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8-19-2015

# How Has the Affordable Care Act Benefitted Medically Underserved Communities? : National Findings from the 2014 Community Health Centers Uniform Data System

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### Recommended Citation

Sharac, Jessica; Shin, Peter; and Rosenbaum, Sara J., "How Has the Affordable Care Act Benefitted Medically Underserved Communities? : National Findings from the 2014 Community Health Centers Uniform Data System" (2015). *Geiger Gibson/RCHN Community Health Foundation Research Collaborative*. Paper 58.  
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**Geiger Gibson /  
RCHN Community Health Foundation Research Collaborative**

**Policy Research Brief # 42**

**How Has the Affordable Care Act Benefitted Medically Underserved  
Communities?**

**National Findings from the 2014 Community Health Centers Uniform Data System**

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**August 19, 2015**

## **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 Milken Institute School of Public Health 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 is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing 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://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy> or at [rchnfoundation.org](http://rchnfoundation.org).

## **Executive Summary**

Community health centers represent the single largest comprehensive primary health care system serving medically underserved communities, operating in more than 9,000 urban and rural locations. Newly-released data for 2014 from the Uniform Data System (UDS; the federal health center reporting system) shed important light on the impact of the Affordable Care Act in its first full year of implementation in medically underserved urban and rural communities across the U.S. These communities experience elevated poverty, heightened health risks, lack of access to primary health care, and a significantly greater likelihood that residents will be uninsured.

The UDS data show the ACA's major national impact on both medically underserved communities and community health centers. Between 2013 and 2014, the number of health center patients with health insurance rose by more than 2.3 million (a 17 percent increase), the number of uninsured patients declined by 1.2 million (a 16 percent decrease), and the total number of patients served rose by over 1.1 million (a 5 percent increase). Since 1996, the total number of patients served at federally funded health centers has nearly trebled, from slightly more than 8 million to almost 22.9 million patients served by 2014.

Consistent with the fact that over 70 percent of health center patients have household incomes at or below 100 percent of the federal poverty level, of the 2.3 million increase in insured patients, approximately 79 percent is the result of an increase of 1.8 million in the number of patients covered by Medicaid. Between 2013 and 2014, the number of privately insured health center patients also rose, from 3.1 to 3.6 million, an increase of 16 percent and by far the greatest increase in private insurance coverage over the 1996-2014 time period.

These findings point to the importance of the ACA in the nation's poorest communities, while also emphasizing the vital role played by Medicaid. The UDS results also underscore the major expansion trajectory for community health centers as a result of insurance expansions and direct Congressional investment in continued health center growth. These findings also reveal that as patients gain coverage, they remain with their health centers, even as health centers continue to reach more community residents.

## **Background**

Now celebrating their 50<sup>th</sup> year, the nation's community health centers offer comprehensive primary health care in the nation's most medically underserved urban and rural communities, whose residents experience elevated poverty and health risks, reduced access to primary health care, and a significantly greater risk of being uninsured.<sup>1</sup> More than 90 percent of all health center patients have incomes below twice

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<sup>1</sup> Rosenbaum, S., Jones, E., Shin, P., & Ku, L. (2009). National health reform: how will medically underserved communities fare? Geiger Gibson/RCHN Community Health Foundation Research Collaborative. Policy Research

the federal poverty level and 71 percent have incomes at or below the federal poverty level.<sup>2,3</sup>

All health centers reflect the needs of their communities, but at the same time, all health centers share four key characteristics: location in medically underserved communities or service to medically underserved populations such as farmworkers or people who are homeless; comprehensive primary health care provided to patients reflecting the full age spectrum; financial accessibility to health services for all community residents regardless of their ability to pay; and governance by community boards, over half of whose members are themselves patients of the health center.

Health center patients are extraordinarily diverse. Over 62 percent are members of racial and ethnic minority groups.<sup>4</sup> Certain populations are highly represented among health center patients, including female patients and children ages 0-17, who comprise 58 percent and 31 percent of health center patients, respectively. Health centers serve one in five low-income children<sup>5</sup> and one in five low-income women of childbearing age.<sup>6</sup>

The Patient Protection and Affordable Care Act (ACA) made three major changes in how health care is financed in medically underserved communities and populations, and these changes can be expected to have a major impact on the reach and strength of the health centers program over time. First, the ACA created two major pathways to affordable health insurance for low- and moderate-income individuals and families: an expanded Medicaid program open to all nonelderly people with household incomes up to 138 percent of the federal poverty level; and a subsidized health insurance Marketplace for people with household incomes between 100 percent and 400 percent of the federal poverty level and not eligible for Medicaid, Medicare, or employer coverage.

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Brief #10.

[https://publichealth.gwu.edu/departments/healthpolicy/DHP\\_Publications/pub\\_uploads/dhpPublication\\_5046C2DE-5056-9D20-3D2A570F2CF3F8B0.pdf](https://publichealth.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublication_5046C2DE-5056-9D20-3D2A570F2CF3F8B0.pdf)

<sup>2</sup> The federal poverty level is \$11,770 for one person and \$20,090 for a family of three in 2015.

<http://aspe.hhs.gov/poverty/15poverty.cfm>

<sup>3</sup> Bureau of Primary Health Care. (2015). National 2014 Health Center Data. Health Resources and Services Administration. <http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2014&state=>

<sup>4</sup> Bureau of Primary Health Care. (2015). 2014 Health Center Data: National Program Grantee Data. Health Resources and Services Administration. <http://bphc.hrsa.gov/uds/datacenter.aspx>

<sup>5</sup> Calculated as the number of health center children multiplied by the low-income percentage divided by the total US number of low-income children. 2013 Uniform Data System state data, Health Resources and Services Administration; U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2013 <http://www.census.gov/cps/data/cpstablecreator.html>

<sup>6</sup> Rosenbaum, S., Shin, P., Wood, S. & Sharac, J. (2015). Using payment reform strategies to strengthen family planning services at community health centers. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Issue No. 38.

[http://www.rchnfoundation.org/wp-content/uploads/2015/01/GGRCHN\\_PolicyResearchBrief\\_38-1.pdf](http://www.rchnfoundation.org/wp-content/uploads/2015/01/GGRCHN_PolicyResearchBrief_38-1.pdf)

Second, the ACA simplified the process for enrolling in and renewing health insurance coverage, whether through Medicaid or subsidized health plans purchased through the Marketplace. Every health center is required to participate in outreach and enrollment initiatives. Outreach and enrollment reports furnished by health centers indicate that health centers assisted more than 10 million people with enrollment between October 2013 and March 2014, during the year in which the data examined in this report were collected.<sup>7</sup>

Third, since 2010, Congress has provided \$11 billion in direct funding (in addition to annual discretionary appropriations) to health centers: \$9.5 billion was allocated to start new health center sites in high-need areas as well as to enable existing health centers to expand staff, delivery sites, and services and to support their operations and \$1.5 billion was directed to support construction and renovation projects.<sup>8</sup> As part of the Medicare and CHIP Reauthorization Act (MACRA, Pub. L. 114-110), Congress extended its health center investment for an additional two years.

## **The Uniform Data System**

As a condition of federal funding, health centers report annually on the patients they serve and the services they provide, as well as certain financial and staffing information, to the Bureau of Primary Health Care of the Health Resources and Services Administration (HRSA). This reporting system is known as the Uniform Data System (UDS). HRSA has now released data for Calendar Year 2014. This means that the most current UDS data capture the time period that included part of the first Marketplace open enrollment period (which began in October 2013) through much of the second open enrollment period (which ran from November 2014 through February 2015). (Special enrollment periods allow people to enroll in Marketplace coverage throughout the year if one of the recognized special circumstances such as loss of insurance arises. By contrast, Medicaid enrollment can occur at any time throughout a year and is not limited to open enrollment or special enrollment periods). Thus, the UDS 2014 national report released in August 2015 offers the first look at health centers and their communities in the first year of full implementation of the ACA's insurance reforms.

This initial analysis presents key national-level findings on coverage gains from the UDS. Subsequent analyses will examine state-level trends as well as additional aspects of the 2014 UDS data such as visit rates and service utilization.

## **Key Findings**

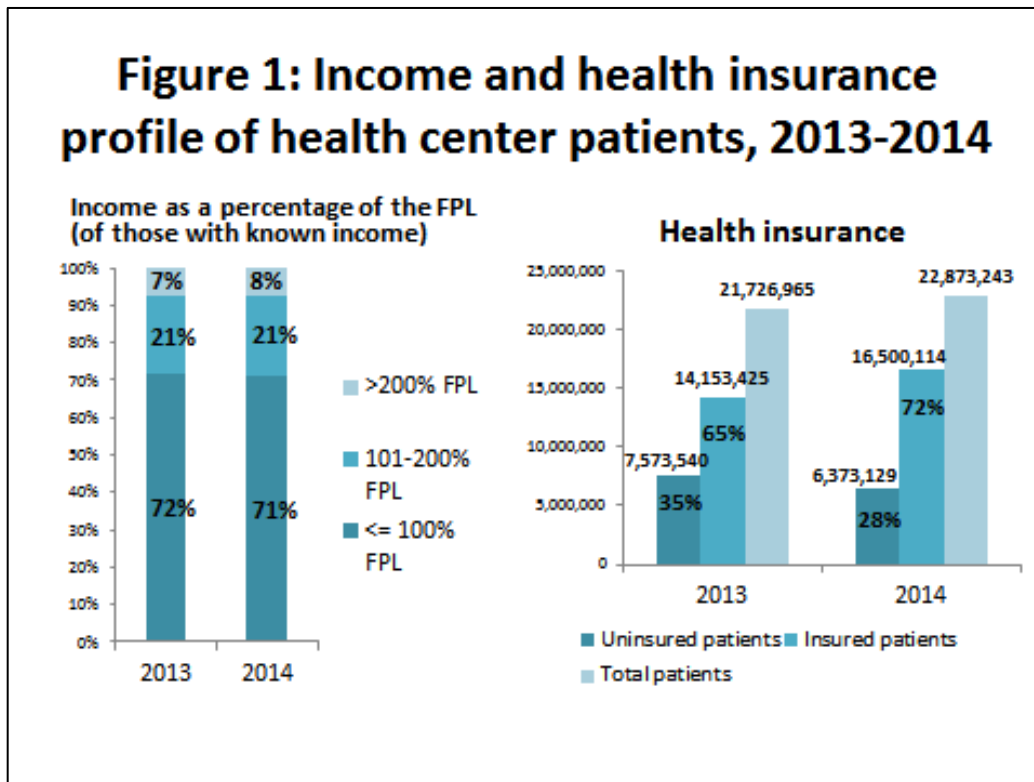
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<sup>7</sup> Personal communication with HRSA staff

<sup>8</sup> Bureau of Primary Health Care. (2015) *Health Center Fact Sheet*. Health Resources and Services Administration. <http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf>

The ACA's insurance expansions coincided with major changes in the health insurance status of health center patients and a surge in total patients served at federally funded health centers. Between 2013 and 2014, the number of insured health center patients grew by nearly 2.3 million, the number without health insurance declined by more than 1.2 million, and total patients served grew by over 1.1 million. As the total number of insured health center patients grew from slightly more than 14,153,000 to over 16,500,000, the number of uninsured patients decreased from over 7.5 million to slightly more than 6.3 million (**Figure 1**).

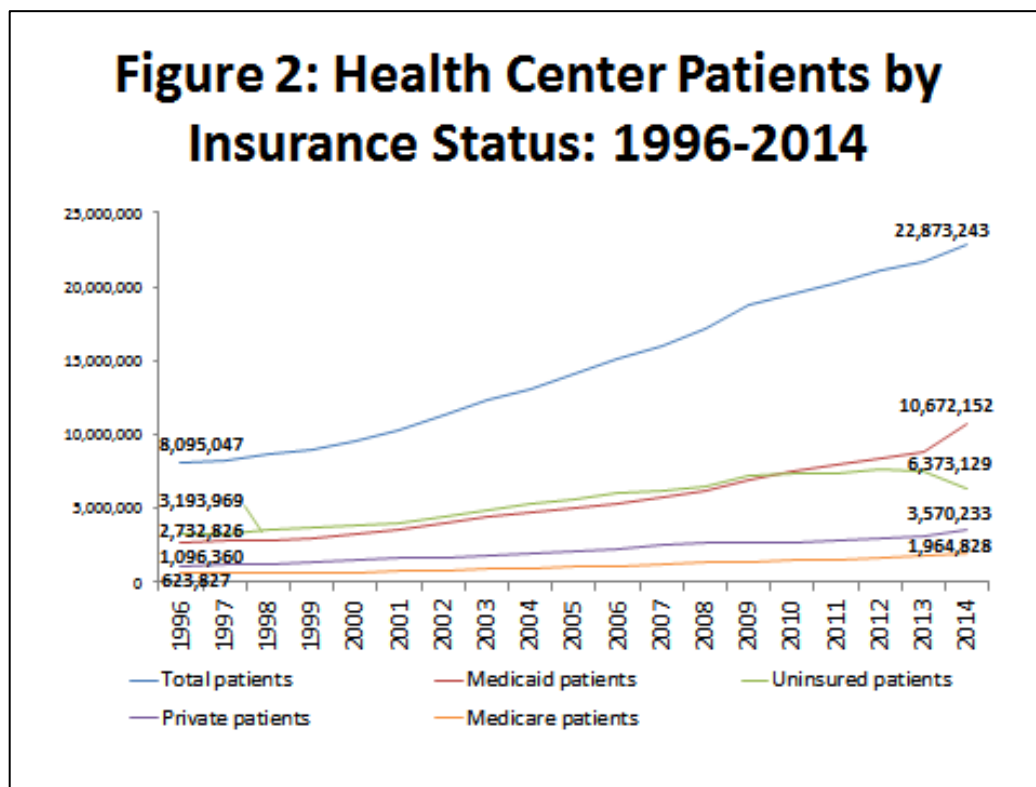
Because of the deep poverty of health center patients (over 70 percent have incomes below the federal poverty level), Medicaid accounted for approximately 79 percent of the increase in the number of insured patients (1.8 million out of nearly 2.3 million). At the same time however, the number of health center patients with private health insurance grew by 16 percent, from 3.1 million in 2013 to 3.6 million in 2014. In view of the low wages of health center patients and their historic limited access to employer coverage, our assumption is that the growth in private insurance among health center patients is the result of access to affordable coverage in the Marketplace.



Source: Bureau of Primary Health Care. (2014). National 2013 Health Center Data. Health Resources and Services Administration. <http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2013&state=>; Bureau of Primary Health Care. (2015). National 2014 Health Center Data. Health Resources and Services Administration. <http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2014&state=>

Even as health centers served an increasingly insured population, they not only maintained their patient base but grew to serve an additional 1.1 million patients. Although the UDS offers point in time estimates rather than longitudinal data about specific patients, the growth of health center patients in an era when millions gained coverage suggests that millions of insured patients remained at health centers despite the possibility that their access to insurance coverage allowed them a greater choice among health care providers.

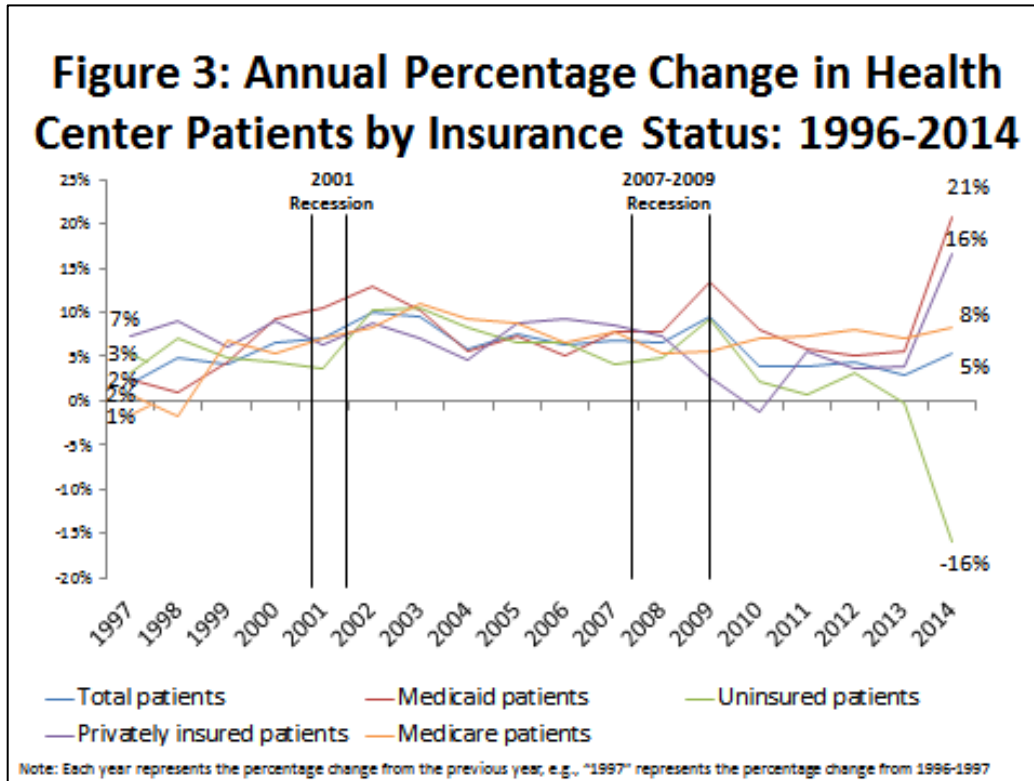
The growth of patients at health centers is consistent with the steady rate of health center growth over the 1996–2014 time period. **Figure 2** shows that the number of health center patients nearly tripled, from 8.1 million in 1996 to 22.9 million in 2014.



Source: UDS national reports 1998-2014, UDS data for 1996-1997

While Figure 2 shows continuous growth over time in total patients as well as growth by source of insurance coverage, **Figure 3** offers clearer evidence of the impact of the ACA expansions. During the recessionary periods of 2001 and 2007-2009, the number of Medicaid patients rose, but so did the number of uninsured patients, both logical consequences of any recession. What is striking about the 2013-2014 time period is that not only did the number of patients with Medicaid and private insurance rise dramatically, but the number of patients without health insurance declined steeply. These changes suggest the real link between the dramatic shift in insurance status among health center patients and implementation of the ACA’s insurance expansions.





Source: Author's analysis of data reported in the UDS national reports 1998-2014 and 1996-1997 UDS data

## Discussion

The UDS statistics suggest the importance of the Affordable Care Act, not only to the population generally, but to the nation's poorest and most medically underserved populations. Because of where they are located and the obligations they undertake in exchange for federal grant funding, the income and insurance profile of patients served by health centers offer important insight into the impact of the ACA in these communities. The national 2014 UDS data underscore the extent to which the ACA has lifted the poorest communities and the providers that serve them.

To be sure, health centers and their communities face key challenges: the large percentage (28 percent in 2014) of health center patients who remain uninsured, particularly in the 20 states that to date have elected not to expand Medicaid;<sup>9</sup> the need for additional service sites, the addition of critically needed services such as mental health, substance abuse and oral health care; the need to recruit and train additional clinical, outreach, and patient support staff to meet the burgeoning need for care; and the ongoing effort to improve the efficiency and quality of the care. For this reason,

<sup>9</sup> Kaiser Family Foundation. (July 20, 2015). State Health Facts: Status of State Action on the Medicaid Expansion Decision. <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

federal health center grant funding continues to play the crucial role in enabling health centers to reach patients who remain uninsured, provide services that insurance tends not to cover or else covers to only a limited degree, expand service capacity, and be active participants in health system transformation efforts.

The results of these investments are reflected in ways that extend beyond an increase in the number of patients served. Progress can be measured by the widespread recognition of health centers as Patient-Centered Medical Homes (65 percent in 2014).<sup>10</sup> The advances made possible by health reform also can be seen in participation by 434 health centers in CMS's Federally Qualified Health Center Advanced Primary Care Practice Demonstration, whose aim is to improve care for Medicare beneficiaries.<sup>11</sup> Progress can be further measured in the growing proportion of health centers that have made an electronic health record system available to all providers and at all sites, from 65 percent in 2011 to 92 percent in 2014.<sup>12</sup> As the ACA continues to provide resources that enable system transformation, ongoing and measurable progress remains achievable.

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<sup>10</sup> Bureau of Primary Health Care. (2015). National 2014 Health Center Data: Electronic Health Record (EHR) Information. Health Resources and Services Administration.

<http://bphc.hrsa.gov/uds/datacenter.aspx?q=tehr&year=2014&state=&fd=>

<sup>11</sup> CMS. (August 6, 2015). FQHC Advanced Primary Care Practice Demonstration.

<http://innovation.cms.gov/initiatives/fqhcs/>

<sup>12</sup> Bureau of Primary Health Care. (2012). National 2011 Health Center Data: Electronic Health Record (EHR) Information. Health Resources and Services Administration.

<http://bphc.hrsa.gov/uds/view.aspx?q=rehr&year=2011&state=> ; Bureau of Primary Health Care. (2015). National 2014 Health Center Data: Electronic Health Record (EHR) Information. Health Resources and Services Administration. <http://bphc.hrsa.gov/uds/datacenter.aspx?q=tehr&year=2014&state=&fd=>