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Using Primary Care to Bend the Cost Curve: The Potential Impact of Health Center Expansion in Senate Reforms

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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 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 gwumc.edu/sphhs/departments/healthpolicy/ggprogram or at rchnfoundation.org.

Using Primary Care to Bend the Cost Curve: The Potential Impact of Health Center Expansion in Senate Reforms

In addition to expanding health insurance coverage and making other critical changes in the health care system, national health reform legislation being considered in Congress would substantially increase the nation's investment in primary care by increasing federal funding for non-profit community health centers. Our recent analyses of draft health reform legislation considered in the House of Representatives (H.R. 3200) estimated that the number of patients who could receive primary health care services from community health centers over the next decade would double to nearly 40 million,[1] generating over $200 billion in overall health care savings, including almost $60 billion in federal Medicaid savings.[2]

This brief report supplements these reports by examining similar provisions now under consideration in the Senate. Draft health reform legislation passed by the Senate Health, Education, Labor and Pensions (HELP) Committee includes provisions to substantially expand federal health center funding (S. 1679).[3] The current Senate Finance Committee bill would also institute a number of reforms to expand health insurance coverage.[4] As the two measures are merged, one plausible scenario is a consolidated measure that follows the Senate Finance Committee's insurance reforms while including the Senate HELP Committee's provisions that address prevention and wellness, and expand health center funding. This brief report assumes, for illustrative purposes, that the combined bill would reflect such a merger by relying on the Senate Finance Committee bill (as analyzed by the Congressional Budget Office on October 7) for insurance reforms while increasing funding for health centers as called for in the Senate HELP Committee bill.

In addition to expanding health insurance coverage, a critical challenge in health reform is investing in a health care delivery system that can foster long-term efficiencies and reduce the rate of growth in health care expenditures. Many have expressed this goal as "bending the curve" of health care costs. This brief report examines the impact of a health center expansion on both access in medically underserved areas and health care costs.

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[1] Ku, L, et al. (2009). "Estimating the Effects of Health Reform on Health Centers' Capacity to Expand to New Medically Underserved Communities and Populations." George Washington University School of Public Health and Health Services, July 23.
http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_9889E996-5056-9D20-3D1F89027D3F9406.pdf

[2] Ku, L., et al. (2009). "Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs." George Washington University School of Public Health and Health Services, Sept. 1.
http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_61D685D5-5056-9D20-3DDB6CDE10382393.pdf

[3] The HELP bill is entitled the Affordable Health Choices Act and was passed by the committee on July 15, 2009. Similar provisions for health centers are included in S. 286, proposed by Senator Sanders and others on Feb. 26, 2009.

[4] For this report, we rely on the version of the Chairman's mark of the Senate Finance Committee bill, America's Healthy Future Act of 2009, as of Oct. 5-6, 2009 and as scored by the Congressional Budget Office on Oct. 7, 2009.

Methods

This report builds on the methodology developed in the two earlier reports, *Estimating the Effects of Health Reform on Health Centers' Capacity to Expand to New Medically Underserved Communities and Populations* and *Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs*. Because the methods have been fully described in recent reports, we refer readers to those reports for more detail. For this analysis, we modified assumptions based on three key differences between the draft House bill and the draft Senate provisions. The House and Senate Finance provisions differ substantially, particularly with respect to their provisions related to health insurance exchanges and federal subsidies. The CBO analysis suggests that the Senate bill would reduce the number of uninsured people by 29 million by 2019, compared to a 37 million- person reduction in the House bill.[5] This difference extends from a lower estimated enrollment in health insurance exchanges under the Senate bill. For this analysis, we base our estimates of health insurance coverage among health center patients on the CBO analysis of the draft Senate Finance bill.

Second, the Senate HELP Committee authorizes up to $34.0 billion in health center grants from fiscal years 2010 to 2015 under Section 330 of the Public Health Service Act (the main source of federal health center grants) and establishes a formula for maximum funding levels in subsequent years. For this analysis, we assume actual appropriations reach the authorized levels from 2010 to 2015 and increase $1.5 billion a year each year after 2015, for a total of $82.3 billion from 2010 to 2019. In contrast, the House bill authorizes up to $39 billion in additional funds above the base annual appropriations, leading to a total of $61 billion over 10 years.

Third, the Senate bill requires that insurance plans offered under the health insurance exchanges pay federally qualified health centers using a prospective payment system (PPS) rate.[6] This rate is comparable to the system used to pay health centers under Medicaid and the Children's Health Insurance Program (CHIP), and it is more generous than reimbursements paid health centers under most private insurance. The Senate bill also lifts the Medicare cap on prospective payments for health centers, requiring payors to cover the full cost of care.[7]

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[5] Elmendorf, D. (2009). Congressional Budget Office estimate sent to Sen. Max Baucus on the Chairman's mark for America's Healthy Future Act, Oct. 7, 2009.

[6] The Senate Finance Committee proposal says "Insurers participating in the state exchanges would be required to provide payment for services furnishes [sic] to enrollees of the insurer by any electing federally-qualified health center at levels no less than such center would receive under Section 1902(bb) of the Social Security Act for such service."

[7] The Senate Finance Committee Chairman's mark "directs the Secretary of Health and Human Services to establish a prospective payment system (PPS) for Medicare-covered services furnished by Federally Qualified Health Centers (FQHCs). The PPS payment structure would be set an initial payment based on a two-year average of a health center's reasonable costs for provider care, and include an appropriate annual update method developed by the Secretary. Additionally, the Mark would add remaining Medicare-covered preventive services to the list of services eligible for reimbursement when furnished by an FQHC. The PPS payment rate would be extended to health plans and health insurers participating in the state exchanges. Insurers participating in the state exchanges would be required to provide payment for services furnished to enrollees by FQHCs must pay these providers at the PPS rate."

Findings

Since health centers are non-profit entities that operate subject to comprehensive federal standards, our models assume that health centers will serve as many patients as their revenues permit. As a result, the number of patients served at health centers depends on the revenue available to health centers and the distribution of insurance coverage among health center patients. The Senate provisions increase health center revenues in three key ways: (1) by increasing federal health center grants; (2) by increasing Medicaid revenues as a result of expanded Medicaid coverage; and (3) by assuring higher private insurance revenues as a result of the extension of the Prospective Payment System (PPS) to health center patients insured through a health exchange. By lowering the number of uninsured patients, health reform thus will allow health centers to use their grant funds to reach additional uninsured patients, thereby increasing the number of patients who can be served.

It is important to note that federal health center grants and payments under Medicaid and private health insurance represent only a portion of total health center revenue. Other important sources include other federal, state, local and private grants or contracts. As in our prior report, we conservatively assume that these other funding sources will grow by only five percent annually.

We estimate that by 2019, these combined policy changes would roughly triple the number of patients receiving care at health centers. The number of patients would rise from an estimated 19.0 million in 2009 to 44.2 million in 2015 and to 60.4 million by 2019. In order to expand to serve this many patients, we assume that the number of health center grantees and the number of health center delivery sites (i.e., clinics) would grow substantially, permitting a major expansion of health centers and clinics into more medically underserved rural, suburban and urban communities.

In our prior paper, we analyzed data from the 2006 Medical Expenditure Panel Survey to compare the medical expenditures of people who receive the majority of ambulatory care at health centers and those who do not. We found that, after adjusting for health status, age, gender, race/ethnicity, and health insurance coverage, the average patient receiving care at a community health center had annual medical expenditures $1,093 lower than an average patient who did not use health centers. This estimated savings includes both reduced ambulatory costs as a result of health center efficiencies as well as reduced inpatient medical expenses, which may be due to the prevention of more severe health problems requiring hospitalization. These findings are consistent with numerous prior studies showing that health centers are efficient providers of quality primary care and that more effective use of primary care can reduce hospital and specialty care costs.[8]

[8] Probst, J. C., Laditka, J. N., & Laditka, S. B. (2009). Association between Community Health Center and Rural Health Clinic Presence and County-Level Hospitalization Rates for Ambulatory Care Sensitive Conditions: An Analysis Across Eight US States. *BMC Health Services Research, 9* (134); National Association of Community Health Centers (NACHC), The Robert Graham Center and Capital Link. (2007) *Access Granted: The Primary Care Payoff;* Marilyn Falik et al. (2006). "Comparative Effectiveness of Health Centers as a Regular source of care". *Journal of Ambulatory Care Management*, Vol. 29, no. 1, pp.24-35; McRae, T., & Stampfly, R. D. (2006). *An Evaluation of the Cost Effectiveness of Federally Qualified Health Centers (FQHCs) Operating in Michigan*. East Lansing: Institute for Health Care Studies at Michigan State University; Starfield, B., Powe, N. R., Weiner, J. R.,

Using the estimate of $1,093 savings per health center patient in 2006, we applied the estimates of the increased number of health center patients and adjusted savings to account for health care inflation to estimate total medical savings associated with the expansion of services at health centers over the next ten years. These are summarized in Table 1.

Table 1. Estimated Increase in Health Center Patients, Total Medical Savings and Federal Medicaid Savings Under the Senate Provisions, 2010 to 2019

	2009	2015	2019	2010-2015	2010-2019
Total Number of Patients (mil)	19.0	44.2	60.4		
Increase Over 2009 Patients (mil.)		25.2	41.4		
Est. Total Med Savings Per Person	$1,262	$1,551	$1,780		
Est. Total Medical Savings (bil.)	--	$39.0	$73.7	$129.1	$369.2
Est. Federal Medicaid Savings (bil).	--	$11.0	$22.5	$34.2	$105.0

Source: Authors' estimates

As seen in Table 1, in 2019, we estimate that the number of patients receiving primary care services at health centers will rise by 41.4 million over the 2009 level of 19.0 million, to 60.4 million total patients. This growing use of health centers to serve an additional 41.4 million patients times the medical savings of $1,780 per patient yields an overall medical savings estimate of $73.7 billion in 2019 alone. Over the 2010-2019 period, we estimate that an increase in the number of patients who receive their health care through health centers will lead to $369 billion in total medical savings. (Following the approach used by the Congressional Budget Office, we estimate only the additional savings due to increases in the number of patients served at health centers. We estimate that the 19 million patients already served in 2009 create medical savings of $24 billion in that year alone; savings from the existing 19 million patients are not included in the estimates shown in Table 1 above.)

This estimate includes all medical savings, whether public or private. From the federal perspective, the critical question is federal savings. We estimate savings attributable to federal spending by focusing on federal Medicaid savings, accounting both for the increased volume of Medicaid patients and the effective increases in federal matching shares for Medicaid. (There are also state Medicaid savings not included in the estimate of federal savings.) This calculation yields an estimated federal Medicaid savings of $22.5 billion in 2019 and $105 billion between 2010 and 2019. This is a conservative estimate of federal savings, since there would also be savings under Medicare as well as in the federal subsidies spent to purchase health insurance through exchanges.

Stuart, M., Steinwachs, D., Scholle, S. H., et al. (1994). Costs vs. Quality in Different Types of Primary Care Settings. *Journal of the American Medical Association, 272* (24), 1903- 1908; Duggar, B., Keel, K., Balicki, B., & Simpson, E. (1994). *Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers.* Center for Health Policy Studies. Bureau of Primary Health Care; Duggar, B., et al. (1993). *Utilization and Costs to Medicaid of AFDC Recipients in California Served and Not Served by Community Health Centers*. Center for Health Policy Studies. Bureau of Primary Health Care.

Discussion

Two principal goals of health reform are to reduce the number of uninsured people in the United States and to create a system of more efficient health care that can simultaneously improve health care quality while "bending the curve" of future health expenditures. This analysis indicates that these goals can be achieved by expanding health centers, whose primary health care is recognized for its quality and accessibility and whose highly efficient performance also has received extensive analysis over the years. Expanded health insurance coverage will be of limited overall health benefit to lower income persons if improvements in coverage are not combined with investments in high quality health care access. The combination of the Senate HELP Committee health center expansion and the Senate Finance Committee insurance expansions would achieve this long-term goal.

This analysis of reforms being considered in the United States Senate reaches conclusions similar to those of our prior analyses of reforms being considered in the House of Representatives. The combination of expanded health insurance coverage and investments in the expansion of community health centers can produce substantial long-term savings both for the overall health care system and for the federal government. Our analysis of the draft House bill estimated that the combined reforms could produce $212 billion in total medical savings from 2010 to 2019, including $59 billion in federal Medicaid savings. Our analysis of the Senate provisions from the HELP and Finance Committees estimates $369 billion in total medical savings, including $105 billion in federal Medicaid savings. The Senate provisions produce larger savings because they authorize larger funding increases for federal health center grants and provide for the use of the prospective payment system for health center payments under health insurance exchange plans. However, it is important to note that, although both the Senate and House bills authorize increased health center appropriations up to certain levels, the House bill also creates a mandatory trust fund which can be tapped for health center appropriations, increasing the likelihood that actual appropriations would reach the levels authorized in the bills.

Investments in the primary care infrastructure serve as a critical complement to health reform efforts to reduce the number of uninsured. This will be particularly important in medically underserved areas where there is already an insufficient supply of primary care providers. The national economic value of the investment can be further enhanced by its ability to bring better health to the nation's most underserved communities. These efforts can improve health in underserved communities and help bend the curve of health care cost growth.