GRANTMAKERS IN HEALTH

The Residual Uninsured:

Taking Stock, Taking Care

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By the time the Affordable Care Act (ACA) is fully implemented in 2019, government analysts estimate that about 89 percent of the nonelderly U.S. population will be covered by health insurance, up from 80 percent in 2013 (CBO 2013). This growth in coverage will have a positive impact on the health security of millions of Americans. Nevertheless, an estimated 11 percent of the nonelderly population, more than 30 million people nationwide, will remain uninsured.

The reduction of the uninsured population to close to half of its present size and the concentration of uninsured people in certain states and local communities have implications for health care delivery systems, policymakers, and grantmakers. This Issue Focus describes the changes that experts foresee and considers ways in which health grantmakers can and are anticipating those changes in their current program work.

WHO WILL CONSTITUTE THE RESIDUAL UNINSURED?

The residual uninsured population will include several distinct categories of people. Because ACA provisions benefit primarily U.S. citizens and legal residents, ***undocumented residents*** are the group least likely to transition to coverage and will thus represent a greater share of the uninsured population after ACA implementation is complete. The residual uninsured population will also include a number of legal residents who are ***qualified*** for a state or federal insurance program, but are not enrolled. Another group comprises those who are legally ***obligated*** to buy insurance, but do not do so because they consider coverage unaffordable; a poor value, with relatively low financial penalties for noncompliance; or for some other reason. This group will include some middle-income people who do not qualify for subsidized coverage, as well as some who do qualify for subsidies. Another group of residual uninsured adults includes those who are ***exempt*** from the requirement to buy coverage, according to criteria specified in the law (for example, low income, unavailability of affordable coverage, religious objection, membership in an Indian tribe). Finally, the residual uninsured population will include some ***transitory uninsured***, people who are experiencing gaps in coverage for a variety of reasons.

Regions, states, and local communities will experience differences in the degree to which populations remain uninsured, reflecting factors such as state-level decisions about Medicaid expansion, as well as the characteristics of their resident populations. In an analysis funded by the Robert Wood Johnson Foundation, researchers found that, if fully implemented in 2011, regional variation in the percentage of uninsured among the nonelderly would range from 4.6 percent in New England to 11.4 percent in the West South Central region. Across states, Massachusetts would have the lowest proportion of uninsured, at 1.1 percent of the nonelderly, whereas Texas would have the highest at 12.8 percent (Buettgens and Hall 2011).

From a demographic perspective, the composition of the uninsured population is expected to remain similar to that of the currently uninsured (Nardin et al. 2013). Approximately 80 percent of the residual uninsured will be U.S. citizens. More than 4.3 million children and nearly 1 million veterans of military service will remain uninsured. While African Americans and Latinos will continue to be overrepresented among the uninsured, the majority of the residual uninsured population will be non-Hispanic, white, low-income, working-age adults, many of whom are employed. Analysis by The Henry J. Kaiser Family Foundation (Kaiser Family Foundation), however, found that African Americans are at highest risk of continuing to face coverage gaps due to state decisions not to expand Medicaid coverage, as nearly 60 percent of uninsured African Americans with incomes below the Medicaid expansion limit reside in states that have chosen not to expand Medicaid as of late June 2013 (Kaiser Family Foundation 2013).

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IMPLICATIONS FOR THE SAFETY NET

The residual uninsured population will rely heavily on the so-

called safety net, those community health centers, rural clinics, public hospitals, and other providers that offer care irrespective of a patient's ability to pay and that serve a population that is largely vulnerable, including uninsured and Medicaid patients. These providers have faced increased demand for their services in recent years, as employer-based health insurance declined during the economic downturn (Summer 2011). At the same time, Medicaid cuts in states facing large budget deficits have had a negative impact on safety net providers for which Medicaid serves as the largest source of revenue.

Safety net providers will face a different environment beginning in 2014, with both opportunities and challenges on the horizon. In many geographic areas, formerly uninsured patients will increase demand for the services furnished by safety net providers, offering the prospect of concurrent increases in revenue. At the same time, a share of the vulnerable patients who have traditionally used safety net providers' services will become privately insured and have alternative sources of care available to them. Additionally, the Medicaid Disproportionate Share Hospital (DSH) program, which subsidizes hospitals that care for uninsured and Medicaid patients, is to be phased out. The impact of ending these payments may be particularly problematic for hospitals in states that elected not to expand Medicaid coverage, since those revenues will not be available to offset the lost DSH payments (Gusmano and Thompson 2012). In May 2013, the Centers for Medicare and Medicaid Services issued a proposed rule that would tie the level of cuts to each state's residual uninsured rate, thereby minimizing the impact on safety net providers in states that have elected not to expand Medicaid (Galewitz 2013).

HEALTH GRANTMAKERS THINKING AHEAD, STEPPING FORWARD

Health grantmakers have been engaged in work to ensure that the residual uninsured and their health care providers are not forgotten in planning for ACA implementation, and are involved in work to minimize the number of people who remain uninsured. Program activities include ones like those described below.

- ***Developing Information and Raising Awareness*** – By funding analyses and projections of the foreseen residual uninsured population like those described above, health grantmakers such as the Kaiser Family Foundation and the Robert Wood Johnson Foundation have helped generate the knowledge needed by policymakers and other decision-makers with respect to the scope and dimensions of the problem.

  Projections of the expected residual uninsured population in states and local areas have provided valuable input to planning efforts. In Texas, a Rice University study, funded by the Methodist Healthcare Ministries of South Texas, Inc., made estimates of the residual uninsured population in each county under alternative scenarios reflecting the extent of success in implementing ACA provisions (Center for Public Policy Priorities 2012). In California, a study funded by the Blue Shield of California Foundation projected that up to 10 percent of the nonelderly population will remain uninsured once ACA implementation is complete, and that certain cities and rural communities within the state will have higher concentrations of uninsured, with 60 percent of California's residual uninsured expected to reside in Los Angeles and other Southern California counties (Lucia et al. 2012).

- ***Supporting Efforts to Reduce the Number of Residual Uninsured*** – Health grantmakers are working with partners to ensure effective outreach and enrollment in public programs and private health insurance to minimize the number of people who will remain uninsured. Grantmakers have lent their support to national enrollment campaigns, as well as outreach and enrollment efforts at the state and local levels. The Healthcare Foundation of New Jersey, for instance, is making a series of grants focusing on outreach targeted to particular population groups considered to be at risk of not enrolling. The California Endowment is targeting outreach to Medicaid-eligible populations and hard-to-reach groups, including those with mental illness, homeless people, and those with limited English proficiency. Other funders are working to develop information that can be used by those focusing on getting people insured. For example, the Kaiser Family Foundation identified five lessons from the Medicaid and the Children's Health Insurance Program experience that can inform outreach and enrollment efforts relating to ACA implementation (Kaiser Commission on Medicaid and the Uninsured 2013).

- ***Shoring up the Safety Net to Meet Tomorrow's Needs*** – Health grantmakers are also working with safety net providers to plan for the transition period and to ensure the financial security required to continue service to vulnerable groups whose coverage status will be changing. This work, in many cases, builds on a relationship extending over many years, as in the case of the California HealthCare Foundation's work with the state's public hospitals, which has helped put them in a stronger position to adapt to the post-reform environment (Brousseau and Chang 2013). The Blue Shield of California Foundation is also working with safety net health centers in the state to see that they are positioned to become providers of choice in the post-reform health care environment.

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