Health Insurance and the Health Safety Net : The Affordable Care Act and its Effects on Safety Net Providers in the United States

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Abstract : The United States is the world's only advanced country with no universal healthcare. Because of the absence of a national health program, health safety net providers, such as public hospitals and community health centers, have been playing major roles in providing healthcare services to uninsured patients. Although the Patient Protection and Affordable Care Act (the Affordable Care Act) is expected to improve health care coverage in the United States, safety net providers will retain their important roles in delivering services to vulnerable people, especially illegal immigrants. The purpose of this study is to consider the role of the health safety net in the United Sates, where universal access to healthcare has not yet been attained. This study shows recent trends of health insurance coverage in the United States, and then, focuses on key features of the Affordable Care Act and its effects on safety net providers. Finally, the study considers some policy implications from the US case for Japan and other advanced countries with universal healthcare.

Keywords : Affordable Care Act, safety net provider, health insurance, health reform, uninsured, United States

Ⅰ. US healthcare system

1. Sources of national health expenditure

The triad of cost, access, and quality of care should be used to evaluate healthcare systems[1]. In the United States, the cost of national healthcare expenditure has been significant. In 2012, national health expenditure was US$ 2.8 trillion, or 17.2% of gross domestic product. Figure 1 shows the sources of national health expenditure funds. Private insurance paid 32.8%, Medicare 20.5%, Medicaid 15.1%, and out-of-pocket payments were 11.7%. Private insurance and out-of-pocket payments have tended to decline in recent years, while Medicare payments have tended to rise, mainly because of the increase of elderly people.

2. Health insurance coverage

Almost all advanced countries have national health programs to attain universal access to healthcare. Universal access means people can obtain needed healthcare services without financial risks[2]. Some countries, such as Japan, France, and Germany, use social insurance schemes to accomplish universal coverage for healthcare insurance.

The United States has not succeeded in achieving universality of healthcare. Because of the lack of

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Figure 1 National health expenditure by source of funds: 1990–2012

source: CMS web site

Table 1 Health insurance coverage rates by type of health insurance: 2000–13

year	people (thousands)	Private iunsurance		Public Insurance		Uninsured
		employer	individual	Medicare	Medicaid	
2000	279,517	65.1	10.2	13.5	10.0	13.1
2005	293,834	60.7	9.9	13.7	13.0	14.6
2010	306,553	55.3	9.9	14.6	15.8	16.3
2013	313,395	53.9	11.0	15.6	17.3	13.4

source: U.S. Census Bureau (2013) and do. (2012)

National Health Insurance (NHI), a large number of people remain uninsured. Table 1 shows recent trends of health insurance coverage. In 2013, more than 42 million people or 13.4% of the total population did not have any type of health insurance, although this proportion had improved from 2010 (16.3%).

In addition, Table 1 indicates the declining rate of insured people enrolled in health insurance through employment. Although 65.1% of the population was covered by employer-sponsored private health insurance in 2000, only 53.9% was covered in 2013. According to a survey conducted by The Kaiser Family Foundation and the Health Research & Educational Trust, the rate of firms offering health benefits is related to firm size. On average, half of all firms offered health benefits to their workers in 2013 but only 45% of workers in small firms (3–9 workers) received health benefits from their firms, compared to 99% of workers in large firms (200 or more workers).

On the other hand, Table 1 shows there is a growing number of Medicaid beneficiaries. Medicaid is a US public assistance program for indigent people run by 50 states and the District of Columbia. People who have dependent children and annual incomes below the federal poverty line can obtain healthcare services through Medicaid. There Medicaid coverage rate was 17.3% in 2013, a 7.3 percentage-point increase from 2000.

The Balanced Budget Act of 1997 introduced the Children's Health Insurance Program (CHIP), which is an expanded Medicaid program for indigent children aged 18 years and younger. The Obama administration reauthorized CHIP in January 2009 (CHIPRA). Nevertheless, about 7 % of children do not yet

have any type of health insurance.

3. Socio-economic characteristics of the uninsured

The socioeconomic characteristics of people are related to their health insurance coverage. Table 2 shows the relationship between insurance coverage and labor status. In 2013, the percentage of uninsured people among part-time workers was 24%, about 1.7 times larger than that of full-time workers (13.9%), and almost the same as that of people who do not work (22.4%).

Table 2 Labor status of uninsured people: 2013

work experience	total (thousands)	Uninsured (thousands)	Percentage (%)
Total	146,252	24,952	17.1
Full Timer	100,855	14,043	13.9
Part Timer	45,397	10,908	24.0
Not Worked	48,581	10,867	22.4

source: U.S. Census Bureau (2013)

Figures 2 and 3 show the demographic characteristics of uninsured people. As for their ethnicity, one quarter or 13.2 million people of Hispanic origin are not covered by any type of insurance (Figure 1). The same disparity is observed with regard to citizenship. Figure 2 shows that a quarter of people without US citizenship (so-called "illegal immigrants") are uninsured. This means 8.3 million who are non-US citizens may face financial risks when the need arises to access healthcare services.

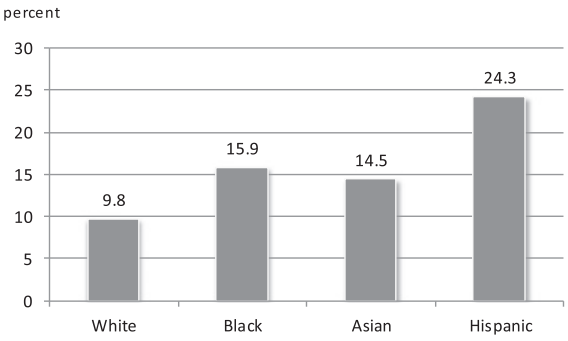

Figure 2 Demographic characteristics of uninsured: 2013

source: U.S. Census Bureau, *ibid*.

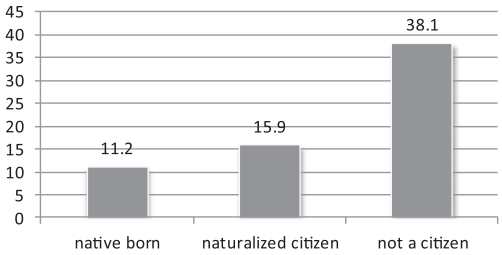

Figure 3 Rate of uninsured by nativity: 2013

source: U.S. Census Bureau, *ibid*.

4. Underinsured patients

In addition to uninsured people, there are insured people who lack insurance coverage for certain necessary services. These patients are called the underinsured. When insurers exclude patients' pre-existing conditions from insurance coverage, insurers restrict or limit core benefits, such as prescription drugs formularies and maximum payments. In these cases, patients become underinsured and face cost burdens in healthcare. Although there are no official statistics about underinsured patients, some researchers estimate

the number at 25 million (Schoen et al., 2008) or 29 million (Short & Banthin, 1995) people.

Underinsurance is found even in US social insurance for the elderly, handicapped, and those suffering from end-stage renal disease under Medicare[3]. Medicare Part A (hospital insurance) covers hospital inpatient stays, skilled nursing facilities stays, hospice care, and home-care services. Table 3 summarizes the costs and limits of benefits under Medicare Part A. There are no deductibles and coinsurance for hospice care and home care. By contrast, for hospital inpatient and skilled nursing facility stays, Medicare patients must pay deductibles and coinsurance. Each patient has to pay a US$ 1,260 deductible per inpatient period and US$ 315 for every day they stay longer than 61 inpatient days. Furthermore, Medicare covers stays of up to 90 days, in addition to 60 lifetime reserve days. When a patient stays longer than 91 days and in case they have used up their lifetime reserve days, Medicare will not pay medical expenses.

Table 3 coinsurance and deductibles in Medicare Part A

Type of services	coinsurace and deductibles
Hospital inpatient stay	$1,260 for each benefit period
Days 1 to 60	no coinsurance
Days 61 to 90	$315 per day
Life time reserve days: 60 days	$630 per day
Beyond life time reserve days	All costs
Skilled nursing facility stay	no deductibles
Days 1 to 20	no coinsurance
Days 21 to 100	$157.50 per day
Days 101 and over	All costs

In addition to high coinsurance and deductibles, there is a coverage gap in Medicare Part D. This part of Medicare was introduced by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 to cover outpatient prescription drug benefits[4]. Until this legislation, Medicare did not reimburse outpatient prescription drug expenses. However, currently, Medicare Part D has a coverage gap. It covers 100% of drug costs to a limit of US$ 2,960, although it pays all drug costs higher than US$ 4,700 Medicare because catastrophic coverage is applied. For payments between US$ 2,960 and US$ 4,700, Medicare covers only 45% of drug costs. This is called the "donut-hole." The Affordable Care Act is intended to relieve this gap until 2020.

Due to cost burdens and limitations of insurance benefits in Medicare, most beneficiaries have enrolled in private health insurance for supplemental coverage. These insurance plans, which meet the criteria set by the federal government, are called Medicare Supplemental Coverage, or Medigap.

5. Unequal access to healthcare

The US Department of Health and Human Services reports disparities of healthcare access and utilization among people who are insured by private insurance and Medicaid, and those who are not insured (DHHS, 2013). Table 4 summarizes some aspects of unequal healthcare access in the United States. In 2012, when asked about their usual sources of healthcare and whether they had undertaken a healthcare visit in the past 12 months, more uninsured people answered "no" than privately insured people and Medicaid beneficiaries. Even among children under 18 years of age, 28.4% of uninsured children had no usual sources

Table 4 Unequal health care access by insurance coverage

	no usual source of health care (2012)		no health care visit within past 12 months (2012)	
	under 18	18–64	under 18	under 65
praivate insurance	1.7	10.1	9.5	13.2
Medicaid	3.1	13.1	10.3	10.6
uninsured	28.4	54.1	31.9	38.4

	use of mammography (2010)	use of pap smears (2010)
	women 40–64	women 40–64
private insurance	75.6	84.2
Medicaid	64.4	78.0
uninsured	36.0	61.9

source: DHHS (2013)

of healthcare. In addition, 31.9% of children did not obtain healthcare services within the past 12 months, which is three times more than insured and Medicaid children (13.2%).

In addition, there is inequality surrounding preventive services. In 2010, among women aged 40–64 years, the rate of having mammographies among uninsured women was only 36% or about half the rates among privately insured women and Medicaid beneficiaries (75.6% and 6.4%, respectively). Furthermore, the rate of having Pap smears among uninsured women was 61.9%, which is smaller than the rates of privately insured and Medicaid beneficiaries (84.2% and 78%, respectively). Apparently, women without health insurance have fewer medical checkups than those who are insured do, and hence, they are at risk of delaying, for example, cancer treatments.

Ⅱ. The Affordable Care Act and its effects on safety net providers

1. Key features of the Affordable Care Act

US President Barack Obama succeeded in historic health reform by enactment of The Patient Protection and Affordable Care Act of 2010. Of the many political concessions, the Affordable Care Act introduced new and innovative policy means to enhance enrollment in private health insurance without sharp growth of healthcare expenditure. Table 5 summarizes key features of the Affordable Care Act.

First, the Affordable Care Act implements individual and employer mandates. All US citizens, except Native Americans and members of some religious groups, have to enroll in federally qualified health insurance plans, or pay penalties. The penalty is set as the higher amount of 2% of household income or US$ 325 (plus US$ 162.50 per child under 18 years) in 2015. In addition, employers have to offer health benefits to their employees, or pay penalties. The employer mandate is applied only to firms with 50 or more employees, while more than 90% of employers already offered health insurance to their employees. Moreover, the employer mandate has been postponed to October 2017.

Second, the Affordable Care Act introduces health insurance market reform. To increase the number of enrollees in qualified health insurance, the statute established the health insurance exchange (Exchange). The Exchange is an online enrollment system in which federally qualified insurance plans are listed. The federal government provides aid to people who enroll in health insurance through the Exchange if their

household income is below 400% of the poverty line. In addition, the federal government supplies tax expenditure to small firms that offer health insurance to their employees.

Each state government has the discretion of whether to establish Exchanges. For people who live in states that have defaulted on establishing Exchanges, the federal government has established its own Exchange, and provides aids to people who enroll in insurance through the federal Exchange instead of the state-run Exchanges. Actually, a lawsuit was instituted against this federal aid, with the plaintiffs arguing that the statute permitted eligibility to enrollees only through state-run Exchanges. However, the US Supreme Court decided that federal aid did not violate the statute[5].

Another market reform implemented by the Affordable Care Act has been to strengthen government regulations to insurance companies. In these new regulations, insurers have to offer minimum coverage, cannot deny enrollment or renewal without specific reasons, and must use adjusted community rating, not experience rating. By means of the Affordable Care Act, the federal government is attempting to regulate the risk-selection behavior of insurance companies, although many states have already set similar regulations using state insurance laws.

Third, the Affordable Care Act is intended to increase Medicaid beneficiaries by expanding Medicaid qualifications to people within 138% of the federal poverty line (about US$ 16,105 for an individual and US$ 32,913 for a family of four in 2015). In addition to higher income extension, the statute qualifies indigent adults who do not have dependent children. Therefore, the trend toward increased Medicaid beneficiaries, as shown in Table 1, will continue. However, the US Supreme Court has decided that mandatory Medicaid expansion violates US law, and that expansion should depend on states' discretion[6]. Since this juridical decision, 24 states have not expanded Medicaid.

Fourth, the Affordable Care Act stresses the enhancement of effective and patient-centered healthcare, and establishes a Medicare Shared Savings Program. In this newly introduced payment scheme, healthcare providers that qualify as an Accountable Healthcare Organization can obtain additional payments for providing healthcare services to Medicare beneficiaries. To acquire the status of an Accountable Healthcare Organization, hospitals or physician groups have to qualify as per guidelines set by the Center for Medicare and Medicaid Services.

Finally, to finance these reforms, the Affordable Care Act is set to impose new taxes, for example: (a) a 0.9% increase in the Medicare tax rate, (b) a new tax of 3.8% on high-income taxpayers (US$ 200,000 for an individual and US$ 250,000 for joint files), (c) a new tax of 40% on "Cadillac insurance," which costs more than US$ 10,200 per individual per year, (d) a new tax of 2.3% on medical devices, and (e) a new tax of 10% on indoor tanning services.

These new taxes and tax hikes have caused frenzied political debate within the Republican Party. However, the Congressional Budget Office has stated that implementation of these reforms could reduce

Table 5 Key features of the Affordable Care Act

(a) Individual mandate (enroll or pay penalty)
(b) Employer mandate (offer insurance to employees or penalty)
(c) Health insurance exchange
(d) Regulations to insurance companies
(e) Expansion of Medicaid beneficiaries
(f) Enhance effective health care
(g) New taxes on health insurance and medical devices

federal budgetary deficits by US$ 124 billion from the fiscal years 2010 to 2019[7].

It is notable that the Affordable Care Act intends neither universal access to healthcare nor the establishment of a social insurance system. Contrary to National Health Insurance (NHI) in Japan or other advanced countries, the Affordable Care Act relies on the health insurance market. According to estimates by the Congressional Budget Office, even after completing the reform, 31 million people will remain uninsured[8]. The bulk of the uninsured population will be unauthorized immigrants, who are ineligible for either Exchange subsidies or Medicaid expansion.

2. Safety net providers in the US healthcare system

Because of the lack of national health program, safety net providers have been playing major roles providing healthcare services to vulnerable patients, such as immigrants (both legal and illegal), ethnic minorities, the homeless, criminals, patients with chronic conditions, patients with serious mental disorders, and those with infectious diseases, like HIV/AIDS[9]. In addition, these safety net providers account for one third of critical and specialty services (e.g., trauma centers, burn-care beds, and psychiatric-care beds) in large cities[10]. Furthermore, safety net providers supply many kinds of preventive services, outreach programs, like health education or social support for vulnerable people, and advocacy activities for uninsured people. These activities may contribute to relieve health disparities among people in the United States.

Health care institutions that provide care for patients regardless of their ability to pay or to Medicaid beneficiaries mainly are called "core" safety net providers. The core safety net providers are composed of state/local government hospitals, community health centers, and local health departments[11].

While community health centers care for patients on an outpatient basis, state or local government hospitals can provide both inpatient and outpatient care (emergency rooms or walk-ins). For this reason, the numbers of state/ local government hospitals are critically important for indigent patients who require inpatient care. Table 6 shows the number of hospitals by ownership: government hospitals decreased from 1,778 in 1980 to 1,037 in 2012. Around the same period, 428 private non-profit hospitals, that is, public charities approved by the US Internal Revenue Service, closed, and the number of private for-profit (investor-owned) hospitals increased by 338. According to Hall and Rosenbaum (2012), there were 318 public hospital closures between 1983 and 2003, although 212 public hospitals opened; most had changed ownership from private non-profit.

The Kaiser Family Foundation estimates the total of uncompensated care costs was US$ 53.3 billion in 2013 (charity care costs, not included in bad debt) (Table7). According to the estimates, Medicaid and Medicare Disproportional Share Hospital payments (additional payments when hospitals provide much more care for Medicaid or Medicare beneficiaries) meet 40.3% of total uncompensated care costs (25.3% and 15%, respectively). State and local governments' aid for uncompensated care accounts for 18.4%, most of which is

Table 6 Number of community hospitals by ownership: 1980–2012

hospital	1980	1990	2000	2012	change
total	5,830	5,384	4,915	4,999	▲ 831
private non-profit	3,322	3,191	3,003	2,894	▲ 428
private for-profit	730	749	749	1,068	338
state/local government	1,778	1,444	1,163	1,037	▲ 741

source: American Hospital Association, *Hospital Statistics*

Table 7 Source of uncompensated care costs: 2013 ($ billion)

	federal	state/local	private	total	%
total	32.8	19.8	0.7	53.3	100.0
Medicaid DSH・UPL	11.8	1.6		13.5	25.3
Medicare DSH・IME	8.0	0.0		8.0	15.0
state/local government aids		9.8		9.8	18.4
satate/local public assistance		7.3		7.3	13.7
Veterans Health Service	8.1			8.1	15.2
Indian Health Service	2.1			2.1	3.9
community health center	1.9	0.8	0.3	3.0	5.6
others	0.9	0.3	0.4	1.6	3.0

source: Kaiser Commission on Medicaid and Uninsured (2013).

spent in public hospitals. Therefore, Medicaid or Medicare Disproportional Share Hospital payment policy, along with state or local governments' budgets, can influence the financial conditions of safety net providers. In other words, through Medicare tax or the government tax system, taxpayers and employers eventually pay the costs of healthcare for the uninsured and there is no manna from heaven in healthcare.

3. Financial impacts on safety net providers of the Affordable Care Act

As the Affordable Care Act is intended to decrease the number of uninsured people, it could also lighten the burden of safety net providers in providing care to the uninsured. Nonetheless, the Affordable Care Act may cause financial crises for safety net providers. One of the reasons is that the statute does not cover *all* uninsured people, especially those without citizenship. Therefore, providing care to such vulnerable people remains a central role of safety net providers after the implementation of health reform.

In addition, Medicaid expansion will cause financial crises for safety net providers because the Affordable Care Act does not address reform of the reimbursement rate of Medicaid, and rapid increase of Medicaid beneficiaries could cause or worsen the deficits of safety net providers[12]. Indeed, the statute rewards Accountable Care Organizations through the Medicare Shared Savings Program, but it is not easy for safety net providers to qualify, because of the shortage of primary care physicians who play major roles in providing "accountable" care, that is, efficient and comprehensive patient-centered care. In addition, bonus payments through the Shared Savings Program are applied to Medicare beneficiaries, not Medicaid.

To consider the role of the safety net providers after health insurance reform, the experiences in Massachusetts' health reform could provide useful implications. In April 2006, the Massachusetts state launched statewide health insurance reform. The state government introduced: (a) easing the MassHealth (a Medicaid program in Massachusetts) qualification for children up to 300% of the poverty line, (b) creating new public health insurance, the Commonwealth Care Health Insurance Program, and (c) implementing individual mandates (up to 300% of the poverty line) and employer mandates for firms with 11 or more workers. The Massachusetts reform, the predecessor of the Affordable Care Act, is more likely to attain state-level universal coverage through a social insurance scheme. In its aftermath, more than 300,000 additional people have obtained health insurance, providing almost of people in the state with health insurance. However, non-economic barriers, such as ethnic, linguistic, and citizenship status, have remained hurdles for people to use healthcare institutions. Ku et al. (2011) estimate that from 2005 to 2009, safety net hospitals, such as Boston Medical Center and Cambridge Health Alliance, received 20% more patient

numbers, mainly outpatients. In addition, community health centers in the state also received 9.2% more patients around the same period.

On the impact of health reform for safety net providers, Neuhausen et al. (2013) show the impact of the Affordable Care Act in the case of California. In their study, the researchers define bad debt and Medicaid shortfalls as total disproportionate share hospital costs (total costs), and estimate total costs of US$ 2.44 billion in 2010. After implementing the Affordable Care Act, total costs will be slashed to US$ 100 million because of decreased numbers of uninsured people, but Medicaid shortfalls will increase from US$ 196 million to US$ 613 million, mainly because of medical inflation, and so, total costs will reach US$ 2.36 billion in 2019. Furthermore, the share of Medicaid disproportionate share hospital costs will fall to between 33% and 42%, depending on cases. Therefore, without setting proper payment rates for Medicaid, the financial conditions of the safety net providers will worsen after health reform.

Ⅲ. Implications for US healthcare reform

1. National Health Insurance in Japan

Japan attained universal access to healthcare in 1961[13]. In the Japanese NHI system, almost all employers have to offer health insurance to their employees and dependents, and municipalities must administer health insurance for people who do not have health insurance, such as the self-employed, unemployed, or retired people under the age of 75 years. In addition to mandatory enrollment in Japan, there are upper limits for copayments and prohibition of "mixed services" (i.e., social insurance must cover almost all required healthcare services, drugs, and devices). These rules can prevent the issues of the uninsured and underinsurance, and can limit patients' burden of medical costs.

In fact, there are uninsured people in Japan. In NHI, people who do not pay insurance premiums for more than 1 year lose their insurance coverage, and have to pay all medical costs when they use healthcare institutions. In 2013, 3.7 million households (18.1% of all households covered by NHI) delayed premium contributions and 277,039 households (1.3%) lost their coverage[14]. There are other types of uninsured people in Japan. Because official certification of residences is needed when people enroll in NHI, homeless people or illegal residents are not covered. According to the Ministry of Health, Labour and Welfare, the number of homeless people was 7,508 in 2014[15]. Self-employed people are another type of uninsured who do not pay social insurance premiums or taxes. Some researchers estimate that around 1.6 million people may be uninsured voluntarily[16].

When uninsured people need healthcare, they face economic barriers to using healthcare institutions. One survey shows that the annual rate of using healthcare institutions by the uninsured patients was fifty times smaller than that of the insured in 2007[17]. The hurdles to healthcare access for uninsured people in Japan are not different from those in US. Therefore, from the viewpoint of universality in healthcare, both Japan and the United States have the same challenges to improve healthcare coverage for uninsured people, although the numbers of people involved differs significantly.

2. Policy implications for Japan

From the perspective of health policy studies or the economics of healthcare, the US Affordable Care Act might provide some innovative policy options for Japan. First, the idea of a health insurance exchange could be a useful policy tool to regulate private insurance markets. In Japan, many people enroll in private health insurance or special contract insurance with life insurance policies to transfer the burden of costs

(copayments, or out-of-pocket payments, like fees for private hospital rooms) in social health insurance. For the purpose of better regulations on private health insurance, the Japanese government could learn from the future experiences of the US Exchanges. Second, as the Ministry of Health, Labour and Welfare in Japan is pursuing a regional comprehensive healthcare system, supply-side reform in US healthcare, especially the trial Accountable Care Organizations, may be insightful. The outcomes of these reforms by the Affordable Care Act remain for future research questions.

Similarly, understanding the roles and experiences of safety net providers in the United States might be important. The number of foreign workers will increase dramatically in Japan, which is facing a rapid population decrease, and healthcare institutions will have to manage healthcare provision for people with different cultures, ethnicities, and languages.

In this study, issues relating to quality of healthcare in the United States are not discussed extensively. In future research, the author will discuss the quality of healthcare services provided by safety net providers, including the variety of outreach or advocacy activities for vulnerable people field.

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Notes

1 I would like to thank Professor James Warner Björkman, Professor Emeritus, Institute of Social Studies, for valuable comments. Professor Bjorkman's second triad, that is, payers, providers, and patients, is also very important viewpoint, especially for analyzing political processes of health policy.

2 Another important component of universal access to health care is geographical distribution of health providers. It is not discussed here owing to space constraints.

3 Medicare is composed of four parts. Part A is hospital insurance, which pays for inpatient stays. Part B is medical insurance for physicians or other clinical services. Part C is Medicare Advantage, which is a substitute for Medicare coverage to private managed care organizations. Part D comprises outpatient prescription drug benefits.

4 Because private insurers carry Medicare Part D, monthly premiums, deductibles, and coinsurance vary by insurer, and mostly depend on the formularies (lists of drugs that are covered by health insurance) they use. The national average monthly premium of Part D was US$ 33.13 in 2013. The Affordable Act introduced extra premiums for Medicare Part D to households with higher income.

5 *King vs. Burwell* 576 US (2015), available at http://www.supremecourt.gov/opinions/14pdf/14-114_qol1.pdf (accessed September 3, 2015).

6 *National Federation of Independent Business vs. Sebelius*, 567 US (2012), available at https://supreme.justia.com/cases/federal/us/567/11-393/ (accessed September 3, 2015).

7 CBO, *H.R. 4872, Reconciliation Act of 2010* (Final Health Care Legislation), available at https://www.cbo.gov/publication/21351 (accessed January 15, 2015).

8 CBO, *Insurance Coverage Provisions of the Affordable Care Act—CBO's April 2014 Baseline*, available at https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-04-ACAtables2.pdf (accessed January 15, 2015).

9 IOM (200051).

10 America's Essential Hospitals (2014) Essential Hospitals Vital Data, available at http://essentialhospitals.org/

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11 Local health departments provide public health services, such as immunization or family planning, school health programs, and nutrition programs for mothers and children.

12 Moreover, the average Medicaid reimbursement rate is one third of private insurance. Hall and Rosenbaum (2012: 13).

13 *The Lancet* published a series on 50 years of universal healthcare in Japan. These articles are available at http://www.thelancet.com/series/japan (accessed September 4, 2015).

14 Ministry of Health, Labor and Welfare, available at http://www.mhlw.go.jp/file/04-Houdouhappyou-12401000-Hokenkyoku-Soumuka/0000035909.pdf (accessed September 4, 2015).

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17 Available at http://hodanren.doc-net.or.jp/news/tyousa/101129kokuho/kekka.pdf (accessed September 4, 2015).

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医療保険と医療のセーフティネット
―米国オバマケア改革とセーフティネット医療機関の役割を中心に―

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本稿の課題は，米国における医療保険制度の改革とセーフティネット医療機関の役割について考察することである。よく知られているように，米国は，先進諸国の中で唯一，普遍的な医療制度を構築していない。そのため，無保険者に対する診療はもっぱら，公立病院やコミュニティ・ヘルスセンターなど，いわゆるセーフティネット医療機関によって担われてきた。セーフティネット医療機関のそうした役割は，医療保険加入者の大幅な拡大を企図したオバマケアの施行後も，とりわけ不法移民の診療において，引き続き重要である。本稿では，まず米国における医療保険加入状況の現状を概観し，次いで，オバマケアの主な内容と，改革がセーフティネット医療機関に及ぼす影響に焦点を当てる。その上で，日本をはじめ普遍的医療制度を有する先進諸国に対する，政策的な含意について考察したい。

キーワード：オバマケア，セーフティネット医療機関，医療保険制度，無保険者，米国

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