Looking at Comprehensive Safety Nets in Seven Communities

Analyzing access to care and the cost of care and looking at the role of safety nets in health reform

SUMMARY

Local safety nets for uninsured patients—which provide care through public hospitals and clinics and sometimes office-based physicians—are a critical component of the U.S. health care system.

From 2009 through 2012, researchers at Wake Forest University in Winston-Salem, N.C., led by Mark A. Hall, JD, analyzed access to care and the cost of care provided by comprehensive safety nets in seven communities. The researchers also examined the makeup of the uninsured population and the role of safety nets under health care reform.

Key Findings

The researchers reported the following findings in journal articles, reports, and issue briefs, and in a report to the Robert Wood Johnson Foundation (RWJF):

- In five communities that had a coordinated safety net offering primary care, hospital care, prescription drugs, and most specialist services, enrolled participants had access to care comparable to that of insured residents. The communities were Asheville, N.C.; Boston; Denver; Flint, Mich.; and San Antonio.

- The average cost of care per enrolled adult per month in four of the above communities—Asheville, Flint, Denver, and San Antonio—in 2008 was 25 to 50 percent less than the average cost of providing similar services through Medicaid and private insurance.

- The nation could achieve near-universal coverage by combining safety-net programs with expanded public and private insurance under the Patient Protection and Affordable Care Act of 2010 (ACA).

Funding

RWJF funded this project with a grant of $399,381 from May 2009 through March 2012 under its first Coverage Ideas from the Field solicitation. The call for proposals, issued in
December 2008, with grants starting May 1, 2009, funded projects to increase the likelihood that the nation’s health care debate would lead to solutions and build momentum to drive federal policy-makers to act. See the Introduction for more information.

**CONTEXT**

Either by legal mandate or explicit mission, safety-net providers care for patients regardless of their ability to pay. In 2009, U.S. hospitals provided some $36.4 billion in uncompensated care, according to the American Hospital Association, while private office-based physicians provided around $7 billion.¹ Despite these efforts, uninsured patients served by an often patchwork safety-net system may face problems such as disrupted and fragmented care, restricted access to specialty services, and long waiting periods.

Many more Americans will gain access to insurance under the ACA—but millions will remain uninsured, and thus still be in need of a safety net. Yet studies of well-functioning safety nets are rare.

**RWJF's Interest in This Area**

Among the studies about the safety net that RWJF has funded are the following:


- **Analysis of Options to Help Remake the Health Care Safety Net (1995–1996).** Investigators at Kalkines, Arky, Zall and Bernstein took a snapshot of the state of the health care safety net in four major urban areas (Boston, Miami, Philadelphia, and New York City). Read the Program Results.

- **In Four Major Cities, Providers to the Poor Just Barely Keep Up With Demand (1995–1996).** The Lewin Group, a health care and social services consulting firm based in Falls Church, Va., took a snapshot of the state of the health care safety net in four urban areas: Dallas, Los Angeles, Memphis, and New York City. Read the Program Results.

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¹ In 2001, hospitals provided $24 billion in uncompensated care and private physicians provided $5.1 billion. The figure for physicians in 2009 extrapolates from the 2001 data to arrive at the “around 7 billion” figure.
THE PROJECT

From 2009 through 2012, researchers at Wake Forest University Health Sciences led by Project Director Hall, examined model health care safety nets in seven communities with varying demographics and delivery systems. Each program provided uninsured low-income residents with access to a fairly complete range of medical services, with at least some coordination through a primary care medical home.

The communities included Boston; Denver; San Antonio; Asheville, N.C.; Flint, Mich.; south coastal Maine; and Exeter and Portsmouth, N.H. The programs in Boston, Denver, and San Antonio tapped traditional safety-net providers, such as public hospitals connected with medical schools and community health centers. The other programs relied on providers throughout the community, including networks of volunteer physicians.

Methodology

To complete each case study, the researchers tapped national, state, and local databases and published studies, and interviewed key stakeholders in each community, to:

- Examine the size, scope, structure, and funding of the safety-net program
- Examine access to primary care and specialist care among participants in the program
- Compare the cost of providing care through the program with the cost of providing similar services to a comparable population covered by either private insurance or Medicaid

The researchers used the Urban Institute’s Health Insurance Policy Simulation Model to evaluate the likely composition of the uninsured population and the role of safety-net organizations under federal health care reform.2

An advisory committee helped select the seven communities and the scope of the case studies, and reviewed findings and reports. See Appendix 1 for a list of members.

Communications

The researchers wrote eight journal articles (six have been published and two are in press as of the posting of this report), seven reports, two issue briefs, and a book chapter on this work.

The researchers also gave presentations at two national conferences, and participated in a webinar hosted by the Association for Community Health Improvement.

See the Bibliography for more information.

2 The Kaiser Commission on Medicaid and the Uninsured, Stoneman Foundation and RWJF funded the development of this model.
Other Funding

The Maine Health Access Foundation funded an analysis of data in that state with a $10,000 grant to the University of Southern Maine.

FINDINGS

The researchers reported the following findings in journal articles, reports, and issue briefs, and in a report to RWJF. (See Appendix 2 for findings on each program.)

- **In five communities with a coordinated safety net offering primary care, hospital care, prescription drugs, and most specialist services, participants received levels of care comparable to those obtained by insured residents.** The communities were Asheville, N.C.; Boston; Denver; Flint, Mich.; and San Antonio.

  — Participants reported visits to physicians at rates similar to those of local and national insured populations. However, participants in two communities that relied on uncompensated care—Asheville and Flint—used hospitals less often than their local and national counterparts.

  — Participants in comprehensive safety-net programs often fail to realize that they lack insurance, or consider their coverage similar to insurance. This suggests that comprehensive safety nets provide at least adequate care.

  — However, safety-net participants in these five communities did not report more access to a usual source of care—or less difficulty obtaining needed care—than uninsured residents in communities without comprehensive safety nets. The researchers surmised that surveys (in person, by mail, and by telephone) may fail to find people who are both low income and uninsured.

- **The average cost of care per member per month in four communities—Asheville, Flint, Denver, and San Antonio—in 2008 was 25 to 50 percent less than the average cost of providing similar services through Medicaid and private insurance.**

  — The cost of care per adult per month averaged $141 to $149 in three programs, and $209 in Denver for more comprehensive benefits that included dental care and extensive mental health services. Providing services to the same patients through private or public insurance would have cost $217 to $347.

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4 Hall MA, Hwang W and Jones AS. “Model Safety-Net Programs Could Care for the Uninsured at One-Half the Cost of Medicaid or Private Insurance.” Health Affairs, 30(9): 1698–1707, 2011. Available at [http://content.healthaffairs.org/content/30/9/1698.full?ijkey=dveS6bA3f5Mz2&keytype=ref&siteid=healthaff](http://content.healthaffairs.org/content/30/9/1698.full?ijkey=dveS6bA3f5Mz2&keytype=ref&siteid=healthaff).
— These costs might have been 5 to 20 percent higher if they had included the value of donated prescription drugs. However, overall costs would still have been significantly lower than costs under Medicaid and private insurance.

— Safety-net programs were not as comprehensive as generous insurance plans, and did not allow participants to choose their providers. The Denver and San Antonio programs required copayments based on income.

— These findings suggest that model safety nets could provide services to both low-income and middle-income uninsured residents.

• **An analysis done before the Supreme Court’s ruling on the ACA, under the assumption that all states would implement the act in full in 2011, found that it would have reduced the number of nonelderly uninsured people by 28 million—from 18.9 percent to 8.7 percent.** However, 23 million adults and children would have remained uninsured. The share of nonelderly uninsured residents in each state would have ranged from 1.1 percent in Massachusetts to 12.8 percent in Texas.

If the act had been implemented in full in 2011, of 19 million uninsured nonelderly adults, only:

— 37 percent would have been eligible for Medicaid but unenrolled. These residents would have been mostly relatively young singles without dependents.

— 25 percent would have been undocumented immigrants. More than half would have had incomes below 138 percent of the federal poverty level, so Medicaid would have covered their emergency care.

— 16 percent would have been exempt from the individual mandate because of a lack of affordable options. These residents would largely have been older adults with relatively low incomes.

— 15 percent of uninsured adults would have been subject to the mandate, having an affordable private insurance option despite not qualifying for a subsidy. These adults would have had relatively high incomes and most would have had dependents.

— 8 percent would have been eligible for subsidized coverage through health exchanges but unenrolled. These would have been mostly younger singles without dependents.

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Conclusions

- The nation could achieve near-universal coverage by combining safety net programs with expanded public and private insurance under the Affordable Care Act. However, organizations that provide safety-net care would need to adapt to the needs of the people who remain uninsured.  

  - These organizations are important in helping low-income residents maintain access to care until reform is completely enacted. They could also play a critical role in helping people enroll in health coverage afforded by the act, and in mitigating short-term gaps in access to care when their financial status changes.

  - Safety-net organizations could serve a wider socioeconomic spectrum, including residents above the poverty line, because of the act. To do so, these organizations would need to design new programs and adopt sliding fee scales for people exempt from the insurance mandate.

LESSON LEARNED

1. When the health care legal landscape changes during a project, look for opportunities to study the new terrain. When Congress passed the Affordable Care Act in March 2010 during the project, the researchers began examining challenges to the safety net arising from the reform. (Project Director/Hall)

AFTERWARD

Project Director Hall is advising several of the case study communities and safety-net organizations on adapting to the provisions of the ACA.

He also coedited a book on health care safety nets in a post-reform world with Sara Rosenbaum, JD, published by Rutgers University Press in 2012. RWJF has supported this work through its Investigator Awards in Health Policy Research program.

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7 According to the Henry J. Kaiser Family Foundation’s website ([http://policyinsights.kff.org/2012/march/the-individual-mandate-how-sweeping.aspx](http://policyinsights.kff.org/2012/march/the-individual-mandate-how-sweeping.aspx)), Health Reform Choice, the mandate’s exemptions cover a variety of people, including: members of certain religious groups and Native American tribes; undocumented immigrants (who are not eligible for health insurance subsidies under the law); incarcerated individuals; people whose incomes are so low they do not have to file taxes (currently $9,500 for individuals and $19,000 for married couples); and people for whom health insurance is considered unaffordable (where insurance premiums after employer contributions and federal subsidies exceed 8% of family income).

8 Grant ID# 60418 to Rutgers University to foster collaborative work by groups of investigators around health policy issues of common interest and important national relevance.
APPENDIX 1

Advisory Committee

(Current as of the end date of the program; provided by the program’s management; not verified by RWJF.)

Lynn Blewett, PhD
Associate Professor
Division of Health Policy and Management, and School of Public Health
University of Minnesota
Minneapolis, Minn.

Robert L. Phillips, Jr., MD, MSPH
Director
Robert Graham Center: Policy Studies in Family Medicine and Primary Care
Washington, D.C.

Randall R. Bovbjerg, JD
Senior Fellow
Health Policy Center
Urban Institute
Washington, D.C.

Marsha Regenstein, PhD
Director
National Public Health and Hospital Institute
George Washington University
Washington, D.C.

Peter Cunningham, PhD
Senior Fellow and Director of Quantitative Research
Center for Studying Health System Change
Washington, D.C.

Thomas Ricketts III, PhD, MPH
Professor and Managing Director
Cecil G. Sheps Center for Health Services Research
University of North Carolina
Chapel Hill, N.C.

Leighton Ku, PhD
Director
Center for Health Policy Research
George Washington University
Washington, D.C.

Sara Rosenbaum, JD
Harold and Jane Hirsh Professor of Health Law and Policy
Department of Health Policy
George Washington University
Washington, D.C.

Marion Ein Lewin
Independent Health Policy Consultant
(Former Senior Staff Officer
Institute of Medicine)
Chevy Chase, Md.

Leiyu Shi, DrPH, MBA, MPA
Professor and Co-Director
Primary Care Policy Center for the Underserved
Johns Hopkins University
Baltimore, Md.

Suzanne Felt-Lisk, PhD
Senior Health Researcher
Mathematica Policy Research
Washington, D.C.

Stephen Zuckerman, PhD
Senior Fellow
Health Policy Center
Urban Institute
Washington, D.C.

Jonathan Oberlander, PhD
Professor
Department of Social Medicine
University of North Carolina
Chapel Hill, N.C.
APPENDIX 2

More Findings from the Case Studies

(Current as of the end date of the program; provided by the program’s management; not verified by RWJF.)

Boston Medical Center’s CareNet, Boston (before state health reform took effect in 2007)

- In 2006, the program enrolled about 30,000 people per month, or 30 percent of low-income adults in Suffolk County. The income eligibility threshold was 200 percent of the federal poverty level.

- The program resembled a health maintenance organization (HMO), tapping a network of primary and specialty care providers affiliated with the inpatient Boston Medical Center, and charged minimal copayments for office visits and prescription drugs.

- All low-income, disadvantaged patients participated in the same system, whether through Medicaid or the safety-net program.

- According to interviewees in an earlier study, Medicaid and uninsured patients “think they are in the same plan.” A 2009 survey indicated that participants were generally satisfied with their access to care.

- The average cost per person per month was $241—17 percent to 20 percent lower than the cost of covering the same population under Commonwealth Care, the state’s new subsidized insurance program, in 2007.

The report on this case study is available online.

Denver Health, Denver

- In 2008, the program enrolled 26,118 people per month, or 56 percent of low-income adults in Denver County. The income eligibility threshold was 250 percent of the federal poverty level.

- The program relied on county health centers and medical school staff for care, and charged for most services on a sliding scale, with a cap on total copayments of 10 percent of income.

- Uninsured patients used care at rates similar to or above national rates for nonelderly adults, most of whom were insured.

- The cost per person per month averaged $200. Medicaid coverage for participants would have cost $273.

The full text of the report is available online.
CareLink, Bexar County (San Antonio)

- In 2008, the program enrolled 41,252 people per month, or about 25 percent of the low-income adults in Bexar County. The income eligibility threshold was 200 percent of the federal poverty level.

- The program provided the full range of services typically covered by commercial and Medicare insurance, with primary care offered by 16 clinics and offices, and most specialist and hospital services provided by the county’s University Hospital and affiliated medical faculty and residents.

- The program billed itself as a “financial assistance program,” requiring patients to pay a portion of the cost of most services, and reimbursing all providers.

- Earlier focus groups and interviews had suggested that the program provides high-quality care, but an internal report indicated constraints on access to specialist services.

- The cost for adult participants averaged $147 to $175 per month, compared with $321 for commercial insurance and $441 for Medicaid for those participants.

The full text of the report is available online.

Project Access, Buncombe County (Asheville), N.C.

- In 2008, the program enrolled about 6,000 people per month, or 35 percent of the low-income adults of Buncombe County. The income eligibility threshold was 175 percent of the federal poverty level.

- The program focused on specialist services—provided through a network of more than 600 volunteer physicians—to complement primary care provided through county clinics, and relied on charity care for hospital services.

- Key informants reported that the program met demand for most specialty services, but that demand for primary care services exceeded the county’s capacity. Many uninsured people may have had access only to urgent, episodic, or short-term care.

- The county safety-net system met the needs of participants at a level between that of residents with insurance and uninsured residents.

- Care for adult participants averaged $149 per person per month. Medicaid coverage would have cost $302.

The full text of the report is available online.
Genesee Health Plan, Genesee County (Flint), Mich.

- In 2008, the program enrolled 21,669 people, or almost all low-income adults in the Genesee County area. The income eligibility threshold was 175 percent of the federal poverty level.
- The program relied on a network of 192 primary care physicians, 289 specialists, and hospitals that provided charity care; it charged minimal copayments.
- Members reported primary care and wellness visits comparable to those of county residents with commercial insurance, but had half the rate of specialist visits, possibly because of care management.
- Annual surveys indicated that patients were satisfied with the program’s services, and that participants considered the program a form of insurance.
- Care for adult members averaged $141 per person per month, compared with $217 if provided by a commercial HMO, and $316 under Medicaid.

The full text of the report is available online.

CarePartners, South Coastal Maine

- The program capped 2008 enrollment at 1,080 people with incomes below 175 percent of the federal poverty level.
- The program covered nearly a full range of services, including all hospital-based services. It relied on a network of more than 850 volunteer physicians and seven hospitals operated by MaineHealth, based in Portland.
- Participants in the program used the emergency room substantially less often than nondisabled adults on Medicaid in the area, and at a rate similar to that reported by Maine residents with private insurance. Hospitalization rates were similar to those for local adults on Medicaid.
- Surveys from 2001 to 2003 showed that members were somewhat or very satisfied with their care.
- Care for adult members averaged $308 per person per month. Medicaid coverage for a similar population would have cost $340.

The full text of the report is available online.

SeaCare, Exeter and Portsmouth, N.H.

- In 2010, the program enrolled 2,290 adult participants with incomes below 185 percent of the federal poverty level.
- The program relied on a network of 400 volunteer physicians across all specialties. The program did not provide hospital services, complex diagnostic imaging, or
prescription drugs. Members paid flat-rate copayments or discounted fees, depending on the service.

- A community-needs assessment by Exeter Hospital showed that 82 percent of people below 300 percent of the federal poverty level had a primary care physician—comparable to the rate among the insured population nationwide.

- Care for adult members averaged $131 per person per month, compared with an average premium for private insurance of $453 per month.

The full text of the report is available online.
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