

KEY FINDINGS FROM HSC'S 2010 SITE VISITS: HEALTH CARE MARKETS WEATHER ECONOMIC DOWNTURN, BRACE FOR HEALTH REFORM

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Lingering fallout—loss of jobs and employer coverage—from the great recession slowed demand for health care services but did little to slow aggressive competition by dominant hospital systems for well-insured patients, according to key findings from the Center for Studying Health System Change's (HSC) 2010 site visits to 12 nationally representative metropolitan communities. Hospitals with significant market clout continued to command high payment rate increases from private insurers, and tighter hospital-physician alignment heightened concerns about growing provider market power. High and rising premiums led to increasing employer adoption of consumer-driven health plans and continued increases in patient cost sharing, but the broader movement to educate and engage consumers in care decisions did not keep pace. State and local budget deficits led to some funding cuts for safety net providers, but an influx of federal stimulus funds increased support to community health centers and shored up Medicaid programs, allowing many people who lost private insurance because of job losses to remain covered. Hospitals, physicians and insurers generally viewed health reform coverage expansions favorably, but all worried about protecting revenues as reform requirements phase in.

Dominant Hospitals Maintain Clout, Strong Bottom Lines

The economic downturn's severity varied across the 12 communities, with 2009 unemployment rates ranging from 6.2 percent in Little Rock, Ark., to 11.1 percent in Greenville, S.C., compared with an average of 9.2 percent across metropolitan areas. Overall, large hospitals and hospital systems in the 12 communities weathered the recession fairly well, maintaining strong bottom lines, even in markets such as Cleveland and Miami, where the recession's impact was particularly severe (see Data Source). Most hospitals did see revenues decline and uncompensated care costs increase as privately insured patients struggled to pay out-of-pocket costs, shifted to Medicaid and other coverage for lower-income people, or lost coverage altogether. Reduced patient demand, particularly for elective procedures, decreased operating revenues, although hos-

pitals noted that volumes already were stabilizing as local economies began to recover.

Most hospitals avoided operating losses during the downturn, however, in part by reducing staff, adjusting salaries and benefits, and improving productivity. Some hospitals postponed, scaled back or even canceled construction projects. "Must-have" hospitals—large hospital systems and individual hospitals that health plans must include in their provider networks to remain attractive to consumers—typically maintained or increased negotiating leverage over private insurers. For these hospitals, commercial payment rates continued to increase faster than unit costs, offsetting losses on Medicaid patients and sometimes Medicare patients. Some independent hospitals and smaller systems—particularly those serving more low-income patients—without the

clout to obtain higher payment rates from private insurers did not fare as well.

In contrast to hospitals with significant market power, many physician practices remained price-takers in negotiations with health insurers, with little, if any, increases in payment rates. However, in several markets, some practices could command sizeable rate increases, including large, hospital-owned or exclusively affiliated practices in Greenville and Boston and large specialty practices in Miami. For most physicians, practice expenses continued to grow as fast as or faster than commercial payment rates, providing little cushion against relatively flat Medicare reimbursement rates. Some physicians continued to protect earnings by increasing volume of services, especially in-office ancillary services, and trimming practice expenses. At the same time, physi-



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cians faced growing pressure to invest in costly electronic health records (EHRs), particularly with the introduction of federal EHR incentive programs.

Hospital Expansion Strategies

Hospitals continued to compete aggressively for patients and increase market share. Notably, strategies to expand geographic market areas, while not new, have become more widespread across most of the 12 communities since 2007. Generally, the hospital geographic expansion race involves pursuing well-insured patients beyond traditional market boundaries, whether in affluent suburbs or nearby urban and rural growth areas. To expand, hospital systems were building new capacity or acquiring or affiliating with existing providers in these areas to attract both physicians and patients to shore up referral bases and capture admissions, respectively.

In some areas, such as Greenville, hospital systems have opened full-service hospitals. In others, hospital systems have opened outpatient centers or freestanding emergency departments (EDs) that can be used in a “hub-and-spoke” model to direct referrals for more complex specialty and inpatient care to existing flagship hospitals. For example, in Cleveland, Indianapolis and Miami, hospital systems have built networks of outpatient centers that include offices for employed or closely aligned physicians, laboratory services, imaging equipment and sometimes urgent care clinics.

A relatively new phenomenon, freestanding EDs provide many of the same services as hospital-based EDs and the same opportunities for increased revenue in locations with well-insured populations. Freestanding EDs typically transfer patients needing advanced care to a system’s nearest hospital, perhaps bypassing closer hospitals if the patient is medically stable. For example, Swedish Medical Center, Seattle’s largest hospital system, was planning a string of freestanding EDs in high-growth areas outside the city. At the same time, nearby smaller community hospitals were pursuing similar strategies to protect their market share.

While geographic competition has accelerated recently in such communities as Miami and Seattle, it has been underway

longer in other communities, including Cleveland and Indianapolis. In those markets, the health care sector is becoming increasingly consolidated over widening regions, as independent hospitals and physicians join these expanding systems.

Hospital-Physician Alignment

The acceleration of geographic expansion strategies complements longstanding hospital efforts to expand profitable specialty-service lines and stepped-up efforts to align more closely with physicians, with physician employment, in particular, increasing significantly. During the 2007 site visits, hospitals were employing specialists as part of broader service-line strategies or to fill gaps in emergency on-call coverage. In a few markets, including Cleveland, Greenville and Indianapolis, hospitals also employed—or were aligned closely with—large numbers of primary care physicians (PCPs).

Since 2007, in many communities, the trend of hospitals employing physicians has accelerated and broadened to include PCPs, as well as a wider range of specialists. Hospitals see physician employment and tighter alignment not only as a way to capture more specialty and hospital referrals in a fee-for-service payment system, but also as central to building the clinical and financial integration needed to succeed under potential new payment models, such as accountable care organizations (ACOs), that involve risk-sharing and reward quality and efficiency.

Physicians in most markets—faced with financial pressures, difficulties recruiting younger physicians who often prefer employment in larger organizations, and growing uncertainty about the future under health reform—were more actively seeking the stability and security of employment in larger physician-owned or hospital-owned groups. While strained relations between hospitals and physicians in some markets have not dissipated, many hospitals reported that physicians were more frequently initiating discussions about employment. Some markets, such as Cleveland, Indianapolis and Greenville, appeared to be nearing saturation in hospital employment of PCPs and specialists, while in other markets, such as northern New Jersey and Miami, hospital and physician interest in

employment lagged. In still other markets, competition between hospitals to employ physicians was heating up.

Hospitals were using an array of strategies to gain the loyalty of physicians choosing to remain independent, including providing physicians with administrative and health plan contracting support and offering financial and administrative support for EHR implementation. In a turnabout from earlier site visits and in response to declining profitability, specialty practices that had invested in ambulatory surgery centers and imaging centers in direct competition with hospitals have been selling these facilities to hospitals or entering joint ventures.

Premium Hikes Attract Scrutiny

Health plans' inability to stem provider payment rate increases was most pronounced in markets like Miami, where a highly fragmented health plan sector—with each plan holding relatively modest market share—lacks clout against increasingly consolidated hospitals and single-specialty physician groups. Rate increases also proved hard to contain in Boston, where a different dynamic was at play: Even more than consolidation, it is prestige and brand-name appeal that have conferred must-have status and the consequent ability to raise payment rates on select academic medical centers. While the pattern of high and increasing provider leverage was evident in many markets, it didn't hold true in all communities. Highly dominant plans in some markets—such as Blue plans in Lansing and Syracuse—continued to keep provider rate increases relatively in check—even when dealing, as in Lansing, with a highly consolidated hospital sector.

Large provider rate increases generally were passed on to employers in the form of premium increases—adding to the acute cost pressures of the economic downturn on employers. Steep premium hikes attracted scrutiny from many state regulators and other policy makers. Massachusetts and New York were among the states that imposed rate review on plans in the individual and small-group markets in 2010.

Views were mixed on the impact of rate review, with some observers concerned that it might lead some plans to exit a market segment already lacking in plan competition in some communities. In addition, many

observers suggested that to make a meaningful impact on costs, regulators would need to focus on underlying provider payment rates—not just insurer premiums. However, many questioned whether sufficient political will could be mustered to curb rates for high-cost hospital systems, given the prominent standing of these institutions in their communities and the potential impact of payment cuts on employment. Not only is the hospital sector among the largest employers in many markets, but it was among the very few sectors that grew during the recession.

Consumer-Driven Health Plans Grow, But Consumerism Lags

In discussing trends in consumerism, it is important to distinguish the broad concept—consumers having sizable financial incentives, information on prices, quality and treatment alternatives, and taking more responsibility for their own health—from a specific approach to benefit design—consumer-driven health plans (CDHPs) requiring large deductibles and often paired with a tax-advantaged savings account. The past few years have seen significant CDHP growth in most markets—often starting from a negligible base and increasing to a modest share of enrollment overall, but a significant portion of small-group enrollment. For example, in Boston—a market with historically rich benefits—CDHPs had grown to 15 percent of commercial enrollment and half of small-group enrollment by 2010. CDHP growth has been boosted primarily by cost pressures on employers—pressures intensified by the recession, but also resulting from longer-term utilization and provider rate trends that health plans have had difficulty containing.

While CDHPs gained some traction in many markets, the broader consumerism movement did not keep pace. There was limited growth in the tools designed to inform and empower consumers, such as Web sites reporting hospital and physician price and quality information. More health plans, along with other private and public entities, have introduced or expanded such transparency initiatives over the last few years, but the number of programs providing actionable, provider-specific price and quality information remained quite limited.

Community Tracking Study Site Visit Researchers

HSC conducted its 2010 site visits in collaboration with researchers from various other research organizations. Site visit researchers are organized into three teams, each covering a major area of interest.

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Along with consumer-driven health plan adoption, employers continued to increase patient cost sharing in traditional insurance products.

And, even when useful consumer-support tools were available in a handful of markets, evidence to date suggested that public awareness and use of these tools were limited.

Plan executives, brokers and benefits consultants in many markets observed that employers adopting CDHPs as the only benefit option were often focused primarily or solely on premium savings rather than promoting consumer engagement. Indeed, an increasingly common practice in some markets among employers seeking to keep premiums down, while also shielding employees from high out-of-pocket exposure, was to pair CDHPs with wraparound arrangements that reimburse employees for expenses incurred within the deductible portion of coverage. Health plans were struggling with this employer practice, arguing that it runs counter to the intent of CDHPs and noting that CDHP premiums were priced under the assumption that enrollees would be exposed to the full deductible. Plans in several markets recently began pushing back by implementing tiered CDHP pricing, making the lowest-priced products ineligible for wrap-around coverage.

Many small employers adopting CDHPs purely for the premium savings were in no financial position to provide either wrap-around coverage or to contribute to health savings accounts or health reimbursement arrangements. Since the start of the recession, small employers increasingly turned to CDHPs as an alternative to dropping coverage altogether. Employees with such coverage “are exposed to the ‘skin in the game’ part of consumerism, perhaps over-exposed [beyond] their ability to pay...but the broader notion of having them take on responsibility for [treatment decisions] or [provider] and lifestyle choices—that hasn’t been part of the equation,” observed one California broker, echoing the views of market observers throughout the 12 communities.

When CDHPs were offered by large employers, they still tended to be offered as a choice rather than as a total replacement of existing benefit options. Many large companies adopting CDHPs were taking a somewhat cautious approach of introducing a CDHP alongside existing traditional product options and encouraging employees to choose the CDHP by offering substantial savings account contributions, sometimes

combined with higher employer premium contributions. Once CDHP enrollment reached a significant level (such as 20% to 25%) after a few years, an employer might switch to the CDHP as the main option, requiring employees to “buy up” for traditional products.

One prominent exception to the pattern of large employers transitioning cautiously to CDHPs was Indianapolis, where pharmaceutical giant Eli Lilly joined early CDHP adopter Marsh Supermarkets in implementing total replacement. In addition, the state of Indiana—while prohibited by state law from offering only high-deductible plans—adopted such strong premium incentives in favor of CDHPs that 85 percent of state employees were enrolled in these plans rather than traditional preferred provider organization (PPO) and health maintenance organization (HMO) options. This stood in marked contrast to most other markets, where public employers were not offering or even contemplating high-deductible plans as options. While less prevalent than in Indianapolis, CDHPs also had taken hold in Greenville, where high-profile employers like Michelin were moving toward total replacement.

Along with CDHP adoption, employers continued to increase patient cost sharing in traditional insurance products. In 2007, many market observers had suggested that patient cost sharing had reached its limit and that employers would have to find alternatives to moderate premium costs. With the recession, however, those views changed, and employers continued to pass more costs along to employees. One result was a blurring of distinctions between CDHPs and conventional PPOs, as average individual-coverage deductibles for the latter climbed to \$1,000 in some markets. In markets with a historically strong HMO presence, employers continued to migrate from HMOs with traditional first-dollar coverage to HMOs with deductibles. In Orange County, for example, an estimated 80 percent of Kaiser Permanente’s employer accounts reportedly offered an HMO with a deductible, either as the sole benefit offering or as part of a “high-low” strategy requiring the employee to pay the premium differential for first-dollar coverage.

Wellness Expands

Generally, there was little innovation in health plan products across the 12 communities, but products featuring prevention and wellness components have proliferated since 2007, spreading well beyond products demanded by large, self-insured employers to target even small-group segments. Nearly all commercial products included a few basic wellness features built into the premium: online health risk assessments (questionnaires completed by employees or dependents about their own health and lifestyle), online action plans (suggestions for treatment or other interventions, typically based on responses to health risk assessments), and access to online resources, such as WebMD.

Beyond these basic features, plans in most markets offered fully insured products rewarding enrollees for completing health risk assessments and participating in lifestyle management programs. To a much lesser extent, plans in some markets had begun offering fully insured products rewarding enrollees for achieving health benchmarks on measures such as body mass index, blood pressure and cholesterol levels. While interest in wellness as a cost-containment strategy had spread well beyond large employers, actual adoption of wellness products by small and mid-sized employers remained modest, in large part because these products carry higher price tags—a particular challenge during the economic downturn.

Among large, self-insured employers—many that first implemented wellness strategies years ago—there was an ongoing push to increase integration between wellness and disease management to create comprehensive care management approaches capable of dealing with the continuum of healthy to unhealthy behaviors. Despite the somewhat dampening effect of the recession, an increasing number of large private- and public-sector employers were taking a more direct role in care delivery by launching workplace health clinics, many of which provide primary care in addition to conventional wellness services. As one benefits consultant observed, “Wellness is...the last tool that’s left in the toolkit to control costs and manage care...so many [large] employers are really investing in it, pursuing it aggressively.” Whether wellness programs will yield

positive returns on investment, however, remains to be seen.

Trading Benefits, Broad Networks for Lower Premiums

In contrast to wellness, which requires employers to invest up front in expectation of future payoffs, other product innovations introduced or retooled by plans in recent years typically featured limited benefits or limited provider networks in exchange for lower premiums. Limited-benefit products, often marketed as “value plans,” were targeted primarily at cost-conscious small employers and individuals. Reduced benefits were marketed in many different forms, including limits on the number of covered office visits, caps on prescription drug coverage (e.g., at \$500), or copayments for office visits but high coinsurance (e.g., 50%) for all other services.

When limited-network benefit designs first attracted attention in the past decade, it was largely the result of large employers demanding these options from health plans as part of a value-based purchasing strategy. Narrow-network products exclude non-preferred providers from the network, while tiered-network products place these providers in a tier requiring higher patient cost sharing at the point of service. To date, however, these products have yet to gain traction in the large-group segment, in part because of strong provider pushback—including litigation—and regulatory scrutiny regarding how health plans designate providers for inclusion in high-performance networks. In addition, many large employers have found the premium differential between narrow-network and full-network products—typically 10 percent—too small to justify giving up broad provider choice.

Instead, it was in the individual and small-group markets where narrow-network and tiered-network products made headway in some markets. While nearly all such products focus on limiting physician networks, Blue Cross Blue Shield of Massachusetts took a different approach, offering products with hospital tiering in Boston—a reflection of the impact of high and fast-growing hospital payment rates on already high premiums in this community. First introduced or revamped in 2010, these products impose



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large out-of-pocket penalties for using lower-tier (higher-cost) hospitals, including the renowned flagships of Partners HealthCare System and Children’s Hospital. According to media accounts, about one-third of individual and small-group accounts renewing in early 2011 switched to one of these tiered-hospital products.

Safety Net Caught More People

The economic recession led to more people needing low- or no-cost health care at the same time the downturn reduced states’ and communities’ financial ability to support these services. While demand for safety net services had been growing for a number of years as the rising cost of health insurance resulted in slimmer benefits or loss of coverage, safety net providers saw demand jump during the recession as even more people became uninsured or covered by Medicaid.

Many of these people were “newly poor” patients who had not used the safety net before. The extent of need varied across communities: in 2009, the percentage of the population that was uninsured or had Medicaid coverage ranged from approximately 22 percent in Boston to 48 percent in Miami. Although challenged, safety net providers generally absorbed much of the increased demand and remained financially stable, often with the help of federal policy that protected Medicaid eligibility and increased direct funding to providers.

Changes in patient volume varied across communities and type of provider. Overall, volume increased most dramatically for primary care providers, including community health centers and free clinics. Safety net hospitals’ emergency department volume typically increased while inpatient admissions often were stable or dropped, possibly because of people postponing elective procedures. However, several safety net providers in Cleveland and Phoenix saw more stable or even declining volumes overall for certain services, which they attributed, respectively, to general population declines and an exodus of undocumented immigrants because of job losses and heightened fears of deportation. Health centers in Miami also typically saw stable or waning demand, which some respondents believed reflected the reduced ability of patients to pay income-related fees.

Stimulus Dollars Stretch the Safety Net

In many cases, community health centers were able to treat additional patients because of an influx of funds from the 2009 American Recovery and Reinvestment Act (ARRA). These federal stimulus dollars helped health centers in five of the 12 communities become federally qualified health centers (FQHCs), a designation that brings enhanced Medicaid reimbursement and direct grants to support the costs of caring for the uninsured. For example, the Ingham County Health Department—the Lansing area’s safety net hub—achieved federal status for some of its clinics, and in Orange County, which previously had a sole FQHC organization for a community of approximately 750,000 low-income people, several more were established.

All existing FQHCs throughout the country received temporary grants to help meet the increased demand for services, and many received grants to add facilities and for capital projects. These grants allowed health centers to expand in several common ways, including increasing or renovating physical space, hiring staff, and purchasing new equipment—often information technology to develop EHRs. While these expansions often focused on primary care, some FQHCs—for example, in northern New Jersey and Indianapolis—expanded dental and behavioral health capacity. Total ARRA funding for FQHCs varied across the 12 communities, largely correlated with their number of health centers: from just over \$1 million for the one FQHC in Little Rock to approximately \$80 million across the 31 FQHCs in Boston.

In contrast, non-FQHC clinics and safety net hospitals did not directly benefit from stimulus funding. Ineligible for ARRA grants, free clinics instead were reliant on continued support from volunteers, grants and philanthropy—giving increased for some clinics and declined for others. Although ARRA increased disproportionate share hospital (DSH) payments to states for fiscal years 2009 and 2010—the funds are intended to support hospitals serving a high percentage of low-income patients—safety net hospitals reported that additional DSH funding typically shored up state Medicaid budgets more generally instead of being passed on to

hospitals. In fact, hospitals in several communities reported a decline in DSH payments in recent years. Yet, both inpatient and outpatient safety net providers in some communities continued to receive funding to treat uninsured people through programs largely or partially funded through DSH mechanisms or Medicaid waivers, including the Ingham Health Plan in Lansing, the Medical Services Initiative in Orange County and the charity care programs in New Jersey.

ARRA's protection of the Medicaid program—requiring that states maintain Medicaid eligibility at July 2008 levels as a condition for receiving a higher rate of federal matching funds—indirectly helped both hospitals and health centers and prevented states from making more severe Medicaid cuts. Without these so-called “maintenance-of-effort” requirements, providers likely would have lost revenue as patients lost coverage. Instead, Medicaid enrollment grew significantly since 2007, and some providers' proportion of Medicaid patients—compared to uninsured patients—increased, improving their financial position. ARRA did not safeguard Medicaid provider reimbursement levels, and about half of the communities experienced provider payment rate reductions, but states still had to provide enhanced Medicaid payment rates to FQHCs. And, in some communities, including Cleveland and Lansing, new or increased hospital taxes that gained matching federal Medicaid dollars and were then redistributed to hospitals helped alleviate these cuts.

Budget Deficits Take Toll

How state and local budget deficits affected health care programs and funding for providers also varied. States, such as Washington and New Jersey, that had extended public insurance programs to cover additional groups—including new or undocumented immigrants, childless adults, and higher-income parents—typically pared back this coverage. In addition, some respondents believed that additional federal dollars for FQHCs supplanted some state and local funding for safety net providers. Indeed, most communities saw state funding sources for health centers decline—even completely eliminated in Phoenix and Orange County—and the few communities,

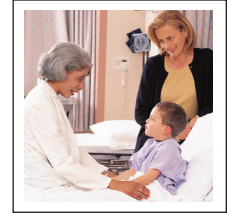
for example, Seattle and Miami, where health centers receive direct local funding typically saw reductions.

Although local tax revenues, which support county hospitals in half of the communities, declined, local officials typically allocated a greater proportion of available funds to these hospitals so that funding levels were at least stable. Maintaining these public expenditures can be financially advantageous for the community as a whole because the funds often can secure federal Medicaid matching funds. By also pursuing internal cost-containment strategies, most safety net hospitals—public and private—weathered the recession, and the financial situation of some even improved from 2007. Miami's public hospital, however, was in significant financial distress, reportedly because of management issues, declining local tax-revenue support and significant growth in uncompensated care costs in this community where almost a third of the population is uninsured.

In an effort to serve more people in a cost-effective way, community safety nets redoubled efforts to advance the medical-home model that has attracted national attention as a goal for all patients. Respondents reported that community health centers embody this approach, given that many health centers serve as a one-stop shop for many additional social services and use health care teams to coordinate patients' care and manage transitions to other providers. A Seattle FQHC director expressed a common sentiment, “We are the medical-home model. It's new for everybody else, but it's what we've been doing forever.”

Still, many safety net providers were unable to keep up with increased demand for certain services. Capacity for services that have long been the most difficult for low-income people to access—specialty, dental and mental health care—typically remained flat or even declined in some communities. Several states cut or reduced coverage of optional Medicaid benefits—especially adult dental services, but also podiatry, vision and other care—and funding for state psychiatric institutions and community-based mental health services.

Although the safety net remained largely intact and even expanded in some areas during the economic downturn, providers



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Data Source

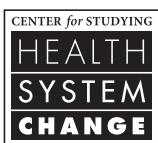
Every two-three years, HSC conducts site visits to 12 nationally representative communities as part of the Community Tracking Study to interview health care leaders about the local health care market and how it has changed. The communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. Almost 550 interviews were conducted in the 12 communities with representatives of health plans, hospitals, physician organizations, major employers, benefit consultants, insurance brokers, community health centers, consumer advocates and state and local policy makers between March and October 2010. This Issue Brief reflects the high-level key findings from these interviews. In the coming months, HSC researchers will complete in-depth analyses on a range of topics that will be published as HSC Issue and Research Briefs and in peer-reviewed journal articles.

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may face mounting challenges depending on how long the recession's effects linger and how implementation of national health reform proceeds. Enhanced federal Medicaid matching funds to states are slated to phase out by mid-2011 and, although the National Conference of State Legislatures reports state revenues are improving, more than half of states were projecting budget deficits for fiscal year 2012. While the federal Patient Protection and Affordable Care Act (PPACA) required states to maintain Medicaid eligibility levels, loss of federal Medicaid funds could cause states to cut other funds that support the safety net.

Bracing for Health Reform

Providers, while positive about the potential to treat newly insured patients, were anxious about the prospect of inadequate reimbursements from Medicaid and from health plans offered through state insurance exchanges scheduled to come on line in 2014. They speculated that primary care physician supply, already tight in some markets, would likely be insufficient to handle additional demand from newly insured patients, especially if physicians are unwilling to treat patients because of low payment rates. Inadequate physician supply, in turn, could exacerbate existing pressures on ED capacity.

Hospitals and physician groups also were exploring how to respond to expected Medicare payment reforms, including the introduction of ACOs and other forms of risk-based payment. Some hospitals and large physician groups were working to develop ACOs. But, in most markets, the early reaction to health reform was increased anxiety about whether payment rates for newly covered patients would be adequate and coming reductions in the growth of Medicare payments, heightening existing pressures to engage in hospital-physician alignment activities, health information technology adoption and cost-cutting measures.

A key concern from safety net respondents was the extent to which support will continue for low-income people who remain uninsured even after the coverage expansions slated for 2014. Although ARRA grants are ending, FQHCs are starting to receive additional funds under the health reform law—\$11 billion over five years to double the number of patients served by 2015. However,

additional community health center funding has already been scaled back, with \$600 million cut this year during the recent budget compromise to keep the federal government from shutting down. Likewise, recent reports indicate some additional drops in state or local public funding for safety net providers, as well as drops in private foundation support and donations that non-FQHC clinics rely on. Also, providers feared that declining DSH funds starting in 2014 may exceed the relative increase in revenues that newly insured patients bring. Indeed, safety net hospitals in Boston—where state health reform in 2006 preceded national reform—struggled financially after much of their direct funding was reallocated to subsidize insurance coverage.

Safety net providers in communities with large Latino populations, including Orange County, northern New Jersey and Miami, were particularly concerned about future resources for the safety net. The Congressional Budget Office estimated undocumented immigrants will account for a third of the 23 million people expected to remain uninsured after full implementation of PPACA. With undocumented immigrants comprising a greater proportion of the uninsured than before, some respondents worried that public and private funding for services for the uninsured could evaporate.

Health plans, while looking forward to opportunities to expand enrollment substantially under national reform, nearly all voiced strong concern about the potential for adverse selection—attracting sicker-than-average enrollees—in the insurance exchanges. The individual mandate's penalties for lack of insurance were widely perceived as too weak, leading many plan respondents and market observers to expect that a substantial portion of healthy people will remain on the sidelines and out of the exchanges. Another concern for many plans—especially national for-profit plans—was complying with minimum medical-loss ratios (MLRs)—the percentage of premium spent on patient care—and additional state and federal regulatory requirements. However, the degree of concern about additional regulation varied widely across markets, with not-for-profit local and regional plans in highly regulated states often already meeting or exceeding MLR and other regulatory requirements imposed by national reform. ■