

Resources on the Health Care Safety Net – Part I

Mark A. Hall, Wake Forest University
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Safety Net: General Descriptions, Overviews, Resources, and Commentaries

Andrulis DP, Siddiqui NJ. Health reform holds both risks and rewards for safety-net providers and racially and ethnically diverse patients. *Health Aff (Millwood)*. 2011 Oct;30(10):1830-6.

The Affordable Care Act of 2010 creates both opportunities and risks for safety-net providers in caring for low-income, diverse patients. New funding for health centers; support for coordinated, patient-centered care; and expansion of the primary care workforce are some of the opportunities that potentially strengthen the safety net. However, declining payments to safety-net hospitals, existing financial hardships, and shifts in the health care marketplace may intensify competition, thwart the ability to innovate, and endanger the financial viability of safety-net providers. Support of state and local governments, as well as philanthropies, will be crucial to helping safety-net providers transition to the new health care environment and to preventing the unintended erosion of the safety net for racially and ethnically diverse populations.

Billings J, Weinick RM. Tools for monitoring the health care safety net. 2003 Rockville, MD, Agency for Healthcare Research and Quality. <http://archive.ahrq.gov/data/safetynet/>

Tools for Monitoring the Health Care Safety Net offers strategies and concrete tools for assessing local health care safety nets. With topics ranging from estimating the size of local uninsured populations to using administrative data to presenting information to policymakers, it can assist State and local health officials, planners, and analysts in assess the capacity and viability of their existing safety net providers as well as understand the characteristics and health outcomes for the populations served.

Blewett LA, Beebe TJ. State efforts to measure the health care safety net. *Public Health Reports* 2004; 119(2):125-135.

<http://www.publichealthreports.org/archives/issueopen.cfm?articleID=1353>

This article describes the role states could play in a national effort to measure and monitor the public health safety net. The authors developed a data collection framework using information from five states on two components of the safety net: structure and demand. Because states are the primary vehicle for access expansions and programs to care for the poor, the authors suggest that they be the primary coordinating mechanism for data collection on the safety net. Because the necessary mechanisms for more uniform standards or criteria to evaluate state data collection



activities and capacity remain undeveloped, they recommend using existing data to begin building state capacity to measure and monitor the safety net.

Bornemeier J. *The Robert Wood Johnson Foundation's safety net programs.* In: **Issacs S, Knickman J, Lavizzo-Mourey R, editors.** To improve health and health care: the Robert Wood Johnson Foundation anthology, Vol. IX. Jossey-Bass, 2006.

Bovbjerg RR, Cuellar AE, Holahan J. Market competition and uncompensated care pools. 2000, The Urban Institute. <http://www.urban.org/UploadedPDF/occa35.pdf>

This paper reports on three states that have long used pools to pay for uncompensated or charitable care, which spread costs beyond the hospital providing the care. Massachusetts, New Jersey, and New York began pooling under comprehensive hospital regulation in the 1980s, but the pools remain important in the competitive era of the 1990s. The authors conclude with a policy discussion of these pools' efforts to raise and redistribute funds equitably and efficiently. Pools are an intermediate policy option between broad, insurance-based strategy and narrow reliance on public hospitals. They seem of most utility to states with a tradition of relying on private as well as public hospitals for safety net care.

Bovbjerg RR, Marsteller JA, Ullman FC. Health care for the poor and uninsured after a public hospital's closure or conversion. 39. 2000, The Urban Institute. http://www.urban.org/UploadedPDF/309647_occa39.pdf

This project conducted in-depth case studies of five localities that stopped operating their public hospitals. In three of the sites studied, the loss of the public hospital occurred in 1995–97, reflecting the current competitive dynamics in health care. Two privatizations occurred decades before, providing some long-term comparative perspective. The recent changes all explicitly created new, alternative programs for supporting and managing indigent care. In each locality, the case studies assessed the reasons for change, the nature of the transition, the design of the resulting safety net, and what happened to care for the poor after privatization.

Buettgens M, Hall MA. Who will be uninsured after health insurance reform? 2011 The Urban Institute <http://www.rwjf.org/files/research/71998.pdf>

The Patient Protection and Affordable Care Act (ACA) will expand insurance coverage by about 30 million people. Although this still falls short of universal coverage, the number of uninsured people will be reduced by more than half. This brief analyzes the likely composition, state by state, of those who will remain uninsured. This information can assist states and communities in health policy planning on several fronts. Principally, knowing more about who will remain uninsured will assist safety net providers, organizations, and support systems to determine ongoing needs for uninsured access and the optimal structures for meeting those needs.

Coye MJ, Partida Y, Rosenfeld S, Bui-Tong N, Tsui E. Care management programs for the uninsured with a conceptual framework and sample tools to guide development. 12-20-2000, The Lewin Group. <http://www.lewin.com/publications/Publication/204/>

This report will help the executive leadership of safety-net organizations assess the benefits of, and determine whether or not to invest in care management programs as well as provide a “road map” for the design and implementation of care management programs. This is a report *and* a how-to guide in one. The report explains the business environment that supports investments in care management programs for the indigent, chronically ill, uninsured population. Additionally, it draws on the experiences of safety net providers to help decision-makers assess the value of these programs in their environment. Using results from expert interviews, case studies, site visits, and the successes and challenges of 24 safety-net providers, the how-to guide specifically describes how care management programs are developed and provides a sampling of tools designed by health centers, hospital networks, and health plans to enable others to build on these efforts.

Cunningham P, Hadley J. Expanding care versus expanding coverage: how to improve access to care. Health Affairs (Millwood) 2004; 23(4):234-244. <http://content.healthaffairs.org/cgi/reprint/23/4/234>

The Bush administration has proposed expanding insurance coverage as well as community health centers (CHCs) to increase access to care for uninsured people. This paper examines the relative effects of insurance coverage and CHC capacity on access to care. Communities that have both high insurance coverage and extensive CHC capacity tend to have the best access, although the former appears more important. Funding of insurance coverage expansions is likely to produce greater gains in access than if an equivalent level of funding were invested in CHCs. Policymakers should consider CHC expansions as complementary to insurance coverage expansions rather than as a substitute.

Cunningham PJ, Bazzoli GJ, Katz A. Caught in the competitive crossfire: safety-net providers balance margin and mission in a profit-driven health care market. Health Affairs (Millwood) 2008; 27(5):w374-w382. <http://content.healthaffairs.org/cgi/reprint/27/5/w374>

This paper describes how intensifying competitive pressures in the health system are simultaneously driving increased demand for safety-net care and taxing safety-net providers' ability to maintain the mission of serving all, regardless of ability to pay. Although safety-net providers adapted to previous challenges arising from managed care, health system pressures have been more intense and more generalized across different sectors in recent years than in the past. Providers are adopting some of the same strategies being used in the private sector to attract higher-paying patients and changing their "image" as a safety-net provider.

Cunningham PJ. The healthcare safety net: what is it, what good does it do, and will it still be there when we need it? Harvard Health Policy Review 2007; 8(2):5-15. <http://www.hcs.harvard.edu/~hhpr/currentissue/Fall2007.pdf>

The article attempts to put into perspective the current role of the safety net as providers of care to the uninsured, emphasizing in particular what uninsured people themselves identify as sources of free or discounted medical care. It also summarizes research on the effects of the safety net on access to care, and how expansions of the safety net compare to insurance coverage expansions as a method for increasing access. Finally, the article discusses how the safety net is changing, in particular, how safety net providers are being subjected to pressures in the healthcare market that may result in some having to compromise their mission of serving the medically indigent.

Davidson PL, Andersen RM, Wyn R, Brown ER. A framework for evaluating safety-net and other community-level factors on access for low-income populations. *Inquiry* 2004; 41(1):21-38. http://www.inquiryjournalonline.org/doi/pdf/10.5034/inquiryjrnl_41.1.21

The framework presented in this article extends the Andersen behavioral model of health services utilization research to examine the effects of contextual determinants of access. A conceptual framework is suggested for selecting and constructing contextual (or community-level) variables representing the social, economic, structural, and public policy environment that influence low-income people's use of medical care. Contextual variables capture the characteristics of the population that disproportionately relies on the health care safety net, the public policy support for low-income and safety-net populations, and the structure of the health care market and safety-net services within that market. Until recently, the literature in this area has been largely qualitative and descriptive and few multivariate studies comprehensively investigated the contextual determinants of access. The comprehensive and systematic approach suggested by the framework will enable researchers to strengthen the external validity of results by accounting for the influence of a consistent set of contextual factors across locations and populations.

Eisert SL, Mehler PS, Gabow PA. Can America's urban safety net systems be a solution to unequal treatment? *Journal of Urban Health* 2008; 85(5):766-778.

Eliminating disparities in care for racial and ethnic minorities remains a challenge in achieving overall quality health care. One approach to resolving issues of inequity involves utilizing an urban safety-net system to address preventive and chronic care disparities. An analysis was undertaken at Denver Health (DH), an urban safety net which serves 150,000 patients annually, of which 78% are minorities and 50% uninsured. Medical charts for 4,795 randomly selected adult patients at ten DH-associated community health centers were reviewed between July 1999 and December 2001. Logistic regression was used to identify differences between racial/ethnic groups in cancer screening, blood pressure control, and diabetes management. No disparities in care were found, and in most instances, the quality of care met or exceeded available benchmarks, leading us to conclude that treatment in urban integrated safety net systems committed to caring for minority populations may represent one approach to reducing disparity.

Felland LE, Lauer J, Cunningham PJ. Suburban poverty and the health care safety net. 2009, Center for Studying Health System Change. <http://www.hschange.com/CONTENT/1074/1074.pdf>

This study provides a community-level examination of the suburban safety net: the health care providers and services available to low-income people in the suburbs. It is not limited to individuals strictly defined as poor, or those with incomes at or below the federal poverty level, or \$22,050 for a family of four in 2009, because the income level of the population served by safety net providers is broader – usually at least two times the federal poverty level. The study examined five metropolitan areas – Boston, Cleveland, Indianapolis, Miami and Seattle – including two suburban areas in each with rising poverty rates (see Data Source). All five areas have relatively extensive safety nets in their central-city areas that benefit from longstanding public financial support.

Felt-Lisk S, McHugh M, Howell E. Study of safety net provider capacity to care for low-income uninsured patients. 2001, Mathematica Policy Research, Inc. <http://www.mathematica-mpr.com/PDFs/safetynet.pdf>

In late 1999 HRSA and OASPE jointly funded a study of Safety Net Provider Capacity to Care for Low-Income Uninsured Patients. The study built on the 1999 Institute of Medicine (IOM) report entitled *America's Health Care Safety Net: Intact but Endangered*. The report concluded that, owing to the combined impact of several forces, safety nets are fragile and at risk. In particular, the study noted the importance of recognizing the fact that local safety nets are composed of various types of providers organized in different configurations in different environments.

Forrest CB, Whelan EM. Primary care safety-net delivery sites in the United States: A comparison of community health centers, hospital outpatient departments, and physicians' offices. *JAMA* 2000; 284(16):2077-2083.

The objective of the study was to develop and contrast national profiles of patient and service mix for primary care. Comparative analyses was done of 3 national surveys of primary care visits occurring in 1994: for data on physician's office visits, the National Ambulatory Medical Care Survey (NAMCS); for hospital outpatient department data, the National Hospital Ambulatory Medical Care Survey (NHAMCS); and for data on community health centers, the Bureau of Primary Health Care's 1994 Survey of Visits to Community Health Centers. A time trend analysis also was conducted using the 1998 NAMCS and NHAMCS. The study concluded that expanding community health centers will likely improve access to primary care for vulnerable US populations. However, enhancing access to of physicians' offices is also needed to bolster the safety net. The greater service intensity and poorer continuity for primary care visits in hospital outpatient departments that were observed raised concern about the suitability of these clinics as primary care delivery sites.

Gresenz CR, Rogowski J, Escarce JJ. Individuals' use of care while uninsured: effects of time since episode inception and episode length. *Journal of the National Medical Association* 2008; 100(12):1394-1404.

Few studies have addressed how an individual's use of care may vary over the course of an episode of their being uninsured or across uninsured episodes of varying duration. This research

models the probability that an uninsured individual has: a) any medical expenditures or charges, and b) any office-based visit during each month of an uninsured episode. We find that the ultimate length of an individual's episode of being uninsured bears relatively little on individuals' use of healthcare in any particular month. We also find that the probability of healthcare utilization rises during the first year of the episode, with more use in the second 6 months of the year compared to the first 6 months.

Hadley J, Cravens M, Coughlin T, Holahan J. Federal spending on the health care safety net from 2001-2004: has spending kept pace with the growth in the uninsured? 2005, The Henry J. Kaiser Family Foundation. <http://www.kff.org/uninsured/upload/Federal-Spending-on-the-Health-Care-Safety-Net-from-2001-2004-Has-Spending-Kept-Pace-with-the-Growth-of-the-Uninsured-Report.pdf>

This report updates the earlier analysis of federal spending in 2001 to support the cost of uncompensated care by tracking spending trends between 2001 and 2004. The analysis is limited to federal spending because of its dominant role in funding the health care safety net and because data on state and local spending, which accounted for about one-third of all government spending on uncompensated care in 2001, are not readily available for 2003 and 2004. Each of the major components of federal spending on uncompensated care is examined, through the Medicare and Medicaid programs, the Veterans Health Administration, the Indian Health Service, the Ryan White CARE program for people living with HIV and AIDS, and grant programs to support community health centers, maternal and child health clinics, and National Health Service Corps sites in medically underserved communities.

Hadley J, Cunningham P, Hargraves JL. Would safety-net expansions offset reduced access resulting from lost insurance coverage? Race/ethnicity differences. *Health Affairs (Millwood)* 2006; 25(6):1679-1687. <http://content.healthaffairs.org/cgi/reprint/25/6/1679>

This study simulated whether increased community health center (CHC) funding under the Bush administration narrowed racial/ethnic gaps in access to care among low-income people. Expanded CHC funding resulted in small increases in access to care, more so for minorities than for whites. Spanish-speaking Hispanics had the largest improvements in access in the simulation. However, minorities experienced bigger drops in insurance coverage. The net result was no improvements in the access measures for Spanish-speaking Hispanics and slight decreases in access for whites, English-speaking Hispanics, and African Americans. Access gaps either remained the same or worsened slightly for English-speaking Hispanics and African Americans relative to whites.

Hadley J, Holahan J, Coughlin T, Miller D. Covering the uninsured in 2008: current costs, sources of payment, and incremental costs. *Health Affairs (Millwood)* 2008; 27(5):w399-w415. <http://content.healthaffairs.org/cgi/reprint/27/5/w399>

People uninsured for any part of 2008 spend about \$30 billion out of pocket and receive approximately \$56 billion in uncompensated care while uninsured. Government programs finance about 75 percent of uncompensated care. If all uninsured people were fully covered, their

medical spending would increase by \$122.6 billion. The increase represents 5 percent of current national health spending and 0.8 percent of gross domestic product. However, it is neither the cost of a specific plan nor necessarily the same as the government's costs, which could be higher, depending on plans' financing structures and the extent of crowd-out.

Hall MA. Getting to universal coverage with better safety-net programs for the uninsured. *Journal of Health Politics Policy and Law* 2011; 36(3):521-526.
<http://jhppl.dukejournals.org/content/36/3/521.long>

Hall MA. Approaching universal coverage with better safety-net programs for the uninsured. *Yale Journal of Health Policy Law and Ethics* 2011; 11(1):9-19.

Hall MA. The mission of safety net organizations following national insurance reform. *Journal of General Internal Medicine* 2011; 26(7):802-805.
<http://www.springerlink.com/content/j9337vhh68735015/>

National health insurance reform will pose considerable challenges to the core missions of safety net organizations that serve the uninsured. Those who currently donate money or time will, rightly or wrongly, view uninsured recipients as less deserving on the whole. Nevertheless, safety net organizations can serve several critical functions that continue to justify their existence and support. One important mission is to maintain access for low-income uninsured until all elements of insurance reform are fully in place. Second, once the reform is implemented, people will need a great deal of assistance and encouragement to determine what they are supposed to do and where they are supposed to sign up. Third, substantial portions of the remaining uninsured will continue to lack affordable insurance options, and large numbers of people eligible for coverage will unavoidably undergo temporary gaps in coverage as their family and financial circumstances change. Finally, not all people with insurance will have affordable access to all needed care. Market conditions will continue pushing higher levels of patient cost-sharing through deductibles and co-payments. To serve these multiple needs, safety net organizations should consider adapting their missions and business models so that they accept both insured and uninsured patients under a sliding fee scale that varies charges according to ability to pay.

Hall MA. Rethinking safety-net access for the uninsured. *The New England Journal of Medicine* 2011; 364(1):7-9. <http://www.springerlink.com/content/j9337vhh68735015/>

Hegner RE. The health care safety net in a time of fiscal pressures. 2001, National Health Policy Forum. http://www.nhpf.org/library/background-papers/BP_SafetyNet_4-01.pdf

The paper reviews the recurrent choice in U.S. health care policy between underwriting public insurance coverage and subsidizing direct provision of health care. After noting reasons for direct federal interest in the safety net and the major findings of the IOM report, the paper looks at the

distinction between core safety-net providers and other health care providers offering safety-net services as well as at local variation in the safety net. The paper then turns to what is known about uninsured Americans and the determinants, dynamics, and medical consequences of uninsurance. Also reviewed are the financial underpinnings of the safety net, including Medicaid (its major source of funding), Medicare, and the intricate system of cross-subsidies that allow safety-net providers to offer uncompensated care. Referencing the principal threats that confront the safety net, such as managed care and competition for insured patients, possible cuts in direct and indirect subsidies, and growth in the numbers of uninsured Americans, the paper goes on to examine the particular jeopardy facing hospital emergency rooms.

Hoadley JF, Felland LE, Staiti AB. Federal aid strengthens health care safety net: the strong get stronger. 2004, Center for Studying Health System Change.
<http://www.hschange.com/CONTENT/669/669.pdf>

Two new federal initiatives – community health center expansion and Community Access Program grants – have improved access to care for low-income people and strengthened linkages among safety net providers, according to findings from the Center for Studying Health System Change’s (HSC) 2002-03 site visits to 12 nationally representative communities. Grant recipients have added services to fill safety net gaps or to improve collaboration among safety net providers. However, communities with weaker safety nets were less likely to receive federal aid, and funding for both programs is limited, hampering the potential impact on the nation’s system of care for low-income and uninsured people.

Hoffman C, Starr Sered S. Threadbare: holes in america's health care safety net. 2005, The Henry J. Kaiser Family Foundation. <http://www.kff.org/uninsured/7245.cfm>

Based on interviews in five regions of the United States, the report primarily draws on the perspectives of those who provide care to the uninsured, as well as first-hand accounts of seeking care by the uninsured themselves. These interviews were obtained as part of a larger research project conducted by Susan Starr Sered and Rushika Fernandopulle, which led to the publication of their recent book entitled, *Uninsured in America*.

Holahan J, Spillman B. Health care access for uninsured adults: a strong safety net is not the same as insurance. 2002, The Urban Institute.
http://www.urban.org/UploadedPDF/310414_anf_b42.pdf

This brief examines the extent to which differences in the safety-net environment account for differences in the uninsureds’ access to and use of health care. After grouping states according to the vulnerability of various aspects of their health care safety nets, we examine whether low income uninsured adults get less care and have poorer access in states where the safety net is weaker. We then explore whether utilization and access gaps between the uninsured and the insured are narrower in states with stronger safety nets. The brief focuses on low-income adults, who are more likely to be uninsured and therefore dependent on the safety net, and on residents of metropolitan areas, where most states’ safety-net resources are concentrated.

It draws on representative samples of the population from 13 states – Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin – using data from the Urban Institute’s National Survey of America’s Families.

Institute of Medicine, Committee on the Consequences of Uninsurance. A shared destiny: community effects of uninsurance. Washington, DC: National Academies Press, 2003.

The authors cover how high rates of uninsurance affect delivery of primary care, specialty care, emergency and trauma services, and hospital care. The report reviews the economic and social effects of uninsurance, including increased pressure on local and state budgets; loss of health care providers and deterioration of local economies; demands on local tax revenues to provide care for the uninsured; loss of providers due to inadequate compensation; and the subsequent decrease in the locality's ability to attract new employers. In addition, the report shows how untreated illnesses affect public health and how high levels of uninsurance worsen competition between health care delivery and public health functions. The authors emphasize the different effects of uninsurance in rural and urban communities and suggest an agenda for further research.

Institute of Medicine, Committee on the Consequences of Uninsurance. Care without coverage: too little, too late. Washington, DC: National Academies Press, 2002.

Many Americans believe that people who lack health insurance somehow get the care they really need. Care Without Coverage: Too Little, Too Late, the second report in a series of six from the Institute of Medicine's Committee on the Consequences of Uninsurance, examines the real consequences for adults who lack health insurance. The study presents findings in the areas of prevention and screening, cancer, chronic illness, hospital-based care, and general health status. The main findings of the report are that working-age Americans without health insurance are more likely to receive too little medical care and receive it too late; be sicker and die sooner; and receive poorer care when they are in the hospital, even for acute situations like a motor vehicle crash.

Isaacs S, Jellinek P. A report to the W.K. Kellogg Foundation. 2006, Volunteer Health Care Programs. <http://www.wkkf.org/knowledge-center/resources/2007/05/Volunteer-Health-Care-Programs.aspx>

Katz MH. Future of the safety net under health reform. Journal of the American Medical Association 2010; 304(6):679-680. <http://jama.ama-assn.org/content/304/6/679.long>

Lewin ME, Altman S. America's health care safety net: intact but endangered. Washington, DC: National Academy Press, 2000.

This explains how competition and cost issues in today's health care marketplace are posing major challenges to continued access to care for America's poor and uninsured. At a time when policymakers and providers are urgently seeking guidance, the committee recommends concrete strategies for maintaining the viability of the safety net--with innovative approaches to building public attention, developing better tools for tracking the problem, and designing effective interventions.

Lewin ME, Baxter RJ. America's health care safety net: revisiting the 2000 IOM report. *Health Affairs (Millwood)* 2007; 26(5):1490-1494.

<http://content.healthaffairs.org/cgi/reprint/26/5/1490>

The committee that wrote the 2000 Institute of Medicine report on the health care safety net reconvened in 2006 to reflect on the safety net from the perspective of rising numbers of uninsured and underinsured people, the aftermath of Hurricane Katrina, high immigration levels, and new fiscal and policy pressures on care for vulnerable populations. Safety-net providers now participate in Medicaid managed care but find it difficult to meet growing needs for specialty services, particularly mental health care and affordable prescription drugs. How current state reforms and coverage expansions will affect care for the poor and uninsured is a critical issue.

Marquis MS, Rogowski JA, Escarce JJ. Recent trends and geographic variation in the safety net. *Medical Care* 2004; 42(5):408-415. <http://www.rwjf.org/pr/product.jsp?id=14634>

The objectives of this study were to investigate variations in the safety net across communities and over time and to explore the effect of market changes on the safety net. Results show that the safety net did not erode in urban areas over the study period. There was substantial variation across communities, but the disparity did not increase over time. HMO penetration and hospital competition are not significantly related to variations in the safety net, although demographic and economic factors are. Local financing capacity is a factor in variations across communities in the safety net. The economic downturn and pressures on state budgets could lead to future problems.

Phillips RL, Bazemore A, Miyoshi TJ. Mapping tools for monitoring the health care safety net. 2003 Rockville, MD, Agency for Healthcare Research and Quality.

<http://archive.ahrq.gov/data/safetynet/phillips.htm>

This chapter offers examples of work with community health centers and describes the basic elements needed from all safety net providers to create more comprehensive service maps. It includes maps of population data that demonstrate potential safety net needs, discusses sources of these data, and illustrates how to combine these data with safety net maps to examine the status of the safety net. This chapter suggests how these analyses can be used to focus clinical and policy options, community action, and political will. Lastly, it addresses how mapping tools combined with community leadership and governmental support/authority could become part of a longitudinal monitoring effort.

Redlener I, Grant R. America's safety net and health care reform--what lies ahead. *The New England Journal of Medicine* 2009; 361(23):2201-2204.
<http://www.nejm.org/doi/full/10.1056/NEJMp0910597>

Shields AE, Ginn-Shapiro M, Fronstin P. Trends in private insurance, Medicaid/State Children's Health Insurance Program, and the Healthcare Safety Net: implications for vulnerable populations and health disparities. *Annals of the New York Academy of Science* 2008; 1136:137-148.

This chapter examines trends in private and public health coverage, as well as implications for vulnerable populations and health disparities. We find that there has been erosion in employment-based health benefits. Both the percentage of employers offering coverage and the percentage of workers with coverage declined in recent years. Those with coverage face eroding benefits and increased cost sharing. Within the public sector, Medicaid enrollment has decreased, with benefits increasingly restricted. Although State Children's Health Insurance Program (SCHIP) enrollment has increased among low-income children, the future of SCHIP remains uncertain. Meeting the healthcare needs of Americans and reducing health disparities requires both the provision of health coverage to all and sufficient comprehensiveness of benefits within private and public programs to meet enrollees' healthcare needs. Our findings suggest that we have a long way to go in reaching these goals.

Siegel B, Regenstein M, Shin P. Health reform and the safety net: big opportunities, major risks. *Journal of Law Medicine and Ethics* 2004; 32(3):426-432.

Snow Jones, A, Sajid PS. A Primer on Health Care Safety Nets. 2009, Robert Wood Johnson Foundation. <http://www.rwjf.org/files/research/49869.pdf>

Spillman BC, Zuckerman S, Garrett B. Does the health care safety net narrow the access gap? 2003, The Urban Institute. http://www.urban.org/UploadedPDF/310668_DP03-02.pdf

This study examines the role of the health care safety net in increasing utilization and access for uninsured adults and narrowing the gap between the uninsured and the insured. Using data from the 1997 National Survey of American Families and county-level data on local safety net conditions, the authors estimate how insurance coverage, safety net capacity, and safety net stresses are related to physician and emergency room visits, hospital use, usual source of care, and confidence. Little variation was found in utilization and access among low-income adults by local safety net conditions, but large differences were found by insurance status, after controlling for several individual demographic characteristics. In addition, most measures of the local safety net conditions were not related to use and access differences between insured and uninsured adults. The results suggest that expanding insurance coverage would be more effective as a means of increasing use and access among low-income adults than expanding the safety net.

Spillman BC, Zuckerman S, Garrett B. Does the health care safety net narrow the access gap? 2003, The Urban Institute. http://www.urban.org/UploadedPDF/310668_DP03-02.pdf

This study examines the role of the health care safety net in increasing utilization and access for uninsured adults and narrowing the gap between the uninsured and the insured. Using data from the 1997 National Survey of American Families and county-level data on local safety net conditions, we estimate how insurance coverage, safety net capacity, and safety net stresses are related to physician and emergency room visits, hospital use, usual source of care, and confidence. We found little variation in utilization and access among low-income adults by local safety net conditions, but we found large differences by insurance status, after controlling for several individual demographic characteristics. In addition, most measures of the local safety net conditions were not related to use and access differences between insured and uninsured adults. Our results suggest that expanding insurance coverage would be more effective as a means of increasing use and access among low-income adults than expanding the safety net.

Spivey M, Kellermann AL. Rescuing the safety net. The New England Journal of Medicine 2009; 360(25):2598-2601. <http://www.nejm.org/doi/full/10.1056/NEJMp0900728>

Symposium. The safety net vs. the market: is the safety net in crisis? Health Affairs 1997; 16(4):6-150.

Waitzkin H. Commentary--the history and contradictions of the health care safety net. Health Services Research 2005; 40(3):941-952.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361178/>

Commentary on what is the health-care safety net in the United States, why is it necessary, how did it arise, and what is its future.

Weinick RM, Shin PW. Monitoring the health care safety net: developing data-driven capabilities to support policymaking. 2003 Rockville, MD, Agency for Healthcare Research and Quality. <http://archive.ahrq.gov/data/safetynet/weinick.htm>

Site visits to the four States (Arizona, Florida, Oregon, and Virginia) selected for this project were conducted in January and February 2003. This data-driven policy framework focuses on the process that evolved from those visits by which States can begin to develop their capacity for formulating data-driven policy concerning the provision, financing, and monitoring of the safety net.

Weissman JS, Moy E, Campbell EG, Gokhale M, Yucel R, Causino N et al. Limits to the safety net: teaching hospital faculty report on their patients' access to care. Health Affairs (Millwood) 2003; 22(6):156-166. <http://content.healthaffairs.org/cgi/reprint/22/6/156>

Many major teaching hospitals might not be able to offer adequate access to specialty care for uninsured patients. This study found that medical school faculty were more likely to have

difficulty obtaining specialty services for uninsured than for privately insured patients. These gaps in access were similar in magnitude for public and private institutions. Initial treatment of uninsured patients at academic health centers (AHCs) does not guarantee access to specialty and other referral services, which suggests that there are limits to relying on a health care safety net for uninsured patients. AHCs and affiliated group practices should examine policies that limit access for uninsured patients.

Young J. A comprehensive view of the U.S. health care safety net. 2003, State Health Access Data Assistance Center (SHADAC). <http://www.shadac.org/files/JeffYoung.pdf>

The objective of this paper is to develop an overview of the safety net through a comprehensive literature review, focusing specifically on how the safety net is defined, including its providers, recipients, funding sources, and measures. The paper also provides a discussion of the policy issues surrounding the safety net, as well as recommendations for future research.

Uninsured Access to and Use of Care: Descriptions and Conceptual Analyses

Blewett LA, Rodin H, Davidson G, Davern M. Measuring adequacy of coverage for the privately insured: new state estimates to monitor trends in health insurance coverage. *Medical Care Research and Review* 2009; 66(2):167-180. <http://www.rwjf.org/pr/product.jsp?id=43908>

The privately insured are assuming a greater share of the costs of their health care, yet little is known about changes in out-of-pocket spending at the state level. The central problem is that national surveys with the relevant data are not designed to generate state-level estimates. The study addresses this shortcoming by using a two-sample modeling approach to estimate state-level measures of out-of-pocket spending relative to income for privately insured adults and children. National data from the Medical Expenditure Panel Survey-Household Component and state representative data from the Current Population Survey are used. Variation in out-of-pocket spending over time and across states is shown, highlighting concern about the adequacy of coverage for 2.9% of privately insured children and 7.8% of privately insured adults. Out-of-pocket spending relative to income is an important indicator of access to care and should be monitored at the state level.

Blewett LA, Ward A, Beebe TJ. How much health insurance is enough? Revisiting the concept of underinsurance. *Medical Care Research and Review* 2006; 63(6):663-700. <http://mcr.sagepub.com/content/63/6/663.abstract>

There is little consensus on what constitutes adequate health insurance coverage. The concept of a lack of adequate coverage, or underinsurance, is a matter of ongoing debate. A measure of adequate coverage is of critical importance as the nature of health insurance products evolves. Changes to health coverage include more direct out-of-pocket spending by consumers and a reduction of covered benefits. This article updates and extends an earlier review of

underinsurance measurement published in 1993. We present a conceptual approach to measuring underinsurance and provide a review of the empirical findings obtained from the application of these approaches. A discussion of the limitations in the selection of a measurement approach includes a review of the extant data sources used. We recommend a national effort to develop a consistent approach to monitor changes in the economic and structural dimensions of health insurance coverage with a concerted effort to define and measure underinsurance.

Dubay L, Cook A. How will the uninsured be affected by health reform? 2009, The Urban Institute. <http://www.rwjf.org/files/research/47860nonelderly.pdf>

This analysis examines the nonelderly, uninsured population. The main source of data is the 2008 Annual Social and Economic Supplement to the Current Population Survey (CPS). Estimates of health insurance coverage have been adjusted for the underreporting of public coverage on the CPS. This adjustment reduced the number of uninsured by 1.1 million, all of whom were children. Information on offers of employer-sponsored coverage and non-group premiums are obtained from the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).

Families USA. Paying a premium: the added cost of care for the uninsured. 2005 http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf

This study quantifies, for the first time, the dollar impact on private health insurance premiums when doctors and hospitals provide health care to uninsured people. In 2005, premium costs for family health insurance coverage provided by private employers will include an extra \$922 in premiums due to the cost of care for the uninsured; premiums for individual coverage will cost an extra \$341.

Felt-Lisk S, McHugh M, Thomas M. Examining access to specialty care for California's uninsured. 2004, California HealthCare Foundation. <http://www.chcf.org/publications/2004/05/examining-access-to-specialty-care-for-californias-uninsured>

Freeman JD, Kadiyala S, Bell JF, Martin DP. The causal effect of health insurance on utilization and outcomes in adults: a systematic review of US studies. *Medical Care* 2008; 46(10):1023-1032.

The purpose of this study is to systemically search and review available evidence of estimated causal effects of health insurance on health care utilization and/or health outcomes among nonelderly adults in the United States. Results of the review of empirical studies that estimate causal relationships between health insurance and health care utilization and/or health outcomes consistently show that health insurance increases utilization and improves health. Specifically, health insurance had substantial effects on the use of physician services, preventive services, self-reported health status, and mortality conditional on injury and disease. These results both confirm and contradict comparable results from the RAND Health Insurance Experiment, the gold standard on relationships between health insurance, utilization, and health.

Gruber J. Covering the uninsured in the United States. *Journal of Economic Literature* 2008; 46(3):571-606.

This article surveys the major economic issues around covering the uninsured. The author reviews the facts on insurance coverage and the nature of the uninsured; explore explanations for why the United States has such a large, and growing, uninsured population; and discusses why we should care if individuals are uninsured. The author then examines policy options to address the problem of the uninsured, beginning with a discussion of the key issues and available evidence and then turning to estimates from a micro-simulation model of the impact of alternative interventions to increase insurance coverage.

Hall MA. Access to care provided by better safety net systems for the uninsured: measuring and conceptualizing adequacy. *Medical Care Research and Review* 2011; 68(4):441-61
<http://mcr.sagepub.com/content/68/4/441.long>

This descriptive study assesses the access to care provided by five model and diverse safety net programs that enroll uninsured adults in a coordinated system offering primary care, hospital care, prescription drugs, and most specialist services. Physician use by safety net program members was similar to insured groups. However, there was less use of hospitals in the two programs that relied on uncompensated charity care. Considering access measures commonly used in population-based surveys, the uninsured in these five communities fared no better than uninsured elsewhere. However, 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 identifying uninsured people in the very communities that have the best safety net programs. On balance the five safety net systems profiled here meet the needs of low-income uninsured residents at a level that is roughly similar to that for people with insurance.

Hall MA, Hwang W, Jones AS. Model safety-net programs could care for the uninsured at one-half the cost of Medicaid or private insurance. *Health Affairs (Millwood)*; 2011; 30(9):1698-707.
<http://content.healthaffairs.org/content/30/9/1698.long>

Because the reforms under the Affordable Care Act of 2010 will leave an estimated twenty million or more people still uninsured, some Americans will continue to seek care at low or no cost through existing safety-net systems. To identify appropriate care models, this comparative case study assessed the costs of care provided by four large, well-structured, comprehensive safety-net programs for the uninsured in Colorado, Michigan, North Carolina, and Texas. The average monthly resource cost-including the value of referred, donated, and in-kind services-in these model programs was \$141-\$209 per adult in 2008. This was 25-50 percent less than the estimated cost of care for comparison groups covered by local Medicaid programs or by private insurance that provided similar services. Although these programs' services are somewhat less comprehensive than those of generous insurance plans, the findings suggest that these model safety-net programs could be adapted to provide an alternative type of coverage for the uninsured, including both low-income and middle-class people.

Institute of Medicine. America's uninsured crisis: consequences for health and health care. Washington, D.C.: National Academies Press, 2009.

The growing number of uninsured Americans--totaling 45.7 million as of 2007--is taking a toll on the nation's health. One in five adults under age 65 and nearly one in ten children are uninsured. Uninsured individuals experience much more risk to their health than insured individuals. In its 2009 report *America's Uninsured Crisis: Consequences for Health and Health Care*, the Institute of Medicine points to a chasm between the health care needs of people without health insurance and access to effective health care services. This gap results in needless illness, suffering, and even death.

Kronick R. Commentary – sophisticated methods but implausible results: how much does health insurance improve health? *Health Services Research* 2006; 41(2):452-460.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702513/>

Margolin B. The uninsured debate: health insurance vs. health care access. 12-2-1999, California Association of Public Hospitals and Health Systems.

Report on presentations and a panel discussion at the 1999 annual conference of the California Association of Public Hospitals and Health Systems, "What Matters Most: Confronting the Health Care Needs of the 21st Century."

Newton MF, Keirns CC, Cunningham R, Hayward RA, Stanley R. Uninsured adults presenting to US emergency departments: assumptions vs data. *JAMA* 2008; 300(16):1914-1924.
<http://www.rwjf.org/pr/product.jsp?id=36808>

This study compares common unsupported statements about uninsured patients presenting to the ED with the best available evidence on the topic. Common assumptions supported by the evidence include assumptions that increasing numbers of uninsured patients present to the ED and that uninsured patients lack access to primary care. Available data support the statement that care in the ED is more expensive than office-based care when appropriate, but this is true for all ED users, insured and uninsured. Available data do not support assumptions that uninsured patients are a primary cause of ED overcrowding, present with less acute conditions than insured patients, or seek ED care primarily for convenience.

Pauly MV, Pagan JA. Spillovers and vulnerability: the case of community uninsurance. *Health Affairs (Millwood)* 2007; 26(5):1304-1314.

This paper studies the uninsured as a vulnerable population. We contend that reducing the size of the uninsured population yields important spillover benefits to the insured population, benefits that go beyond a lower charity care burden. Evidence presented in this paper reinforces studies in the literature that show that problems of health services quality and access facing insured people increase when the proportion of uninsured people in their local communities is

greater. The size of such spillover benefits is reduced if the local market is large enough to be segmented based on insurance status.

Ricketts TC, Goldsmith LJ. Access in health services research: The battle of the frameworks. *Nursing Outlook* 2005; 53(6):274-280. <http://www.sciencedirect.com/science/article/B6WNY-4HTM0CB-D/2/871ef3417c0f9906cc4aa1271f3cfd1b>

Background Access is an important concept in the study of the organization, financing and delivery of healthcare services. It is also an important political symbol and policy goal. **Purpose** This article reviews the major theoretical frameworks that have been used to support the study of access and measure the degree to which healthcare systems have met standards of access. **Method** The article uses a critical review of the major works of the leading theorists in the field of access studies. **Discussion** Theories of access accept that it is a dynamic process where there is the potential for individuals and families to learn and modify their behavior. That learning and adaptation is less often explored in empirical research of access to health care. **Conclusion** Researchers should consider the more dynamic aspects of access as they attempt to understand how to improve the health care delivery system. Access models can be used to direct the formulation of better health policy if they reflect real world processes.

Ross JS, Bradley EH, Busch SH. Use of health care services by lower-income and higher-income uninsured adults. *JAMA* 2006; 295(17):2027-2036.

The paper examines whether having higher income attenuates the association between being uninsured and using fewer recommended health care services. Even among higher-income adults, lack of health care insurance was associated with significantly decreased use of recommended health care services; increased income did not attenuate the difference in use between uninsured and insured adults. Efforts to improve the use of recommended health care services among the uninsured should focus on patient education and expanding insurance eligibility for both lower-income and higher-income adults.

Schwartz K, Artiga S. Health insurance coverage and access to care for low-income non-citizen adults. 2007, The Henry J. Kaiser Family Foundation. <http://www.kff.org/uninsured/upload/7651.pdf>

This brief analyzes health insurance coverage and access for low-income non-citizen adults and provides insight into the obstacles they face in obtaining coverage and receiving care. It finds that, largely due to their high uninsured rate, low-income non-citizen adults have very poor access to care. Having insurance significantly improves their access to care and increases their likelihood of receiving preventive care, but, even with insurance, they continue to face access barriers. Although they have more limited access to care, low-income non-citizen adults are not relying on the emergency room for their care. Instead, many rely on clinics and health centers.

Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics* 2004; 113(5 Suppl):1493-1498.

The paper reviews the extent to which the literature supports the position that a medical home is important and to review the extent to which insurance is related to having a medical home. A review of literature concerning the benefits of a medical home on effectiveness, costs, and equity (reducing disparities) was conducted. A medical home, with its 4 key features, provides better effectiveness as well as more efficient and more equitable care to individuals and populations. A concerted attempt to provide a means of universal financial access as well as a medical home should be of high priority for the United States.

State Health Access Data Assistance Center. State health access profile: a chartbook of health care access indicators for states. 2007.

http://www.rwjf.org/files/newsroom/interactives/shadac/downloads/profile_allstates.pdf

State Health Access Data Assistance Center. The coverage gap: a state-by-state report on access to care. 2006 <http://www.rwjf.org/files/newsroom/CoverageGap0406.pdf>

The Henry J. Kaiser Family Foundation. Covering the uninsured in 2008: key facts about current costs, sources of payment, and incremental costs. 2008.

<http://www.kff.org/uninsured/upload/7810.pdf>

The costs to individuals, families, and communities are enormous when the consequences of forgoing unaffordable health care are fully tallied. Lost health, decreased workforce productivity, developmental and educational losses among children, and shorter life spans have all been linked to being uninsured. These indirect costs are steep; with an estimated annual cost to the U.S. economy of between \$100 and \$200 billion in 2006 (Axeen and Carpenter, 2008). This report focuses on the direct costs, specifically on the costs of health care the uninsured receive, and who is paying those costs in 2008.

Ward A. The concept of underinsurance: a general typology. *Journal of Medicine and Philosophy* 2006; 31(5):499-531. <http://jmp.oxfordjournals.org/cgi/reprint/31/5/499>

In a 2002 speech, Mark McClellan, a member of the Council of Economic Advisors at the White House, said that "[I]n the president's vision, all Americans should have access to high-quality and affordable healthcare." However, many healthcare researchers believe that a growing number of Americans are underinsured. Because any characterization of underinsurance will refer to the value judgments of people about what counts as "adequate" and "inadequate" healthcare, the goal of characterizing and measuring the underinsured is difficult to achieve. In this article, I examine the various dimensions of underinsurance, and propose a typology incorporating those dimensions.

Uninsured Access to and Use of Care: Econometric and Statistical Analyses

Bazzoli GJ, Lindrooth RC, Kang R, Hasnain-Wynia R. The influence of health policy and market factors on the hospital safety net. *Health Services Research* 2006; 41(4 Pt 1):1159-1180.

The paper examines how the financial pressures resulting from the Balanced Budget Act (BBA) of 1997 interacted with private sector pressures to affect indigent care provision. The authors distinguished core and voluntary safety net hospitals in our analysis. Core safety net hospitals provide a large share of uncompensated care in their markets and have large indigent care patient mix. Voluntary safety net hospitals provide substantial indigent care but less so than core hospitals. We examined the effect of financial pressure in the initial year of the 1997 BBA on uncompensated care for three hospital groups. Data for 1996-2000 were analyzed using approaches that control for hospital and market heterogeneity. Core safety net hospitals reduced their uncompensated care in response to Medicaid financial pressure. Voluntary safety net hospitals also responded in this way but only when faced with the combined forces of Medicaid and private sector payment pressures. Nonsafety net hospitals did not exhibit similar responses. The results are consistent with theories of hospital behavior when institutions face reductions in payment. They raise concern given continuing state budget crises plus the focus of recent federal deficit reduction legislation intended to cut Medicaid expenditures.

Brown ER, Davidson PL, Yu H, Wyn R, Andersen RM, Becerra L et al. Effects of community factors on access to ambulatory care for lower-income adults in large urban communities. *Inquiry* 2004; 41(1):39-56. http://www.inquiryjournalonline.org/doi/pdf/10.5034/inquiryjrnl_41.1.39

This study examines the effects of community-level and individual-level factors on access to ambulatory care for lower-income adults in 54 urban metropolitan statistical areas in the United States. Drawing on a conceptual behavioral and structural framework of access, the authors developed multivariate models for insured and uninsured lower-income adults to assess the adjusted effects of community- and individual-level factors on two indicators of access: having a usual source of care, and having at least one physician visit in the past year. Several community factors influenced access, but they did so differently for insured and uninsured adults and for the two measures of access used. The findings of this study confirm that public policies and community environment have measurable and substantial impacts on access to care, and that expanded public resources, such as Medicaid payments and safety-net clinics, can lead to measurable improvements in access for vulnerable populations residing in large urban areas.

Cunningham PJ, Hadley J, Kenney G, Davidoff AJ. Identifying affordable sources of medical care among uninsured persons. *Health Services Research* 2007; 42(1 Pt 1):265-285. <http://www.rwjf.org/healthpolicy/product.jsp?id=18592>

This paper examines the effects of policy, health system, and socio-demographic characteristics on the likelihood that uninsured persons pay a lower price at their regular source of care, or that they are aware of lower priced providers in their community. The 2003 Community Tracking Study household survey, a nationally representative sample of the U.S. population and 60

randomly selected communities. Although increased safety-net capacity may lead to more uninsured having a lower priced provider, many uninsured who live near safety-net providers are not aware of their presence. Greater outreach designed to increase awareness may be needed in order to increase the effectiveness of safety-net providers in improving access to care for the uninsured.

Eisert SL, Mehler PS, Gabow PA. Can America's urban safety net systems be a solution to unequal treatment? *Journal of Urban Health* 2008; 85(5):766-778.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2527432/>

Eliminating disparities in care for racial and ethnic minorities remains a challenge in achieving overall quality health care. One approach to resolving issues of inequity involves utilizing an urban safety-net system to address preventive and chronic care disparities. An analysis was undertaken at Denver Health (DH), an urban safety net which serves 150,000 patients annually, of which 78% are minorities and 50% uninsured. Medical charts for 4,795 randomly selected adult patients at ten DH-associated community health centers were reviewed between July 1999 and December 2001. Logistic regression was used to identify differences between racial/ethnic groups in cancer screening, blood pressure control, and diabetes management. No disparities in care were found, and in most instances, the quality of care met or exceeded available benchmarks, leading us to conclude that treatment in urban integrated safety net systems committed to caring for minority populations may represent one approach to reducing disparity.

Gresenz CR, Rogowski J, Escarce JJ. Dimensions of the local health care environment and use of care by uninsured children in rural and urban areas. *Pediatrics* 2006; 117(3):e509-e517.

<http://pediatrics.aappublications.org/cgi/reprint/117/3/e509>

Despite concerted policy efforts, a sizeable percentage of children lack health insurance coverage. This article examines the impact of the health care safety net and health care market structure on the use of health care by uninsured children. Uninsured children had low levels of utilization over a range of different health care provider types and settings. The availability of safety net providers in the local area and the safety net's capacity to serve the uninsured influence access to care among children. Possible measures for ensuring access to health care among uninsured children include increasing the density of safety net providers in rural areas, enhancing funding for the safety net, and policies to increase primary care physician supply.

Gresenz CR, Rogowski J, Escarce JJ. Health care markets, the safety net, and utilization of care among the uninsured. *Health Services Research* 2007; 42(1 Pt 1):239-264.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955237/>

The paper assesses the relationship between utilization of care among the uninsured and the structure of the local health care market and safety net. Distances between the rural uninsured and safety net providers are significantly associated with utilization. In urban areas, we find that the percentage of individuals in the area who are uninsured, the pervasiveness and competitiveness of managed care, the primary care physician supply, and safety net capacity have a significant relationship with health care utilization. Facilitating transport to safety net

providers and increasing the number of such providers are likely to increase utilization of care among the rural uninsured. Findings for urban areas suggest that the uninsured living in areas where managed care presence is substantial, and especially where managed care competition is limited, could be a target for policies to improve the ability of the uninsured to obtain care. Policies oriented toward enhancing funding for the safety net and increasing the capacity of safety net providers are likely to be important to ensuring the urban uninsured are able to obtain health care.

Hadley J, Cunningham P. Availability of safety net providers and access to care of uninsured persons. *Health Services Research* 2004; 39(5):1527-1546.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361082/>

The objective of the paper is to understand how proximity to safety net clinics and hospitals affects a variety of measures of access to care and service use by uninsured persons. Closer proximity to the safety net increases access to care for uninsured persons. However, the improvements in access to care are relatively small compared with similar measures of access to care for insured persons. Modest expansion of the safety net is unlikely to provide a full substitute for insurance coverage expansions.

Herring B. The effect of the availability of charity care to the uninsured on the demand for private health insurance. *Journal of Health Economics* 2005; 24(2):225-252.

The economic reasons why some people do not obtain health insurance are unclear. In this paper, I test the hypothesis that the availability of charity care to the uninsured reduces the likelihood of obtaining private coverage. I utilize variation in the availability of charity care across the different markets in the Community Tracking Study's Household Survey (CTS-HS) using an "access to care" measure of the uninsured's cost-related difficulties in obtaining medical care, to both aggregate across the various "safety net" providers and control for its potentially endogenous supply. I find evidence supporting this hypothesis for low-income people, in both the individual market and the employment-based group market. I also estimate a joint model of offer and take-up decisions for the group market sample and find that the availability of charity care reduces low-income workers' offer rates but not their take-up rates.

Holahan J, Garrett B. The cost of uncompensated care with and without health reform. 2010, Urban Institute. http://www.urban.org/UploadedPDF/412045_cost_of_uncompensated.pdf

Kronick R. Health insurance coverage and mortality revisited. *Health Services Research* 2009; 44(4):1211-1231.
<http://www.cfah.org/hbns/archives/viewSupportDoc.cfm?supportingDocID=763>

The paper tried to improve understanding of the relationship between lack of insurance and risk of subsequent mortality. The Institute of Medicine's estimate that lack of insurance leads to 18,000 excess deaths each year is almost certainly incorrect. It is not possible to draw firm causal inferences from the results of observational analyses, but there is little evidence to suggest that

extending insurance coverage to all adults would have a large effect on the number of deaths in the United States.

Marquis MS. The role of the safety net in employer health benefit decisions. *Medical Care Research and Review* 2005; 62(4):435-457.

The potential for sizable crowd-out of private expenditures by public insurance and delivery programs has been demonstrated. However, there is limited evidence about whether this stems from decisions of employers about their health benefit package or by decisions of workers. This study focuses on the role of public programs on employer decisions to offer insurance and the amount the employer contributes to the premium, using data from a large survey of employers and a database describing community characteristics. The study finds that both public insurance and public delivery programs have a significant effect on employer decisions, but the magnitude of the effect is small. Policies to limit crowd-out should focus on incentives to make continued private insurance purchase attractive to workers rather than incentives to employers.

McWilliams JM. Health consequences of uninsurance among adults in the United States: recent evidence and implications. *Milbank Quarterly* 2009; 87(2):443-494.

Uninsured adults have less access to recommended care, receive poorer quality of care, and experience worse health outcomes than insured adults do. The potential health benefits of expanding insurance coverage for these adults may provide a strong rationale for reform. However, evidence of the adverse health effects of uninsurance has been largely based on observational studies with designs that do not support causal conclusions. Although recent research using more rigorous methods may offer a better understanding of this important subject, it has not been comprehensively reviewed. Based on the evidence to date, the health consequences of uninsurance are real, vary in magnitude in a clinically consistent manner, strengthen the argument for universal coverage in the United States, and underscore the importance of evidence-based determinations in providing health care to a diverse population of adults.

Rust G, Baltrus P, Ye J, Daniels E, Quarshie A, Boumbulian P et al. Presence of a community health center and uninsured emergency department visit rates in rural counties. *Journal of Rural Health* 2009; 25(1):8-16. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2711875/>

Community health centers (CHCs) provide essential access to a primary care medical home for the uninsured, especially in rural communities with no other primary care safety net. CHCs could potentially reduce uninsured emergency department (ED) visits in rural communities. The authors compared uninsured ED visit rates between rural counties in Georgia that have a CHC clinic site and counties without a CHC presence. The absence of a CHC is associated with a substantial excess in uninsured ED visits in rural counties, an excess not seen for ED visit rates among the insured.

Stanley A, Cantor JC, Guarnaccia P. Holes in the safety net: a case study of access to prescription drugs and specialty care. *Journal of Urban Health* 2008; 85(4):555-571.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2443252/>

The health care safety net in the United States is intended to fill gaps in health care services for uninsured and other vulnerable populations. This paper presents a case study of New Brunswick, NJ, a small city rich in safety net resources, to examine the adequacy of the American model of safety net care. Substantial gaps in access to care are found despite the presence of a medical school, an abundance of primary care and specialty physicians, two major teaching hospitals, a large federally qualified health center and other safety net resources in this community of about 50,000 residents. Few local areas can claim the depth of safety net resources as New Brunswick, NJ, raising serious concerns about the adequacy of the American safety net model, especially for people with complex and chronic health care needs.

Wilper AP, Woolhandler S, Lasser KE, McCormick D, Bor DH, Himmelstein DU. Health insurance and mortality in US adults. *Am J Public Health* 2009.
<http://ajph.aphapublications.org/cgi/reprint/99/12/2289>

The relationship between uninsurance and death was analyzed with more recent data. The authors conducted a survival analysis with data from the Third National Health and Nutrition Examination and found that uninsurance is associated with mortality. The strength of that association appears similar to that from a study that evaluated data from the mid-1980s, despite changes in medical therapeutics and the demography of the uninsured since that time.

Medicaid Funding for Safety Nets

Hearne J. Medicaid disproportionate share payments. 1-10-2005, Congressional Research Service, Library of Congress.
<http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/97-48301102005.pdf>

Henry J. Kaiser Family Foundation. Health centers' role as safety net providers for medicaid patients and the uninsured. 2000.
<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13457>

In order to understand the role of health centers as safety net providers, as well as the potential impact of these trends, this issue paper provides an in-depth examination of federally-funded health centers. Using data from the Uniform Data System (UDS), a government-maintained system that collects extensive patient, revenue, and service data on a calendar-year basis from health centers that receive federal grants, this issue paper profiles federally-funded health centers. It presents information on health center patients and revenue sources and analyzes similarities and differences both between health centers and private practices and among health centers. The paper also reviews trends in health center patients and funding and concludes with an assessment of current challenges facing health centers.

McKethan A, Nguyen N, Sasse BE, Kocot SL. Reforming the Medicaid disproportionate-share hospital program. *Health Affairs (Millwood)* 2009; 28(5):w926-w936.
<http://content.healthaffairs.org/cgi/content/abstract/28/5/w926>

Congress and the Obama administration are considering redirecting federal spending on the Medicaid disproportionate-share hospital (DSH) program to help pay for health reform. In this paper, we propose linking federal Medicaid DSH funding to state-level Medicaid enrollment or uninsured populations, or both. This approach could produce as much as \$44 billion in federal savings over time without exposing hospitals to uncertain or across-the-board spending cuts. It could also gradually address state variations in Medicaid DSH funding. We also offer ideas to ensure that DSH spending is more directly connected than it is now to improvements in care for vulnerable populations.

Mechanic RE. Medicaid's disproportionate share hospital program: complex structure, critical payments. 2004, National Health Policy Forum.
<http://www.nhpf.org/index.cfm?fuseaction=Details&key=527>

Rousseau D, Schneider A. Current issues in medicaid financing - an overview of IGTs, UPLs, and DSH. 2004, The Henry J. Kaiser Family Foundation.
<http://www.kff.org/medicaid/upload/Current-Issues-in-Medicaid-Financing-An-Overview-of-IGTs-UPLs-and-DSH.pdf>

States have only recently begun to emerge from one of the worst fiscal situations they have faced since World War II. At the same time, the federal government has increased its scrutiny of several controversial mechanisms states have employed in recent years to finance their share of Medicaid expenditures. The purpose of this paper is to explain briefly the mechanisms at issue and present the most recent available data on the states most affected. As discussed in the paper, although these transactions involve large sums, they represent only a small part of a much larger Medicaid program that directly benefits over 50 million low-income Americans and the health care providers that serve them. Similarly, the challenge to Medicaid financial management extends beyond these transactions.

Rowland D. Medicaid: implications for the health safety net. *New England Journal of Medicine* 2005; 353(14):1439-1441.

Medicaid, which finances the healthcare of low-income families, disabled persons and senior American citizens, is facing a financial crisis and has become the target for improvement that could basically reshape the whole program. Suggestions that it is long-term and not short-term schemes for investing in Medicaid, which will restrain costs and encourage improved control of chronic illness, disease prevention, and coordination with Medicare, are presented.

Local Safety Net Systems: In General, or Multiple Case Studies

Andrulis D, Gusmano M. Community initiatives for the uninsured: how far can innovative partnerships take us? 2000, The New York Academy of Medicine.

Baxter RJ, Mechanic RE. The status of local health care safety nets. *Health Affairs (Millwood)* 1997; 16(4):7-23.PM:9248145. <http://content.healthaffairs.org/cgi/reprint/16/4/7>

This paper examines variations in the composition, concentration, financing, and community context of local health care "safety nets" and the market pressures that they face. It also reviews financing mechanisms that support these systems and strategies being undertaken to retain publicly insured patients. As safety-net providers compete more aggressively, the availability of the public health, behavioral health, and social services they provide may be affected. Communities may have to consider more explicit investments in these "public goods" if competitive markets remove existing cross-subsidies.

Blewett LA, Ziegenfuss J, Davern ME. Local access to care programs (LACPs): new developments in the access to care for the uninsured. *Milbank Quarterly* 2008; 86(3):459-479.

New, locally based health care access programs are emerging in response to the growing number of uninsured, providing an alternative to health insurance and traditional safety net providers. Although these programs have been largely overlooked in health services research and health policy, they are becoming an important local supplement to the historically overburdened safety net. This article is based on a literature review, Internet search, and key actor interviews to document programs in the United States, using a typology to classify the programs and document key characteristics. New, locally based health access programs are being developed to meet the health care needs of the growing number of uninsured adults. These programs offer an alternative to traditional health insurance and build on the tradition of county-based care for the indigent. It is important that these locally based, alternative paths to health care services be documented and monitored, as the number of uninsured adults is continuing to grow and these programs are becoming a larger component of the U.S. health care safety net.

Brennan N, Guterman S, Zuckerman S. The health care safety net: an overview of hospitals in five markets. 2001, The Henry J. Kaiser Family Foundation.
<https://www.policyarchive.org/handle/10207/14488>

A report focusing on the circumstances facing selected safety net hospitals in five major metropolitan areas around the United States, and their responses in the context of the market conditions they face.

Caroll SS, Alteras T, Sacks H. Community-based health coverage programs: models and lessons. 2004, Community Voices Healthcare for the Underserved.
http://www.communityvoices.org/Uploads/CommunityBasedCoverageFINAL_00108_00044.pdf

The programs described in this report are not the only community-based coverage programs in the U.S. — in fact, numerous programs have emerged around the country — but this collection represents a range of up-to-date models. They vary in target population, benefit package, vehicle for coverage, size, cost, financing mechanism, lead agency, and stage of development.

Chazin S, Friedenjohn I, Martinez-Vidal E, Somers SA. The future of U.S. charity care programs: implications of health reform. 2010, Center for Health Care Strategies, Inc. <http://www.academyhealth.org/files/publications/FutureofCharityCarePrograms.pdf>

Coye MJ, Partida Y, Rosenfeld S, Bui-Tong N, Tsui E. Care management programs for the uninsured with a conceptual framework and sample tools to guide development. Dec. 2000, The Lewin Group. <http://www.lewin.com/publications/Publication/204>

This report will help the executive leadership of safety-net organizations assess the benefits of, and determine whether or not to invest in, care management programs as well as provide a “road map” for the design and implementation of care management programs. This is a report *and* a how-to guide in one. The report explains the business environment that supports investments in care management programs for the indigent, chronically ill, uninsured population. Additionally, it draws on the experiences of safety-net providers to help decision-makers assess the value of these programs in their environment. Using results from expert interviews, case studies, site visits, and the successes and challenges of 24 safety-net providers, the how-to guide specifically describes how care management programs are developed and provides a sampling of tools designed by health centers, hospital networks, and health plans to enable others to build on these efforts.

Felt-Lisk S, McHugh M, Howell E. Monitoring local safety-net providers: do they have adequate capacity? *Health Affairs (Millwood)* 2002; 21(5):277-283. <http://content.healthaffairs.org/cgi/reprint/21/5/277>

The safety-net providers that serve the nation's thirty-nine million uninsured residents are vulnerable organizations even in good economic times, yet efforts to monitor their capacity have been limited at best. This study of the safety-net in five cities found that capacity was strained for specialty services and that access to pharmaceuticals was difficult, while primary care capacity was more often adequate to serve those who presented themselves for care. Also, free clinics grew during the 1990s, while many other safety-net providers focused on improving their efficiency and collecting more fees from patients.

Hall MA. The costs and adequacy of safety net access for the uninsured. 2010, Robert Wood Johnson Foundation. <http://www.rwjf.org/healthpolicy/product.jsp?id=49869>
In May 2009, the Robert Wood Johnson Foundation (RWJF) awarded a two-year grant to examine well-functioning safety nets that provide low-income patients affordable access to comprehensive care. As part of the project, several case studies highlight better-functioning safety nets in both metropolitan and rural settings. The safety net systems examined include Boston Medical

Center's CareNet program in Boston, Mass.; Denver Health in Denver, Colo.; CareLink in San Antonio, Texas; Project Access in Asheville, N.C.; Genesee Health Plan in Flint, Mich.; Care Partners in south coastal Maine; and SeaCare in Exeter and Portsmouth, New Hampshire. Each case study assesses how these systems allow for low-income uninsured people to have access to a fairly complete range of medical services and evaluates the available data regarding the structure, adequacy and costs of the systems.

Hasnain-Wynia R. Overview of the community care network demonstration program and its evaluation. *Medical Care Research and Review* 2003; 60(4 Suppl):5-16.

<http://www.rwjf.org/pr/product.jsp?id=14605>

This article provides an overview of the evaluation of the National Community Care Network Demonstration Program, which began with 25 public-private partnerships selected from a diverse range of communities across the United States to address problems of lack of insurance, limited access to health care, and the health status of their most disadvantaged residents. The 25 public-private partnerships included an array of individual organizations representing health care providers, public health and human service agencies, local governments, community-based organizations, and religious and educational institutions. The specific findings of the evaluation are the focus of the articles in this issue. This overview article supplies the underpinnings of the evaluation, including the conceptual framework, methodological challenges, and a brief discussion of each of the papers and how they are linked.

Lutzky AW, Holahan J, Wiener JM. Health policy for low-income people: profiles of 13 states. 2002, The Urban Institute. http://www.urban.org/UploadedPDF/310490_ANF_OP57.pdf

This report provides brief summaries of the findings from 13 states. Not surprisingly, states differ considerably in terms of their long- and short-term fiscal circumstances as well as their policy objectives. Therefore, it is difficult to draw conclusions that would apply in all states. Nonetheless, the following key points emerge from the state summaries.

Meyer JA, Legnini MW, Fatula EK, Stepnick LS. The role of local governments in financing safety net hospitals: Houston, Oakland, and Miami. 1999, The Urban Institute.

http://www.urban.org/UploadedPDF/309102_occa25.pdf

This study examines how safety net hospital systems in three large urban areas—Houston/Harris County, Texas; Oakland/Alameda County, California; and Miami-Dade County, Florida—are struggling with how to fund hospital care for people who lack health coverage. The study covered the Harris County Hospital District (HCHD) system in Houston/Harris County, composed of the Lyndon Baines Johnson and Ben Taub Hospitals; Highland Hospital in Oakland/Alameda County; and Jackson Memorial Hospital in Miami-Dade County. Each of these hospitals provides a significant portion of the safety net services within its local area.

Minyard K, Chollet D, Felland L, Loneragan L, Parker C, Smith TA et al. Lessons from local access initiatives: contributions and challenges. 2007, The Commonwealth Fund.
http://www.commonwealthfund.org/usr_doc/Minyard_lessonslocalaccessinitiatives_1050.pdf

Community health initiatives – locally crafted responses to health care access problems – have been steadfast in their efforts to connect uninsured and medically indigent people to health care services and health insurance. These programs assist in outreach, coordinate and integrate care, and help clients use limited resources efficiently. This report offers five case studies of community health initiatives. All five local community initiatives seek to improve access and coverage for those most likely to be uninsured: low-income, nonelderly adults. Some, like Community Health Works in Forsyth, Ga., offer coverage for a limited period of time, often for individuals who seek care after contracting an illness, while others, like Choice Regional Health Network, in Olympia, Wash., manage care for clients with complex needs, chaperoning them through systems they characteristically have trouble navigating.

Moylan C. Managing care for uninsured patients. 2005, National Association of Public Hospitals and Health Systems. <http://naph.org/Publications/managingcareforuninsuredpatients.aspx>

Ormond BA, Lutzky AW. Ambulatory care for the urban poor: structure, financing, and system stability. 2001, The Urban Institute. <http://www.urban.org/UploadedPDF/occa49.pdf>

This study examines the organization and financing of ambulatory care for the poor in three urban communities – Houston, Denver, and Los Angeles – and the challenges posed to these systems by ongoing changes in the health care sector. Specifically, this study describes each community’s ambulatory care safety net, the challenges each community faces and their responses to these challenges, and the possible determinants of the level of success each has achieved in meeting the ambulatory care needs of their vulnerable populations. In addition, each system is examined from the perspective of long-term stability.

Quincy L, Collins P, Andrews K, Stone C. Designing subsidized health coverage programs to attract enrollment: a review of the literature and a synthesis of stakeholder views. 12-31-2008, Mathematica Policy Research, Inc. <http://aspe.hhs.gov/health/reports/08/subenroll/report.pdf>

Regenstein M, Nolan L, Wilson M, Mead H, Siegel B. Walking a tightrope: the state of the safety net in ten U.S. communities. 2004, Robert Wood Johnson Foundation.
<http://www.urgentmatters.org/reports>

Ryan J. Local coverage initiatives: solution or band-aid for the uninsured? June 2005, National Health Policy Forum. <http://www.nhpf.org/library/details.cfm/2491>

This issue brief surveys health coverage expansion initiatives that are operating on the county or local level, often without the benefit of federal funding. The paper explores the circumstances

that have made these initiatives possible and considers the ongoing barriers that local policymakers face in sustaining the programs. Descriptions of four initiatives illustrate the range and variety of programs in operation today and offer both best practices and lessons learned for other communities. The paper also includes a brief analysis of the key elements that make up a successful coverage initiative. Finally, this issue brief considers the role of local and county-based initiatives in the context of overall health care delivery in the national policy framework, highlighting the prospects for sustainability and replication on a broader scale.

Symposium. Community coverage initiatives. Health Affairs 2006; w150(w190).
<http://content.healthaffairs.org/content/full/hlthaff.25.w150v1/DC1>

Taylor EF, Cunningham P, McKenzie K. Community approaches to providing care for the uninsured. Health Affairs (Millwood) 2006; 25(3):w173-w182.
<http://content.healthaffairs.org/cgi/reprint/25/3/w173>

Faced with rising uninsurance rates and little response at the state or federal levels in recent years, communities have developed various strategies to provide care for uninsured people. This paper profiles local strategies in the Community Tracking Study sites, focusing on efforts that go beyond traditional safety-net access. Our findings suggest that more-recent community efforts--which tend to be privately sponsored--are relatively modest in scope compared with more-mature programs that enjoy public financing. Although local strategies can fill some holes, communities often do not have the resources necessary to fully address the problems of the uninsured on their own.

Taylor EF, McLaughlin CG, Warren AW, Song PH. Who enrolls in community-based programs for the uninsured, and why do they stay? Health Affairs (Millwood) 2006; 25(3):w183-w191.
<http://content.healthaffairs.org/cgi/reprint/25/3/w183>

Faced with growing numbers of uninsured people, many communities are developing local programs to provide coverage or improve access. Some might predict that only those with health problems would participate; however, little is known about who enrolls. This paper examines participation and retention in three different community programs aimed at low-income uninsured adults. In two of the three programs, the typical participant had no health problems. Improved access to preventive and routine physician care, and increased security about getting access to care should the need arise, appeared to be the primary benefits of both initial and continued enrollment.