WHITE PAPER
Preserving the Health Care Safety Net

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Ethics Committee

Approved by:
The Health Council of South Florida
Board of Directors

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"...the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadow of life; the sick, the needy and the handicapped." ~

Last Speech of Hubert H. Humphrey

"A nation's greatness is measured by how it treats its weakest members." ~

Mahatma Gandhi

The Health Council of South Florida, Inc. (HCSF) is the state designated local health planning agency for Miami Dade and Monroe counties and is authorized under F.S. 408.033 to promote the health of the local community it serves. In 1989, the HCSF established a community based Health Care Ethics Committee, which is the oldest such committee in Florida and stands as an exemplar for the nation. Its members include health care providers, educators, researchers, community advocates, clergy, and experts in the fields of bioethics and law. Its purpose is to serve as an unbiased forum, a collective voice and a resource to identify and address the ethical components of important health care issues that arise in our community.

In 2011, the Ethics Committee spearheaded the development of this White Paper on Preserving the Health Care Safety Net in order to address the issues surrounding its current state, importance to the community and the consequences that would occur should the community allow it to fail. As a result of our deliberations, the Ethics Committee of the Health Council of South Florida supports the position that the community and its leaders have an ethical and moral obligation to preserve and strengthen the health care safety net in order to protect the health and safety of ALL members of the South Florida community. The 2012 HCSF state legislative agenda also supports this position. In addition, the HCSF endorses the position of the World Health Organization that health encompasses "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Disclaimer: *The contents of this white paper represent the most current information available at the time of publication***.**

I. OVERVIEW

People mistakenly believe that everyone receives health care when they need it. In reality, however, 65% of Miami Dade County was classified as medically underserved in 2005[1,2] In Monroe County, where 20.6% of adults could not afford to see a physician in 2009,[3] the situation is at least as severe. When people who have lost their insurance, or never had insurance, need healthcare, they typically rely upon an umbrella of community based healthcare groups collectively referred to as the healthcare safety net. This safety net includes free clinics, federally qualified health centers (FQHCs), public and non-profit hospitals, and other health organizations that are mandated by law to provide "reasonably sufficient" [4] care to all.

When the safety net adequately serves the community, its members receive timely care, their health and productivity are protected, and the entire nation is fortified. This is especially true since most uninsured individuals are employed[5], and so their health and wellbeing are central to our national prosperity. At present, however, planned changes to Medicaid[6] and implementation of healthcare reform will reduce funding for the safety net and threaten its ability to meet the community's needs. If the safety net cannot meet community needs, people will not receive timely care. Their conditions will worsen until they are forced to seek treatment in hospital emergency departments (EDs),[7] from which no one is turned away. This preventable sequence of events will increase suffering, reduce productivity and inflate cost.

Every member of society, not just those with adequate health care insurance, has a right to health care. As the US Department of Health and Human Services states in Healthy People 2010, "every person…across the nation deserves equal access to…health care…"[8] And equal access to health care depends on a viable safety net. The Ethics Committee of the Health Council of South Florida therefore maintains that all stakeholders have a moral and ethical obligation to preserve and strengthen the safety net by rejecting all planned funding cuts and bolstering support for those entities that lose direct funds because of healthcare reform.

II. WHAT IS THE SAFETY NET?

The safety net is an umbrella of community based healthcare groups that provide care to all members of the community. A component of every community, the safety net provides critical security to the community, should established systems fail. Originally, alms houses were created to treat the poor, and religious orders opened refuges for any in need. In Miami Dade and Monroe counties, these developed into publically funded hospital systems (i.e. Jackson), and the non-profit hospitals, such as Baptist, Mariners and Mount Sinai Hospitals. Today Florida's safety net is made up of 44 Federally Qualified Healthcare Centers (FQHCs)[9], 15 safety

net hospital systems, more than 129 community health centers and 104 free clinics. Additional free clinics have not been identified, although they certainly exist. Payment methods for provided services include Medicare, Medicaid, sliding fee scales based on ability to pay, or free of charge, as is the case with free clinics.

Safety net providers offer immunizations[10], care to the elderly, treatment and prevention of infectious diseases, oral and mental health services, and public health information.[11] They also assist in the education, development and preparation of the healthcare workforce.[12] By keeping the community healthy, helping to prevent the spread of communicable diseases, and providing training ground for the healthcare workforce, the safety net benefits all members of the community – those who seek care there as well as those who do not.

III. WHY WE NEED THE SAFETY NET

Employer-based health insurance has been the backbone of our health delivery system since the 1930's. Most people in the United States who carry health insurance have that insurance through their employer. But not all health insurance policies are equal or cover everyone equally. Many have high deductibles or high co-pays. Separately, as businesses engaged in cost-saving measures during the recession which began in 2007, many dropped health insurance for their employees. Others are requiring their employees to share this cost or pay for it totally with post-tax dollars. Those who cannot afford this additional expense opt out or choose high deductible policies, which act as a deterrent to seeking care.

Others think that they are well covered, until they have an accident or develop a medical condition that prevents them from returning to work. Since they cannot return to work, they lose their job and with it their health insurance. They can apply for the Consolidated Omnibus Budget Reconciliation Act (COBRA), the government mandated system that allows people to continue on their previous plan until they find a new job or 18 months, whichever comes first. But COBRA is very expensive, and with no job is often unaffordable. Suddenly, an upstanding, hard-working, dues-paying member of society is un-insured and in need of continuing health care.

Still others are self-employed and carry insurance purchased as an individual policy. If they become profoundly ill or suffer a serious accident, they may exceed the coverage of their policies and lose their insurance.

Thus, everyone who has health insurance is in jeopardy of losing it. Given the way that Americans receive health insurance, everyone is just one accident, one illness or one employer

decision away from being without coverage and needing to rely on the safety net. This fail safe is not for just the 25% of American residents living in poverty. It is the fail safe system for ALL!!!

IV. NUMBER OF UNINSURED AND UNDERINSURED

Greatly affected by the recession,[13] Florida has the nation's third highest rate (27.42%) of uninsured residents.[14,15] The problem is especially severe in the City of Miami, where 50.4% of 18 to 64 year olds are uninsured [16]and in Miami Dade and Monroe counties, where the 31.8% and 32% rates (respectively) of uninsured is nearly double the average national rate of 16.3% and exceeds state averages for all income, age and work status groups.[17]

In Monroe County, unemployment is notably low at 6%. However, because the local economy is anchored in self-employment and low-paying small businesses that cannot provide benefits, a staggering 40% of employed residents between 18 and 64 and 23.7% of children are uninsured, compared to the state level of 15.1%. Moreover, 12.6% of residents (16% of children) were living in poverty and 14% reported poor health.

Low unemployment in Monroe County notwithstanding, the continued pace of unemployment elsewhere in the state indicates that safety net providers have not yet experienced the full impact of the recession as many more individuals will be without insurance coverage. Compounding the problem, the safety net is now and will, under forthcoming healthcare reform, remain the only source of medical care for undocumented immigrants,[18] who comprise the primary workforce of Florida's agricultural industry, second only to tourism in economic importance.[19]

Strain on the safety net is intensified by the needs of women, who comprise 56% of Medicare beneficiaries 65 and older, 62% of beneficiaries 80 and older, and 75% of Medicaid beneficiaries ages 18-64. Over 50% of women have problems accessing care because of cost, 45% incur higher medical debt than men, and 7 out of 10 are either uninsured or underinsured.[20] Women, who generally have less access to health care than men, depend more on the safety net than men do; its weakening will increase the existing gender disparity.

Fifty percent of the total Miami-Dade population is foreign born, compared with 19% for all of Florida and 13% nation-wide. Although nationally, the majority of uninsured are citizens,[21] the foreign-born population[22] has higher uninsured rates (33.48%) than the native population (12.86%).[23] Again, the problem in Miami-Dade County is especially severe. Here, as in the rest of the nation, most uninsured Hispanics are employed, but are concentrated in low wage jobs that do not offer insurance.[24] In Miami-Dade County, where over 60% of the population is Hispanic (foreign and native born combined), more are employed but uninsured (61%) than

anywhere else in the state and they comprise more than 50% of the patients of FQHCs. Central and South Americans, whose Miami-Dade population is the largest in the state (20% versus 5%), have the highest risk of being uninsured. [25]

The enormous number of Miami-Dade and Monroe residents who lack access to mainstream healthcare is reflected in the numbers who seek treatment from safety net centers. Unfortunately, Florida, Miami-Dade and Monroe statistics are unavailable; nationwide, however, Community Health Centers treated more than 31 million people between 2006 and 2008.[26] The total number of safety net visits increased 14% between June 2008 and June 2009.[27] At the same time, budget woes are resulting in cuts to these vital providers. Thirty six states and the District of Columbia have reduced funds towards their safety net; Idaho and South Dakota have cut off funding entirely.[28]

The ethical position that the healthcare safety net should be fully funded is further supported by narrowing the scope of the statement to the health and welfare of children. The healthcare safety net for uninsured children under age 19 in Florida is KidCare, the Children's Health Insurance Program (CHIP). In 2011, KidCare enrollment increased 3.9 percent and its Medicaid component by 4.4 percent. KidCare currently provides health care to more than 2 million and Medicaid to 1.7 million. Despite the millions enrolled in KidCare or Medicaid, "nearly 400,000" are still uninsured[29].

Florida KidCare services are provided via a network of managed care organizations, private and state funded providers. The network providers are reimbursed at the current Medicaid rates, which are about 57 percent of Medicare[30]. The current Medicaid rates are so low that providers are unwilling to accept new patients. Compounding the low provider reimbursement rates, there is an issue with a general lack of providers.

The Florida KidCare Coordinating Council, responsible for making the program's implementation and operation recommendations, identified a single priority for 2012: "Fully fund the Florida KidCare program…"[31] Their recommendation is of great significance to the preservation of the safety net, given that the safety net is dependent on Medicaid funds to offset the cost of providing uncompensated care.

V. WHERE ARE WE?

While demand for care in the safety net system is increasing, budget cuts have reduced the capacity of safety net providers. Because of the lack of available and timely care in other safety net settings, the ED has become a major source of care for communities with a high rate of uninsured members.[32] Also contributing to the high rates of ED usage is its proximity to public

transportation, the availability of around-the-clock care without an appointment and the promise of the Emergency Medical Treatment and Active Labor Act (EMTALA). This law states that anyone who comes to the ED requesting care must receive an examination and, if he or she is suffering from "an emergency medical condition," must be stabilized. Because the ED is their only option, the uninsured are more likely than the insured to be diagnosed in the ED with an advanced disease[33] and to be hospitalized for conditions that could have been avoided had earlier care been available.[34] The Miami experience is consistent with the national data.[35] According to a study by the Urban Institute in 2006, 22,000 people died because they lacked insurance and had limited access to care. These deaths have been increasing by about 1000 every year.[36] The continued pressure that EDs experience to provide care stresses the whole system and reduces everyone's access to emergency care. This, in turn, puts the entire community at risk.

In Monroe County, these problems are exacerbated by the rural nature and the geography of the County, the high incidence of poverty, the large number of residents without health insurance, and unusually high numbers of elderly and seasonal residents. Just three small hospitals and one free clinic serve the 71,000 residents of this county, a 125-mile-long chain of islands linked by a single two-lane road with more than 60 bridges. With speed limits averaging 45-55 miles per hour, it takes over three hours to drive from Key West to the mainland. Yet only one hospital in the Keys provides a labor and delivery unit. A single OB-GYN, who sees patients just one day a week and does not accept Medicaid, serves all the Upper Keys. There is just one primary care physician for every 1,145 persons, nearly twice the national benchmark of one per 631. And few pediatricians accept new Medicaid or SCHIP patients. To complete this dire picture, the County offers no Medicaid managed care network even though Florida Medicaid reform requires all Medicaid recipients to enroll in managed care. These realities demonstrate the urgent need to strengthen the existing safety net in Monroe County and expand it into a robust, well-coordinated system.

VI. BENEFITS OF PRESERVING AND STRENGTHENING THE SAFETY NET

If what needs to be done to correct the budget crisis is to control spending by reducing costs, then the logical step is to preserve and strengthen the safety net so that it can provide primary care and timely interventions for developing and chronic diseases. It is well known that access to coordinated care emphasizing primary care is more cost effective and produces better outcomes than denying care until conditions deteriorate and then relying on the ED for emergency treatment.[37] In fact, it has been demonstrated that the cost of care provided by well structured, comprehensive safety net programs for the uninsured is less than the estimated cost of care by Medicaid programs or by private insurance.[38] According to a study of four model programs assessing per-patient-per-month costs, actual per-patient-per-month

costs in Asheville, North Carolina, ran $149, compared to $302 estimated Medicaid costs. In San Antonio, Texas, actual safety net costs were $129 compared to $267 estimated Medicaid costs.[39] Moreover, by bolstering these programs, thereby providing access to affordable care for the uninsured, the government can protect large segments of the population from incurring the kinds of costs that lead to financial ruin. In the process, it will help to keep this population healthy and productive. Affordable care for the uninsured thus remains a critical issue for states and communities, as well as for the federal government.[40]

VII. CHALLENGES FACED

Several factors threaten to overwhelm "the structure, function, and mission of the safety net".[41] In short, the system is losing funding just as the number of people who need it and rely on it is growing.

As people have lost insurance, demand on the safety net has increased. It struggles to provide services and anticipates increased pressure with more than 49.9 million uninsured[42] and many more underinsured. Florida's FQHCs experienced an increase in visits from 2.3 million in 2004 to 3.7 million in 2009. Out of the 13 existing free clinics in Miami Dade and one in Monroe, 3 were opened between 2007 and 2009. The number of patients visiting free clinics has doubled during that time period as well. The roles of the free clinic in providing care and lessening the load on hospital EDs in Miami Dade County has been recognized as indispensable.[43] Still, the burden on Florida's 15 safety net hospitals to provide general care is enormous. According to Jim Nathan, LMHS President, these hospitals, which "represent just 11.5% of the state's hospitals, provide half of charity care and treat 43% of all Medicaid care. Their trauma caseload is 66% higher than other hospitals".[44]

Separately, the expansion of Medicaid managed care as a solution to the current budget crisis[45] is causing a two-fold problem: One, it is compromising access to care for Medicaid recipients. Two, it is reducing revenue to the safety net providers.

For the purpose of cost-containment, Florida implemented a Medicaid reform initiative changing the program from one of "defined benefit" to that of "defined contribution." Whereas previously recipients commonly sought care from safety net providers, they were now required to enroll in one of 24 managed care health plans. In Miami Dade County, 64% of Medicaid recipients have been placed in managed care, compared to 53.6% in the rest of the nation.[46] A recent review by the Health Foundation of South Florida revealed that this shift was problematic in numerous ways: Chief among them were that recipients were experiencing harmful delays and denials of essential services, people with special needs encountered barriers to care, and inadequacies of "regular" Medicaid (such as a shortage of specialists)

persisted.[47] Yet, there is no clear evidence that the program has successfully reduced cost. In other words, it is not clear whether apparent cost reductions are the result of more efficient care, denial of certain services or reduced access to care.[48]

Regardless, shifting Medicaid recipients away from safety net providers and into managed care is funneling resources away from the safety net system, which relied heavily on Medicaid reimbursement for funding. At the same time, because of problems noted above, large numbers cannot find care. Unable to obtain timely care, they have no alternative but the ED, which must care for them despite diminished resources. Compounding the problem, as healthcare reform is instituted, the national average monthly enrollment in Medicaid is projected to exceed 55 million, and a projected 70 million people, or roughly one in five Americans, will be covered by the program for one or more months during the year.

In his landmark study of 2000, then Surgeon General David Satcher described oral health as essential to the general health and well-being of all Americans and that untreated dental disease was a "silent epidemic." Serious health problems such as infections, bone or nerve damage, tooth loss and even death can result from untreated dental disease. In Florida in 2010, 40,000 Medicaid patients visited the ER for dental reasons, a 40 percent increase from 2008. Dental-related, emergency hospital visits produced charges exceeding $88 million. This is a particularly costly form of dental care for mostly preventable ailments.

Currently in Florida there are only 49 dentists per 100,000 individuals. Of those dentists, over 90 percent are in private practice and similar to all other health care fields, fewer are accepting Medicaid patients. In Florida there are approximately 912 dentists that are accepting Medicaid. The Medicaid dentist ratio is currently 1 per 41,039. As a result, Medicaid enrollees and the uninsured must turn to the safety net for necessary dental care.

Nowhere is this problem more evident than in Monroe County. In Florida, the pediatric Medicaid dentist ratio is currently 1 per 9,747. There are currently no pediatric Medicaid dentists in Monroe County accepting new patients. In children, the most prevalent chronic disease is tooth decay— five times more common than asthma. For every child without medical insurance, there are nearly three children without dental insurance. To make matters worse, there are only four dental care safety net providers for all of Monroe County. Compounding the barrier to dental care accessibility in Monroe County are issues with the limited countywide public transportation system.

The safety net, which provides services to both Medicaid and uninsured patients, depends on Medicaid payments to help compensate the cost of providing care for the uninsured and those who are unable to pay.[49] The ability of the safety net to serve a community is tightly linked to

Medicaid. Any changes to Medicaid directly threaten its only stable source of funding and, in turn, the millions of people who rely upon it. Additionally, "safety net providers reported reduced support from charitable foundations, whose investment portfolio values also declined." [50]

While dealing with the problems of the uninsured requires expanding health insurance coverage, it also requires guaranteeing the sustainability of safety net programs. And while the focus of the Affordable Care Act (ACA) is on expanding health insurance coverage, millions are expected to continue to fall through the cracks. It is estimated that by 2019 between 23 to 35 million people will remain uninsured requiring the preservation of the safety net.[51]

VIII. CONCLUSION

The Universal Declaration of Human Rights states that "everyone has the right to…medical care." [52] Liberty, justice and fairness, responsibility, and medical progress are concrete values that have roots in the accepted ethical principles that define health care systems. Justice and fairness in public health are the premises on which the concept of equal access to a basic standard of health care and the fair distribution of resources for all are based. When taken as a whole, it is clear that providing health care to each member of society is an ethical obligation.

These same ethical standards are mirrored in many established US government programs and are made evident throughout their stated missions and goals. According to the Ethics Working Group of the White House Health Care Task Force charged with defining the principles and values for the national health care reform, Medicare, Medicaid and EMTALA serve to support the understanding that all members of society have the same value and as such have the same right to health care.

It is therefore imperative for the general health and welfare of all residents of Miami Dade and Monroe Counties that the safety net be preserved and fully funded.

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