Caring for the Uninsured in a Pandemic Era

Sara Rosenbaum, JD, George Washington University; Morgan Handley, JD, George Washington University

SUMMARY. On the eve of the COVID-19 pandemic, millions of Americans were uninsured despite a booming economy and a decade of health reform. The pandemic and its associated job losses have significantly increased the number of uninsured Americans – predominantly low-income, working-age adults and their families. Underlying drivers are the pandemic-triggered economic crisis, the inherent limits of the Affordable Care Act (ACA), the 2012 United States Supreme Court's ruling on the constitutionality of its nationwide Medicaid expansion, and policies pursued by the Trump administration and certain states that further restrict the ACA's reach. Especially serious during a public health emergency, the uninsured are significantly less likely to receive necessary care and are more likely to forgo care because of cost. Health care safety net providers established and operated under federal, state, and local law offer vital care for the uninsured and medically underserved rural and urban populations and communities. Federal COVID-19 legislation enacted to date appropriates funding to directly support health care providers, but the administration's implementation approach may be limiting the effectiveness of this funding for the highest-need populations and communities. Beyond reforms aimed at improving how federally appropriated emergency health care funding is spent, states should use Medicaid to foster greater safety net provider stability and should pursue policies that promote accountability by tax-exempt hospitals with charity care obligations.

Introduction

Who are the Uninsured and How Has the Pandemic Worsened the Problem?

On the eve of the COVID-19 pandemic — a decade after passage of the Affordable Care Act (ACA), and during a booming economy with historically low unemployment levels — tens of millions of working-age Americans remained uninsured, without access either to employer-sponsored coverage or affordable insurance through Medicaid or the ACA's health insurance Marketplace. Although the ACA achieved major coverage gains, government data show that in 2018, 8.5% of the population (27.9 million people) were uninsured (Berchick, Barnett and Upton, 2019), an increase of more than one million since 2016 (Tolbert et al., 2019).

The vast majority of the uninsured (86%) are working-age adults; 83% live in full-time or part-time working households, and 51% have incomes less than twice the poverty level (Figure 14.1). Nearly 60% are racial and ethnic minority Americans, who bear the greatest health risks during the pandemic, and 75% are U.S. citizens. Beyond those uninsured all year, millions more experience intermittent coverage, with frequent interruptions.

States that have not expanded Medicaid tend to have the highest uninsured rates. (Figure 14.2)

The pandemic has illuminated both the ACA's achievements and limitations. The Medicaid expansion and subsidized Marketplace plans created by the ACA provide a vital coverage lifeline for those without employer plans (See Chapters 12 and 13). But the ACA offers relatively low Marketplace insurance subsidies, leaving policies unaffordable for many (Gunja and Collins, 2019), even as pandemic-induced job loss has heightened the need for an alternative coverage source.

Marketplace shortcomings were exacerbated by the 2012 United States Supreme Court's decision in *National Federation of Independent Business v. Sebelius*, which effectively transformed the Medicaid expansion into a state option. As of summer 2020, Medicaid expansion remains unimplemented in 14 states. This leaves about 2.3 million poor adults (92% of whom reside in the South) uninsured – too poor to qualify for subsidized Marketplace plans because premium subsidies do not begin until household income reaches 100% of the federal poverty level and yet ineligible for Medicaid (Garfield, Orgera, and Damico, 2020).

The risk of being uninsured is especially pronounced among immigrant populations. As explored at greater length in Chapter 33, the ACA excludes undocumented immigrants from Marketplace subsidies, while publicly-funded coverage is limited to emergency Medicaid. The problem, as Chapter 33 notes, has been further deepened by Trump administration rules that classify Medicaid as a

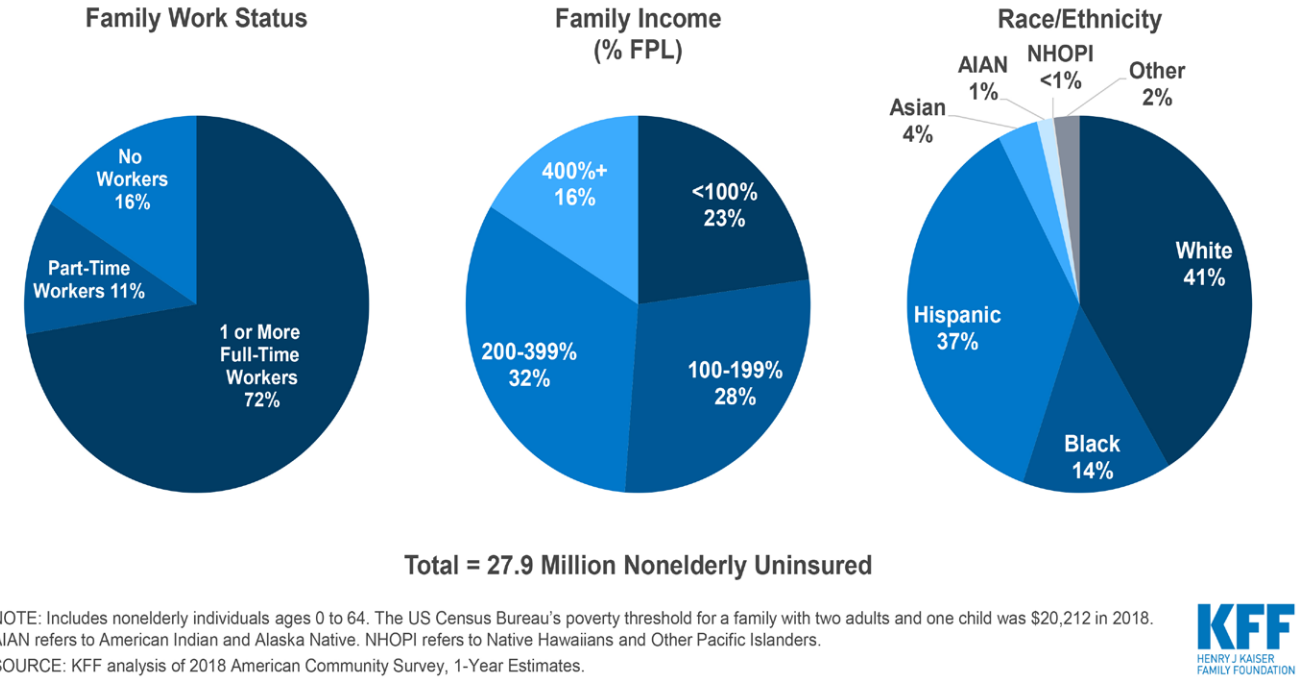


Figure 14.1. Characteristics of the Nonelderly Uninsured, 2018

form of public benefit that can threaten people's U.S. legal status.

Decades of research shows that the uninsured are less likely to receive necessary health care and more likely to go without needed care because they cannot afford it (Tolbert et al. 2019). During a pandemic, decisions to avoid care raise the risk of community spread.

Health Care Safety Net Providers and the Response to COVID-19

An Overview of Health Care Safety Net Providers: Mission, Services, and Funding

Safety net providers defined. The health care safety net can be thought of as a class of providers of both institution-based and outpatient care whose principal purpose is to care for low-income and medically vulnerable patients and communities at risk for exclusion because of multiple factors: structural racism; underlying social and economic circumstances; geographic isolation; or disability or health status. Safety net providers are characterized by significantly higher-than-average numbers of Medicaid and uninsured patients and location in, or service to, communities, patients, and populations considered medically underserved because of poverty, elevated health risks, and serious provider shortages.

Beyond what can be thought of as the core health care safety net are tax-exempt hospitals that may not be considered safety net providers but that have a "community benefit" obligation under Section 501(c)(3) of the Internal Revenue Code. At a minimum, this obligation requires tax-exempt hospitals to operate transparent financial assistance programs for patients and to make this assistance accessible. States and localities may impose additional charity care obligations, such as establishing a minimum level of hospital financial assistance expenditures.

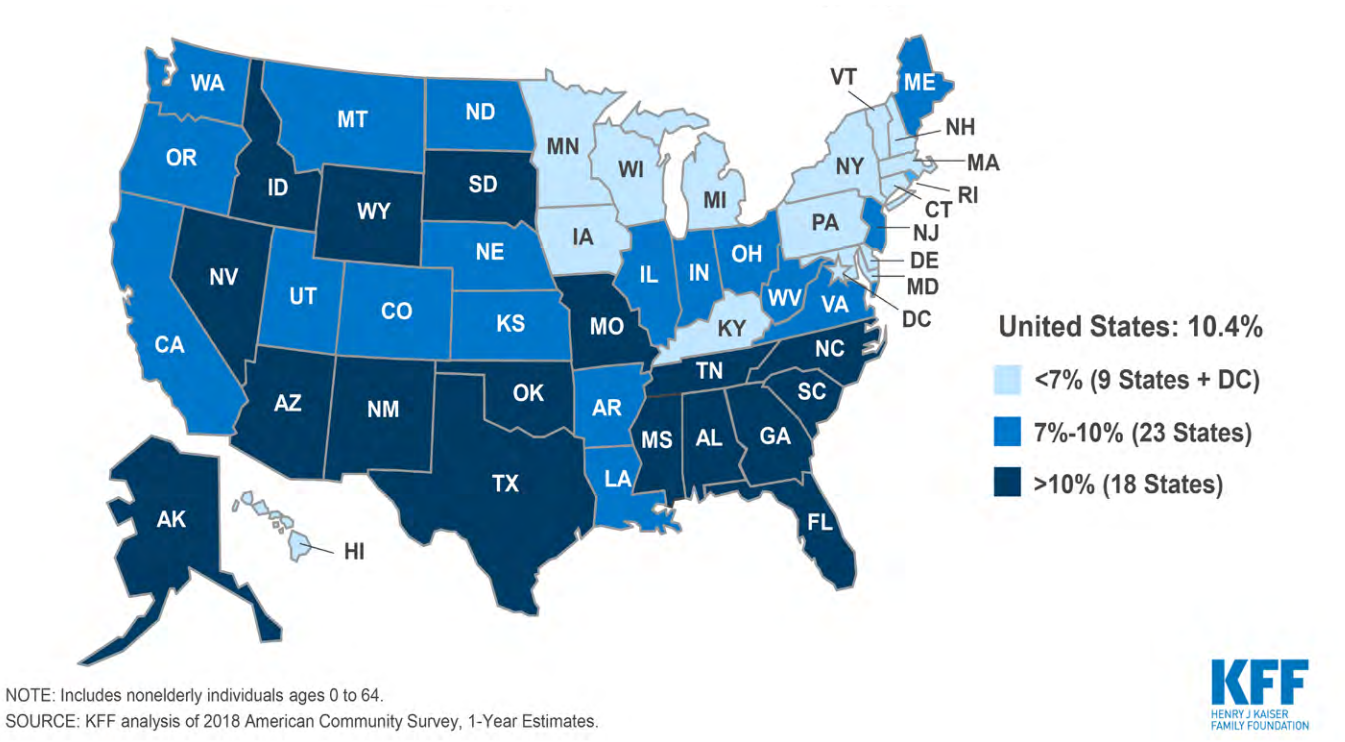
Laws Establishing and Directly Supporting Safety Net Providers

Certain providers assume special prominence in any health care safety net discussion. Some safety net providers operate under the authority of state and local law, such as public hospitals and hospital authorities, state and local health agencies, and community nonprofit health care organizations. Others are creatures of federal law. The Public Health Service Act (PHS Act) establishes community health centers (CHCs), family planning programs, and programs serving people with mental illness and substance use disorders. The Ryan White Care Act funds services for people living with HIV/AIDS. Title V of the Social Security Act authorizes state maternal and child health programs, while the Indian Health Service (IHS) and related programs operate under the Indian Health Care Act.

State laws play a major role in the activities of all safety net service organizations, even in the case of federally-administered programs such as the IHS and CHCs. States regulate health care practice and establish medical liability rules (both the IHS and CHCs are protected against medical liability claims through the Federal Tort Claims Act).

Regardless of the laws under which they operate, safety net providers share certain distinctive features:

- a primary focus on certain vulnerable populations with heightened health and social needs;



NOTE: Includes nonelderly individuals ages 0 to 64.
SOURCE: KFF analysis of 2018 American Community Survey, 1-Year Estimates.

14.2. Uninsured Rates among the Nonelderly by State, 2018

- services located in or designed to reach low-income and medically underserved communities and populations (e.g., people with serious physical or behavioral health conditions, farmworkers, or people experiencing homeless);
- provision of free or reduced-cost care to low-income patients;
- services that span health and social service needs and include supportive services such as care management, transportation, translation, and community outreach; and
- financial reliance on a combination of Medicaid and grant or other public support such as dedicated taxes, in the case of public hospital authorities.

The federal grants that fuel safety net provider operations come with conditions of participation, such as location in or service to medically underserved communities, making free and reduced-cost care available to residents of the service area, and making certain types of care available. Examples are CHC and family planning operating grants under the PHS Act, maternal and child health funding under Social Security Act Title V, grants for behavioral health under the PHS Act, and other PHS Act screening and treatment programs administered by state public health agencies and overseen by the Center for Disease Control and Prevention (CDC). States also may provide supplemental grants that create additional requirements regarding services to be offered and populations to be served. Additionally, public hospitals and hospital authorities may receive operating support through dedicated taxes that carry their own service obligations.

Safety net providers are best known for their services targeted to high-need communities, but public hospitals also may be a principal source of highly specialized care for the entire population, such as Level 1 trauma care or highly-advanced newborn intensive care. Furthermore, during a public health pandemic, safety net providers assume a role as public health first responders for their communities, an essential activity for the entire population since pandemics know no geographic boundaries.

The Role of Medicaid Funding

Maintaining a safety net depends virtually entirely on public financing because of the work the health care safety net does and the patients and communities it serves. As the nation's most important insurer for the low income population, Medicaid is a central funding source for virtually all types of health care safety net providers. Medicaid is essential to health care safety net survival because, as a primary source of insurance for the low income population, it accounts for a major portion source of health care safety net operating revenue. For some safety net providers, Medicaid payment is governed by special rules. For example, payment to CHCs (known as "federally qualified health centers" (FQHCs) under Medicare and Medicaid) is governed by a prospective, per-encounter rate-setting formula known as the prospective payment system (PPS) that applies to both Medicare and Medicaid. This formula effectively yields a bundled, per-encounter rate for covered services tied to operating costs. The PPS system also governs payments to rural health clinics (RHCs) designated as such under Medicare and Medicaid because of their location in rural,

medically underserved communities experiencing primary care shortages and their use of midlevel health professionals, such as nurse practitioners and physician assistants. Hospitals may qualify for disproportionate share hospital (DSH) payments under Medicare and Medicaid and also may be deemed Critical Access Hospitals (CAH) for purposes of payment under both programs.

States also have substantial leeway to shape safety net provider Medicaid payment rules. They have the flexibility to recognize costs not typically paid in private practice settings (e.g., care management, transportation, translation), compensate providers at higher rates given greater intensity of care needs, or pay for services in offsite settings such as homeless shelters or farmworker camps.

By reducing the financial burden of uncompensated care, Medicaid's (DSH) payment system is especially important for safety net hospitals (MACPAC 2020). Unlike the general Medicaid program, federal DSH payments to states are subject to an aggregate upper limit. Although states have considerable leeway over how to allocate their annual DSH allotments, certain hospitals are "deemed" (i.e., mandatory) DSH recipients because they treat an exceptionally high level of low-income patients. These hospitals may also receive other supplemental Medicaid payments authorized under law.

Medicaid's centrality to the safety net is evident in its role as a funder of care. The program is the single largest funder of HIV/AIDS care, family planning services for low-income patients, and treatment for people experiencing serious mental illness or substance use disorders. CHCs derive 44% of their operating revenue from Medicaid (Rosenbaum et al., 2019). Compared to other hospitals, safety net hospitals derive a significantly greater proportion of their operating revenue through Medicaid (MACPAC 2016). Medicaid insures one in four IHS patients (IHS, 2020).

As patient visits and admissions for non-COVID reasons have plummeted during the pandemic, so has Medicaid revenue, creating a major survival test for safety net providers, even as their costs of adapting to and treating COVID have skyrocketed. Weekly federal CHC reporting data provide insight. Over the April-June period alone, CHCs experienced a 38% visit decline nationwide, with an estimated $3.2 billion in Medicaid revenue losses (Shin et al., 2020). Federal CHC funding alone is far below the amount needed to offset steep insurance revenue losses, and safety net providers have reduced services, closed sites, and laid off staff. Telehealth likely has mitigated some of the losses, particularly for primary care, but the jury is out on how well telehealth can substitute for in-person care in the case of medically vulnerable patients and on how effective telehealth has been in keeping providers afloat.

Figure 14.3. COVID-19 Provider Relief Fund: Overview of HHS Distributions to Date[1]

General Distribution *$50 Billion*	• **Tranche 1: $30 billion** to Medicare providers based on their share of total 2019 Medicare fee-for-service expenditures *Distributed April 10 and April 17*
	• **Tranche 2: $20 billion** to Medicare providers based on the lesser of 2% of a provider's net patient revenue or the sum of incurred losses for March and April. If a provider's Tranche 1 payment is at least 2% of annual patient revenue, it may not receive a Tranche 2 payment *Distributed on a rolling basis to providers that submitted the required data by June 3*
Medicaid Distribution *~$15 Billion*	• **$15 billion** to providers that: (1) billed Medicaid (managed care or fee-for-service) between January 1, 2018 and December 31, 2019; and (2) have *not* received a General Distribution payment. Payments will be at least 2% of annual patient revenue *HHS launched an enhanced portal for providers to submit applications by July 20; payments made on a rolling basis*
Hot Spot Hospitals *$22 Billion*	• **$12 billion** to the 395 hospitals that provided inpatient care to 100+ COVID-19 patients through April 10 *Distributed on or around May 1*
	• **$10 billion** based on COVID-19-positive inpatient admissions through June 10 (methodology TBD) *Providers were required to submit data via TeleTracking by June 15 at 9:00 pm ET; distribution timing and methodology TBD*
Safety Net Hospitals *$10 Billion*	• **$10 billion** to safety net hospitals defined as having: (1) a Medicare Disproportionate Patient Percentage (DPP) of 20.2% or greater (2) average uncompensated care per bed of $25,000 or more (3) profitability of 3% or less, as reported to CMS in its most recently-filed cost report. Payments will be based on each hospital's share of "individual facility scores" (number of facility beds multiplied by DPP) among all qualifying hospitals *Distributed on or around June 12*
Rural Providers *$10 Billion*	• **$10 billion** to rural acute care general hospitals, Critical Access Hospitals, Rural Health Clinics and Community Health Centers located in rural areas *Distributed on or around May 1*
Uninsured Claims *Unspecified*	• **Unspecified amount** based on claims submitted to HHS by providers for testing or treating uninsured COVID-19 patients on or after February 4 (reimbursed at Medicare rates) *Claims reimbursement is ongoing; payments began on May 18*
IHS *$500 Million*	• **$500 million** for Indian Health Service (IHS) facilities *Distributed on or around May 22*
Dentists *Unspecified*	• HHS is "working on an additional allocation to distribute relief broadly to dentists"

HHS has distributed/is currently distributing payments
Payments have not yet been made
June 9-announced allocations

1. Manatt Health analysis, based on HHS' June 9 press release; HHS Provider Relief Fund FAQs as of June 20, 2020; and Medicaid/CHIP Provider Relief Fund Payment Forms and Guidance.

The Federal Response To Date

By early June, Congress had enacted four laws that together establish a series of public and private insurance reforms (which are explored in other chapters) as well as direct emergency health care funding aimed at covering the cost of the COVID response and stabilizing health care providers. In addition to the Provider Paycheck Program (PPP), for which health care providers may be eligible, these laws provide $175 billion in funding to offset provider losses and help defray unreimbursed COVID-related costs.

Figure 3 shows the various funding streams available to health care providers directly. Essentially, the Trump administration has established two online distribution mechanisms: the CARES Act Provider Relief Fund, and a COVID-19 provider uninsured claims reimbursement fund to cover testing and treatment costs (HRSA, 2020). The uninsured claims reimbursement fund operates as a capped $2 billion federal allocation covering claims in connection with testing or treatment for "uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020." Because a diagnosis is needed, asymptomatic testing costs appear to be excluded. According to the administration, provider payments "generally" will be at Medicare rates, "subject to available funding."

The Provider Relief Fund consists of a general fund as well as a series of "targeted" funds aimed at specific providers and populations: rural health; "high-impact distribution"; skilled nursing facilities; Indian Health Service (including IHS urban centers); "safety net" hospitals; and Medicaid providers as well as providers caring for children insured through separately-administered Children's Health Insurance Programs (CHIP). (Most states now use their CHIP funding at least in part to enhance coverage for children through Medicaid rather than separate CHIP plans).

The Medicaid targeted fund was not unveiled until weeks after the general fund came online, after protests by Congressional leaders, state Medicaid agencies, and Medicaid experts pointed to the length of time taken to move funding into action for the highest-need communities. Experts also pointed to the General Fund's built-in bias against providers, since to date the Fund has favored providers with high net revenue, while safety net providers typically have very low operating margins. The Medicaid Fund bars aid to Medicaid and CHIP providers that received any amount of assistance from the General Fund, even though they would have had no way of knowing about a Medicaid Fund as yet to be established, and even if they return the General Fund allotment they received. Indeed, administration policy provides that simply being eligible for small payments out of the General Fund is enough to disqualify safety net providers from receiving targeted Medicaid funds. Moreover, unlike the other funds, applicants to the Medicaid Fund must go through additional procedural steps. Further complicating matters, in developing the Medicaid Fund, the Trump Administration devised its own distribution formula rather than consulting closely with state Medicaid agencies regarding the criteria and qualifications that should guide the allocation process.

The shortcomings evident in the Medicaid Fund must be understood against the fact that the administration also has refused to give Medicaid agencies flexibility to provide additional assistance to hard-hit providers in the form of grants that do not have to be repaid – something that past administrations, Republican and Democratic alike, have permitted (Rosenbaum and Handley, 2020).

Recommendations for Action

Federal government:

- The federal government should increase its support for health care safety net providers by better targeting federal emergency provider grants, giving states greater Medicaid flexibility to help safety net providers, and helping uninsured patients gain access to the Provider Uninsured Claims Fund.
- HHS should increase the targeted Medicaid Fund and lift restrictions against assisting high-Medicaid-reliant providers that qualify for limited help from the General Fund.
- Rather than attempting to control distribution, HHS should allocate targeted Medicaid Funds directly to states in order to better ensure a more coordinated strategy with additional state reforms.
- The HRSA Uninsured Claims Fund should be reformed to operate with greater transparency in terms of which providers receive funding and accessible help for patients in need of financial assistance, including help in languages spoken by the community.
- HHS should lift restrictions that prevent use of the fund by certain safety net providers. Specifically, there should be no bar against receipt of funding by Ryan White Care Act (RWCA) clinics that also receive RWCA funding for costs associated with HIV/AIDS treatment.
- Congress should appropriate additional direct payment funding to providers.
- Congress should instruct HHS to open the targeted Medicaid Fund to health care providers obligated under federal, state, or local law to providing free and low-cost care to the uninsured, regardless of whether providers also have received help through the General Fund.
- Congress should direct HHS to administer the uninsured claims fund with greater transparency to patients while restricting access to such funding to hospitals that are deemed DSH hospitals and tax-exempt hospitals that can demonstrate that they maintain a published and accessible financial assistance policy as required under the Internal Revenue Code.
- Congress should give state Medicaid programs the flexibility to make retainer payments to Medicaid providers that furnish elevated levels of health care to medically underserved populations and communities.

State governments:

- State Medicaid Agencies should adopt the following strategies to help safety net providers.
- States should consider adjusting payment rules rates to recognize extraordinary investment and operational costs incurred in adapting to COVID testing and treatment.
- States should add payment for services furnished in nontraditional care settings and payment for telemedicine care, both of which are permitted under § 1135 of the Social Security Act (Rosenbaum, 2020) and through regular state Medicaid plan amendment process.
- States should pursue demonstrations under HHS's Social Security Act § 1115 special research and demonstration authority that enable states to expand eligibility and benefits on an experimental basis.
- States should use Medicaid managed care to expand safety net provider relief, including moving to partial capitation payment methodologies for primary care services furnished by network safety net providers in order to improve revenue flow.
- States should take advantage of an existing federal option to make additional stabilization payments (known as retainer payments) for habilitation and personal care services, even though the administration has barred retainer payments for other types of providers.
- States also should instruct their managed care plans to speed the credentialing of out-of-state COVID testing and treatment providers serving residents living in border areas and streamline utilization and medical management requirements.
- States should expand and strengthen the duties of tax-exempt hospitals, particularly those with net revenue that exceeds the statewide average.
- States should supplement tax-exempt hospitals' financial assistance obligations under § 501(c)(3) by setting targeted dollar assistance levels pegged to hospitals' net revenue and should ensure that all tax-exempt hospitals offer accessible application assistance patients, adapted to the languages spoken in the community.

About the Authors

Sara Rosenbaum, JD, is the Harold and Jane Hirsh Professor of Health Law and Policy and Founding Chair of the Department of Health Policy at George Washington University's Milken Institute School of Public Health. Professor Rosenbaum has devoted her career to health justice for medically underserved populations. Professor Rosenbaum is a member of the National Academies of Sciences, Engineering, and Medicine, served on CDC's Director's Advisory Committee and Advisory Committee on Immunization Practice, and was a founding Commissioner of Congress's Medicaid and CHIP Payment and Access Commission (MACPAC), which she chaired from January 2016 through April 2017.

Morgan Handley, JD, is a Senior Research Associate in the Department of Health Policy at George Washington University's Milken Institute School of Public Health. Her work focuses on Medicaid, health reform, and medically underserved populations.

References

Berchick, E. R., Barnett, J. C., & Upton, R. D. (2019). Health Insurance Coverage in the United States: 2018 Retrieved July 7, 2020, from https://www.census.gov/library/publications/2019/demo/p60-267.html#:~:text=The%20percentage%20of%20people%20with,in%202017%20(92.1%20percent)

Garfield, R., Orgera, K., & Damico, A. (2020). The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid Retrieved July 7, 2020, from https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

Gunja, M. Z. & Colins, S. R. (2019). Who are the Remaining Uninsured, and Why Do they Lack Coverage? Retrieved July 7, 2020, from https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage

Health Resources & Services Administration ("HRSA") (2020). COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Retrieved July 7, 2020, from https://www.hrsa.gov/CovidUninsuredClaim#:~:text=President%20Trump%20is%20providing%20support,The%20President%20signed%20the%20bipartisan%3A&text=Within%20the%20Provider%20Relief%20Fund,uninsured%20individuals%20with%20COVID%2D19

Indian Health Service ("IHS") (2020). IHS Profile Retrieved July 7, 2020, from https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/IHSProfile.pdf

Medicaid and CHIP Payment and Access Commission ("MACPAC") (2020). Issue Brief: Medicaid Base and Supplemental Payments to Hospitals Retrieved July 7, 2020, from https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf

Medicaid and CHIP Payment and Access Commission ("MACPAC") (2016). Report to Congress on Medicaid Disproportionate Share Hospital Payments Retrieved July 7, 2020, from https://www.macpac.gov/wp-content/uploads/2016/01/Report-to-Congress-on-Medicaid-DSH.pdf

Rosenbaum, S., Sharac J., Shin, P. and Tolbert, J. (2019). Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained Retrieved July 12 from https://www.kff.org/report-section/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained-issue-brief/

Rosenbaum, S. & Handley, M. (2020). Broadening Medicare's Accelerated and Advance Payment Program to Save Health Care Providers that Serve Our Most Vulnerable Populations Retrieved July 7, 2020, from https://www.commonwealthfund.org/blog/2020/broadening-medicares-accelerated-and-advance-payment-program-save-health-care-providers

Rosenbaum, S. (2020). Using Medicaid Waivers to Help States Manage the COVID-19 Public Health Crisis Retrieved July 7, 2020, from https://www.commonwealthfund.org/blog/2020/medicaid-waivers-states-covid-19

Shin, P., Sharac, J., Hernandez, J., Velasquez, M., Morris, R., Rosenbaum, S., & Jacobs, F. (2020). Key Updates from the Health Center COVID-19 Survey (Update #8): Nearly 2,000 Sites are Temporarily Closed, Testing Has Dropped, Telehealth Use Has Declined, and Revenue Losses are Estimated in the Billions Retrieved July 7, 2020, from https://www.rchnfoundation.org/wp-content/uploads/2020/06/Week-8-HRSA-COVID-19-Update-Final-6-2-20-3.pdf

Tolbert, J., Orgera, K., Singer, N., & Damico, A. (2019). Issue Brief: Key Facts About the Uninsured Population Retrieved July 7, 2020, from http://files.kff.org/attachment/Issue-Brief-Key-Facts-about-the-Uninsured-Population