The Role of Free Clinics in the Era of Health Reform

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Free Clinic Overview

Free and charitable clinics are a critical part of the health care safety net system in the United States. All are nonprofit and serve the uninsured for free or with nominal charges. Most free clinics are primary care focused but a small portion provides other services such as dental, behavioral health and optical care. Free clinics range from small organizations staffed by a volunteer physician offering care once a month from a church basement to large multi-practitioner facilities with substantial budgets.

The most recent national survey of all known free clinics in the U.S. was completed in 2006 and found 1,007 free clinics operating in 49 states and the District of Columbia. Together, these clinics provided care for approximately 2 million people. The mean annual budget was $287,810, and the mean number of hours open per week for patient care was 18. Seventy-three percent of these clinics provided chronic disease care, 81 percent conducted physicals, 62 percent provided urgent and acute care and 87 percent dispensed medications. Only 4 percent of clinics received reimbursement from third-party payers.[i] Free clinics also do not receive financial support or technical assistance from the federal government. They are supported nationally, however, by the National Association of Free and Charitable Clinics (NAFC), which serves as an organizing body for the group and advocates for issues and needs facing the free and charitable clinic community.

Health Care Landscape

In 2012, approximately 48 million Americans were uninsured[ii] and 32 million more were underinsured.[iii] The Commonwealth Fund defines underinsurance as out-of-pocket costs greater than 5 percent of income for someone earning up to 200 percent of the federal poverty level (FPL) or 10 percent of income for those earning more than 250 percent FPL.[iv] The Affordable Care Act (ACA) is designed to expand health insurance coverage to millions of Americans and protect consumers with new regulations placed on the insurance industry. The law has rolled out in piecemeal fashion since its enactment in 2010. The most significant changes took effect this year (2014) and will have considerable impact on the uninsured and the free clinics that serve them.

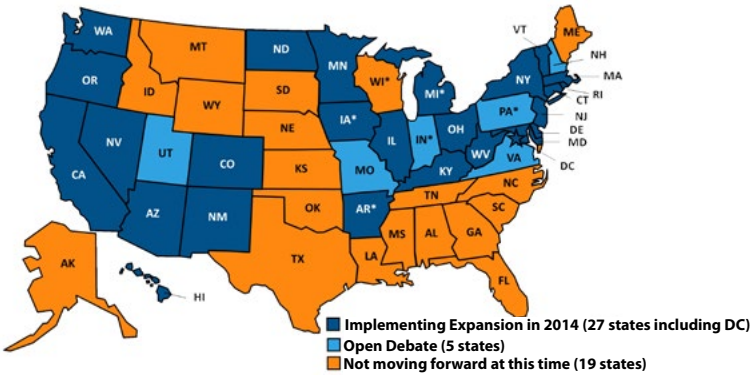
ACA Implementation

Starting March 31, 2014, almost all Americans will be required to obtain health insurance.[v] This deadline was originally January 1, 2014, but the enrollment period was extended due to technical difficulties with the healthcare.gov website, where Americans can purchase insurance through health insurance exchanges. People who are currently uninsured have the opportunity to obtain coverage through the new health insurance exchanges or, for low-income Americans, through newly expanded state Medicaid programs. A number of barriers to implementation and coverage exist for both Medicaid expansion and the health insurance exchanges however, and tens of millions of Americans will remain uninsured as a result. The following is a review of these issues with analysis on how they will impact free clinics and the low-income, uninsured patients they serve.

Medicaid Expansion

When the Supreme Court upheld the ACA in June 2012, it ruled that the federal government could not force states to expand their existing Medicaid programs. This expansion would have covered nonelderly adults with incomes below 133 percent FPL, or about $31,721 for a family of four.[vi] The Medicaid expansion component of the legislation was essential to covering the uninsured. If implemented nationwide, it would have insured 17 million people – half of the total population intended to be covered through full implementation of the ACA. Currently, 26 states and the District of Columbia are proceeding with Medicaid expansion, 19 states have chosen not to expand their Medicaid programs and five are still debating expansion.

Current Status of State Medicaid Decisions, 2014



MAP NOTES: Data are as of March 26, 2014. *AR and IA have approved waivers for Medicaid expansion; MI has an approved waiver for expansion and plans to implement in Apr. 2014; IN and PA have pending waivers for alternative Medicaid expansions; WI amended its Medicaid state plan and existing waiver to cover adults up to 100% FPL, but did not adopt the expansion. NH has passed legislation approving the MEdicaid expansion in Mar. 2014; the legislation calls for the expansion to begin July 2014.

SOURCES: States implementing in 2014 and not moving forward at this time are based on data from CMS here. States noted as "Open Debate" are based on KCMU analysis of State and of the State Addresses, recent public statements made by the Governor, issuance of waiver proposals or passage of a Medicaid expansion bill in at least one chamber of the legislature. [vii]

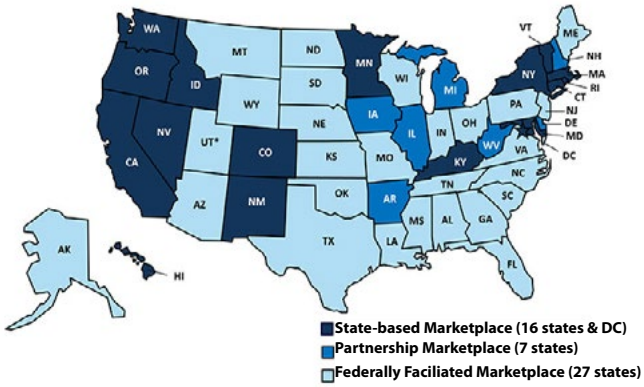
Middle-income people in states that do not expand Medicaid will have the opportunity to purchase insurance through the health insurance exchanges, but the poorest (about 5 million people) will remain uninsured and without access to affordable care.[viii, ix] These same people also will not qualify for a subsidy to help defray the cost of purchasing insurance through the exchanges, as these tax credits are available only to people with incomes between 133 and 400 percent FPL. According to Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services, there will be a "huge gap" between what these people can afford and what is available to them. As a result, free clinics in the states that do not expand Medicaid will remain as needed and relevant as ever.

Further compounding the problem of access to affordable care are the funding cuts to disproportionate share hospitals (DSH), which serve a significantly disproportionate number of low-income patients. During fiscal year 2013 (FY13), DSHs were preliminarily allotted $11.5 billion in federal funds to help defray the costs of providing uncompensated care.[x] In September 2013, the Centers for Medicare and Medicaid Services (CMS) ruled that $500 million worth of cuts in FY14 and $600 million worth of cuts in FY15 will be made to DSHs.[xi] These reductions will particularly impact hospitals in states that are not expanding Medicaid, as these states will continue to have higher numbers of uninsured residents.

Health Insurance Exchanges

Health insurance exchanges, or marketplaces, are the other critical element of the ACA related to ensuring coverage for the uninsured. This portion of the ACA is intended to cover 27 million people by 2016 and is where middle-income individuals can purchase private coverage. States were given the option of building a state-based marketplace, developing a state-federal partnership marketplace, or defaulting to a federally-run marketplace. Sixteen states and the District of Columbia are implementing state-based exchanges, seven are employing a state-federal partnership exchange, and 27 defaulted to the federally-run exchange model.[xii] Enrollment commenced on October 1, 2013, and coverage went into effect on January 1, 2014. As of March 27, 2014, 6 million people had signed up for health insurance through the exchanges.[xiii]

State Health Insurance Marketplace Decisions, 2014



MAP NOTES: *In Utah, the federal government will run the marketplace for individuals while the state will run the small business, or SHOP, marketplace.

SOURCE: State Decisions for Creating Health Insurance Marketplaces. 2014. KFF State Health Facts: http://kff.org/health-reform/state-indicator/health-insurance-exchanges/[xiv]

The number of states opting for a federally-run exchange is considerably larger than the government anticipated and will have a significant impact on consumer enrollment. States relying on the federal government to run their marketplaces are receiving far less money than states with independently-run exchanges because of how the ACA was written. When Congress passed the ACA in 2010, it assumed most states would run their own marketplaces and authorized funding accordingly. The law did not set aside money for the federal government to operate the marketplaces, either alone or in partnership with states, as turned out to be the case in the majority of states. This funding differential poses a major challenge to increasing coverage of the uninsured at the level planned for, as consumer knowledge and compliance are essential to successful implementation. Approximately 17 percent of nonelderly adults still have not heard about the marketplaces, regardless of whether they were state or federally run.[xv] However, a Pew Research Poll conducted in September 2013 found awareness that health exchanges are available is significantly higher in states with state-run programs than in those that have federally-run exchanges.[xvi]

This is likely due to the limited funding that federally-run exchanges have for marketing, supplemental in-person assistance programs and support. As of March 1, 2014, state-based exchanges accounted for 38 percent of all enrollees to date.[xvii]

Further compounding this problem is the confusion and uncertainty among the general public about the ACA and how it impacts them personally. According to the February 2014 Kaiser Health Tracking Poll, awareness of ACA-related details is particularly low among the uninsured, with 76 percent of uninsured people indicating they were unsure of the deadline to sign up for coverage.[xviii] In addition, only 12 percent of uninsured respondents reported knowing "a lot" about the ACA compared to 26 percent who reported knowing "nothing at all." In the middle were 24 percent who reported knowing "some" information about the ACA and 36 percent knowing "a little."

A survey conducted by Bankrate.com in March 2014 found that 41 percent of uninsured respondents do not plan to obtain health insurance because they think it will be too expensive. Further, 70 percent of respondents were unaware of the federal tax subsidies that are available to help defray the costs of purchasing insurance through the exchanges.[xix] Another recent study by McKinsey found that only 27 percent of people enrolled through the health insurance exchanges were previously uninsured.[xx] These findings indicate that enrollment momentum among the uninsured may be even slower than the federal numbers suggest, making a strong case for the continued need and relevance of free clinics.

The nation's poorest states will be hit hardest by implementation challenges with Medicaid expansion and the health insurance exchanges. Of the 34 states that have opted for a partnership or federally-run exchange, 18 will not expand Medicaid and five are currently still debating Medicaid expansion. Furthermore, 11 of the 25 states that are not expanding Medicaid or are still undecided about doing so are among the top 20 most impoverished states in the U.S.[xxi]

A good example of this is Texas, which has 6.2 million uninsured residents, is not expanding its Medicaid program and opted for a federally-run exchange.[xxii] At 29 percent, Texas has the highest rate of uninsured adults in the U.S.[xxiii] It is also the ninth-most impoverished state in the country[xxiv] and ranks 12th in chronic disease.[xxv] The decision to decline Medicaid expansion precludes 1.8 million Texans from obtaining insurance. The impact of the state's decision to decline running its own exchange, and thus receive inadequate funding for outreach and enrollment, has also had a negative impact on coverage. As of March 1, 2014, only 295,025 Texans had signed up for insurance through the marketplace, despite the fact that nearly 2 million of the uninsured in the state are eligible for premium tax credits.[xxvi]

Undocumented Populations

According to a recent report by the State Health Access Data Assistance Center and the Robert Wood Johnson Foundation, 17 percent of all low-income, uninsured, nonelderly adults will remain uninsured because of their immigration status.[xxvii] There are approximately 11 million undocumented immigrants in the U.S., and almost one-quarter of this population resides in California. Based on findings from the most recent California Health Interview Survey, undocumented immigrants tend to be younger (90 percent are between 18 and 44 years of age) and have a higher labor force participation rate as compared with lawful permanent residents or naturalized citizens. Not surprisingly, undocumented immigrants also experience the highest rates of poverty, the highest rates of being uninsured, and the highest rates of having no usual source of care.[xxviii]

As the ACA excludes undocumented immigrants from its provisions, this population will remain uninsured, with even more limited access to care. Since undocumented immigrants are concentrated in a small number of states, safety net hospitals in states with high numbers of undocumented immigrants will disproportionately be affected by cuts to DSH payments. Free clinics will particularly be needed in states with high concentrations of undocumented immigrants as a result.

Expanding the Underinsured Population

The cost-sharing provisions of the health insurance exchange plans are also expected to create challenges for low-income people who purchase coverage. It is anticipated that there will be a significant population of newly insured people who cannot afford their deductibles and co-pays, resulting in a larger underinsured population. As of March 1, 2014, 63 percent of people who enrolled through the health insurance exchanges chose silver plans, and another 18 percent chose bronze.[xxix] According to Kaiser Health News, silver plan insurers will cover approximately 70 percent of costs, leaving the consumer responsible for the remaining 30 percent. Bronze plans, the plans with the lowest premiums but highest deductible, leave the consumer to pay about 40 percent of medical costs out of pocket.[xxx] These costs may deter many low-income people from seeking medical care even though they have coverage.[xxxi] As a result, access to care is expected to remain limited for many.

Low-income people with chronic illnesses are at particular risk. Despite caps on spending and federal subsidies, patients with chronic illnesses who purchase bronze and silver level plans are highly likely to hit their out of pocket maximums.[xxxii] Recently published analyses of the 2011 National Health Interview Survey showed

that 23 percent of people with chronic illness take their medication less often than prescribed because of cost.[xxxiii] This percentage is probably higher amongst the chronically-ill uninsured, and will likely continue to some extent if projections about out-of-pocket costs of bronze and silver coverage plans are correct.

Provider Shortage

Access to care is also expected to be negatively impacted by the existing shortfall of primary care providers (PCPs) in the U.S., a shortfall that is expected to worsen with the implementation of the ACA. There are currently 62 million Americans that are experiencing shortages of primary care, 20 percent of which are uninsured.[xxxiv] Compounding this problem is the fact that only 70 percent of PCPs currently accept new Medicaid patients.[xxxv] These issues will leave many newly insured Americans unable to access primary care services.

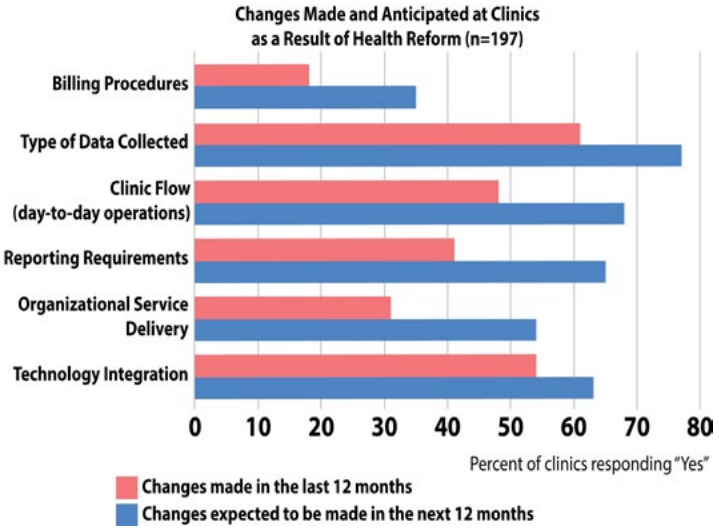
The provider shortage coupled with the influx of newly insured patients seeking care is also expected to adversely impact the volunteer pool for physicians and other medical providers in free clinics. Clinics have reported anecdotally that they are concerned that providers will be so overwhelmed and inundated with patients in their usual settings that they will not have the time to volunteer in free clinics, leaving these resource-constrained facilities with fewer provider hours to offer patients.

Impact of ACA Implementation on Free and Charitable Clinics

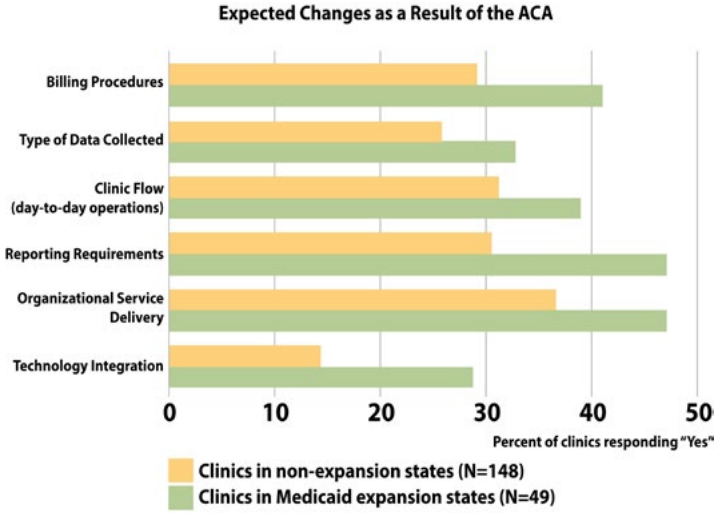
In October 2013, AmeriCares U.S. Medical Assistance Program surveyed its domestic safety net partner network as part of an external program evaluation. The survey included questions about the impact of the ACA on partner operations and plans. Two hundred three clinics responded to the survey, for a response rate of 59 percent. Thirty-two percent of responding free clinics anticipate an increase in the number of patients seen at their clinic as a result of the ACA, and approximately 40 percent anticipate an increased need for donated medicine and medical supplies through AmeriCares and pharmaceutical patient assistance programs (PAPs).

Anticipated Impact of the ACA on patient load & product & service needs	Free Clinics	
	N=197	%
Increase in number of unique patients	64	32%
Increase need for product donations from AmeriCares	78	40%
Increased need for medications from PAP	76	39%
Increase in scope of services provided	55	28%

Clinics were also asked what, if any, changes had been made in the preceding 12 months due to health reform and what changes they were planning to make in the coming 12 months. Free clinic preparations for the ACA run the spectrum. Some clinics are deliberately waiting until it becomes clearer how ACA rollout will affect the uninsured in their state, whereas others are actively preparing in numerous ways in anticipation of the impact of the ACA. As shown below, clinics plan to make more changes in the coming 12 months than they made in the previous year. However, it is interesting to note that 31 percent of clinics have already begun altering the types of data they collect and 27 percent have begun to integrate additional technology. Interviews with a selection of clinics revealed that many are already starting to notice changes in reporting requirements for various grants and programs, likely a result of the changing health care landscape.



Further investigation of the data found that a greater percentage of clinics in Medicaid expansion states anticipate having to make changes due to the ACA's impact than their counterparts in non-expansion states. This held true across all six areas of clinic operations about which the survey inquired.



Summary

Regardless of how the details described in this report ultimately play out, millions of people who are currently uninsured will remain so not only in 2014 but for years to come and millions more will move from uninsured to underinsured status. The latest projections from the Congressional Budget Office estimate that 31 million people will be uninsured 10 years from now when the ACA is in full effect.[xxxvi] Given that the existing network of free clinics serves only two million people, there will clearly be a continued role for these organizations and more demand from uninsured patients than can be met by them.

About AmeriCares

AmeriCares is a nonprofit global health and disaster relief organization that delivers medicines, medical supplies and aid to people in need across the United States and around the world. Since it was established in 1982, AmeriCares has distributed more than $11 billion in humanitarian aid to 164 countries. AmeriCares U.S. Medical Assistance Program is the largest provider of donated medicine, vaccines and medical supplies to the U.S. health care safety net. The program partners with 635 free clinics, community health centers and health departments serving five million uninsured and underinsured people in 1,485 health delivery sites. The U.S. Medical Assistance Program is generously funded by the GE Foundation.

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