve the only segment of their patient base that provided stable funding. In addition, many public health departments are moving away from the delivery of personal health care services to population based services. These changes mean that local sources of funding are becoming increasingly important to the financial viability of the safety net, making these providers vulnerable to an economic downturn threatening their financial health.

Financial concerns have reduced the range of services delivered by safety net providers. Although little quantitative information exists regarding the impact of safety net responses to market changes on care to the uninsured, a number of studies indicate that safety net providers have not reduced their committment to care for this population. However, their attempts to reduce costs as a result of financial pressures may have reduced comprehensive services delivered to the low-income uninsured. For instance, a review of FQHCs in States that were implementing mandatory managed care demonstrations found that they significantly reduced the range of services provided to patients.

Care delivered by safety net providers is often uncoordinated and fragmented, and providers cannot be held accountable for health outcomes. Many safety net providers do not have automated data systems that accurately track the services delivered to individual patients, forcing them to rely on written records and making it difficult to evaluate program quality and to determine the most efficient way to allocate limited resources. In addition, most safety net providers do not have compatible data systems, making it impossible for primary, secondary, and tertiary safety net providers in a region to effectively coordinate patient care. There is also insufficient provider capacity in some specialties, including mental health and substance abuse.

If the safety net collapses, access to critical tertiary care services are compromised. Large public hospitals, an integral piece of the safety net in their communities, are often the only source in a region for trauma care, burn units, neonatal intensive care units, and other specialized services that not cost effective but are critical to all of the residents in a service area. If these institutions succumb to the burden of uncompensated care costs, both the insured and uninsured residents of the service area will be forced to seek these essential health care services elsewhere.

ADDITIONAL INFORMATION ON SAFETY NET PROVIDERS

- **Public Hospitals.** Of the nation's 6,500 community hospitals, about 1,400 are "public" in that they are owned and operated by states, cities or counties. Most public hospitals also offer services to the community at large that are often underfunded by private insurance, such as trauma care, burn centers, neonatal intensive care units, poison control units, emergency psychiatric care and disaster response teams. Between 1980 and 1990, urban public hospitals accounted for approximately 7 percent of all hospitals, but provided 19 percent of all emergency room visits and 18 percent of outpatient visits, nearly half of which were provided to patients who were uninsured.

- **Community Health Centers and Migrant Health Centers.** The national network of nearly 600 community and migrant health centers provides comprehensive, case-managed primary and preventive care. With 2,500 delivery sites, the centers are key outpatient components of the health care safety net. Located primarily in inner-city and rural areas with shortages of health care professionals, they serve an estimated 9 million people each year. Community health centers are thought to provide care to about 20% of those they could serve, while migrant health centers serve only about 14% of migrant and seasonal farm workers.

- **Family Planning Clinics.** More than 4,000 clinics in this federally funded program, provide primary care, cancer screening, sexually transmitted disease prevention services, and family planning services to approximately 4 million women and teenagers. Approximately 85% of clinic clients have incomes under 150% of poverty.

- **Ryan White AIDS Program.** The federal Ryan White CARE Act provides a variety of health care and social services, including testing, risk reduction, counseling, transmission prevention and clinical care through 136 projects with 500 delivery sites serving an estimated 80,000 patients who have AIDS or are HIV-positive.

- **Public Health Departments.** Local governments spent $13.7 billion in 1992 on public health, which includes a wide variety of services primarily aimed at preventing the spread of communicable diseases and educating people about personal health risks ranging from child immunizations to home health care to rat control. Public health departments also deliver some personal health care services, including maternal and child services.

- **Rural Health Clinics.** Largely privately owned and operated, the nearly 2,500 federally designated rural health clinics provide critical access to health care services for some 4 million patients each year. These clinics are paid by Medicare and Medicaid under special rules, reflecting the fact that 70% of their patients are insured under one of the two programs and that the clinics frequently are the sole source of medical care in the community.

DETERMINANTS OF SAFETY NET VIABILITY

The following four market and policy characteristics are often considered integral to safety net providers' ability to continue providing care to low income populations.

Level of demand for services. Three factors determine the level of demand for safety net services: the structure of the private insurance market and the resultant coverage of the low income population, the eligibility standards in the State's Medicaid program and the availability of other subsidized insurance programs for the low-income uninsured, and the percentage of the population with special health care needs or chronic illness. It is important to note that community level data tracking these factors are unavailable, and so it is difficult to determine the level of demand for safety net services for individual regions or localities. In addition, the distribution of demand across providers within a particular community may vary considerably. For instance, studies indicate that publicly owned hospitals tend to bear a higher share of uncompensated care market than private safety net hospitals.

Medicaid managed care penetration. The impact of Medicaid managed care on safety net providers differs based on the proportion and type of the Medicaid population covered by mandatory enrollment policies and the State program design features, some of which are specific to safety net providers. In addition, reports suggest that not just the proportion, but the rate of growth in the proportion of Medicaid managed care enrollees has a significant impact on the vaibility of the safety net, since a rapid increase in managed care gives safety net providers little time to adapt.

Level of commercial market competition. The factors that contribute most to the level of competition include the penetration of private managed care, the concentration of market share among providers, and the presence of for-profit providers. Safety net providers across the country have indicated that the penetration of managed care in the private market has resulted in an increase in price-based competition. In addition, there has been a general increase in competition on the basis of non-price aspects of care, including consumer choice of providers and non-medical amenities.

Federal and State financial support for the safety net. Federal and State subsidy programs for both ambulatory and inpatient care providers are used by institutions to cover the Medicaid shortfall as well as to cover the cost of the uninsured. In addition, these funds can free resources to be used for infrastructure upgrade and the development of ambulatory care capacity, information systems, and managed care capacity.

ABOUT THE SAFETY NET

What is the safety net? The safety net ensures that any American experiencing a medical emergency will receive essential health care services. Safety net providers are providers who are legally required to provide health care services to patients regardless of their ability to pay for the services they receive. Services are provided for free or on a sliding fee scale. Public hospitals, community health centers, family planning clinics, Ryan White providers, public health departments, and rural health clinics are critical components of the safety net. In addition, although it is not a stated part of their mission, many academic health centers often provide free or low cost health care to those who cannot afford to pay for it.

Who does the safety net serve? Safety net providers are the primary source of health care for the 43 million people who are presently uninsured, as well as for the ___ individuals living in rural or urban areas with a shortage of health care providers. Many of these individuals have a broad range of complex health and psychosocial needs, exacerbated by limited access to primary care services.

What services does the safety net provide? In some areas, the safety net provides the full range of health care services. In others, it is limited to the primary care provided by public health departments and community health centers and the emergency care provided by public hospitals. [lack of secondary care services here -- primary through outpatient clinics, emergency/tertiary through emergency room and public hospitals, but lack of providers for secondary care services...is this right?]

How is the safety net financed? Safety net providers have diverse funding sources. Although some of the funding for the care delivered by safety net providers comes from private insurers and patients, most of their funding comes from Federal sources. The PHS funds community health centers, family planning clinics, maternal and child health block grants, and other specicial programs to provide preventive and treatment services individuals. In addition, both Medicaid and Medicare provide funds to hospitals serving disproportionate numbers of low income patients; in 1992, these payments totaled more than $17 billion. Most States also make significant investments in the safety net, sponsoring bad debt and charity care pools to help reimburse providers for care provided to the uninsured. Local governments also play an important role in funding the safety net; in 1992, counties spent nearly $85 billion on health care, representing approximately 17 percent of their budgets. Of that amount, almost 40% was used to support public hospitals, with smaller amounts used to support public health departments and to finance the State share of Medicaid spending. In thirty States, counties are legally reponsible for care for the uninsured. In the end, however, many safety net providers bear the ultimate financial responsibility for those who are unable to afford the cost of their own care. According to CBO, hospitals and other providers delivered an estimated $28 billion in uncompensated care in 1995.

HOLES IN THE SAFETY NET

The safety net is financially unstable. Regional safety net systems face high demand for services. Approximately 43.4 million people (16.1 percent of the total population) in the United States were without health insurance coverage during the entire 1997 calendar year, an increase of 1.7 million from the previous year. In addition, as more and more States enroll their Medicaid beneficiaries in managed care plans in order to save money, safety net providers are forced to compete with other local providers to serve the only segment of their patient base that provided a stable source of financing. Local sources of funding, which often fluctuate from year to year, are becoming increasingly important to the financial viability of the health care safety net. This makes these critical providers vulnerable to an economic downturn that could threaten their financial health.

Pressure on the safety net is increasing. [The implicit cross subsidy of care for the uninsured is eroding as a result of the Federal, State, and private industry's aggressive approach to seeking low cost care for a defined population excluding the uninsured, reductions in employer sponsored coverage or declines in Medicaid rolls re: welfare reform; economy growth may end; public health departments moving to more population based services, although personal health care services still consume largest share of local health department's staffing and funds] The number of uninsured is increasing rapidly, up 1.7 million from 1996. Although CHIP and Medicaid can potentially provide coverage to many of the approximately 11 million uninsured children, roughly 32 million adults remain uninsured. Over half of those have incomes below 200 percent of the poverty level. Since Medicaid does not provide [coverage below 100% FPL], these individuals have no option but to rely on the safety net for care, as health insurance and health care services are often unaffordable. In addition, marketplace pressures have made it increasingly difficult for hospitals to make up these losses. Traditionally, hospitals and other providers have paid for uncompensated care by charging paying patients more (cost shifting). However, with increasing market competition in the health care sector, the increasing dominance of managed care in both the private sector and Medicaid, and the phase-out of Medicaid cost based reimbursement for community health centers, insurers are less willing to pay inflated prices for health care services, making it much more difficult to cross subsidize care for the uninsured internally.

Financial concerns have reduced the range of services delivered by safety net providers. Although little quantitative information exists regarding the impact of safety net responses to market changes on care to the uninsured, a number of studies indicate that safety net providers have not reduced their committment to care for this population. However, their attempts to reduce costs as a result of financial pressures may have reduced comprehensive services delivered to the low-income uninsured. For instance, a review of FQHCs in States that were implementing mandatory managed care demonstrations found that they significantly reduced the range of services provided to patients.

Care delivered by safety net providers is often uncoordinated and fragmented. While the acute and emergency care component

Safety net providers do not have coordinated data systems and cannot be held accountable for health care outcomes.

If the safety net collapses, access to critical tertiary care services are compromised.

ADDITIONAL INFORMATION ON SAFETY NET PROVIDERS

- **Public Hospitals.** Of the nation's 6,500 community hospitals, about 1,400 are "public" in that they are owned and operated by states, cities or counties. Most public hospitals also offer services to the community at large that are often underfunded by private insurance , trauma care, burn centers, neonatal intensive care units, poison control units, emergency psychiatric care and disaster response teams. Between 1980 and 1990, urban public hospitals accounted for approximately 7 percent of all hospitals, but provided 19 percent of all emergency room visits and 18 percent of outpatient visits, nearly half of which were provided to patients who were uninsured.

- **Community Health Centers and Migrant Health Centers.** The national network of nearly 600 community and migrant health centers provides comprehensive, case-managed primary and preventive care. With 2,500 delivery sites, the centers are key outpatient components of the health care safety net. Located primarily in inner-city and rural areas with shortages of health care professionals, they serve an estimated 9 million people each year. Community health centers are thought to provide care to about 20% of those they could serve, while migrant health centers serve only about 14% of migrant and seasonal farm workers.

- **Family Planning Clinics.** More than 4,000 clinics in this federally funded program, provide primary care, cancer screening, sexually transmitted disease prevention services, and family planning services to approximately 4 million women and teenagers. Approximately 85% of clinic clients have incomes under 150% of poverty.

- **Ryan White AIDS Program.** The federal Ryan White CARE Act provides a variety of health care and social services, including testing, risk reduction, counseling, transmission prevention and clinical care through 136 projects with 500 delivery sites serving an estimated 80,000 patients who have AIDS or are HIV-positive.

- **Public Health Departments.** Local governments spent $13.7 billion in 1992 on public health, which includes a wide variety of services primarily aimed at preventing the spread of communicable diseases and educating people about personal health risks ranging from child immunizations to home health care to rat control. Public health departments also deliver some personal health care services, including maternal and child services.

- **Rural Health Clinics.** Largely privately owned and operated, the nearly 2,500 federally designated rural health clinics provide critical access to health care services for some 4 million patients each year. These clinics are paid by Medicare and Medicaid under special rules, reflecting the fact that 70% of their patients are insured under one of the two programs and that the clinics frequently are the sole source of medical care in the community.

SAFETY NET MODELS THAT WORK

DETERMINANTS OF SAFETY NET VIABILITY