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in Focus

Key points for policymakers:

As health care leaders consider the operational and economic implications of the Affordable Care Act (ACA), it is critical to explore how the needs of individuals remaining uninsured will be met. This paper highlights the challenges of serving this population; the role that charity care programs can play in meeting their needs; and how these programs can best be supported as ACA is implemented. Findings suggest that:

- Among the millions who will remain uninsured, it is unclear who will enroll in charity care.
- Regardless, charity care programs will remain vital and integral to the broader safety net of both service provision and coverage.
- Charity care programs have insights and experience that can benefit states and health plans as they enroll newly eligible members.
- As individuals move among coverage options and the uninsured population is redefined, the financial and operational viability of charity care programs will continue to be critical.

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The Implications of Health Reform for U.S. Charity Care Programs: Policy Considerations

Over the next decade, the Affordable Care Act (ACA) will lead to an historic expansion of health care coverage, reaching a large proportion of the nation's 46 million uninsured individuals. While it is expected that 95 percent of all legal U.S. residents will eventually have coverage, most people who are uninsured will remain so until 2014, and approximately 20 million will be uninsured thereafter.[1] These individuals include: (1) those exempt from the coverage mandate because insurance options are not affordable; (2) those who opt out of the mandate and face resulting penalties; and (3) undocumented immigrants and legal residents of less than five years.

As policymakers and health system leaders prepare for this new health care landscape, it is important to consider how to meet the needs of the remaining uninsured population. This paper describes how state, regional and local charity care programs are currently providing uninsured individuals with low- and no-cost access to health care, then discusses how reform could affect these programs from now until 2014, and beyond.

Broadly speaking, charity care programs will have three options as reform is implemented: (1) continue doing exactly what they are doing now; (2) re-tool to adapt to the needs of the remaining uninsured population; or (3) cease operating. Given the expected number and needs of individuals who will remain uninsured, option two will be the most likely, and will require substantial strategic and financial support. The following discussion highlights the challenges of serving individuals who are uninsured; the role that charity care programs can play in meeting their needs; and how these programs can best be supported as health reform is implemented.

Overview of Charity Care Programs: The Current Environment

In August 2009, the Kaiser Permanente Institute for Health Policy engaged AcademyHealth and the Center for Health Care Strategies (CHCS)* to explore methods used by charity care programs to care for individuals who are uninsured, and the challenges these programs face in serving a largely transient, culturally diverse and potentially low-literate population.

Through expert interviews in late 2009, charity care programs were identified that: (1) take a proactive, upstream approach to reaching the uninsured; (2) are privately funded or involve a public-private partnership; and (3) attempt to measure their impact. The eight programs selected for inclusion were: Access to Healthcare Network (NV); Ascension Health Care System (multiple states); adultBasic (PA); Healthy San Francisco (CA); Hillsborough County Health Care Plan (FL); Ingham Health Plan (MI); Kaiser Permanente Charitable Health Coverage programs (multiple states); and Portico Healthnet (MN).

These and other charity care programs across the country play a critical role in the health care safety net for thousands of individuals without access to private or public insurance. While the programs selected for this analysis vary in function, funding, scope of services, and care delivery, they all share a mission to provide access to essential services for a population that otherwise would go without.

Following are key features of the programs' delivery systems and business models:

1. Benefit design: All of the programs provide for primary and some degree of specialty care, prescriptions, and laboratory tests; most also cover inpatient care and emergency room use; and a number provide links to social services. Despite their breadth of services, many programs report an insufficient number of providers—particularly specialists—willing to participate at reduced payment rates. The resulting insufficient access to specialty care can lead to exacerbations of illness and use of more expensive inpatient services.

2. Eligibility and outreach: Eligibility for the programs included in the study ranges from ≤ 100 percent to ≤ 500 percent of the federal poverty level (FPL). While none of the programs requires U.S. citizenship, some limit coverage to a particular region or require documented legal residency. Some programs are able to meet recently increasing demand, while others lack resources to do so. The majority are reaching enrollment goals based on resources and capacity, serving five percent to 80 percent of their region's uninsured population. Some have waiting lists; several others struggle to enroll members, largely due to inadequate funds for outreach. Member misperceptions about enrollment, re-enrollment, and scope of coverage are key education challenges, often addressed at enrollment or at point of service. Though several programs are designed as bridges to permanent coverage, many of their members are not eligible for or cannot afford other options. They are left without coverage if their eligibility for charity care expires.

3. Care coordination and patient navigation: All of the programs offer a medical home to coordinate care and promote wellness; many include patient navigation. Nurse care managers or social workers are assigned to members. Some coordinate care with social services and community resources. Programs cite a need to help members navigate levels of care, use program resources cost-effectively, and manage chronic conditions.

4. Financing and provider incentives: Financing varies across and within charity care programs. It is provided by: member fees and copays; employer contributions; individual/corporate donors; federal, state and county sources; provider subsidies; a sales tax levy; tobacco settlement funds; and health plans and systems (which often underwrite charity care programs to fulfill requirements of their nonprofit status[2]). Several programs use payment incentives to encourage providers to pursue lower-cost, appropriate treatment options—suggesting the "purchasing power" of charity care programs to drive these behaviors.

Considerations for Policymakers

As policymakers develop regulations and programs in fulfillment of the new health reform law, a number of considerations will be critical to providing health care to the uninsured population. Underscoring these is the imperative: First, do no harm. The majority of the charity care programs included in this analysis are very effective at caring for the uninsured in their target regions. With the infrastructure, provider relationships, and insights into the health and social needs of diverse, low-income populations, these programs are ideally positioned to serve those who remain uninsured in 2014. Policymakers should consider the impact of reform measures on the financial viability and operational stability of these programs, which will remain critical in the new health care landscape. Other important considerations are:

1. *An estimated 20 million individuals will remain uninsured after ACA is fully implemented, including many who still will not be able to afford coverage.* Of those remaining uninsured, only about one-third will be undocumented residents. Many of the other two-thirds may have higher incomes, but still be

unable to afford coverage options and out-of-pocket (OOP) expenses.[3] At greatest risk are people in the threshold just above Medicaid eligibility (133 percent FPL), including:

- Individuals with incomes too high to qualify for subsidized coverage, but too low to afford full-price premiums (up to 400 percent FPL)—a problem that will grow as cost-sharing subsidies phase out. For example, a person at 250 percent FPL reaching the OOP maximum would spend more than 20 percent of income on copays and deductibles, plus up to eight percent of income on premiums;
- People with high medical needs who can afford the premiums, but not the corresponding service copays and deductibles;
- Low-income workers of large employers that offer coverage, but at unaffordable rates; and
- Older individuals, who may be charged more for policies in non-group markets, due to age-rating bands.

As the new law will keep the government's share of premiums constant—and medical costs grow significantly faster than incomes and general prices—family premiums are likely to rise faster than incomes.[4] This will make premiums even less affordable over time. A real danger is that policymakers, health system leaders, and private and corporate philanthropists will conclude that individuals who do not qualify for subsidized coverage have the resources to access and utilize adequate health coverage and care. As suggested above, affordability will be a challenge to many.

2. *Little is known about who will be walking through the doors of charity care programs in 2014.* Charity care programs are uncertain about who they will or should be serving in 2014. Much is unknown about the health status, demographics and service needs of the remaining uninsured population. For example, while the chronically ill are likely to enroll given their health care needs, frequent users of emergency departments may not embrace a new system that would alter the way they access care. Undocumented residents—largely young and healthy—may enroll in charity care, or wait until they require emergency care. In addition, the population's cultural and linguistic diversity will warrant corresponding diversity in care coordination, patient navigation and provider care. Programs must consider whether they have the workforce to support this.

3. *The role of charity care programs will not decline, but simply shift.* The large number of uninsured expected in 2014 and beyond suggests that demand for charity care programs will not decline, but shift to a different population, as described above. In addition, the programs' expertise positions them well to be subcontractors for health plans and Medicaid as the organizations serve a newly insured population. Charity care programs could screen and enroll members, or advise plans and Medicaid on outreach and health management.

4. *Charity care programs will face new financial challenges.* Current financial support for charity care programs may diminish amid health reform implementation. For example, donors may perceive a reduced need for funding, given the extensive coverage expansions. Even if they do appreciate the *number* of remaining uninsured, demographic perceptions (e.g., higher-income, legal/illegal immigration status) may undermine financial support, as well as political attention to their needs. While perhaps perceived as less needy, many of these individuals still may not be able to afford coverage. Policy (and charitable) efforts must be undertaken to ensure they do not "fall through the cracks."

Another financial challenge may arise as Medicaid reimbursement rates for primary care increase to Medicare levels in 2013 and 2014. Charity care programs may find it more difficult to recruit and retain providers, who will be able to receive higher reimbursement through Medicaid. As programs consider matching those rates, and Disproportionate Share Hospital funding (redirected to subsidize coverage via the exchanges) declines, the drain on their resources may reduce the number of members they can serve.

5. *Enrollment and eligibility will be a challenge.* States will have to consider what mechanisms are needed for eligibility determination and enrollment through the insurance exchanges and Medicaid, and examine whether current information systems are sufficient to perform these functions and reach a broader population (e.g., childless adults).[5] A related issue is how to provide enrollment incentives to individuals who would not be affected by non-participation penalties (i.e., those who do not pay taxes, the mechanism for penalties). Charity care programs, already adept at serving much of the population that will become eligible, can be valuable partners in these efforts.

Charity care programs themselves must consider: (1) their role in education, enrollment, and transition to new coverage options; (2) their eligibility guidelines (e.g., will they serve those who cannot afford or choose not to buy subsidized policies?); and (3) how to reach the uninsured population, which will be smaller, more diverse, and farther "off the radar screen" due to their immigration status.

6. *Individuals opting out of the insurance exchanges to enroll in a charity care program may face "scofflaw" penalties.* Most charity care programs reviewed in this project are not licensed as insurance products. The question remains whether, under certain circumstances, membership in these programs would be considered creditable coverage, and would satisfy the federal individual coverage mandate. Will members be treated as scofflaws and face a penalty for remaining uninsured even if they pay charity care membership fees of $200 to $300 per month?

7. *Hospitals and health systems may need new ways of satisfying community benefit requirements.* It is reasonable to expect that ACA will eventually lead to a decline in the number of uninsured individuals using hospital charity care services. Consequently, guidelines for hospitals and health systems to satisfy their community benefit requirements may need to change. Many hospital systems have relationships with safety net programs similar to the ones reviewed under this project. It will be important that they cultivate these relationships, which may undergo transformations over time.

Conclusion

Charity care programs are an integral and critical component of the broader safety net of both service provision and coverage. They do not, and cannot, operate in isolation. As individuals move among various coverage options, and the uninsured population is redefined under health care reform, the connectivity of these programs to federally qualified health centers, community hospitals, and public payers such as Medicaid will be critical to minimizing the number of individuals remaining unserved by a vastly improved, but still imperfect, health care system.

Notes:

1 "The Patient Protection and Affordable Care Act of 2009" (Public Law 111-148), and "The Health Care and Education Reconciliation Act of 2010" (Public Law 111-152).

2 Typical requirements are: the provision of uncompensated care; services to Medicaid beneficiaries; and specialized services that are generally unprofitable. Congressional Budget Office (December 2006). "Nonprofit Hospitals and the Provision of Community Benefits." Available at http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf.

3 L. Blumberg. "Gaps in Federal Health Reform: Opportunities for Charity Care Programs." Presentation given at the *Understanding Charitable Coverage/Care Roundtable Discussion,* April 14, 2010.

4 L. Blumberg, op cit.

5 G. Volk and A. Jacobs. Implementing State Health Reform: *Lessons for Policymakers.* AcademyHealth, March 2010.

*For more information on the Center for Health Care Strategies (CHCS), please visit www.chcs.org. For more information on AcademyHealth, please visit www.academyhealth.org.

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