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Geiger Gibson Program in Community Health Policy

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Geiger Gibson /
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How Could Repealing Key Provisions of the Affordable Care Act Affect Community Health Centers and their Patients?

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The **Geiger Gibson Program in Community Health Policy**, established in 2003 and named after 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.

Executive Summary

Analyses of repeal of the Affordable Care Act (ACA) have tended to focus on coverage. This study, which gauges the potential effects of repealing certain ACA provisions, looks at the question of primary health care access itself, with a focus on medically underserved communities. A survey developed and fielded in early 2017 asked community health centers to estimate the impact of ending the Health Centers Fund established under the ACA as well as ending expanded Medicaid coverage and subsidies designed to make private insurance affordable for lower income patients. Forty-one percent of health centers responded; 69 percent were located in Medicaid expansion states and 31 percent in non-expansion states. Responses were weighted to ensure representativeness.

- Nearly half of all respondents estimated catastrophic funding losses, in excess of 40 percent of total revenue, flowing from the combined loss of Medicaid, subsidized health insurance, and federal grant funding;
- Nearly 60 percent indicated they would need to close one or more service sites in response to revenue losses under a repeal scenario;
- Respondents estimated staffing reductions averaging 34 staff members, including medical, behavioral health, dental, and administrative staff, as well as staff who work with patients to break down barriers to coverage and care;
- Over 90 percent responded that they would eliminate or reduce services. The most common services targeted for elimination were nutrition and health education, care management for persons with chronic health conditions, and patient enabling services;
- Respondents estimated that revenue losses under a repeal scenario would result in fewer patients served. Among respondents, three-quarters estimated that their health center would serve at least 1,000 fewer patients, while nearly one in four estimated that their health centers would serve at least 5,000 fewer patients.

A decline in primary care access on this scale – flowing from a combined revenue loss – would be unprecedented. Paradoxically, this type of reduction would coincide with a surge in need for affordable care in lower-cost settings as the number of uninsured patients surges, thereby placing a growing burden on state and local governments and hospitals, particularly for emergency care.

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Background

Community health centers are the nation's single largest source of comprehensive primary health care for medically underserved communities. In 2015, 1,375 federally-funded health centers, operating in nearly 9,800 rural and urban locations, served just under 24.3 million patients[1] – one in 13 Americans.[2] That same year, 54 look-alike health centers (clinics that meet all federal health center requirements but do not receive federal health center grant funding) served an additional 709,293 people.[3]

By law, health centers operate in or serve communities and populations designated as medically underserved as a result of poverty, elevated health risks, and insufficient access to primary health care. Seventy-one percent of health center patients have household incomes at or below the federal poverty level ($12,060 for a one person household in 2017)[4] and 92 percent have incomes at or below twice the poverty level.[5] Health centers serve 1 in 3 poor Americans.[6]

Thirty-one percent of health center patients (7.6 million) are children, 26 percent (6.4 million) are women of childbearing age, and 8 percent (1.9 million) are elderly. Health centers account for roughly 1 in 10 births to low-income women,[7] care for 1 in 9 low-income children[8] and are a major source of health care to Medicare beneficiaries dually enrolled in Medicaid, who depend on Medicaid both for cost-sharing assistance as well as services not covered by Medicare. One in 6 Medicaid beneficiaries is a health center patient.[9]

In medically underserved urban and rural communities, health centers are a critical part of provider networks offered by health plans serving Medicaid and Children's Health Insurance Program (CHIP) enrollees, and the health insurance Marketplace. Health centers are a major source of primary health care for some of the nation's most vulnerable populations, such as people who are homeless and migrant and seasonal agricultural workers and their families.[10]

By law, health centers must provide or arrange for comprehensive primary health care for their patients. Three-quarters (76 percent) of all health centers offer dental care, 82 percent provide mental health services, and one in five offers substance abuse services.[11] Substance abuse treatment has been a particular focus of federal policy in the wake of the Affordable Care Act (ACA). In FY 2016, the Health Resources and Services Administration (HRSA) awarded $94 million to 271 health centers to improve and expand substance abuse services, with a particular focus on treating opioid addiction.[12] Health centers also conduct ongoing community outreach to promote

access to services, offer access-enabling services, such as translation and transportation, and collaborate extensively with other providers of health and social services.

To make care accessible and affordable, health centers are required by federal law to adjust their charges in accordance with patients' ability to pay, so that uninsured and underinsured health center patients (including those with health plans that require patient cost-sharing) are able to afford care. A large body of research has documented the high quality of care furnished by health centers.[13]

In 2015, health centers reported total revenues of $21 billion.[14] Of this total, 44 percent came from Medicaid (the single largest source of health center funding), seven percent from Medicare, nine percent from private insurance, including subsidized Marketplace health plans, and 18 percent from Bureau of Primary Health Care (BPHC) federal health center grants.[15] Consistent with the deep poverty in which health center patients live, only four percent of health center revenues come from self-pay by patients.

Health centers are important job creators in their communities, employing nearly 189,000 full-time equivalent (FTE) staff members in 2015[16] and generating more than $45.6 billion in total economic activity.[17]

Recent studies document how health centers and their patients have benefited from the ACA's combination of expanded Medicaid coverage, health insurance subsidies tied to family income, and expansion of health center grant funding through a special Health Centers Fund established under the ACA and extended by subsequent legislation through September 2017. Research shows greater health center capacity growth in expansion states[18] as well as improvements in health care quality, including asthma treatment, Pap testing, body mass index assessment, and hypertension control.[19]

Health centers in states that have adopted the ACA Medicaid expansion derive a larger proportion of their revenues from Medicaid (49 percent in Medicaid expansion states compared to 29 percent in non-expansion states) and a smaller proportion of their revenues from federal grants from the HRSA Bureau of Primary Health Care (15 percent compared to 25 percent in non-expansion states).[20] These health centers also have a significantly smaller proportion of uninsured patients (19 percent in expansion states compared to 36 percent in non-expansion states). Health centers in non-expansion states report a higher proportion of privately insured patients (19 percent compared to 16 percent in expansion states), likely a result of the fact that in non-expansion states, Marketplace subsidies begin at 100 percent of poverty.[21]

Despite the ACA's insurance expansions, federal grant funding remains a crucial source of health center support, enabling care for uninsured patients as well as many types of health care that may not be included in insurance plans, such as vision and dental care.

What Might Eliminating Key Provisions of the ACA Mean for Health Centers?

The American Health Care Act (AHCA) now before Congress would not eliminate states' option to continue coverage for the ACA adult Medicaid expansion population. However, the bill would end enhanced funding for the expansion population. Furthermore, the bill would end the system of income-sensitive subsidies for low- and moderate-income people who purchase Marketplace plans. These changes are expected to severely curtail access to affordable coverage for the lower-income population, while significantly increasing cost-sharing exposure for those who are able to afford a premium. The Congressional Budget Office (CBO) projects that, if this legislation becomes law, the number of insured Americans will decline by 24 million people by 2026. CBO further projects that, by 2026, 14 million fewer people will be enrolled in Medicaid, a 17 percent reduction in total Medicaid enrollment. According to CBO, by 2026 most states that either have opted to expand or will do so will have rolled back coverage because of lost enhanced federal funding; that year, only 30 percent of Medicaid-eligible adults will live in expansion states; under current policy, CBO projects that by 2026, eighty percent of eligible adults would live in expansion states.[22]

The AHCA also would cap federal funding on a per-person basis beginning January 1, 2020, with annual increases below actual growth levels. While per capita caps ensure that funding increases if the beneficiary population grows, CBO notes that caps could result in both eligibility and benefit reductions, particularly among high-cost populations and services. Many optional populations for Medicaid eligibility (such as near-poor children and parents) seek care at health centers, and health centers offer services (such as adult dental care) that frequently have been a target for cuts.

Finally, the AHCA does not extend either CHIP or the Health Centers Fund. This issue may be addressed in later legislation, but the AHCA is silent on the question of continued financial support for the Health Centers Fund.

As CBO notes, it is not possible to know with certainty how the AHCA actually will affect state choices regarding Medicaid, but as noted, the CBO projects both a rollback of Medicaid coverage for the expansion population and potential cuts under the per capita

cap. CBO also notes that more limited private health insurance subsidies, coupled with changes that dramatically increase the price of coverage for older people and reduce the level of coverage offered, will factor into a widespread decline in private coverage, especially among those with lower incomes. States could choose to use special new funding in the bill to help keep coverage affordable for near-poor residents, but whether they will do so and by how much cannot be known.

Despite these uncertainties, it is important that health centers at least begin to gauge the implications of major revenue declines flowing from a large reduction in insurance coverage coupled with a major loss of grant funding. As health care providers to tens of millions of residents of rural and urban medically underserved communities, health centers have become integral to the primary health care landscape in the U.S. and their ability to carry out their mission could be severely affected by major changes in federal programs that especially benefit high-poverty communities.

Study Approach

In order to gauge the potential effects of ACA repeal legislation, the Geiger Gibson Program in Community Health Policy, with assistance from the National Association of Community Health Centers and support from the RCHN Community Health Foundation, undertook a survey of health centers. The Survey on the Impact of Potential Federal Funding Losses, conducted between January and February 2017, sought to measure the potential effects of repeal legislation on health center finances; in addition, it aimed to estimate how health centers might alter their services and operations in the face of the following changes: (1) elimination of the ACA Medicaid expansion; (2) elimination of the ACA's income-sensitive system of premium subsidies and cost-sharing assistance for Marketplace enrollees; and (3) failure to extend the Health Centers Fund. Health centers were not asked to estimate the impacts of any specific legislation. The survey also asked about the steps that health centers would expect to take to absorb the effects of revenue losses, such as service reductions, site closures, and staff layoffs.

All federally-funded and look-alike community health centers in the 2015 Uniform Data System (UDS) received the survey. An analysis of 2015 UDS data compared the characteristics of health centers and their patient populations to determine if survey respondents significantly differed from non-respondents. Survey respondents were representative of health centers in terms of their location in expansion versus non-expansion states. The survey data were then weighted based upon three variables — total patients, the percentage of patients who are racial/ethnic minorities, and total revenue per patient — in order to make the survey responses reflective of the entire

universe of health centers nationally. Descriptive survey results are presented below for all respondents to each question. Bivariate statistical analyses using Chi-square and t-tests were also conducted to compare survey results for health centers based on their location in Medicaid expansion states (31 states and the District of Columbia)[23] or non-expansion states (19 states)[24] as of 2017.[25] Health centers located in US territories were excluded from the Medicaid expansion analyses but were included in the results for all respondents to each question.

Findings

There were 589 survey responses, with responses from all 50 states, the District of Columbia, and three US territories, resulting in an overall response rate of 41%. Excluding health centers in US territories (n=4), 69% of health center survey respondents were located in Medicaid expansion states and 31% were located in non-expansion states.

Health centers project major reductions in revenue under a repeal scenario.

REVENUE LOSSES STEMMING FROM CHANGES TO MEDICAID COVERAGE FOR THE ACA EXPANSION POPULATION

Overall, two thirds of health centers projected Medicaid revenue losses as a result of ending the ACA Medicaid expansion; this was true even for health centers in non-expansion states, since more aggressive outreach tends to have some spillover effects even in non-expansion states by helping to identify people eligible under traditional Medicaid standards. In Medicaid expansion states, virtually all health centers project Medicaid revenue losses. Eighty percent of responding health centers in expansion states projected revenue losses exceeding ten percent of Medicaid revenues, 56 percent projected revenue losses exceeding 20 percent, and one in three projected revenue losses exceeding 30 percent (**Table 1**).

Table 1: Projected Medicaid Revenue Impact of Ending the ACA Medicaid Expansion

Projected Medicaid revenue losses resulting from ending the ACA Medicaid expansion	Total	Health centers in Medicaid expansion states
Not applicable	33%	1%
No change	0.4%	1%
<5%	3%	4%
5-10%	10%	15%
11-20%	16%	24%
21-30%	15%	23%
31-40%	11%	16%
>40%	11%	17%

REVENUE LOSSES RESULTING FROM ENDING INCOME-RELATED PRIVATE HEALTH INSURANCE SUBSIDIES

Respondents also were asked to estimate their losses in private insurance revenues as a result of ending income-related premium tax subsidies and cost-sharing assistance. Because the proportion of health center revenues from private insurance is higher in non-Medicaid-expansion states owing to the lower threshold for subsidies in these states (100 percent of poverty as compared to 138 percent of poverty in expansion states), higher percentages of health centers in non-expansion states estimated significant revenue losses from an end to the subsidy system.

Among all responding health centers, 32 percent of health centers reported projected private insurance losses exceeding 10 percent of such revenues, while 14 percent projected losses exceeding 20 percent (**Table 2**). In non-expansion states, 39 percent of health centers projected revenue losses exceeding 10 percent of private insurance revenue; by contrast, in Medicaid expansion states the figure (29 percent) was a full 10 percentage points lower. Health centers in non-expansion states were significantly more likely to estimate losses of greater than ten percent compared to health centers in non-expansion states. Sixteen percent of health centers in non-expansion states projected revenue losses above 20 percent, compared to 13 percent of centers in expansion states.

Table 2: Projected Private Insurance Revenue Impact of Ending Income-Related Subsidies for Health Insurance Marketplace Plans

Projected private insurance revenue losses resulting from ending income-related health insurance subsidies for Marketplace health plans	Total		Health centers in non-expansion states	Health centers in Medicaid expansion states
Not applicable	3%		3%	3%
No change	4%		2%	4%
<5%	33%		23%	39%
5-10%	28%		33%	26%
11-20%	18%		23%	16%
21-30%	7%		8%	6%
31-40%	3%		4%	3%
>40%	4%		4%	4%

The distribution of responses was significantly different by Medicaid expansion status ($p<0.017$).

PROJECTED REVENUE LOSSES RESULTING FROM THE COMBINED EFFECTS OF MEDICAID COVERAGE REDUCTIONS, THE LOSS OF INCOME-RELATED PRIVATE INSURANCE SUBSIDIES, AND DISCONTINUING THE HEALTH CENTERS FUND

Finally, respondents were asked to estimate the percentage reduction in total revenue if the Medicaid expansion and subsidized private health insurance were repealed and if their federal grants were reduced by 70 percent. (Look-alike health centers, which do not receive federal grants, were asked to consider only the effects of their patients' loss of Medicaid and private insurance coverage.) **Table 3** presents the estimated loss of total revenue.

Among all health centers, 82 percent projected total revenue losses exceeding 20 percent, while nearly half (47 percent) projected losses exceeding 40 percent. These figures did not change appreciably when health centers in expansion and non-expansion states were compared. In both types of states, roughly half of all health centers projected total revenue losses exceeding 40 percent.

Table 3: Projected Total Revenue Losses among Health Centers under a Repeal Scenario

Estimated total revenue losses from ending the Medicaid expansion, income-related private insurance subsidies, and 70% of federal grant funds	Total		Health centers in non-expansion states	Health centers in Medicaid expansion states
<10%	4%		7%	2%
10-20%	14%		10%	16%
21-30%	17%		13%	19%
31-40%	18%		18%	18%
>40%	47%		51%	45%

The distribution of responses was significantly different by Medicaid expansion ($p<0.03$).

Communities served by health centers, and health center patients, will experience extensive losses of care under a scenario of reduced public and private insurance coverage and a loss of federal grant funds.

REDUCTIONS IN SERVICES, SITES, AND STAFFING

Respondents were asked to describe the immediate steps that they would take to offset revenue losses of the magnitude that are possible under a repeal scenario. **Table 4** shows the results for all respondents and separately for those in Medicaid expansion and non-expansion states. Nine in ten respondents in all states reported that they would eliminate or reduce services, approximately half reported that they would reduce hours of operation, and virtually all health centers reported that they would lay off staff. Respondents projecting site closures reported that they would close, on average, nearly three sites (2.9 sites), and the average number of sites expected to be closed did not significantly differ in Medicaid expansion and non-expansion states (data not shown).

Health centers in non-expansion and expansion states reported different approaches to addressing the potential loss of revenue. Respondents in non-expansion states were significantly more likely to indicate that they would close one or more service sites to offset revenue losses. Health centers in Medicaid expansion states were significantly more likely to indicate that they would delay or cancel plans to open a new site, as well as to reduce or lay off staff.

Table 4: Actions Health Centers Would Take to Offset Revenue Losses Possible Under a Repeal Scenario

	Total		Health centers in non-expansion states	Health centers in Medicaid expansion states
Close one or more service sites*	59%		67%	55%
Delay or cancel plans to open a new site*	50%		42%	54%
Eliminate or reduce services	91%		89%	92%
Reduce hours of operation	54%		57%	53%
Reduce or lay off staff*	96%		93%	97%

*Significant difference by Medicaid expansion status at the p<0.05 level.

REDUCTIONS TO THE NUMBER OF PATIENTS SERVED

The widespread expected impact on services, sites, and staffing resulting from revenue losses under a repeal scenario would be expected to greatly reduce patient care capacity, resulting in fewer patients served. **Table 5** shows that three-quarters of respondents estimated patient losses exceeding 1,000 or more patients, with nearly one in four respondents reporting that the number of patients who could be served would be reduced by 5,000 or more. Over four in five (82 percent) health centers in non-expansion states expected to lose 1,000 or more patients compared to 73 percent of health centers in Medicaid expansion states. Health centers in non-expansion states were significantly more likely to project patient losses of 1,000 or more compared to health centers in Medicaid expansion states. At the 5,000 or more patient-loss level, respondents in both expansion and non-expansion states reported similar results, that is, about one in four anticipate that the number of patients they would be able to serve would be reduced by 5,000 people or more.

Table 5: Estimated Reduction in Patients Served as a Result of Revenue Losses Possible Under a Repeal Scenario

	Total		Health centers in non-expansion states	Health centers in Medicaid expansion states
Not applicable	2%		4%	2%
No change	3%		2%	4%
<1000	19%		13%	21%
1,000-5,000	51%		59%	48%
5,001-10,000	14%		13%	14%
>10,000	10%		10%	11%

The distribution of responses was significantly different by Medicaid expansion status ($p<0.036$). Percentages were rounded to the nearest whole number.

SPECIFIC TYPES OF SERVICE REDUCTIONS

We asked respondents about specific types of service reductions that they would consider under a repeal scenario. For mobile services, after excluding "not applicable" responses, 75 percent of respondents reported that they would reduce or eliminate mobile services, a critical service in rural communities and a common means of addressing health needs for specific populations in urban communities (data not shown). An example of mobile services is using mobile clinics that may move among schools or sites that serve people experiencing homelessness.

In response to other service-specific questions, the most common response, shown in **Table 6**, was that an effort would be made to reduce a service rather than eliminate it entirely. However, services most likely to be eliminated entirely were mental health and substance abuse services, dental services, care management for people with chronic health conditions, school-based health care, nutrition and health education, and patient enabling care. Many of these services have been the subject of specific expansion initiatives following passage of the ACA.

Table 6: Reduction or Elimination of Specific Types of Health Center Services under a Repeal Scenario

Type of service	Eliminate	Reduce
Nutrition and health education	24%	45%
Care management for persons with chronic health conditions	21%	60%
Patient enabling services (transportation, translation, etc.)	21%	55%
Mental health services	16%	59%
Dental services	15%	58%
Substance abuse services	14%	35%
School-based health care	14%	19%
Social services available at or through the health center, such as child care, housing assistance, and adult education	14%	26%
Obstetric services	10%	28%
Vision services	9%	15%
Prenatal care services	8%	36%
Family planning services	8%	42%
Other services	8%	12%
Pharmacy services	7%	30%
Services for homeless families and individuals	7%	28%
STD screenings	5%	41%
Mammography services	5%	14%
Pediatric services	5%	44%
General medical services	4%	66%
Special services for farmworkers	4%	10%
Cervical cancer screenings	3%	42%

Note: This analysis was limited to survey respondents who indicated in an earlier question that they would eliminate or reduce services (Table 4). Percentages for "not applicable" and not checked are not shown.

In the case of select services, responses differed significantly by the Medicaid expansion status of the state.[26] These percentages are presented in **Table 7**, which shows that, in the case of mental health services, services for homeless families and individuals, and patient enabling services that improve access to care, health centers in non-expansion states would be more likely to eliminate these services entirely, whereas centers in expansion states would be more likely to reduce access to these services as well as to social services available at or through the health center.

Table 7: Type of Services to be Eliminated or Reduced, by Status of State Medicaid Expansion

Services that health centers would eliminate or reduce as a result of revenue losses possible under a repeal scenario	Health centers in non-expansion states	Health centers in Medicaid expansion states	Health centers in non-expansion states	Health centers in Medicaid expansion states
	Eliminate		Reduce	
Mental health services*	23%	14%	53%	61%
Services for homeless families and individuals*	10%	5%	20%	31%
Patient enabling services (transportation, translation, etc.)*	29%	18%	42%	61%
Social services available at or through the health center*	14%	14%	17%	29%

*Significant difference by Medicaid expansion status at the p<0.05 level.

STAFFING REDUCTIONS

Survey respondents who indicated that their health center would have to reduce or lay off staff to offset revenue losses possible under a repeal scenario were asked which categories of staff would be affected by lay-offs (**Table 8**). The categories of staff most commonly cited were administrative staff (86 percent), outreach workers (72 percent), eligibility assistance workers (66 percent), mental health staff (61 percent), nurses (60 percent), other enabling services staff (60 percent), advanced practice nurses and physician assistants (55 percent), and dental staff (53 percent). On average, respondents expected to lay off nearly 34 staff members (33.9), a figure that did not differ significantly in expansion versus non-expansion states (data not shown). This figure represents fully one-quarter of the average health center's staffing (137 FTEs in 2015).[27]

Survey respondents in Medicaid expansion states were significantly more likely to indicate that eligibility assistance workers, health educators, and social workers would be affected by lay-offs, while health centers in non-expansion states were significantly more likely to indicate that physician assistants and advanced practice nurses would be affected. Across both Medicaid expansion and non-expansion states, 41 percent of respondents identified physicians as potential targets for lay-offs.

Table 8: Categories of Staff Affected by Lay-Offs under a Repeal Scenario

Types of health center staff affected by staffing layoffs following revenue losses possible under a repeal scenario	Total		Health centers in non-expansion states	Health centers in Medicaid expansion states
Administrative staff	86%		84%	86%
Outreach workers	72%		72%	72%
Eligibility assistance workers*	66%		59%	69%
Mental health services staff	61%		60%	61%
Nurses	60%		62%	59%
Other enabling services staff	60%		54%	63%
Physician assistants/nurse practitioners/certified nurse midwives*	55%		62%	52%
Dentists/dental health staff	53%		56%	53%
Health educators*	47%		40%	50%
Physicians	41%		41%	41%
Social workers*	41%		32%	45%
Substance abuse services staff	34%		32%	35%
Nutritionists/dietitians	31%		28%	33%
Pharmacy staff	21%		24%	19%
Vision care staff	12%		10%	12%
Other staff	9%		6%	10%

*Significant difference by Medicaid expansion status at the $p<0.05$ level. This analysis was limited to survey respondents who indicated in an earlier question that they would reduce or lay off staff (Table 4).

Discussion

Estimates of the impact of a loss of Medicaid funding and coverage for the ACA expansion population as well as the loss of a private insurance subsidy system designed to more generously help people with lower incomes have tended to focus on the implications for insurance coverage. Here, we take the next step and focus on how large revenue losses resulting from the loss of coverage due to a repeal scenario might affect medically underserved communities that have seen large coverage gains and experience both elevated health risks and a shortage of primary health care. To our knowledge, this is the first study to attempt to gauge how the revenue declines associated with insurance coverage could translate into changes in access to primary health care itself. Because health insurance represents such a critical funding source for

primary health care, both those who remain insured and those who lose insurance coverage could be significantly affected by funding losses at health centers.

The results of this survey are sobering. Close to half of all respondents projected what can only be described as catastrophic financial losses, in excess of 40 percent of total revenue, stemming from lost Medicaid revenues, lost revenues from subsidized health insurance, and lost federal grant revenues. As a consequence of these financial losses, three-quarters of respondents estimated that the number of patients served would decline by more than 1,000, while one in four estimated patient reductions exceeding 5,000. According to a recent estimate from HRSA of the effects of the loss of the Health Centers Fund, health centers would lose nearly $7.5 billion in revenues, leading to the closure of 2,800 health center sites and the loss of care for nine million patients.[28] When the elimination of insurance coverage also is factored in, clearly the losses would be much greater.

The ACA is associated with a 20-million-person increase in the number of Americans covered by health insurance, and gains have been especially strong among lower-income people. Our findings suggest that the consequences of reduced coverage also would be reduced access to care stemming from a major withdrawal of the revenues needed to maintain health care services at their existing levels. Eliminating the Medicaid expansion, ending income-related private insurance subsidies, and not extending the Health Centers Fund can be expected to hit medically underserved rural and urban communities the hardest, potentially leading to a loss of accessible primary health care unprecedented in size.

There is much uncertainty regarding how states that have expanded Medicaid will react to the loss of enhanced funding. States might attempt to hold onto the expansion population even at normal funding rates by reducing expenditures elsewhere, but Medicaid costs are driven by enrollment, not high expenditures per beneficiary. Indeed, compared to other insurers, Medicaid costs per member are lower. While greater efficiencies might result in savings, those savings likely would be modest, leaving states with little choice but to rein in eligibility itself. Moreover, states likely would lack the considerable resources needed to maintain coverage for near-poor residents who previously had more generous income-sensitive subsidies but who, under a more constrained subsidy system, would lack the funds necessary to buy insurance or meet steep cost-sharing requirements.

To the extent that ending insurance for poor and near-poor populations ultimately leads to a diminution of primary care capabilities in poor communities, such a loss would

coincide with other types of fallout from insurance declines, such as strained state and local budgets and enormous stress on hospitals, including hospital emergency departments. While improving the efficiency of health care is an enduring and vital goal, the findings here suggest that undifferentiated reductions that fall hardest on the poorest communities have consequences that stretch beyond loss of coverage and implicate access to highly appropriate health care itself.

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[23] AK, AR, AZ, CA, CO, CT, DC, DE, HI, IA, IL, IN, KY, LA, MA, MD, MI, MN, MT, ND, NH, NJ, NM, NV, NY, OH, OR, PA, RI, VT, WA, and WV
[24] AL, FL, GA, ID, KS, ME, MO, MS, NC, NE, OK, SC, SD, TN, TX, UT, VA, WI, and WY
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[26] This analysis was limited to survey respondents who indicated in an earlier question that they would eliminate or reduce services (Table 4). Percentages for "not applicable" and not checked are not shown. The p value refers to the significant difference in the distribution of responses (not applicable, eliminate, reduce, or not checked).
[27] GW analysis of 2015 UDS data.
[28] Health Resources and Services Administration. (December 20, 2016). Response to Congressional request. "Community Health Centers."