

medicaid and the uninsured

January 2008

Health Centers: An Overview and Analysis of Their Experiences with Private Health Insurance

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Introduction

Steady growth in the number of uninsured and under-insured has sparked health reform proposals at the national and state levels. With many proposals emphasizing expanded access to private health insurance among the low-income population through the use of tax credits and an emphasis on stable and continuous primary care as a key to improving health care access, the interaction between health centers and private health insurance becomes an important aspect of national health policy. This policy brief provides an overview of health centers, with a special focus on the relationship between health centers and private health insurance.

Following a general overview of health centers, this analysis then uses 10 years of national data from the Uniform Data System (UDS)¹ to examine reimbursement from commercial insurers and the impact on the financial stability of health centers. The UDS allows an examination of the performance of the health center program, including information on the patients served, revenues by payer source, health centers' operating costs, staffing arrangements, and services furnished. The data presented here report on the 1996-2005 time period.² The analysis reveals that health centers do not receive adequate reimbursement from private insurers to cover the costs of treating commercially insured patients. The cumulative shortfalls jeopardize the ability of health centers to fulfill their mission of providing access to care for low-income patients.

Health Centers: An Overview

In general

From their roots in a handful of pioneering clinics,³ community health centers have grown into the nation's largest single source of comprehensive, primary health care. In 2005, 952 grantees provided care to more than 14 million patients in more than 5,000 rural and urban service sites. In addition, more than 100 "look-alike" health centers (that is, clinics that meet all requirements applicable to federally funded health centers but do not receive federal operating grants) served an additional one million patients.⁴

Health centers represent the single largest source of comprehensive primary health care for uninsured, publicly insured, and under-insured low-income patients. In 2005, health centers furnished care to one quarter of all low-income persons.⁵

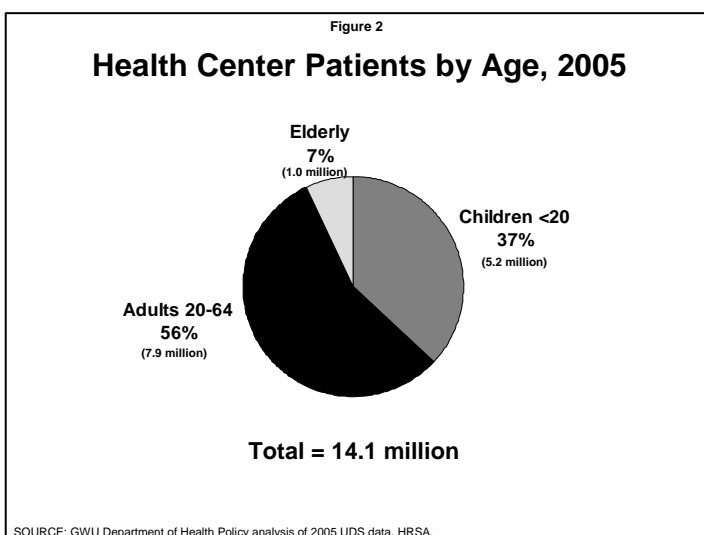
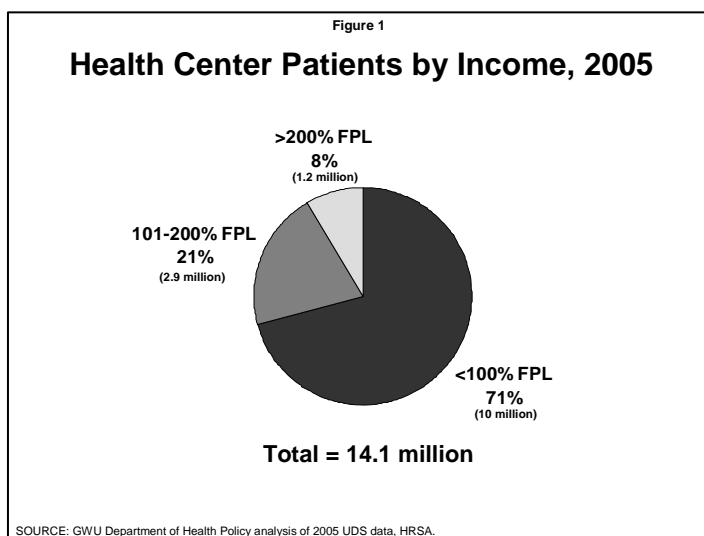
Key characteristics of health centers

Whether federally funded or “look-alike,” health centers possess four key characteristics that are required by law and that collectively distinguish them from other providers of affordable health care for low-income persons. First, health centers are located in, or are targeted to serve, populations and communities that are medically underserved or are experiencing a shortage of primary health care professionals. Second, health centers must furnish a comprehensive array of primary health care services, including preventive, treatment, management, and patient support services, must adhere to federal quality and productivity standards, and must fully participate in government insurance programs. Third, health centers must establish sliding fee scales based on patients’ ability to pay for care; their uncompensated care obligations thus fundamentally differ from a decision simply to forgive uncollectible bills. Finally, in order to assure accountability, health centers by law are governed by community boards, a majority of whose members are health center patients.

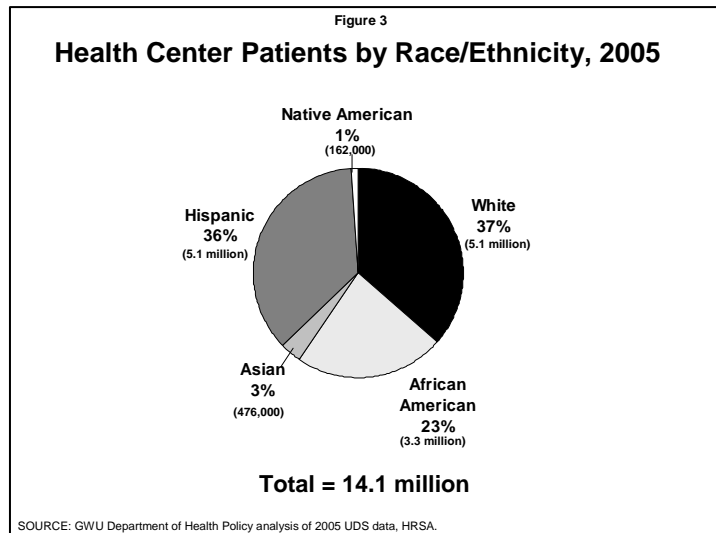
Health center patients

The commitment of health centers to serve anyone regardless of their ability to pay and their location in medically underserved communities means that nearly all health center patients are low-income (low-income is defined as having family income at or below twice the federal poverty level or \$41,300 for a family of four in 2007).⁶ In 2005, more than 70 percent of all patients had family incomes at or below 100 percent of the federal poverty level, while more than 90 percent had family incomes at or below twice the federal poverty level (Figure 1).

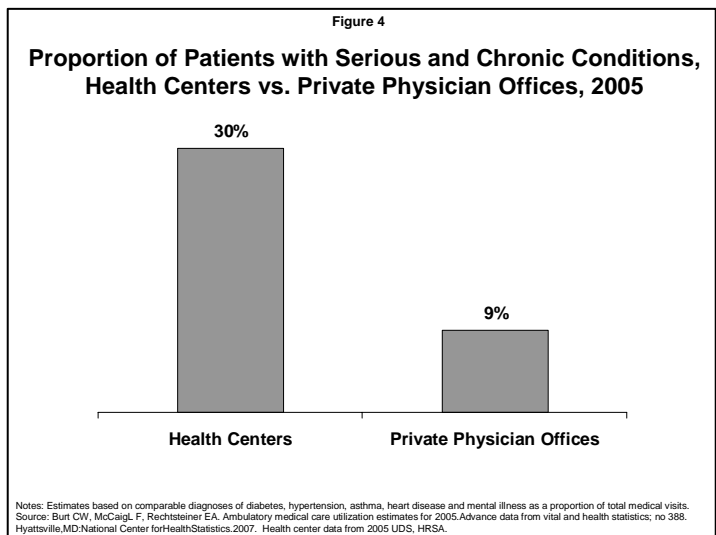
Demonstrating the breadth of services provided, health center patients span all ages. More than one-third of health center patients in 2005 were children and adolescents, making health centers a major source of pediatric health care for low-income children (Figure 2). Health centers also serve a racially and ethnically diverse patient population. In 2005, nearly two-thirds of all health center patients were members of racial or ethnic minority groups (Figure 3).



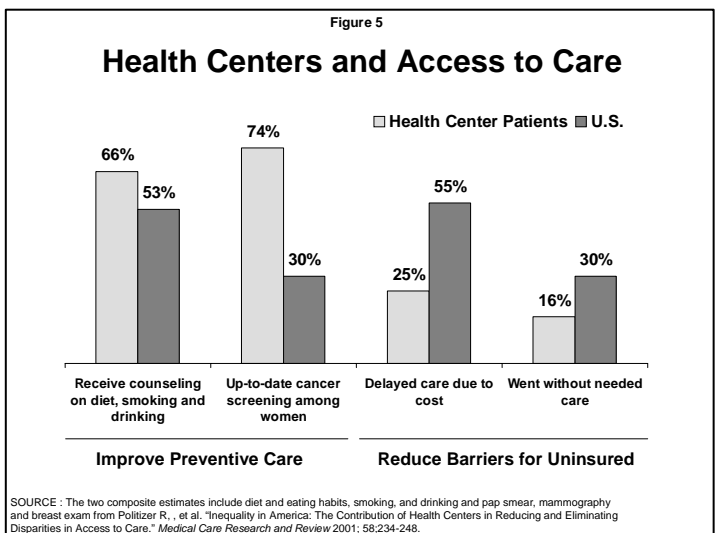
Elderly persons and adults with disabilities comprise an important⁷ proportion of health center patients. Between 1996 and 2005, the number of elderly patients increased 67 percent, mirroring the growth in the overall health center patient population, but was quadruple the growth rate in the elderly population nationwide.⁸ Moreover, although elderly patients as a total percentage of health center patients remains relatively low, these patients are low-income elderly, who experience worse health status and a greater level of need.



Their role in caring for low-income patients means that health centers serve patient populations with significantly elevated health risks. Health center patients are more than three times as likely as patients served by office-based physicians to experience one or more serious and chronic health conditions (Figure 4). As a result, health centers have developed special skills in the management of low-income patients with serious and chronic health conditions.



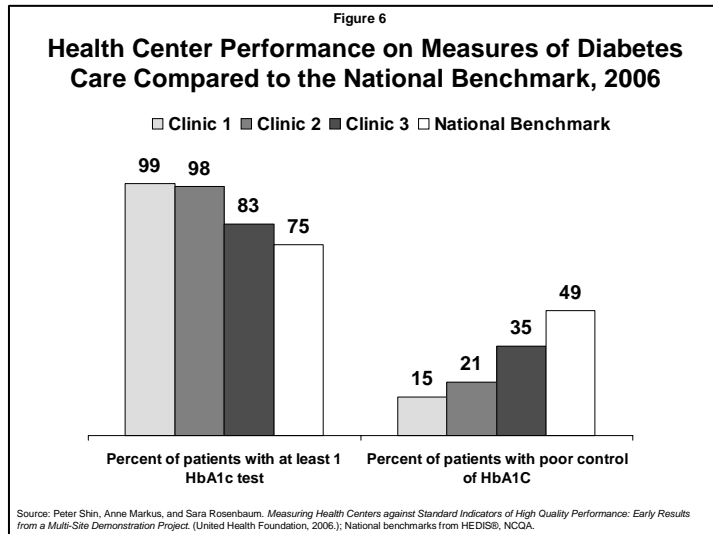
Despite the high prevalence of illness and disability among patients, health centers are known for the quality of their care. An extensive body of literature documents the quality of health center services and their impact on reducing racial, ethnic, and socioeconomic health disparities.⁹ Health center patients are more likely to receive prevention services such as counseling on diet, smoking, and drinking and uninsured patients are less



likely to delay care due to cost or go without needed care (Figure 5).

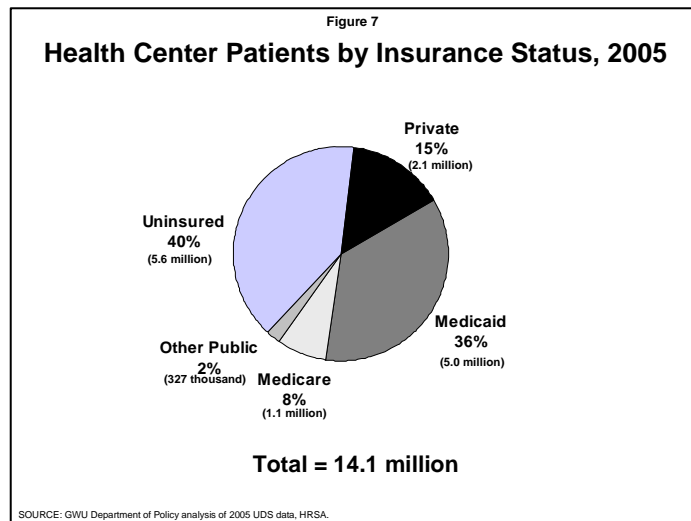
Patient outcome data from a funded quality of care improvement demonstration in three health center sites further illustrates health centers' superior performance in caring for patients with chronic diseases. On specific measures of diabetes care, the three health centers participating in the demonstration exceeded the national benchmarks (Figure 6).¹⁰

Health center services are of particular importance to low-income women of childbearing age, infants, and children. In 2005, more than 400,000 infants were born to health center patients, making health centers a source of care for approximately one in ten U.S. births and one in five low-income births.¹¹ Pediatric care is a centerpiece of health centers. In 2005, health centers furnished care to 5.2 million children, approximately one in seven low-income children. As with populations with chronic illnesses, health center services have improved access to care and health outcomes for infants and children. The availability of health center services has led to reductions in community infant mortality rates, increases in the number of children with a regular source of primary care, and increased use of preventive pediatric care.¹²



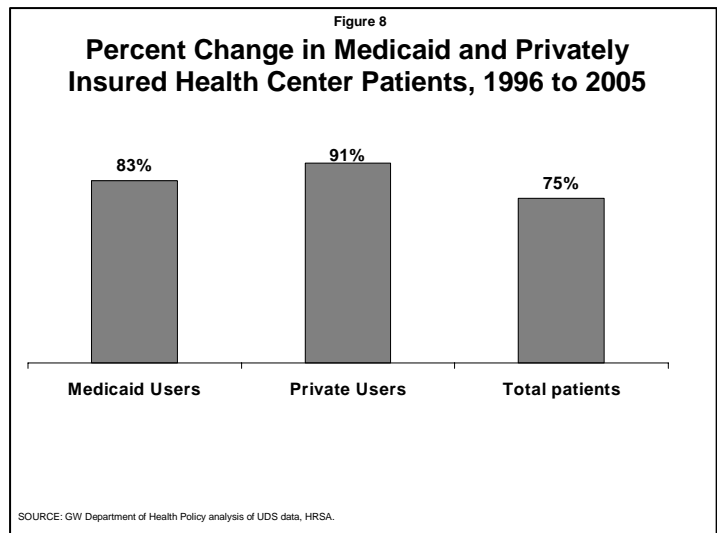
Health insurance coverage among health center patients

By virtue of their mission, health centers treat large numbers of low-income, uninsured patients. In part because they are overwhelmingly low-income, health center patients are more likely to be uninsured (Figure 7). Indeed, low-income health center patients are more likely than low-income non-elderly persons generally to be uninsured -- 40 percent of health center patients are uninsured, compared to 32 percent of the low-income non-elderly population generally.¹³ For those health center patients with health care coverage, Medicaid is the principal source of that coverage, reaching more than one-third of all health center patients; conversely, health centers are a central source of care for Medicaid beneficiaries, serving an estimated one in nine Medicaid patients nationally.¹⁴ Because the great majority of children served by health centers have family



incomes below 100 percent of the federal poverty level, most insured children served by health centers are enrolled in Medicaid rather than separate State Children’s Health Insurance (SCHIP) programs.¹⁵

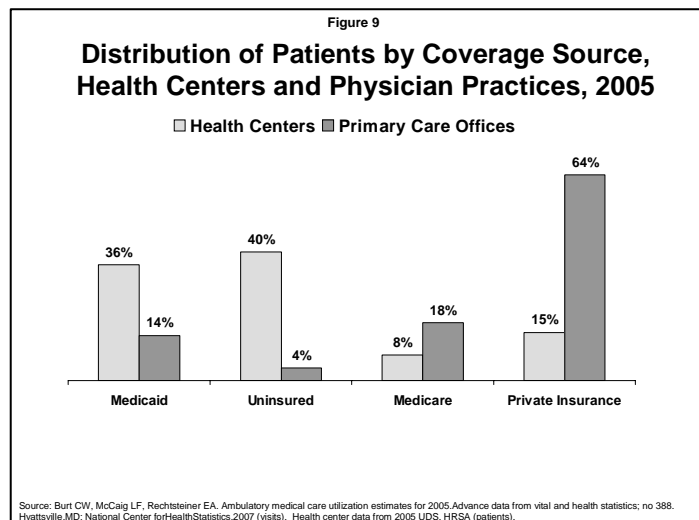
In 2005, a relatively small, but significant, proportion of health center patients – 15 percent (2.1 million persons) – had some form of private health insurance. Between 1996 and 2005, the number of privately insured health center patients nearly doubled from 1.1 million patients to 2.1 million patients, and grew slightly as a proportion of total patients (Figure 8).



This increasing number of privately insured patients over a period of declining private coverage nationally may be the result of two distinct developments.¹⁶ The first development is the expansion of health centers (both new grantees and additional sites offered by existing grantees) into rural and non-inner-city metropolitan communities. These communities may be more likely to have low-income residents with private insurance, but nonetheless, are experiencing a primary care physician shortage as older physicians retire or move their practices and younger physicians choose to settle and practice elsewhere.¹⁷ As a result of these physician shortages, more low-income residents may be turning to health centers to receive primary care. A second possible explanation relates to the changing nature of private coverage for low-income workers. Workers, particularly in small firms, are increasingly facing large deductibles that leave them underinsured for basic primary and specialty care services.¹⁸ They may seek care at health centers where the costs of the services are tied to their ability to pay. Thus, health centers continue to be an important source of care for a growing number of privately insured patients.

Financing Health Center Operations

In order to maintain their operations, health centers must rely on multiple sources of funding. The patient mix at health centers differs significantly from that found in private medical care practices, as does the source of revenues (Figure 9). Whereas 14 percent of patients treated by private physicians are enrolled in Medicaid, over one-third of health center patients are covered by Medicaid.

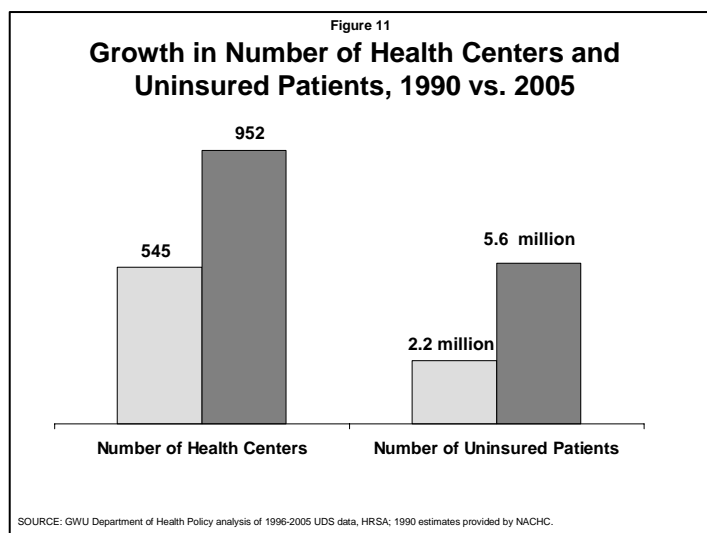
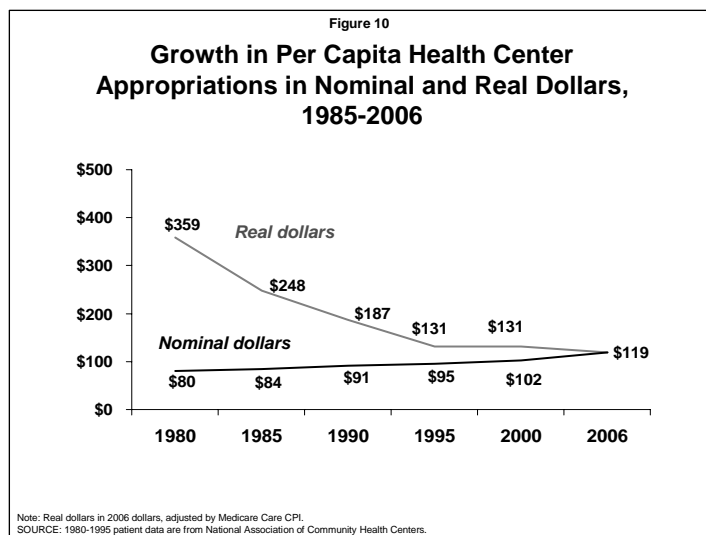


Similarly, uninsured patients represent 40 percent of health center patients, yet only 4 percent of patients seen at private physicians' offices. Privately insured patients represent 15 percent of health center patients, but nearly two-thirds of the patients seen in private physicians' offices.

This high proportion of Medicaid and uninsured patients means that health centers rely heavily on two sources of funding: federal grants and Medicaid. Federal grants (and in the case of "look alike" health centers, grants received from state and local governments) enable health centers to offset the costs associated with treating low-income uninsured patients who pay only an income-adjusted fee for care. Medicaid, which provides comprehensive coverage and protections designed to ensure low out-of-pocket cost sharing for covered services, also pays health centers in accordance with a prospective payment rate that is tied to operating costs.

Thus, Medicaid's broad coverage rules and cost-related payment standard help ensure that federal health center grant funds are not used to offset operating losses incurred in serving patients with Medicaid coverage. This protection against the diversion of grants is especially crucial because in calculating health center costs for purposes of paying operating grants, the federal government does not calculate the costs of caring for under-insured patients; only costs of treating uninsured patients are taken into account when setting the payment level.

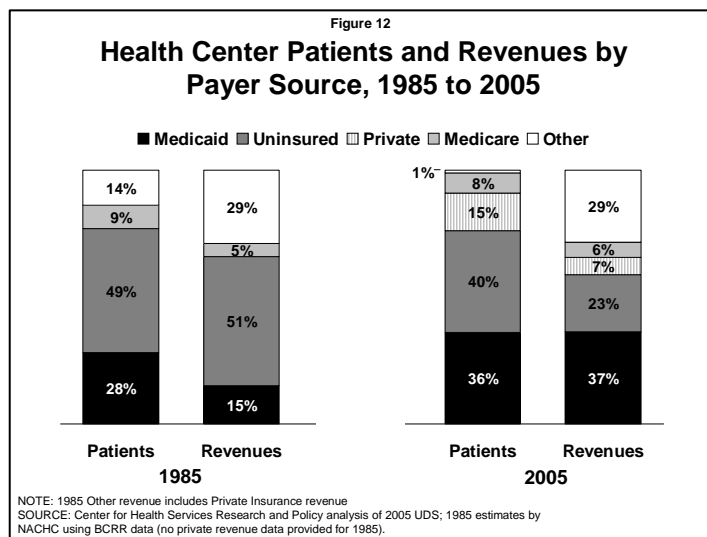
Medicaid's link to cost is also important because federal appropriations to health centers have failed to keep pace with inflation and with the rising number of uninsured patients. While per capita health center funding, in nominal dollars, has increased modestly since 1980, in real dollar terms, funding continues to fall (Figure 10). During this time period, the number of health centers has greatly expanded, as has the number of patients, particularly uninsured patients, served by health centers (Figure 11). The failure of federal funding to respond to these changes has further added to the strain on health center resources.



In contrast to federal grant funding, the cost-related payment structure of Medicaid has been instrumental in helping to ensure the growth of health centers to address rapidly escalating population needs. Medicaid has supported the expansion of health centers in several ways.

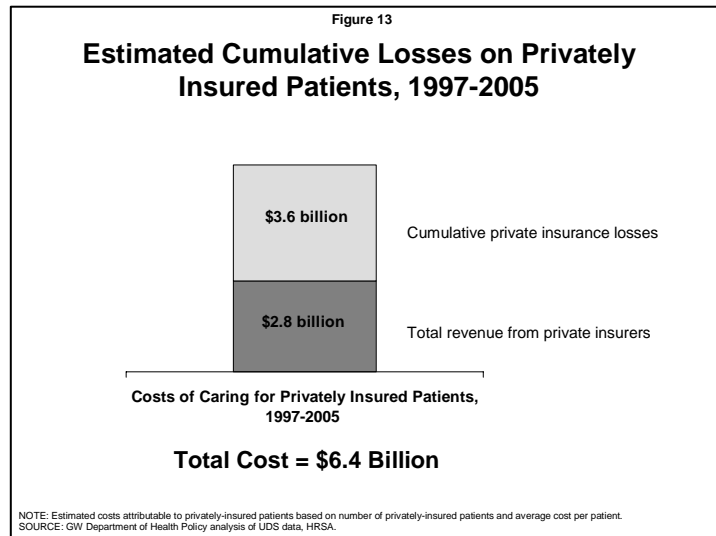
- First, as Medicaid eligibility has grown, so has the proportion of health center patients – particularly children, women, and poor Medicare beneficiaries – with primary or supplemental health insurance.
- Second, health center services are considered mandatory services in the Medicaid statute, which ensures coverage of all of the professional and ancillary services furnished by physicians, nurse practitioners and physician assistants, and psychologists and social workers employed by health centers. Furthermore, because the unit of payment is the health center rather than an individual clinician, the payment reflects the operational costs of the clinic, not merely the time, effort and resources of an individual clinician.
- Third, the special cost-related payments health centers receive from Medicaid are designed to ensure that payments to health centers are not heavily discounted and remain reasonable in relation to the cost of care provided. This special payment rule applies even when health centers participate (as virtually all do) in Medicaid-sponsored health insurance and managed care arrangements that otherwise would pay them only the negotiated, and often heavily discounted, rate typically paid to network providers.

The effects of Medicaid payment policies are significant for health centers. In 1985, Medicaid patients comprised 28 percent of health center patients but only 15 percent of health center revenues. By 2005, Medicaid patients and revenues were in alignment. As a result, health centers were better able to target their grant funds on caring for uninsured patients (Figure 12). While uninsured patients as a percent of total patients declined slightly over this time period, primarily due to federally mandated Medicaid eligibility expansions, the actual number of uninsured patients served by health centers increased dramatically.

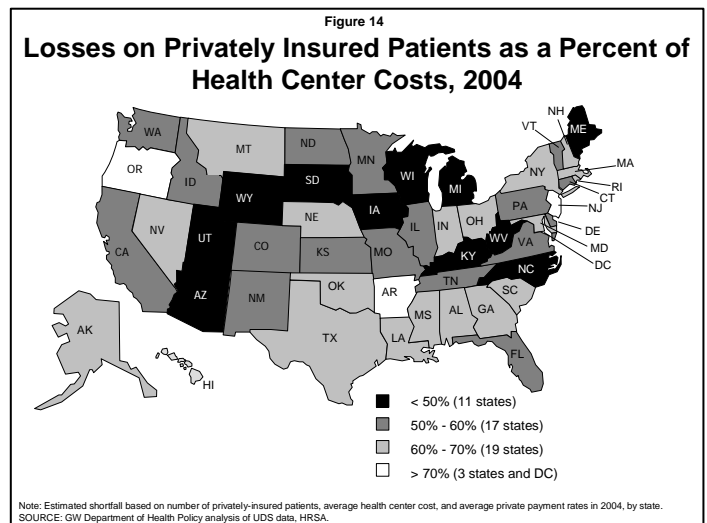


Private Health Insurance and Health Center Finances

Unlike Medicaid, payments from commercial insurers are typically not sufficient to cover the costs health centers experience in treating privately insured patients. Between 1997 and 2005, the costs of providing care to privately insured patients amounted to \$6.4 billion nationally. However, health centers only received \$2.8 billion in payments from commercial insurers resulting in total cumulative losses of \$3.6 billion (Figure 13).



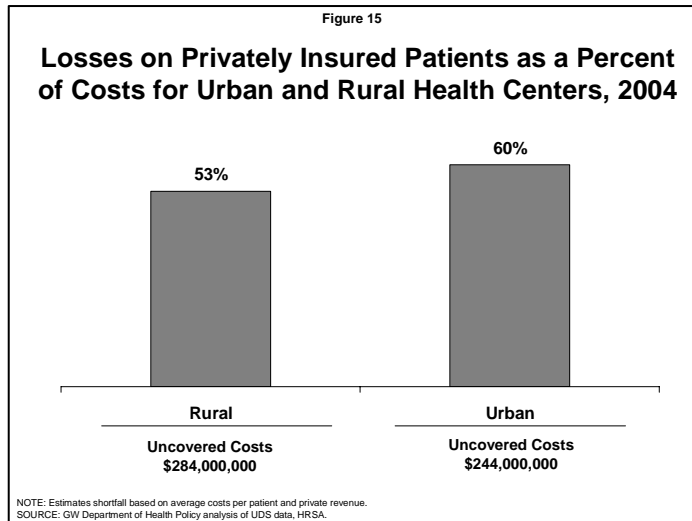
Payments from commercial payers represented less than half (44 percent) of the costs of treating privately insured patients. Although the proportion of health center patients who have private insurance is relatively low, the failure of revenues from insurers to account for the full costs of the care provided leaves health centers with significant financial shortfalls. In 2005, these shortfalls amounted to nearly 10 percent of revenues. This lost revenue means health centers have fewer funds to invest in their core mission of serving the uninsured. They also have less money to increase staffing and the range of services they provide and to make much needed capital investments, particularly in health information technology.



The commercial losses experienced by health centers vary across states and are influenced by a number of factors, including geographic variations in health care costs, insurance market rules and payment rates. In three states and the District of Columbia, the private insurance shortfalls as a percent of the costs of treating privately insured patients exceeded 70 percent, while in only 11 states did these shortfalls represent less than 50 percent of costs (Figure 14).

The location of health centers in urban versus rural settings also affects the magnitude of their commercial losses. Urban health centers experience higher losses than their rural counterparts (60 percent versus 53 percent of costs that private insurers failed to cover), a finding consistent with the higher cost of operating health centers in urban areas (Figure 15).

A recent health center payment study focusing on six major health center networks operating in New York State echoes the finding from this analysis.¹⁹ The New York study found that commercial payment rates per visit received by the study centers averaged \$38 less per visit than Medicaid fee-for-service rates. The study further found that even without taking into account coinsurance and copayments, commercial insurance revenues received per visit were \$41 below the reasonable cost of each visit within each network.



Cumulatively, the six networks experienced losses of \$5.8 million in 2006 alone.

Numerous factors related to the nature of private insurance coverage and payment structures may account for the low reimbursement from private insurers.

- *Eligibility-related factors:* Much has been written about the unstable nature of Medicaid coverage and short periods of enrollment. However, data from national panel surveys of health insurance show comparable patterns for privately insured persons, particularly for those with low-income.²⁰ For example, in some cases, privately insured children may be more likely than those with Medicaid to experience coverage interruption.²¹ These disruptions in coverage do not, of course, equate to reduced health care needs. But when patients with serious health problems are in a period without coverage, health centers must absorb the cost of that care. Because these individuals show up as insured patients when annual grant calculations are made, they are not factored into the health center's grant funding calculation.
- *Waiting periods and pre-existing condition exclusions.* One recent study showed that as many as 73 percent of all health plans, particularly those offered by smaller employers (who are more likely to hire low wage workers), make extensive use of waiting periods and exclusions in order to keep costs low.²² Insurers' ability to impose exclusions based on patient characteristics extends to pregnancy as well, one of the most important services provided by health centers. The Pregnancy Discrimination Act (PDA)²³ prohibits employer-sponsored health plans from refusing to cover pregnancy to the same extent that other health conditions are covered; yet it applies only to employers with 15 or more full-time employees. To the extent that health centers, particularly health centers operating in rural areas, care for pregnant patients with private coverage through very

small employers, the potential for pregnancy exclusion is significant unless the state has enacted laws prohibiting such exclusions by all group insurers. Some but not all pregnant women whose care is excluded may qualify for Medicaid or SCHIP coverage in their states.

- *Limited benefit and coverage design:* Private insurance plans often provide limited coverage for services that may be offered by health centers, such as dental or vision care, immunization services for children and adults, and mental health and substance abuse treatment services. These plans may also impose limits on the coverage, both in terms of strict dollar limits or limits on the number of services a patient can receive. To the extent that health centers provide these services, they are unlikely to receive payment from the insurance companies.

The differences between commercial insurance design and Medicaid for children become particularly important. Where children are concerned, the Medicaid EPSDT benefit package prohibits the imposition of limits on covered services that are determined to be medically necessary. Commercial insurance on the other hand may impose significant limits based on health condition, as well as aggregate limits that apply to all patients regardless of age. Examples are limits of \$500 in any year for prescription drugs, or strict treatment limits applicable only to mental illness or emotional disorders. Private insurers may also exclude treatments for children whose conditions are developmental in nature rather than the result of an accident or illness.²⁴

In addition to the more limited coverage design, the actual payments made to health centers by private insurers typically cover only the services of the physician involved in the patient care. However, health centers generally rely heavily on a mix of health professionals to provide care. The high efficiency of health centers noted above suggests that coverage of all services of health professionals may contribute to, rather than detract from, this efficiency.

- *Patient cost sharing:* Most private insurance plans require consumer cost sharing, even for those with low-incomes. This cost sharing often takes the form of point-of-service copayments or coinsurance. Increasingly, these plans include high deductibles, which require the consumer to pay for all health services, except preventive care in some cases, out-of-pocket up to a certain limit. For low-income families, these cost sharing requirements can be burdensome. Health centers generally accept as a loss any cost sharing that the patients are unable to pay.

Numerous factors may be at work in the lower per-patient revenues associated with private health insurance revenues at health centers. The cumulative effects of these low revenues in relation to cost can have serious adverse consequences for health centers' operating margins, a key measure of the financial health of any medical care facility.²⁵ At health centers that care for large numbers of privately insured patients, the effects can be financially enormous, as illustrated by the profile below.

Hudson Headwaters Health Network has provided care for more than 30 years, serving 56,000 patients in rural New York communities in 2006. Over the past decade the region has lost numerous private physicians as a result of retirement and the lack of new physician entry; as a result, privately insured low-income patients depend heavily on the health center. A startling 55 percent of Hudson Headwaters' patients are privately insured, and even though their incomes are slightly higher than those of Medicaid patients, they have incomes low enough to qualify for discounted services.

Dr. John Ruge, Hudson Headwaters' Executive Director, indicates that private insurer revenues received by his clinic cover less than 30 percent of the actual costs of services provided. With privately insured patients accounting for more than half of all patients and 45 percent of encounters, Hudson Headwaters is forced to "scramble for grants and do community fundraising to subsidize the costs of services provided to privately insured patients and use funding out of an ever shrinking fund balance." Dr. Ruge identifies high deductibles, high copayments, and payment lags and disallowances as critical problems. In effect, much of the financial losses experienced by Hudson Headwaters is attributable to the under-payments made by private payers.

Wisconsin, in recognition of the problem of low payments from private insurers, has devised a partial solution. Working with its health centers, which, like the Marshfield Clinic highlighted below, are often sole providers in their communities, the state of Wisconsin assures that all privately insured health center patients who also are eligible for Medicaid obtain coverage from both sources. In these cases, Medicaid will "wrap-around" the private insurance, providing coverage for services not included in the private policy and supplementing the reimbursement from the private insurers up to the Medicaid payment level. Wisconsin's higher Medicaid eligibility levels for parents and childless adults means that many privately insured health center patients can also be enrolled in Medicaid. As a result, Wisconsin's health center patients continue to receive comprehensive coverage, and its health centers receive cost payment for covered benefits and services regardless of lower private rates. This coordination of Medicaid and private insurance thus lessens the losses that health centers otherwise would incur from treating patients with private health insurance.

Family Health Center of Marshfield, Inc. (FHC) in partnership with Marshfield Clinic serves over 46,000 low-income patients in north central Wisconsin. A large percent of FHC patients are covered under Medicaid (which includes a Medicaid-expansion SCHIP program). A significant portion of Medicaid-enrolled children also have access to private insurance through their parents. According to Executive Director Greg Nycz, the health center's ability to include these dually enrolled children's health care costs in their Medicaid cost reports results in full coverage and cost-related revenues for the health center. The inclusion of dual enrollees when calculating health center payments under Medicaid is consistent with federal legal requirements that assure FQHC coverage and payment for all Medicaid-enrolled categorically needy persons. It also helps promote the stability of the state's health centers. Mr. Nycz underscores the importance of Wisconsin's approach: "Wisconsin health centers are likely to experience substantial increases in revenue shortfalls as low-wage earners with current employer-sponsored insurance are increasingly facing higher cost-sharing burdens through benefit redesign and the loss of benefits altogether due to increasing premium cost sharing requirements."

Conclusion and Implications

As the debate over health reform proceeds, it is important to assess the effects of various health reform proposals on community health providers, particularly those providers that serve large numbers of uninsured or under-insured low-income patients with higher health risks. The findings of this analysis of health centers' experience with private insurance suggest that proposals that would lessen Medicaid's role in providing health coverage for low-income patients or substitute private coverage policies for Medicaid coverage carry significant implications for safety net providers such as health centers. Any broad-based shift away from Medicaid and toward private coverage for low-income populations would likely result in significant financial losses for health centers that would undermine their ability to continue to serve as a key component of the health care safety net.

Broadening health care coverage for those who are currently uninsured or under-insured is absolutely essential for health center patients, and may be the only way to address the enormous challenges in securing access to out-of-clinic specialty care.²⁶ At the same time, ensuring that third-party financing arrangements do not impair the functioning of community primary health care services is equally important. In this paper, we highlighted the strategy adopted by Wisconsin to ensure adequate payments to health centers; however, there are other options states could consider. One option would be to regulate the rates paid to certain providers by commercial insurers. Another option would be to create a publicly financed pool to provide additional funding to certain clinical providers that offer comprehensive services in lower income communities and that meet standards of affordability, quality, efficiency, and community accountability. Regardless of the mechanism, providing health centers with fair and adequate payments will preserve the access to high quality, primary care services on which so many low-income people rely.

Endnotes

¹ UDS reporting is compulsory for all community health centers and provides comprehensive, grantee-level information on program performance in the areas of patients, services, revenues, staffing, and clinical, management and financial operations. Because of certain modifications to the reporting requirements over this time period, portions of the analyses may be limited to a smaller time period. For example, the 1996 UDS does not include financial data for any of the grantees. In addition, beginning in 2005, the Health Resources Services Administration (HRSA) began to withhold previously publicly available grantee-level information related to staffing and financial matters. As a result, for certain aspects of the analysis, we use 2004 UDS data, which, along with 1996-2003 data, were readily made available before HRSA instituted its new policy.

² A predecessor reporting system, the BCRR, was replaced in 1996. BCRR data are comparable, but not identical, to UDS data.

³ Bonnie Lefkowitz, 2007. *Community Health Centers: A Movement and the People Who Made It Happen*. Rutgers University Press, N.J.

⁴ National Association of Community Health Centers and the Robert Graham Center. *Access Denied: A Look at America's Medically Disenfranchised*. http://www.nachc.com/research/Files/Access_Denied.pdf (Accessed April 7, 2007).

⁵ National Association of Community Health Centers. *A Sketch of Community Health Centers: Chartbook 2006*. <http://www.nachc.com/research/Files/Chart%20Book%202006.pdf> (Accessed April 7, 2007).

⁶ In 2007, the federal poverty level was \$20,650 annualized and \$1720 in monthly income for a family of four. <http://www.cms.hhs.gov/MedicaidEligibility/downloads/POV07ALL.pdf> (Accessed August 19, 2007).

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⁸ Based on 1990 and 2006 estimates. Wan H, et al., U.S. Census Bureau, Current Population Reports, P23-209, 65+ in the United States: 2005, U.S. Government Printing Office; U.S. Census Bureau, Census 2000 Summary File 1; 1990 Census of Population, *General Population Characteristics, United States* (1990 CP-1-1).

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¹⁰ Shin P, Markus A, and Rosenbaum A. *Measuring Health Centers against Standard Indicators of High Quality Performance: Early Results from a Multi-Site Demonstration Project*. (United Health Foundation, 2006.) http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/United_Health_Foundation_report_082106.pdf (Accessed October 2, 2007).

¹¹ National Association of Community Health Centers. *America's Health Centers: Making Every Dollar Count*. <http://www.nachc.com/research/Files/Cost%20Effectiveness%20Fact%20Sheet%202012.06.pdf> (Accessed April 7, 2007).

¹² Hadley J, Cunningham P, and Hargraves JL, "Would safety-net expansions offset reduced access resulting from lost insurance coverage? Race/Ethnicity differences." 2006 *Health Affairs* 25(6): 1679-1687; O'Malley AS, et al. "Health center trends, 1994-2001: What do they portend for the federal growth initiative?" 2005 *Health Affairs* 24(2): 465-472; Shi L, et al., "America's health centers: Reducing racial and ethnic disparities in perinatal care and birth outcomes." 2004 *Health Services Research* 39(6/Part I): 1881-1901; Shin P, et al., 2003. *Reducing Racial and Ethnic Health Disparities: Estimating the Impact of Community Health Centers on Low Income Communities*. (National Association of Community Health Centers, Washington, D.C.).

¹³ Kaiser Family Foundation, *Uninsured rates for the nonelderly by federal poverty level, 2005*. <http://www.statehealthfacts.org/comparebar.jsp?ind=141&cat=3> (Accessed September 4, 2007).

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This brief was prepared by researchers at the School of Public Health and Health Services at The George Washington University. This research was commissioned by the Henry J. Kaiser Family Foundation. Conclusions or opinions expressed in this report are those of the authors and do not necessarily reflect the views of the Foundation or George Washington University.

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