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Estimating the Effects of Health Reform on Health Centers' Capacity to Expand to New Medically Underserved Communities and Populations

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after health center and human rights pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on health centers, their history and contributions, and the major policy issues that affect health centers and the communities and patients they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit operating foundation whose purpose is to support community health centers through strategic investment, advocacy, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on a 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved, medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Estimating the Effects of Health Reform on Health Centers' Capacity to Expand to New Medically Underserved Communities and Populations

Nearly 100 million persons reside in urban and rural communities that can be considered medically underserved as a result of inadequate supply of primary care physicians and elevated health risks.¹ A report by the National Association of Community Health Centers and the Robert Graham Center estimated that 60 million people are “medically disenfranchised” and lack access to adequate primary health care because of where they live, even though many have health insurance.² This brief assesses the potential effects of national health reform on health centers and on the number of patients they can serve. Many experts regard expanding access to affordable primary care services as a key to the success of health reform, along with reducing the number of uninsured. Thus, it is important to understand how Congressional health reform proposals would affect health centers' ability to expand the availability of primary care in communities across the country.

We examine the effects of the draft House Tri-Committee (Energy and Commerce, Education and Labor and Ways and Means Committees) health reform bill, as issued July 14, 2009. Like the health reform proposals being developed by the Senate Health, Education, Labor and Pensions Committee and the Senate Finance Committee, the House bill would provide subsidies for low- and moderate-income people to buy insurance from newly-formed health insurance exchanges, expand Medicaid, and mandate individuals to secure health insurance coverage. In addition, the House bill provides additional funding for federally qualified health centers. We focus on the House bill because it is the version that is most complete at this time and for which there is a complete preliminary analysis by the Congressional Budget Office (CBO).³

Briefly, the analysis finds that the draft House bill, which combines insurance reforms and direct investments in health centers, would both reduce the number of uninsured people and at least double the capacity of health centers to provide primary care services to those who are newly insured as well as to those who remain uninsured. Some of the growth occurs because of increases in federal grants to health centers, but much of the growth results from the fact that health reform would reduce the size of the uninsured population and expand Medicaid and private insurance coverage among health center patients, thereby generating revenues essential to expansion. In addition to serving more people, the expansions would mean that the number of health center sites would likely double, so that thousands of additional communities across rural, suburban and urban areas of the nation would have greater primary care service.

An important limitation on health center expansion capacity will be the reimbursement rates paid by health insurers selling under the proposed health insurance exchanges. Under

¹ Rosenbaum, S., Jones, E., Shin, P. and Ku, L. “National Health Reform: How Will Underserved Communities Fare?”, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, July 2009.

² National Association of Community Health Centers and the Robert Graham Center, “Primary Care Access: An Essential Building Block of Health Reform,” March 2009.

³ Letter from Douglas Elmendorf, Director of the Congressional Budget Office, to Charles Rangel, Chairman of the House Ways and Means Committee, dated July 17, 2009.

existing law, Medicaid and Medicare pay a special, cost-related prospective payment (PPS) to health centers. This payment assures that the cost of treating Medicare and Medicaid patients are mostly covered and that federal grant funding can be preserved for care to the uninsured. In the case of private insurance, payments fall far below health centers' reasonable operating costs.⁴ Our analysis finds that health centers would be able to serve more patients if plans sold through health insurance exchanges paid the PPS rate. Payment at the PPS rate would enable health centers to serve millions of additional patients beyond those who could be served under existing private insurance rates.

Assuring policies that enable the maximum possible expansion of primary care services from health centers is an important element of reform. A recent report examined the experience of health centers in Massachusetts (whose comprehensive reform effort has served as a bellwether for national health reform) and found that though the number of uninsured people in the Bay State plunged after reform, community health centers became even more important as a source of primary health care for both the newly insured people and those who remained uninsured.⁵ The report also found that even as health insurance expansions significantly improved health care access, newly insured persons also experienced ongoing limitations on health care access because of out-of-pocket costs resulting from coverage limits such as deductibles and cost sharing and because of a shortage of primary care physicians. For low- and moderate-income patients, it is essential to find health providers who provide affordable care.

Background

Community health centers are non-profit organizations that provide comprehensive primary care services to low-income people, regardless of their ability to pay. All federally funded health centers are designated under Medicare and Medicaid as federally-qualified health centers (FQHCs); a small number of clinics that do not receive federal grants but meet all health center requirements are considered FQHC "look-alikes." Prior research has established that health centers provide high quality care and can be effective in controlling chronic disease among their disadvantaged patients.⁶

As shown in Table 1, in 2007 (the latest data reported), FQHCs served 16.1 million patients, of whom 39 percent were uninsured and 35 percent were covered by Medicaid. More

⁴ Manatt Health Solutions, *Improving Commercial Reimbursement for Community Health Clinics: Case Studies and Recommendations for New York*, (RCHN Community Health Foundation and Manatt Phelps and Phillips, LLP) New York, New York, 2007.

⁵ Ku, L., Jones, E. Finnegan, B. Shin, P. Rosenbaum, S. "How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform." Kaiser Family Foundation and Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Mar 2009.

⁶ Shin, P., Ku, L., Jones, E., Finnegan, B., Rosenbaum, S. "Financing Community Health Centers as Patient- and Community-Centered Medical Homes: A Primer." The Commonwealth Fund, The George Washington University Department of Health Policy Geiger Gibson Program in Community Health Policy, Washington, DC. May 27, 2009; Chin MH, et al., 2004. "Improving diabetes care in Midwest community health centers with the health disparities collaborative." *Diabetes Care* 27(1):2-8; Landon BE, et al., 2007. "Improving the management of chronic disease at community health centers." *NEJM* 356(9):921-934; Hicks LS, et al., 2006. "The quality of chronic disease care in US community health centers." *Health Affairs* 25(6):1713-1723 (Nov/Dec); Politzer RM, et al., 2003. "the future role of health centers in improving national health." *Journal of Public Health Policy* 24(3/4):296-306. .

Table 1.
Type of Coverage of Health Center Patients and Gaps
in Patient-Related Payments and Costs, 2007

	Health Center Patients		% Gap in Patient-Related Payments & Costs
	Millions	Percent	
Medicaid	5.7	35%	-14.9%
Medicare	1.2	8%	-28.0%
Other Public	0.4	3%	-34.4%
Private Insurance	2.5	15%	-42.5%
Self-pay/Uninsured	6.2	39%	-77.6%
TOTAL	16.1	100%	-39.6%

Note: Columns might not sum to 100% due to rounding.

Source: HRSA's Uniform Data System, 2007

than 90 percent of all health center patients have family incomes below 200 percent of the federal poverty line.

Table 1 also shows that, even though the majority of health center patients are insured, health insurance payments typically do not cover the full costs of health services provided at health centers.⁷ Under federal law, Medicaid and Medicare pay enhanced reimbursement rates, based on a health center-specific, cost-based prospective payment system (PPS). Even so, the rates tend to fall short of the cost of care. Federal data indicate that Medicaid, the best payer, tends to pay about 15 percent less than full costs. Private insurers pay much worse; their reimbursements fall about 43 percent below the actual costs of providing care.⁸ Health centers charge sliding scale fees, based on patients' income levels, so even the uninsured contribute a small portion (about 22 percent) to the cost of their care, but patient payments fall 78 percent short of the costs of care.

Despite these payment gaps, health centers manage to serve millions of patients because they earn other revenue from federal, state, local and private grants, contracts and contributions to support their health care services. Since health centers are nonprofit entities, on balance these additional revenues offset the losses in patient-related revenues, particularly the cost of care for uninsured patients, as well as uncovered health care costs for low income persons who are insured but whose coverage leaves them with significant and unaffordable out-of-pocket costs.

The Effects of National Health Reform

The most dramatic effect of health reform will be to reduce the number of uninsured Americans. The preliminary CBO analysis⁹ estimated that the draft House bill would reduce the

⁷ See the appendix for a discussion of data, methodology and costs. We modified the percent gap for Medicare patients because the Medicare Improvements for Patients and Providers Act of 2008 increased the cap on Medicare payments to FQHCs and that change would not have been apparent in the unadjusted 2007 Medicare data.

⁸ Shin, P., Finnegan, B., Sharac, J., Rosenbaum, S. "Health Centers: An Overview and Analysis of Their Experience with Private Health Insurance." The Henry J. Kaiser Family Foundation, Washington, DC. Jan 2008.

⁹ Elmendorf, *op cit.*

percentage of non-elderly people who are uninsured from 19 percent in 2010 to 6 percent by 2015. Excluding unauthorized immigrants, the percentage uninsured would fall from 17 percent to 3 percent. It does so by creating subsidies to buy insurance through health insurance exchanges, expanding Medicaid, and creating insurance coverage mandates for both individuals and employers. Our analysis focuses on 2015 because according to the CBO analysis, it is the first year in which the full effects of the reform package become evident, while 2019 since is the final year presented by CBO.

Section 2101 of the House bill increases funding for health centers by adding funds in addition to amounts that would otherwise be appropriated. This funding increase begins at \$1.0 billion in 2010, growing to \$4.4 billion in 2015 and \$6.4 billion by 2019. Given the current appropriations level of \$2.2 billion, this suggests total Section 330 funding levels of \$6.6 billion in 2015 and \$8.6 billion in 2019.

The combination of reduced uninsurance and higher funding levels will allow health centers expand to serve millions of additional needy low-income people. As seen in Table 2, we estimate that under the draft House bill, health centers would be able to provide primary care services to 35.6 million patients in 2015 and to 39.0 million by 2019; both levels are more than double the 16.1 million served in 2007. (These projections are based in part on CBO's estimates of the effects of the House bill; our methodology is presented in the appendix.) But these levels still fall short of the 56 million estimated to be "medically disenfranchised."

There are community health centers in every state, the District of Columbia and in the territories. As of 2007, they provided care in 6,672 sites (e.g., clinics) across the nation. The

	2015					
	Millions of Patients			Percent Distribution		
	Current Law	Under Reform	Difference	Current Law	Under Reform	Difference
Medicaid	11.3	15.0	3.7	36%	42%	6%
Medicare	2.5	2.9	0.3	8%	8%	0%
Other Public	0.2	0.2	0.0	1%	1%	0%
Private Insurance	4.8	5.7	0.9	15%	16%	1%
Exchange Plans	0.0	2.6	2.6	0%	7%	7%
Self-pay/Uninsured	12.5	9.3	-3.3	40%	26%	-14%
TOTAL	31.3	35.6	4.3	100%	100%	
	2019					
	Millions of Patients			Percent Distribution		
	Current Law	Under Reform	Difference	Current Law	Under Reform	Difference
Medicaid	12.2	17.2	5.0	36%	44%	8%
Medicare	2.8	3.2	0.4	8%	8%	0%
Other Public	0.2	0.2	0.0	1%	1%	0%
Private Insurance	5.1	5.1	-0.1	15%	13%	-2%
Exchange Plans	0.0	3.2	3.2	0%	8%	8%
Self-pay/Uninsured	13.5	10.1	-3.4	40%	26%	-14%
TOTAL	33.8	39.0	5.2	100%	100%	

Note: "Current Law" assumes anticipated grant funding levels, but not changes in health insurance coverage under the bill. Columns might not sum to 100% due to rounding.

Source: GW estimates

projected expansion of health center caseloads suggests that the number of health center sites across the nation will at least double in the next decade. This means that thousands of additional medically underserved communities across the nation, in rural, suburban and urban areas, will gain health centers that can provide affordable, quality primary care, helping to better serve both the newly insured as well as those who remain uninsured.

We can partition the effects of the direct health center funding increase and the national changes in insurance coverage. The “current law” estimates in Table 2 show the estimated number of health center patients, based on the increased funding levels in the House bill, but without the changes in insurance coverage. That is, if funding levels for FQHCs were increased but broader health reforms do not take place, then 31.3 million patients would be served in 2015, rising to 33.8 million patients by 2019.

Since health reform would dramatically reduce the number of uninsured people and increase the number of Medicaid, privately-insured and exchange-insured patients, its effect would be to reduce the number of uninsured patients receiving care at health centers. This reduction would, in turn, lower health centers’ uncompensated care costs, allowing them to use their grants and other revenues to serve more patients, including both the newly insured and those who remain uninsured. Thus, the additional impact of the insurance reforms means that the number of patients served by health centers would rise by an additional 4.3 million in 2015, to 35.6 million patients. The number of patients served by 2019 would rise by an additional 5.2 million in 2019 to 39.0 million.

We expect that the proportion of health center patients who are uninsured will not fall as steeply as the rate of decline in the overall population. In Massachusetts, the level of uninsurance among health center patients fell only half as much as for the general population. In fact, health centers became more important as a primary source of care for people who remained uninsured. While Massachusetts health centers served about one-fifth of the statewide uninsured in 2006 before reform, they served more than one-third in 2007, the first post-reform year.¹⁰ Health centers also played an important role in providing care for the newly insured population. Many of the newly insured were already patients at health centers when they were uninsured and remained patients once reform commenced. In addition, a shortage of primary care physicians statewide meant that many other newly insured people sought care at health centers, because they were accessible, while it was difficult to get appointments with other physicians.

As discussed above, financing health centers requires a careful balancing of insurance-related revenues (which typically do not pay the full costs) and other revenues. Table 3 depicts how these revenue streams would balance. We present projections of the gaps between patient-related payments and actual health care costs and the revenues from federal, state, local and private grants, contracts and other sources. In both 2015 and 2019, there are substantial gaps for insurance payments from Medicaid, private insurance and exchange plans, as well as large gaps for uninsured patients. As shown in Table 1, the gaps are particularly large because, based on previous research, private insurance (either employer-sponsored coverage or health insurance purchased through the exchanges) can be expected to pay health centers about 43 percent below their costs.

¹⁰ Ku, et al. *op cit.*

Most of these gaps are filled by the increased grant funding from the Bureau of Primary Health Care (BPHC) Section 330 grants. Given current economic and budget circumstances, we conservatively assumed that other federal, state, local and private funding will grow at an average rate of 5 percent per year through 2019. If health centers are actually more successful in earning additional federal, state, local or private revenue, then they would be able to serve more patients than we have projected. For example, the historical average for other revenue growth at health centers was 11 percent per year from 2002 to 2007. If other revenues grew that rapidly through 2015 and 2019, health center caseloads could reach 40 million by 2015 and 44 million by 2019.

The National Association of Community Health Centers (NACHC) recently released estimates of the potential effects of the House proposal.¹¹ They presented potential caseload levels for health centers over the next decade. Our estimates fall in the range projected by NACHC, but on the low side. As noted above, we acknowledge our estimates are conservative and that the actual number of patients served could be higher, if other revenues rise at a faster pace than we projected.

The Potential Effect of Raising Payment Levels for Exchange Plans

Under Medicaid and Medicare, health centers are paid enhanced reimbursement rates under the PPS system because federal policy seeks to minimize the use of Section 330 grant funds designed to help those who are uninsured to fill gaps left by inadequate insurance payments. The enhanced rates also help support health care providers who are located in medically underserved areas where there are inadequate numbers of health professionals and other known health risk conditions. This similar logic could be applied to plans that provide services under the health insurance exchanges, since they would largely be subsidized with federal funds. That is, the same basis used for enhancing payment rates in Medicaid or Medicare could be applied to justify enhancing health center payments in the health insurance exchanges.

Table 3.
Estimated Health Center Gaps in Costs and Patient-Related Payments and Offsetting Revenues Under Draft House Tri-Committee Bill

	Billions of \$	
	2015	2019
Gaps in Costs and Patient-Related Payments		
Medicaid	-\$2.05	-\$2.75
Medicare	-\$0.73	-\$0.97
Other Public Insurance	-\$0.09	-\$0.12
Private Insurance	-\$1.58	-\$1.67
Exchange Plans	-\$0.73	-\$1.05
Self-pay/uninsured	-\$4.29	-\$5.56
TOTAL	-\$9.48	-\$12.11
Offsetting Grant, Contract and Related Revenues		
BPHC Grants (Sec. 330)	\$6.59	\$8.59
Other Federal Grants or Contracts	\$0.29	\$0.35
State/Local/Private Grants or Contracts	\$2.27	\$2.76
Other Private Funding	\$0.33	\$0.40
TOTAL	\$9.48	\$12.11

Note: Columns might not sum to 100% due to rounding.

Source: GW estimates

¹¹ National Association of Community Health Centers, "House Health Reform Proposal and Health Centers: Expanding Access to Care and Bringing Down Costs," July 2009.

The current House draft bill does not include provisions for the application of the PPS system for exchange plans, however. Instead, we anticipate that exchange plans would underpay health centers by about as much (43 percent) as private insurance currently does.

What would happen if exchange plans paid better rates, based on the PPS system? We estimated this by assuming that the gap between payments and costs for patients covered by exchange plans would be 15 percent – the gap rate for Medicaid – rather than 43 percent as it is for private insurance. As seen in Table 4, this would enable health centers to serve another two million patients each year, rising to 37.5 million in 2015 or 41.3 million in 2019.

	Millions of Patients	
	2015	2019
Current Law	31.3	33.8
House Tri-Comm Bill	35.6	39.0
House Tri-Comm <u>Plus</u> PPS for Exchange Plans	37.5	41.3
Difference, with and without PPS	1.9	2.3
Note: Columns might not sum to 100% due to rounding.		
Source: GW estimates		

Conclusions

National health reform could greatly reduce the number of people who lack health care coverage. But health insurance alone is insufficient if there are not enough physicians and other health care providers who can render care for the newly insured. The expansion of health centers is an appropriate way to expand primary care capacity in the United States, particularly for those with low or moderate incomes living in medically underserved areas.

As exemplified by the draft House proposal, health reform can go a long way in not only providing health insurance coverage but in expanding the capacity of the primary health care safety net that serves the nation. It can do so by both reducing the number of people who are uninsured, which would reduce uncompensated care burdens at non-profit health centers and free up resources to serve those who are newly insured, and by increasing federal grant funding as an investment in capacity expansion. Together, this can more than double the capacity of the community health center network in the United States and enable millions of additional people and thousands of additional communities to gain access to affordable primary care. On the other hand, if many of the newly insured are covered by health insurance exchange plans and those plans continue to provide inadequate reimbursements, this will hobble the ability of health centers to provide quality primary care to those who need it.

Appendix – Methodology

The estimates in this analysis are based on two main sources: (1) administrative data about FQHCs reported in the annual Uniform Data System (UDS) reports and (2) CBO's preliminary analysis of the draft House proposal.¹² The UDS data provided information about the current mix of patients and finances at health centers as shown in Table 1. We projected that the cost per patient at health centers would grow at an average rate of 4.3 percent per year, based on the past five years of data. UDS data report “charges” applied by health centers and actual payments received for patients. Analysis indicated that total patient charges equaled \$8.89 billion in 2007, while total accrued costs at health centers equaled \$8.79 billion, excluding donated goods and services and revenue obtained from non-patient related sources (i.e., other health center business activities). Given the almost exact match of cumulative costs and charges, we assumed that reported charges were a reasonable measure of actual health care costs for each class of patient, leading to the computed gap between patient-related revenues and costs shown in Table 1.

We projected these caseload patterns and finances forward to 2015 and 2019, guided by the CBO projections of baseline insurance coverage and projected coverage under the draft House bill. We anticipated that the overall reduction in uninsurance levels in the nation, as estimated by CBO, would be about twice as large as the reduction in uninsured patients seen at health centers, based on the experience in Massachusetts.¹³ This yielded the percent insurance distribution of health centers patients seen in Table 2.

We assumed that the average total costs per patient by insurance type remained proportionate to their 2007 levels. The exception was that we assumed that newly insured patients had costs that were equal to those for privately insured patients. Other analyses have indicated that existing Medicaid patients tend to be sicker than those who are uninsured, so the newly insured should have lower average health care expenses, similar to those of the privately insured.¹⁴ We assumed that average costs and gap rates were similar for those currently privately insured and those covered by exchange plans. The gap for privately-insured and exchange populations may be considered conservative given that such studies focus on general population health and costs whereas health centers patients may be at higher-risk for poor health.

To estimate the total size of the patient caseload at health centers, we estimated the grant and contract revenues as shown in Table 3. We assumed that Section 330 (i.e., federal health center grants) maintains a basic appropriation of \$2.2 billion in future years, but that additional \$4.4 billion was provided in 2015 and \$6.4 billion more in 2019, based on Sec. 2101 of the House bill. We conservatively assumed that all other grant, contract and other revenue grew 5 percent per year. We calculated that health centers had reached their expected caseloads when the dollar gap in patient-related revenues and costs equaled the sum of grant, contract and other offsetting revenues in each year. Since health centers are non-profit, we assume that expenses and revenues must equalize.

¹² Elmendorf, *op cit.*

¹³ Ku, et al. *op cit.*

¹⁴ Ku, L. and Broaddus, M. “Public and private health insurance: Stacking up the costs,” *Health Affairs*, 27(4):w318-327, June 2008.