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School of Public Health & Health Services
THE GEORGE WASHINGTON UNIVERSITY

Geiger Gibson Program in Community Health Policy

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Geiger Gibson /
RCHN Community Health Foundation Research Collaborative

Policy Research Brief # 33

Assessing the Potential Impact of the Affordable Care Act on Uninsured Community Health Center Patients: A Nationwide and State-by-State Analysis

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October 16, 2013

About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center 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 the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

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

Additional information about the Research Collaborative can be found online at http://sphhs.gwu.edu/projects/geiger-gibson-program or at rchnfoundation.org.

Executive Summary

In this brief, we estimate the number of uninsured community health center (CHC) patients who would gain coverage under the Affordable Care Act using data from the 2009 HRSA Survey of CHC patients and 2011 Uniform Data System. We find that were all states to implement the Affordable Care Act Medicaid expansion, an estimated 5 million uninsured health center patients – or two-thirds of all uninsured patients served by CHCs nationally – would be eligible for coverage. However, over one million uninsured patients – 72% of whom live in southern states -- who would have been eligible for coverage will remain uninsured because of states' decisions to opt out of the expansion. The spillover effects of the decision to opt out of the Medicaid expansion are likely to be significant. Health centers in opt-out states can be expected to struggle, falling further behind their expansion state counterparts in terms of service capacity, number of patients served (both insured and uninsured), and in their ability to invest in initiatives that improve the quality and efficiency of health care.

Introduction

The Affordable Care Act (ACA) can be expected to provide access to affordable health insurance coverage to most low income Americans. The Act achieves this aim through a combination of two approaches. The Act expands Medicaid to cover all nonelderly adults with incomes up to 138% of the federal poverty level (FPL). The Act also creates new Health Insurance Marketplaces that make subsidized private insurance coverage through Qualified Health Plans (QHPs) available for people with family incomes between 100 and 400% of the FPL. The most significant level of assistance is available to people with family incomes up to 200% FPL, who are eligible for subsidies that reduce the cost of coverage under a reasonably comprehensive insurance plan to 5% of family income or below. For example, a family of 4 with $40,000 in income in 2014 would qualify for a $6,325 subsidy toward a health plan purchased in the Marketplace, which otherwise would cost $8,290 – a discount of more than two-thirds.[1]

Health Insurance Marketplace subsidies were designed to work in tandem with Medicaid. With the exception of certain recently-arrived legal U.S. residents who qualify for subsidies even with poverty-level incomes, eligibility for Marketplace subsidies does not begin until family income exceeds 100% FPL. In states that expand Medicaid to cover all low income adults, Medicaid coverage will extend to 138% FPL and Marketplace subsidies will begin only above this point. In any state that opts out of the Medicaid expansion,[2] the poorest uninsured adults – those with incomes below 100% FPL – will remain completely uninsured unless they can qualify for coverage under the state's traditional program. Traditional Medicaid eligibility rules for nonelderly adults are far more restrictive, however. Eligibility is limited to adults who are pregnant, persons with disabilities, or parents; furthermore, financial eligibility standards for low-income parents average well below 138% FPL.[3] As a result, in a state that opts out, a poor adult who does not fall into a traditional category cannot qualify for Medicaid coverage at any income level, while parents may be unable to qualify unless their incomes are extremely low. As of September 30, 2013, 26 states had elected to opt out of the Medicaid expansion.[4] On October 10th, 2013, Ohio received federal approval for its Medicaid expansion, and final state action is expected by the end of October.[5]

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[1] Kaiser Family Foundation, subsidy calculator, Available at: http://kff.org/interactive/subsidy-calculator/#state=&zip=&income-type=dollars&income=40%2C000&employer-coverage=0&people=4&adult-count=2&adults%5B0%5D%5Bage%5D=21&adults%5B0%5D%5Btobacco%5D=0&adults%5B1%5D%5Bage%5D=21&adults%5B1%5D%5Btobacco%5D=0&child-count=2&child-tobacco=0 (Accessed online October 8, 2013).

[2] This option was not part of the original law but was instead created by the United States Supreme Court's decision in *NFIB v Sebelius,* which held that states could not be compelled to expand their existing programs to encompass all non-elderly low income adults.

[3] Kaiser Family Foundation State Health Facts. (October 1, 2013). Medicaid Income Eligibility Limits for Adults at Application, Effective January 1, 2014. Available at: http://kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-adults-at-application-effective-january-1-2014/

[4] Centers for Medicare and Medicaid Services (CMS). (September 30, 2013). State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014. Available at: http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf

[5] Higgs, R. (October 11, 2013). Ohio gains federal approval to expand its Medicaid program to cover state's working poor. http://www.cleveland.com/open/index.ssf/2013/10/ohio_gains_federal_approval_to.html

In 2011, the nation's 1,128 community health centers (CHC) operating at more than eight thousand medically underserved urban and rural sites provided health care to over 20.2 million patients.[6] An additional 100 "look alike" health centers served another 1 million patients that year. Health center patients are extremely poor. As a result, health center patients are extremely sensitive to state Medicaid eligibility decisions. Nationally, 72% percent of all patients who receive care at health centers have family incomes below 100% of the federal poverty level ($19,530 for a family of 3 in 2013), while 92% have family incomes below twice the FPL ($58,590 for a family of 3 in 2013). In 2011, 36% of all patients (7.4 million people) were uninsured.

As their uninsured patients gain coverage, health centers in turn can be expected to realize significant growth in financial resources, a crucial consideration in light of the fact that health centers by law serve all community residents, regardless of their insurance status. Despite the insurance expansions resulting from the ACA, health centers can be expected to continue to see large numbers of patients who remain uninsured on either a short-term or long-term basis. They will also serve as a source of care for patients who are covered but unable to afford the deductibles and coinsurance that are part of qualified health plans sold in the Marketplace, even at the reduced levels made possible through the cost-sharing assistance also available under the ACA. The added revenues realized from the coverage expansions, however, will enable health centers to expand into new communities, to increase the number of patients served, to add badly needed services such as adult dental and mental health care, and to increase clinical staffing levels.

Previous research has documented the favorable spillover effects on health centers of expanding insurance coverage to the poor. Studies have demonstrated the link between higher levels of insurance coverage among adult patients and improved health center capacity as measured by the level and scope of health care, the number of patients served, the number of service locations, clinical staffing levels, and health care quality.[7] Other research, which focused on the unique experience of Massachusetts's health centers, shows how comprehensive health reform affects health center capacity for both insured and uninsured patients.[8] Massachusetts's 2006 health reform law helped fuel a significant expansion in health centers' service capacity; at the same time, while the overall proportion of uninsured patients served by health centers declined significantly in the years following health reform, the proportion of CHC patients without health insurance stood at 21.3% in 2011, more than 6 times

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[6] Bureau of Primary Health Care. (2012). *Uniform Data System (UDS) Report 2011*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services. Available at: http://bphc.hrsa.gov/uds/doc/2011/National_Universal.pdf

[7] Kaiser Family Foundation. (2012) *Medicaid and community health centers: The relationship between coverage for adults and primary care capacity in medically underserved communities*. Available at: http://kff.org/health-reform/issue-brief/medicaid-and-community-health-centers-the-relationship/

[8] Ku, L., Jones., E., Shin, P., Byrne, F.R., and Long, S.K. (2011) Safety-net providers after health reform: Lessons from Massachusetts. *Arch Intern Med*, 171(15): 1379-84.

the statewide average of 3.4%.[9] Furthermore, while the overall proportion of uninsured patients fell, the actual number of uninsured residents receiving care at Massachusetts health centers increased by 6% between 2007 and 2011.[10] In sum, the ACA insurance expansions can be expected to strengthen health centers' overall operations, while also growing their capacity to treat the remaining uninsured residents.

Estimated Impact

Because of the ACA's income eligibility rules for Medicaid and for substantial premium subsidies and cost sharing assistance, three distinct income ranges become important in estimating the potential effects of state coverage choices on health centers and patients. The first is the number of patients with incomes at or below 138% FPL, the Medicaid eligibility upper income limit in states that expand. The second key income range is the number of patients with incomes at or below 100% FPL, the population that will remain ineligible for Marketplace premium subsidies and cost-sharing assistance in states that opt out of the Medicaid expansion. The third pertinent income range is the number of health center patients with incomes between the Marketplace threshold (either 100% or 138% FPL) and 200% FPL, where premium subsidies and cost-sharing assistance are sufficiently generous to make a significant difference in patients' ability to afford care.

Using data from the 2009 Health Center User Survey and the 2011 Uniform Data System (UDS), we estimated the potential impact of the ACA on uninsured CHC patients both nationally and by state. We present results in Tables 2 and 3, which display estimates for states that expand Medicaid as well as for those that opt out of the expansion. The 2009 survey, which was administered by the Health Resources and Services Administration (HRSA), represents the most current patient-level information available on CHC patients nationally.[11] Because the proportion of low income non-elderly adults nationally who are uninsured appears to have changed little (0.2% increase) from 2007-2011,[12] the survey

[9] Bureau of Primary Health Care. (2012). *Uniform Data System (UDS) Massachusetts Rollup Report 2011*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services. Available at: http://bphc.hrsa.gov/uds/doc/2011/UDS_2011_Rollups_MA_Universal.pdf ; US Census Bureau. (2012). Current Population Survey, Annual Social and Economic Supplement. http://www.census.gov/cps/data/cpstablecreator.html

[10] Number of uninsured in MA increased from 123,388 in 2007 to 131,141 in 2011. Bureau of Primary Health Care. (2008). *Uniform Data System (UDS) Massachusetts Rollup Report 2007*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services. Available at: http://bphc.hrsa.gov/healthcenterdatastatistics/statedata/2007/MA/07rollup_statema_08jul2008.pdf; Bureau of Primary Health Care. (2012). *Uniform Data System (UDS) Massachusetts Rollup Report 2011*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services. Available at: http://bphc.hrsa.gov/uds/doc/2011/UDS_2011_Rollups_MA_Universal.pdf

[11] The CHC survey estimates are based on 4,562 CHC patients that represent a weighted total of over 16.5 million CHC patients. The survey included questions on family income and family size that were combined with 2009 poverty guidelines to categorize federal poverty levels.

[12] Kaiser Commission on Medicaid and the Uninsured. (2013). Reversing the Trend? Understanding the Recent Increase in Health Insurance Coverage among the Nonelderly Population. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8264-02.pdf

continues to be a source of reliable information in estimating the impact of the ACA on uninsured CHC patients. The 2011 UDS data consist of organizational, financial, patient mix, and utilization summaries submitted to HRSA by each federally-funded health center.

Table 1 shows the income distribution of uninsured CHC patients by various eligibility levels. For states expanding Medicaid, the key ranges consist of Medicaid assistance up to 138% FPL coupled with Marketplace premium assistance between 138% and 200% FPL. (Because of Medicaid's 5-year waiting period, legal residents generally would receive help through Marketplace premium assistance regardless of income). For states that opt out of the Medicaid expansion, the critical ranges are incomes up to 100% FPL and 100%-200% FPL. Table 1 shows, not surprisingly, that the majority of CHC patients who are uninsured are poor and are most likely to qualify for Medicaid.

Table 1. Uninsured health center patients by federal poverty level

Income range	Distribution of uninsured CHC patients (2009), by income	Estimated number of uninsured health center patients (2011)*
≤100% FPL	53%	3,903,005
101-200% FPL	31%	2,282,890
201-400% FPL	13%	957,341
>400% FPL	3%	220,925
≤138% FPL	70%	5,154,913
139-400% FPL	27%	1,988,323
≤400% FPL	97%	7,143,236

*Calculated by multiplying 2nd column percentages by the 7,364,161 uninsured reported in the 2011 UDS
Source: 2009 CHC User Survey, HRSA and the 2011 UDS, HRSA

Tables 2 and 3 present state-level data on the overall size of the health center patient population and the number of health center patients who are uninsured. In order to illustrate the impact of states' Medicaid expansion decisions on health center revenues, we also estimate, separately for non-expansion/opt-out and expansion states, the potential state-specific revenue gains and losses under a full Medicaid expansion scenario as compared with a non-expansion scenario.[13] This was calculated by multiplying the number of uninsured health center patients who were expected to gain coverage by the average per capita Medicaid revenue received by health centers in 2011.

Because the 2011 UDS does not report on uninsured patients by income, we applied the Urban Institute's estimated share of uninsured residents who are expected to gain

[13] Eligibility levels in effect as of January 1, 2014 based on information current as of September 30, 2013, provided to CMS by states either for purposes of FFM programming of state-specific Medicaid/CHIP rules, through state plan amendments, or by direct request from CMS. These levels are subject to change.

coverage in opt-out and opt-in states (see Table A2 in Appendix).[14] Using the Urban Institute formula, we find that approximately 5 million CHC patients nationwide could be expected to gain coverage were all states to expand Medicaid.

Health centers in the opt-out states

Table 2 shows that health centers in the 25 non-expansion states serve approximately 3.1 million uninsured patients. Based on the Urban Institute statewide projections, we estimate that about 1.2 million CHC patients in these opt-out states can be expected to become eligible for coverage. This means that an estimated one million patients in the opt-out states who would have gained coverage will remain uninsured. Approximately 72% of health center patients who would have gained coverage but will remain uninsured live in southern states[15] (AL, FL, GA, LA, MS, NC, OK, SC, TN, TX, VA).

Some patients might be expected to qualify for Medicaid under traditional eligibility rules (i.e., pregnancy, disability, or status as parents of minor children), but since eligibility levels for parents average below 50% FPL in the opt-out states, the number who qualify on traditional eligibility criteria will be relatively low. At the same time however, the number of eligible health center patients who fail to gain insurance coverage as a result of living in non-expansion states represent approximately half the expected number who would have gained coverage had these states expanded Medicaid. The actual share of health center patients who remain uninsured may be higher than the overall share of the state low income population that remains uninsured in the opt-out states, given the fact that health centers are by law located in the poorest communities with higher concentration of potentially Medicaid-eligible residents.[16]

Opting out of the Medicaid expansion can be expected to have significant spillover effects on health center operations. Had expansion occurred in the opt-out states, health centers would have been expected to generate approximately $1.2 billion in 2014, adjusted for inflation. Under an opt-out scenario, health centers in these states are expected to receive approximately half that amount, shown on Table 2.

[14] Buettgens, M., Kenney, G.M., Recht, H., & Lynch, V. (2013). *Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States*. Robert Wood Johnson Foundation. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf408158

[15] Based on the U.S.Census Bureau regions.

[16] Kaiser Family Foundation (2013) *Community Health Centers in an Era of Health Reform: An Overview and Key Challenges to Health Center Growth.* Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8098-03.pdf; Rosenbaum, S., Jones, E., Shin, P. and Ku, L.(2009) *National Health Reform: How Will Underserved Communities Fare?* Geiger Gibson/RCHN Community Health Foundation Research Collaborative. Available at: http://www.rchnfoundation.org/?p=864; Ku, L., Shin, P., and Rosenbaum, S. (2009) *Estimating the Effects of Health Reform on Health Centers' Capacity to Expand to New Medically Underserved Communities and Populations*. Geiger Gibson/RCHN Community Health Foundation Research Collaborative. Available at: http://www.rchnfoundation.org/?p=866

Table 2. Estimated Impact on Uninsured Patients and Health Center Revenues in States that Opt Out of the ACA Medicaid Expansion

State	Number of CHCs (2011)	Total CHC patients (2011)	Uninsured CHC patients (2011)	Uninsured eligible with Medicaid expansion	Uninsured eligible without Medicaid expansion	Potential revenue gained in 2014 under Medicaid expansion	Potential revenue gained in 2014 without Medicaid expansion
Alabama	14	320,044	152,414	121,931	57,917	$55,006,620	$26,128,144
Alaska	25	91,020	32,216	24,162	13,853	$29,452,818	$16,886,283
Florida	44	1,080,695	504,432	343,014	186,640	$188,666,714	$102,656,888
Georgia	27	317,299	162,305	113,614	56,807	$41,472,145	$20,736,072
Idaho	11	126,354	65,318	48,989	27,434	$41,565,975	$23,276,946
Indiana	19	273,536	102,076	79,619	43,893	$42,721,645	$23,551,676
Kansas	13	147,489	75,668	54,481	31,024	$29,088,881	$16,564,502
Louisiana	24	223,095	86,976	66,102	33,921	$33,426,925	$17,153,290
Maine	18	181,171	26,385	20,844	13,984	$14,806,379	$9,933,393
Mississippi	21	324,046	134,212	106,027	48,316	$34,849,947	$15,880,989
Missouri	21	420,130	145,288	114,778	61,021	$79,115,667	$42,061,494
Montana	15	101,406	50,835	41,176	23,892	$23,444,078	$13,603,354
Nebraska	6	63,532	33,674	24,245	13,806	$11,406,865	$6,495,576
New Hampshire	10	65,466	19,267	14,643	9,441	$9,590,343	$6,183,248
North Carolina	28	411,015	214,217	147,810	81,402	$73,440,392	$40,445,433
Oklahoma	17	135,272	54,478	39,224	22,336	$29,228,346	$16,643,919
Pennsylvania	35	637,928	164,857	126,940	70,889	$66,923,667	$37,372,957
South Carolina	20	326,829	129,838	98,677	50,637	$50,887,002	$26,113,067
South Dakota	6	58,003	21,328	17,062	8,531	$9,223,857	$4,611,928
Tennessee	23	372,360	150,413	114,314	61,669	$49,637,726	$26,778,247
Texas	64	975,509	501,327	315,836	170,451	$180,192,888	$97,246,956
Utah	11	112,794	62,782	42,692	25,113	$35,245,488	$20,732,640
Virginia	25	285,359	108,328	74,746	40,081	$36,786,082	$19,725,870
Wisconsin	16	281,591	67,793	51,523	29,151	$42,776,643	$24,202,574
Wyoming	5	18,022	7,512	5,334	3,305	$2,421,402	$1,500,587
Total	**518**	**7,349,965**	**3,073,939**	**2,207,782**	**1,185,514**	**$1,211,378,495**	**$656,486,033**

Health centers in the expansion states

Table 3 shows that health centers in expansion states will potentially see 2.8 million patients gain coverage and, as a result, will generate a potential revenue increase of over $2 billion. Again, the number of CHC patients eligible for new coverage is likely underestimated given the higher prevalence of poverty among CHC patients than the general population.

Table 3. Estimated Impact on Patients and Health Center Revenues in States that Implement the ACA Medicaid Expansion

State	Number of CHCs (2011)	Total CHC patients (2011)	Uninsured CHC patients (2011)	Uninsured eligible with Medicaid expansion	Uninsured eligible without Medicaid expansion	Potential revenue gained in 2014 with Medicaid expansion	Potential revenue gained in 2014 without Medicaid expansion
Arizona	16	408,737	118,255	73,318	40,207	$65,195,104	$35,752,154
Arkansas	12	156,159	65,858	49,394	26,343	$23,070,616	$12,304,329
California	121	3,104,183	1,287,447	823,966	450,606	$637,033,588	$348,377,743
Colorado	15	474,241	191,596	126,453	72,806	$88,070,409	$50,707,205
Connecticut	13	315,992	73,956	48,071	28,103	$39,839,839	$23,290,983
Delaware	3	38,861	15,074	10,401	6,331	$5,132,612	$3,124,199
D.C.	4	122,891	20,124	13,282	6,238	$7,329,804	$3,442,786
Hawaii	14	137,266	33,911	26,111	11,869	$21,340,024	$9,700,011
Illinois	37	1,098,483	339,834	224,290	115,544	$108,105,419	$55,690,671
Iowa	13	179,120	61,935	47,071	26,013	$27,540,900	$15,219,971
Kentucky	19	278,242	105,406	85,379	43,216	$56,382,656	$28,539,369
Maryland	16	282,831	61,633	39,445	21,572	$33,264,557	$18,191,554
Massachusetts	36	615,708	131,141	85,242	85,242	$59,550,775	$59,550,775
Michigan	29	546,245	178,903	144,911	73,350	$96,842,052	$49,018,816
Minnesota	15	165,474	65,113	46,881	27,999	$28,909,207	$17,265,221
Nevada	2	57,987	27,730	17,747	9,706	$7,423,394	$4,059,669
New Jersey	20	454,243	196,515	115,944	68,780	$61,669,906	$36,583,842
New Mexico	15	285,700	111,181	76,715	38,913	$49,372,208	$25,043,874
New York	52	1,489,141	373,617	246,587	141,974	$204,705,824	$117,860,929
North Dakota	4	32,404	8,975	7,090	4,308	$3,502,831	$2,128,302
Ohio[17]	33	484,631	162,444	131,580	68,226	$60,346,341	$31,290,695
Oregon	25	289,731	110,401	80,593	46,368	$93,573,777	$53,836,967
Rhode Island	8	123,095	39,004	26,133	15,602	$17,796,267	$10,624,637
Vermont	8	121,682	12,362	9,272	6,305	$7,024,584	$4,776,717
Washington	25	794,485	278,369	194,858	111,348	$198,253,434	$113,287,677
West Virginia	27	379,702	91,295	73,949	38,344	$44,822,471	$23,241,281
Total	**582**	**12,437,234**	**4,162,079**	**2,824,683**	**1,585,313**	**$2,046,098,599**	**$1,152,910,377**

[17] Ohio was added to the expansion group based on Governor Kasich's recent submission of a federally approved expansion plan to his state budget control board for final approval. Approximately 63,354 eligible patients would have remained uninsured had Ohio not expanded Medicaid.

Discussion

These estimates illustrate the potential impact of the Affordable Care Act on uninsured health center patients and health center capacity. In the states that expand Medicaid, the number of patients expected to be eligible for coverage through Medicaid and premium assistance is approximately 2.8 million. In these states, health centers can expect to gain approximately $2 billion (adjusted to 2014 dollars) in additional revenues from Medicaid and payments by qualified health plans. Because patient cost-sharing under qualified health plans will be higher, even with cost-sharing assistance, total revenues received may be slightly lower than estimated here, but since more than 90% of health center patients have incomes below twice the FPL, health centers can nonetheless be expected to realize significant revenues from insurance reform, similar to the experience of Massachusetts health centers.

By contrast, the 518 health centers in states that do not couple Marketplace premium subsidies with Medicaid expansions–nearly half (46%) of all grantees in 2011–can be expected to struggle. Over one million uninsured patients in these states who would have been eligible for coverage are likely to remain uninsured, and health centers in these states stand to lose nearly $555 million in revenues in 2014 dollars. Health centers in the opt-out states will be able to qualify some of their patients under traditional Medicaid eligibility rules, but we anticipate that this number will be modest, since most of those previously eligible would have been identified and enrolled because of health centers' outreach and enrollment assistance efforts that predate health reform. With the opt-out states representing the nation's highest proportions of uninsured poor,[18] the Medicaid expansion becomes especially vital. It is the residents of these states who, research shows, bear the greatest burden of illness and poor health and stand to gain the most from the health care access improvements that Medicaid produces.[19]

Because of the close association between high concentrations of uninsured poor populations and medical underservice – the key indicator of need used to determine where health centers will be located – health centers in these opt-out states already face especially deep challenges. Health centers in opt-out states can be expected to fall further behind over time compared to those in expansion states in terms of number of patients served (both insured and uninsured), expanded service capacity, recruitment and retention of clinical staff, expansion of service sites, and the introduction of further improvements in clinical quality.

In the coming years, more states may expand Medicaid. But in the near-term, health centers in non-expansion states can be expected to confront more significant growth challenges, more limited service capacity, and more limited ability to invest in the types of system reforms that improve quality and efficiency. Assessing the Affordable Care Act's impact on health centers and their communities thus emerges as a principal means of enabling policymakers to understand how health insurance reform ultimately enables the types of community health system transformations that extend beyond the immediate receipt of care at an individual patient level and affect health and health care on a community-wide basis.

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[18] Tavernise, S. & Gebeloff, R. (October 2, 2013). Millions of Poor Are Left Uncovered by Health Law. *The New York Times.* Available at: http://www.nytimes.com/2013/10/03/health/millions-of-poor-are-left-uncovered-by-health-law.html

[19] Commonwealth Fund, Health Care in the Two Americas http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Sep/1700_Schoen_low_income_scorecard_FULL_REPORT_FINAL_v4.pdf (Accessed online October 12, 2013)

Appendix

Table A1 shows the breakdown of health centers by income status and the proportion of each income group of patients who are uninsured. Approximately 97% of all CHC patients have incomes below and at 400% of FPL. In general, the majority of CHC patients have incomes less than 100% (and 138%) of FPL.

A1. Income Profile of CHC Patients

Income range	Proportion of all CHC patients	Proportion of patients within income level who are uninsured
≤100% FPL	54%	35%
101-200% FPL	32%	36%
201-400% FPL	11%	42%
>400% FPL	3%	38%
≤138% FPL	73%	35%
139-400% FPL	24%	41%
≤400% FPL	97%	36%

Source: 2009 CHC User Survey, HRSA.

Table A2 is derived from the Urban Institute's report which examined how many uninsured would be eligible for Medicaid, the Children's Health Insurance Program and subsidized private insurance.

A2. Uninsured Eligible for Coverage, By State

State	With Expansion	Without Expansion	State	With Expansion	Without Expansion
Alabama	80%	38%	Montana	81%	47%
Alaska	75%	43%	Nebraska	72%	41%
Arizona	62%	34%	Nevada	64%	35%
Arkansas	75%	40%	New Hampshire	76%	49%
California	64%	35%	New Jersey	59%	35%
Colorado	66%	38%	New Mexico	69%	35%
Connecticut	65%	38%	New York	66%	38%
Delaware	69%	42%	North Carolina	69%	38%
District of Columbia	66%	31%	North Dakota	79%	48%
Florida	68%	37%	Ohio	81%	42%
Georgia	70%	35%	Oklahoma	72%	41%
Hawaii	77%	35%	Oregon	73%	42%
Idaho	75%	42%	Pennsylvania	77%	43%
Illinois	66%	34%	Rhode Island	67%	40%
Indiana	78%	43%	South Carolina	76%	39%
Iowa	76%	42%	South Dakota	80%	40%
Kansas	72%	41%	Tennessee	76%	41%
Kentucky	81%	41%	Texas	63%	34%
Louisiana	76%	39%	Utah	68%	40%
Maine	79%	53%	Vermont	75%	51%
Maryland	64%	35%	Virginia	69%	37%
Massachusetts	65%	65%	Washington	70%	40%
Michigan	81%	41%	West Virginia	81%	42%
Minnesota	72%	43%	Wisconsin	76%	43%
Mississippi	79%	36%	Wyoming	71%	44%
Missouri	79%	42%			

Source: Buettgens, M., Kenney, G.M., Recht, H., & Lynch, V. (2013). *Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States*. Robert Wood Johnson Foundation.

The following tables (A3-A4) show the distribution of CHC patients by income less than or equal to 100% FPL. The source for all estimates is the 2011 UDS data.

A3. CHC Patients with
Incomes Less than 100% FPL in Non-Expansion States

State	Total CHC patients	Reported number of CHC patients ≤ 100% FPL	No. of CHC patients ≤ 100% FPL*	Pct. Of CHC patients ≤ 100% FPL
Alabama	320,044	202,237	226,027	70.6%
Alaska	91,020	21,394	47,243	51.9%
Florida	1,080,695	626,933	759,554	70.3%
Georgia	317,299	173,229	225,899	71.2%
Idaho	126,354	64,985	80,624	63.8%
Indiana	273,536	156,147	216,140	79.0%
Kansas	147,489	83,014	103,433	70.1%
Louisiana	223,095	117,589	170,450	76.4%
Maine	181,171	57,810	81,418	44.9%
Mississippi	324,046	203,480	235,477	72.7%
Missouri	420,130	249,652	316,772	75.4%
Montana	101,406	49,861	63,649	62.8%
Nebraska	63,532	32,693	42,472	66.9%
New Hampshire	65,466	28,252	34,669	53.0%
North Carolina	411,015	237,794	312,153	75.9%
Oklahoma	135,272	68,709	94,105	69.6%
Pennsylvania	637,928	323,087	418,130	65.5%
South Carolina	326,829	192,874	253,390	77.5%
South Dakota	58,003	18,265	31,617	54.5%
Tennessee	372,360	214,404	306,960	82.4%
Texas	975,509	599,230	717,432	73.5%
Utah	112,794	65,950	84,586	75.0%
Virginia	285,359	100,609	165,968	58.2%
Wisconsin	281,591	135,608	181,516	64.5%
Wyoming	18,022	6,345	10,886	60.4%
Total for non-expansion states	7,349,965	4,030,151	5,180,571	70.5%

*This was calculated by adding the reported number of patients <=100% FPL in the UDS with the number of patients with unknown income multiplied by the percentage of those <=100% FPL

A4. CHC Patients with Incomes Less than 100% FPL in Expansion States

State	Total CHC patients	Reported number of CHC patients ≤ 100% FPL	No. of CHC patients ≤ 100% FPL*	Pct. reported ≤ 100% FPL
Arizona	408,737	196,932	308,023	75.4%
Arkansas	156,159	70,551	103,068	66.0%
California	3,104,183	2,174,229	2,445,913	78.8%
Colorado	474,241	317,026	354,809	74.8%
Connecticut	315,992	179,452	207,332	65.6%
Delaware	38,861	18,933	22,844	58.8%
District of Columbia	122,891	73,068	93,523	76.1%
Hawaii	137,266	81,541	102,547	74.7%
Illinois	1,098,483	672,932	844,626	76.9%
Iowa	179,120	72,620	126,581	70.7%
Kentucky	278,242	124,003	164,941	59.3%
Maryland	282,831	120,125	177,555	62.8%
Massachusetts	615,708	296,337	403,895	65.6%
Michigan	546,245	269,346	363,935	66.6%
Minnesota	165,474	71,928	118,462	71.6%
Nevada	57,987	25,227	42,958	74.1%
New Jersey	454,243	303,646	358,172	78.9%
New Mexico	285,700	129,684	190,957	66.8%
New York	1,489,141	654,197	1,018,864	68.4%
North Dakota	32,404	10,487	21,344	65.9%
Ohio	484,631	199,882	342,416	70.7%
Oregon	289,731	182,700	221,493	76.4%
Rhode Island	123,095	43,681	83,527	67.9%
Vermont	121,682	15,842	37,483	30.8%
Washington	794,485	473,696	539,288	67.9%
West Virginia	379,702	125,167	194,120	51.1%
Total for expansion states	12,437,234	6,903,232	8,888,674	71.5%

*This was calculated by adding the reported number of patients <=100% FPL in the UDS with the number of patients with unknown income multiplied by the percentage of those <=100% FPL