Financing Health Care

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HEALTH CARE FINANCING

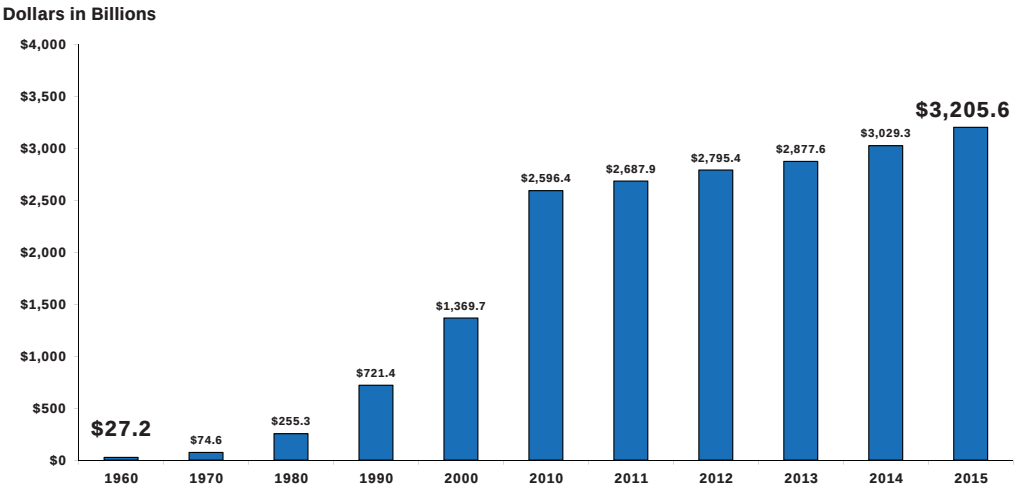
Health care financing is the money acquired and applied to the development and delivery of medical services

Impacts:

- Current and future medical services (supply and demand)
- Individual and societal health
- National, regional, and local economies
- Medical and other health professionals' practices
- Livelihood of physicians and other health professionals

Directly affects cost, access, quality, equity, and sustainability of health care in the United States

NATIONAL HEALTH EXPENDITURES, 1960-2015

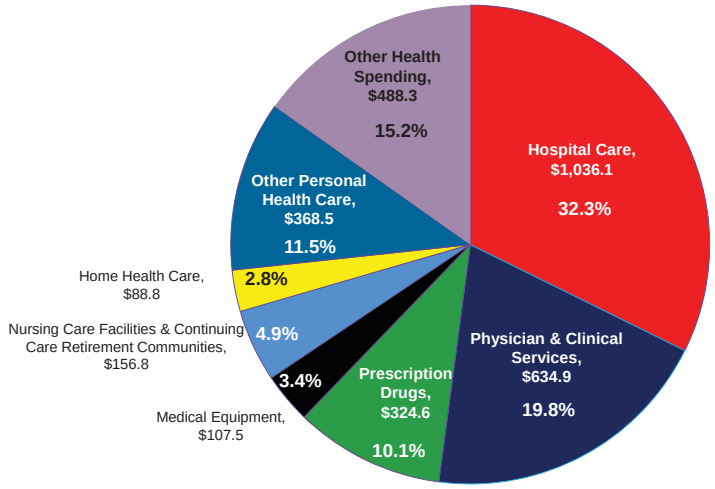


1960
$146 per capita
5.2% of GDP

2015
$9,986 per capita
17.8% of GDP

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary, CY 1960-2015).

NATIONAL HEALTH EXPENDITURES BY TYPE OF SERVICE, 2015

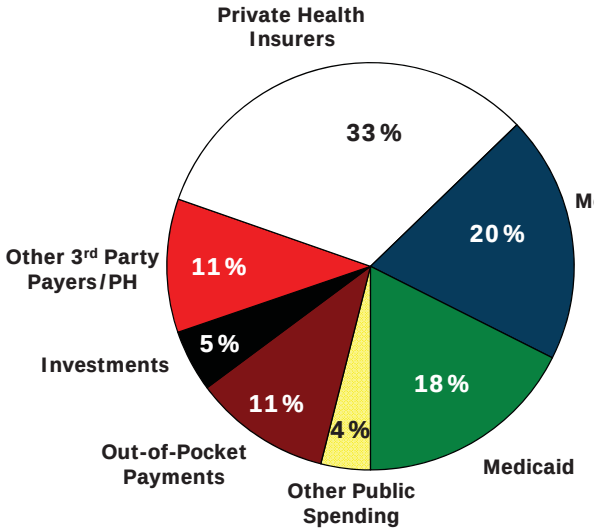


NHE Total Expenditures: $3,205.6 billion

NOTE: Medical Equipment includes both durable and non-durable equipment. Other Personal Health Care includes dental and other professional health services. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.

SOURCE: Health Affairs, 36:3.

NATIONAL HEALTH EXPENDITURES BY SOURCE OF PAYMENT, 2015



Paid by:
- ***Taxes***
- ***Premiums***
- ***Out-of-Pocket Funds***
- ***Other Payers***
- ***Private Investments***

NHE Total Expenditures: $3,205.6 billion

NOTE: Other 3rd Party Payers/PH includes health expenditures of charitable and other non-profit organizations, and public health programs. Other Public Spending includes CHIP, Departments of Defense and Veteran's Affairs, and Title XIX and XXI.
SOURCE: Health Affairs, 36:3.

HEALTH INSURANCE

Insurance is a contractual means for spreading financial risks from one entity to another in exchange for a fee; health insurance is one type of insurance

Principles:
- Risk is unpredictable at the individual level
- Risk can be predicted for large groups/populations
- Insurance allows transfer/shifting of risk via pooling of resources
- Actual losses must be shared on some basis by the insured group

DEMAND FOR HEALTH INSURANCE

- Patients desire insurance … to shift the financial risk of illness/injury to others and spread costs over time
- Physicians and other providers encourage the use of insurance … to improve payment for service

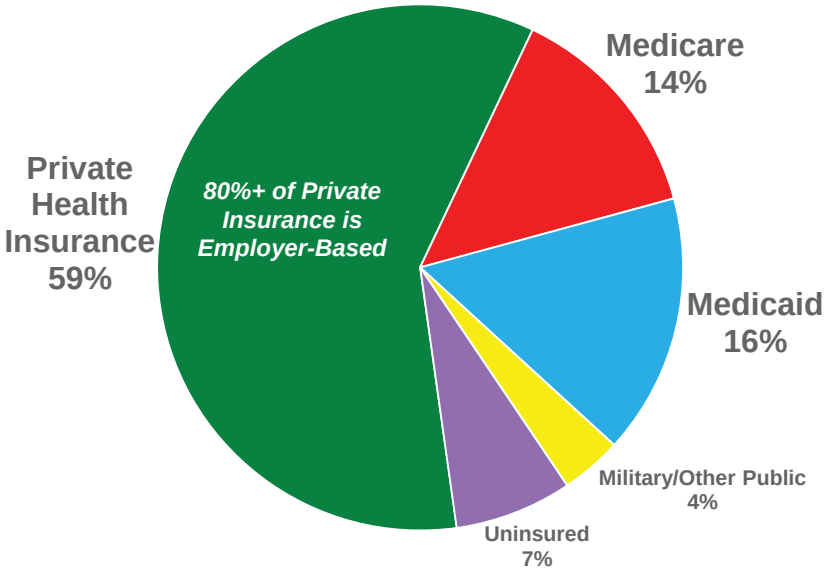
But … insurance desensitizes patients and providers from the price of care ("moral hazard") and stimulates demand ("provider-induced")… prompts higher utilization

INSURER/PAYER SYSTEM OPTIONS

- Single-Payer Systems: single organization (single insurer), usually a government agency, pays all health care claims; funded via taxes, mandatory premiums, and/or global budgets
- Multiple-Payer Systems: numerous organizations (insurers) fund and pay health care claims; may include a mix of public and private organizations; funded via taxes, premiums, and/or other means specific to the payer

United States has a Multiple-Payer System

U.S. HEALTH INSURANCE COVERAGE BY TYPE (ADJUSTED) - POPULATION, 2016



SOURCE: US Census Bureau. Health Insurance Coverage in the US: 2016. Table 1. As individuals can be covered by more than one insurance type during the year, numbers are based on whether the individual had this type at any point during the year, adjusted to 100%.

Private Insurance

PRIVATE HEALTH INSURANCE

Health insurance provided by private insurers to patients (beneficiaries; insured) covered under contractual arrangement in exchange for a fee. Typically covers hospital, medical, surgical, and related expenses.

Private insurers include:
- Commercial insurance companies (stock or mutual companies)
- Blue Cross/Blue Shield plans
- Managed Care Organizations (MCOs)
- Self-Insured companies/organizations

Private insurers: (active or passive)
- Set and collect premiums
- Form "risk pools"
- Establish or utilize existing provider networks (e.g., MCOs)
- Pay providers

FINANCING OF PRIVATE INSURANCE

- Premium: amount paid before service is provided; "membership fee" (sum of …)
  - Cost Component: health care cost expected for the insured person
    - Experience Rated: based on cost experiences of the group or individual
    - Community Rated: based on cost experiences of the population
  - Overhead: (aka, loading fee, medical loss) costs of administration, sales, debt service, and other overhead items; profit
- Cost Sharing: out-of-pocket amounts paid as/after service is provided
  - Deductible: annual amount paid by insured person before insurance pays anything (e.g., first $1000)
  - Copayment: amount paid by insured person at time of service (e.g., $50/visit)
  - Coinsurance: portion of medical charges that the insured person must pay (e.g., 20%)

Higher Premiums usually come with lower Cost Sharing …

PRIVATE INSURANCE TYPES

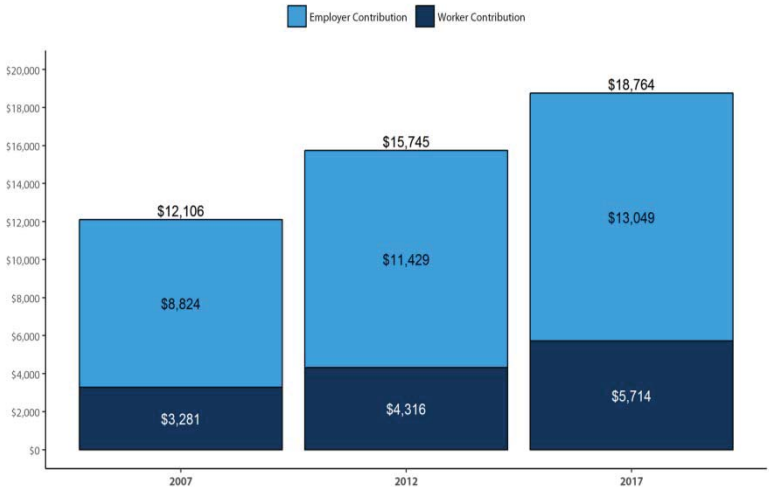
- Group Health Insurance: insurance purchased through another entity (e.g., employer; union) and offered to all members of the group
  - Employer-Based Group Health Insurance: employer pays portion of premium for employees
- Individual Health Insurance: insurance purchased by/for an individual not in a group (e.g., self-employed)
  - Individual Private Market Health Insurance: health insurance purchased through insurance agent
  - ACA Health Care Exchange Insurance: health insurance purchased on state or federal Health Care Exchanges
  - Supplemental Insurance: private insurance purchased to supplement gaps in coverage of primary plans (e.g., Medigap)
- Self-Insurance: entities (e.g., employer) assume financial risk for care; opt to directly fund their employees'/ members' health care costs

OTHER TYPES

- Managed Care Organizations (MCOs): integrates the functions of health financing, insurance, delivery, and payment; uses mechanisms to control health care utilization/costs.
  - Preferred Provider Organizations (PPOs): offers a panel of preferred providers who are paid according to a discounted fee schedule (discounted FFS).
  - Health Maintenance Organizations (HMOs): provides comprehensive medical care for a predetermined annual or monthly fee per enrollee (capitation); "at risk" contracts.
  - Accountable Care Organizations (ACOs): providers joining together to provide range of health care services to a designated population; pay-for-performance or "at risk" contracts, accountable for cost and quality.
- High-Deductible Health Plans (HDHPs): combines high-deductible health insurance with a savings option; savings account pays for routine health care expenses and the purchase of insurance with a high deductible.
  - Health Savings Accounts (HSAs): meet federal standards as a "qualified health plan"; funds belong to the account holder.

EMPLOYER-BASED HEALTH INSURANCE

Figure B
Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2007-2017



NOTE: Since 2007, the average family premium has increased 55% and the average worker contribution toward the premium has increased 74%.
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Employee Cost Sharing (2017)

81% w/ deductible

67%-71% w/ copayment

22%-26% w/ coinsurance

98% w/ OOP maximum

TAX IMPACTS

Private Insurance Element	Tax Treatment
Employer-Based Group Health Insurance	• Business expense – reduces corporate taxes (employer) • Not taxed as income, unless over ACA limits (employee)
Individual Health Insurance – Private Market	• Taxed with income, but itemized deductions or small business expenses (individual)
Individual Health Insurance – ACA Exchanges	• Premium and cost sharing subsidies for low-income individuals (individual) • Taxed with income, but itemized deductions or small business expenses (individual)
Self-Insurance	• Business expense – reduces corporate taxes (employer) • Not subject to state insurer taxes (employer) • Not taxed as income, unless over ACA limits (employee)
Health Savings Accounts	• Tax preferred – taxed above a limit (individual)

Tax policy shapes private health insurance … different plans have different tax treatments

HOW DO INSURERS PAY PROVIDERS?

Low Risk to Providers

High Risk to Providers

- Fee-For-Service (FFS): single payment for each visit or procedure
- Pay-for-Performance (P4P): payment is linked to predetermined measures of quality, cost, and other elements of performance
  - Merit-Based Incentive Payment System (MIPs)
- Pay-for-Coordination: payment for specified case coordination
  - Medical Home
- Bundled Payment/Illness Episode: single payment is made for all services delivered during a single illness occurrence; examples:
  - Diagnosis-Related Groups (DRGs)
  - Resource-Based Relative Value Systems (RBRVS)
- Capitation: single payment made prospectively for all services given in a fixed period of time (e.g., per member/per month)
- Global Budget: single payment made to finance all services for a whole population during a fixed period of time (e.g., year)

Payment methods impact behaviors – patient and provider

TAKE HOME MESSAGE

- Health care is expensive and presents financial risk
- Patients and physicians/providers use health insurance to mitigate the financial risk
- Many sources of funds and many insurers (public and private) are used in the US … no one system
- Private health insurance (particularly employer-based) continues to be the primary insurer
- But … private health insurance's costs and restrictions put it out of reach of many individuals

aetna

Allstate. You're in good hands.

ASSURANT

BlueCross BlueShield

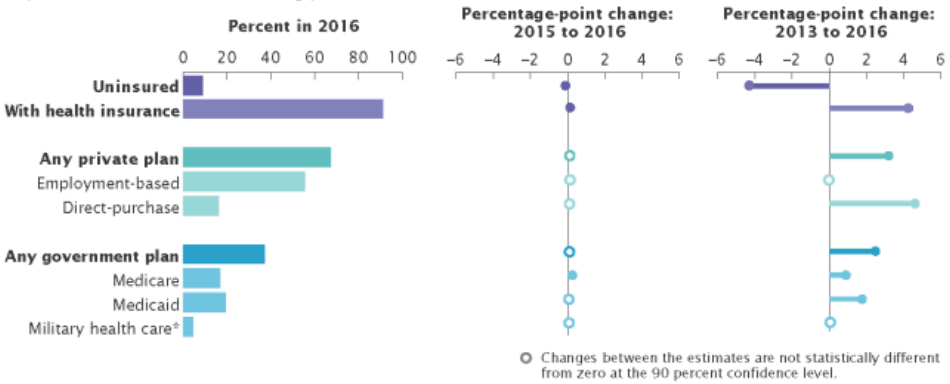
HUMANA one

Public Insurance

Figure 1.

Percentage of People by Type of Health Insurance Coverage and Change From 2013 to 2016

(Population as of March of the following year)



* Military health care includes TRICARE and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs and the military.

Note: For information on confidentiality protection, sampling error, nonsampling error, and definitions in the Current Population Survey, see <www2.census.gov/programs-surveys/cps/techdocs/cpsmar17.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2014 to 2017 Annual Social and Economic Supplements.

PUBLIC INSURANCE

Health insurance coverage or healthcare services paid for by the state or federal government.

- Medicare
- Medicaid/CHIP
- Indian Health Service
- Military
- Veterans Administration
- Prison healthcare

MEDICARE

- Federal government
- 65+ or disabled
- 4 parts
  - Part A – hospitals and some skilled nursing facilities, surgery, hospice, home health care
  - Part B – doctors office visits, home health care, PT, DME, some preventive care
  - Part C – Medicare Advantage –a private health plan (like an HMO) contracts with Medicare to provide A & B, and sometimes D, coverage to patients
  - Part D – prescription drug coverage

Not covered: vision, dental, hearing

More info at medicare.gov

MEDICARE PART A COSTS

Part A premium	Most people don't pay a monthly premium for Part A (sometimes called "premium-free Part A"). If you buy Part A, you'll pay up to $413 each month ($422 in 2018). If you paid Medicare taxes for less than 30 quarters, the standard Part A premium is $413 ($422 in 2018). If you paid Medicare taxes for 30-39 quarters, the standard Part A premium is $227 ($232 in 2018).
Part A hospital inpatient deductible and coinsurance	You pay: ◆ $1,316 deductible for each benefit period ($1,340 in 2018) ◆ Days 1-60: $0 coinsurance for each benefit period ($0 in 2018) ◆ Days 61-90: $329 coinsurance per day of each benefit period ($335 in 2018) ◆ Days 91 and beyond: $658 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) ($670 in 2018) ◆ Beyond lifetime reserve days: all costs (all costs in 2018)

MEDICARE PART B COSTS

Part B premium	The standard Part B premium amount is $134 (or higher depending on your income) ($134 in 2018). However, some people who get Social Security benefits will pay less than this amount ($109 on average in 2017; $130 on average in 2018).
Part B deductible and coinsurance	$183 per year ($183 in 2018). After your deductible is met, you typically pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy, and durable medical equipment.

MEDICARE PART C COSTS

Example of a Medicare Part C plan, for 62704, for a patient taking generic Lasix and Lipitor

Health Alliance Medicare HMO Basic Rx (HMO) (H1463-009-0) CP1

Organization: Health Alliance Medicare

Estimated Annual Drug Costs: [?]	Monthly Premium: [?]	Deductibles [?] and Drug Copay [?] / Coinsurance: [?]	Health Benefits: [?]	Drug Coverage [?], Drug Restrictions [?] and Other Programs:	Estimated Annual Health and Drug Costs: [?]	Overall Star Rating: [?]
Retail Pharmacy Status: Standard Cost-Sharing Annual: $418 **Mail Order** Annual: $415	$33.00 Drug: $26.40 Health: $6.60 **Part B Premium Reduction :No**	Annual Drug Deductible: $0 Health Plan Deductible: $0 Drug Copay/ Coinsurance: $0 - $47, 33% - 50%	Doctor Choice: Plan Doctors for Most Services Out of Pocket Spending Limit: $6,700 In-network D V H	All Your Drugs on Formulary :Yes Drug Restrictions: No Lower Your Drug Costs MTM Program : Yes	$3,910	★★★★ 4 out of 5 stars

https://www.medicare.gov/find-a-plan/questions/home.aspx

MEDICARE PART D COSTS

Aetna Medicare Rx Select (PDP) (S5810-291-0)

Organization: Aetna Medicare

Estimated Annual Drug Costs: [?]	Monthly Premium: [?]	Deductibles: [?] and Drug Copay [?] / Coinsurance: [?]	Drug Coverage [?], Drug Restrictions [?] and Other Programs:
Retail Pharmacy Status: Preferred Cost-Sharing Annual: $236 **Mail Order** Annual: N/A	$16.70	Annual Drug Deductible: $405 Drug Copay/ Coinsurance: $0 - $47, 25% - 41%	All Your Drugs on Formulary :Yes Drug Restrictions: Yes Lower Your Drug Costs MTM Program : Yes N

Original Medicare (H0001-001-0)

Includes Part A (Hospital Insurance) and/or Part B (Medical Insurance) - Excludes Part D Drug Coverage

Estimated Annual Drug Costs: [?]	Monthly Premium: [?]	Deductibles: [?] and Drug Copay [?] / Coinsurance: [?]	Health Benefits: [?]	Drug Coverage [?], Drug Restrictions [?]	Estimated Annual Health and Drug Costs: [?]
Retail Annual: $1,940	Standard Part B: $134	Part B Deductible: $183	Doctor Choice: Any Willing Doctor Out of Pocket Spending Limit: Not Applicable N	N/A	$5,820 Includes $1,940 for drug costs

MEDICARE ALSO PAYS…

- DGME – Direct Graduate Medical Education
  - about 40% of residency funding
- IME – Indirect Medical Education
  - Higher costs of teaching hospital
- DSH – Disproportionate Share Hospital
  - DSH Patient% = (Medicare SSI Days/Total Medicare Days) + (Medicaid, Non-Medicare Days/Total Patient Days)

https://www.aamc.org/download/253380/data/medicare-gme.pd

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME.html

Medicaid & CHIP

What's the Difference?

Medicaid and the Children's Health Insurance Program (CHIP) are both:
- Public insurance programs that cover children
- Jointly funded by a combination of state and federal matching dollars
- An important source of care and coverage for 35.9% of CYSHCN

This infographic is on the web at http://cahpp.org/resources/medicaid-chip-difference/

But there are some important differences between these two programs.

Medicaid		CHIP
Required for ages 0–19 for family income up to 138%* of the federal poverty level (FPL) *Note: States may set income limits higher than the federal requirement noted above.*	**Children's eligibility**	For uninsured children, 0 – 19, with family income too high for Medicaid (varies by state). *Note: States receive enhanced matching funds up to 300% FPL; for higher income eligibility, states receive the Medicaid match rate (FMAP)*
FMAP	**Federal match rate**	eFMAP
Guaranteed – no cap	**Federal funding**	Capped amount
Not permitted	**Waiting lists**	Permitted
Yes	**Dual private & public coverage allowed?**	No
Full Medicaid benefits including EPSDT mandate. *Note: CYSHCN may not be mandatorily enrolled in benchmark coverage.*	**Benefits**	May receive benchmark coverage, no mandate for EPSDT
Generally not, but states may charge for family income > 150% FPL	**Premiums & co-payments allowed?**	Generally yes

Children & Youth With Special Health Care Needs = CYYSHCN

IL ALL KIDS

What will All Kids premiums and co-payments cost an average family?

Here are some examples of what All Kids will cost. If you apply for All Kids and qualify, we will send you a notice telling you how much All Kids will cost your family. We will send you a bill every month if you have to pay a premium.

Example - A family of four that makes up to *$36,168 of gross income each year does not have to pay any premiums or co-payments for their children.

Example - A family of four that makes about *$36,180 to $38,628 of gross income each year does not have to pay any premiums. A family like this pays a $3.90 co-payment for each doctor visit, and $2 or $3.90 for each prescription. This family would pay a maximum of $100 in total co-payments in a year.

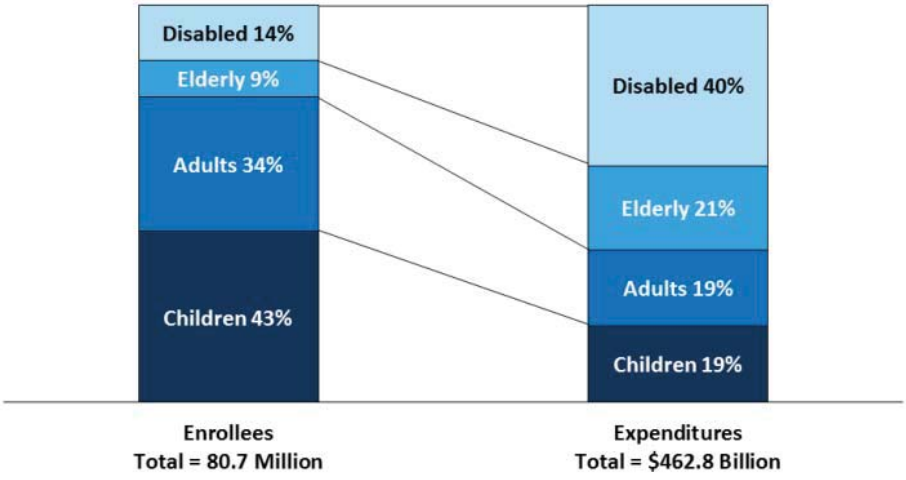
Example - A family of four that makes about *$38,640 to $51,420 of gross income each year pays premiums of $15 per month for one child, $25 for two children or $30 for three children. A family like this pays co-payments of $5 for a visit to a doctor, and $3 or $5 for each prescription drug. This family would pay a maximum of $100 in total co-payments in a year.

Example - A family of four that makes about *$51,432 to $78,228 of gross income a year pays a premium of $40 per month for one child and $80 a month for two children. A family like this would pay $10 for each doctor visit, and $3 or $7 for each prescription drug. This family would pay $100 if a child was hospitalized and 5 percent of the cost of any hospital outpatient service.

Remember, no family ever has to pay for their children's regular check-ups and immunizations.

Figure 1

Nearly two-thirds of Medicaid spending is for the elderly and people with disabilities, FY 2014.



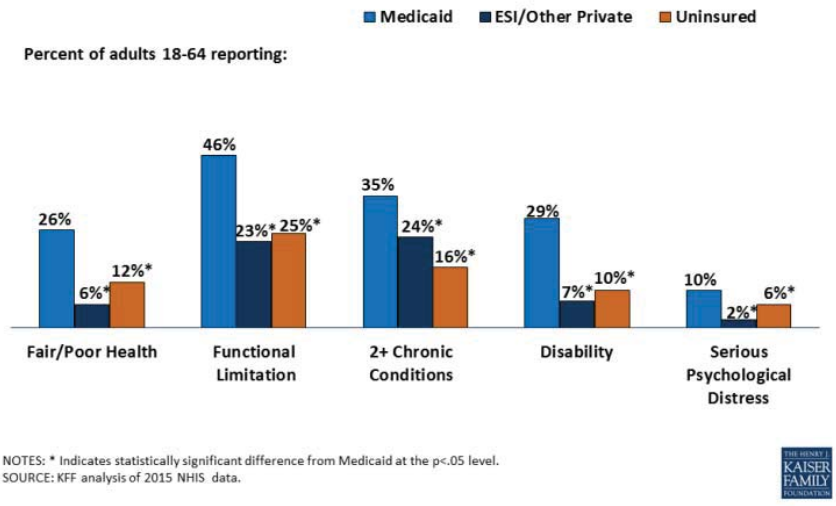
NOTE: Totals may not sum to 100% due to rounding.
SOURCE: KFF estimates based on analysis of data from the FFY2014 Medicaid Statistical Information System (MSIS) and CMS-64 reports. Because FFY2014 data was missing some or all quarters for some states, we adjusted the data using secondary data to represent a full fiscal year of enrollment.

THE HENRY J. KAISER FAMILY FOUNDATION

Figure 1: Nearly two-thirds of Medicaid spending is for the elderly and people with disabilities, FY 2014.

Figure 2

Medicaid covers a population with high rates of disease and disability compared to the population with private insurance.

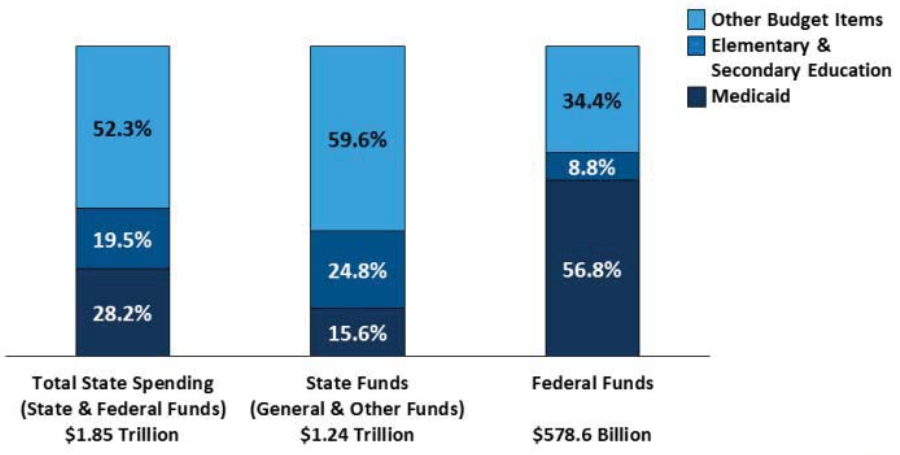


NOTES: * Indicates statistically significant difference from Medicaid at the p<.05 level.
SOURCE: KFF analysis of 2015 NHIS data.

Figure 2: Medicaid covers a population with high rates of disease and disability compared to the population with private insurance.

Figure 4

Medicaid is both a spending item and a federal revenue source for states.



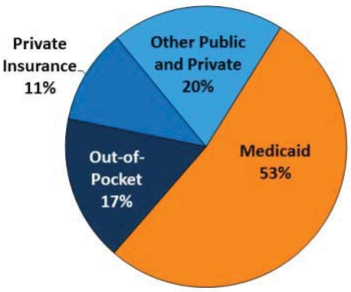
SOURCE: Kaiser Program on Medicaid and the Uninsured estimates based on the NASBO's November 2016 State Expenditure Report (data for Actual FY 2015.)

Figure 4: Medicaid is both a spending item and a federal revenue source for states.

1 IN 5 MEDICARE PATIENTS ARE DUAL-ELIGIBLE

Figure 9

Medicaid is the primary payer for long-term services and supports(LTSS), 2015.



Total National LTSS Spending = $331.2 billion

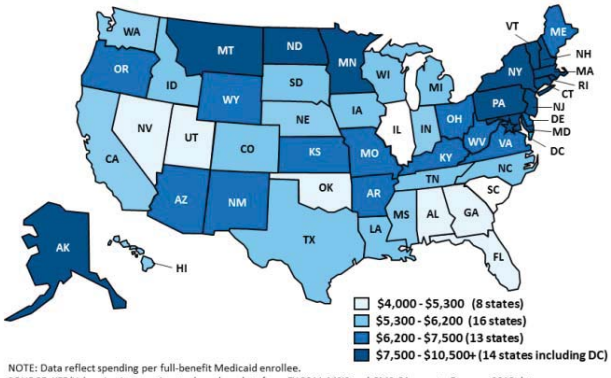
NOTE: Total LTSS expenditures include spending on residential care facilities, nursing homes, home health services, and home and community-based waiver services. Expenditures also include spending on ambulance providers and some post-acute care. This chart does not include Medicare spending on post-acute care ($77.7 billion in 2015). All home and community-based waiver services are attributed to Medicaid.
SOURCE: KFF estimates based on 2015 National Health Expenditure Accounts data from CMS, Office of the Actuary.

Figure 9: Medicaid is the primary payer for long-term services and supports(LTSS), 2015.

STATES HAVE FLEXIBILITY

Figure 5

Wide state variation in Medicaid spending per enrollee reflects states' programmatic design choices as well as other state factors.



NOTE: Data reflect spending per full-benefit Medicaid enrollee.
SOURCE: KFF/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports. Because 2010 data were unavailable, 2009 MSIS data were used for CO, ID, MO, NC, and WV.

Figure 5: Wide state variation in Medicaid spending per enrollee reflects states' programmatic design choices as well as other state factors.

INDIAN HEALTH SERVICE

- Part of HHS
- For members of federally recognized tribes
- Direct health care and public health services
- 2.2million of 3.7million Native Americans use IHS
- Some tribes have their own system

- https://www.ihs.gov/

WHERE IS THE IHS?

MILITARY HEALTH CARE

- Part of DoD
- Health care delivery to Active duty
  - Dependents & Retirees as available
  - CHAMPUS → TRICARE → Defense Health Agency
- Medical education
  - Uniformed Services University of the Health Sciences
  - GME
  - Trains public health, doctors, nurses, and dentists
- Public health
- Private sector partnerships
- Research and development
- Serves about 10 million people

https://health.mil/About-MHS

TRICARE

Active Duty Service Members

You must enroll in one of the Prime plans. You will have:

- No out-of-pocket costs
- No enrollment fees
- No network copayments
- No point-of-service fees

Active Duty Family Members*

If you enroll in one of the Prime plans, you will have:

- Minimal out-of-pocket costs
- No enrollment fees
- No network copayments
- Point-of-service fees if using the point-of-service option

*Includes family members of activated Guard/Reserve members

All Others

You can enroll in TRICARE Prime depending on where you live. You will pay:

- Annual enrollment fees
- Network copayments
- Point-of-service fees if using the point-of-service option

US NAVY HOSPITAL SHIPS

PRISON HEALTHCARE

- Required under the Constitution
- Move to privatize
- Sometimes requires co-pays
- Providers of mental health services
- Continuity of Care issues

- https://www.ncchc.org/

PPACA

- Goal: universal coverage, lowered per-capita costs
- Methods: Medicaid expansion, exchanges, employer sponsored care
- Based on “Romeycare” in Massachusetts
- Who to follow: Health Affairs Blog, Twitter
- WATCH THIS SPACE

Community Health Center Program

Community Health Center Program
also referred to as
Federally Qualified Health Centers

Part of the Solution to
healthcare access and
health costs in the US

WHEN AND HOW DID THE HEALTH CENTER PROGRAM BEGIN

- Health centers began over fifty years ago as part of President Lyndon B. Johnson's declared "War on Poverty."
- Their aim then, as it is now, is:

to provide affordable, high quality, comprehensive primary care to medically underserved populations, regardless of their insurance status or ability to pay for services.

WHAT IS REQUIRED TO BECOME A HEALTH CENTER?

- Must be located in a federally designated medically underserved area OR serve a federally designated medically underserved population **and**
- Must have non-profit, public or tax exempt status **and**
- Provide comprehensive primary health care services **and**
- Have a governing board, the majority (51%) of whose members are patients of the health center **and**
- Provide services to all in a given service area regardless of ability to pay and offer a sliding fee scale that adjusts according to family income

PROVIDE ACCESS TO ENABLING SERVICES

- Medication Assistance through the 340B Drug Program
- Behavioral Health Integration -- Psychiatrists, LCSW's, LCPC's integrated into medical visits
- Care Coordination – Staff to assist patients with appointments, transportation, labs and visits to specialists
- Transitions of Care - RN's to assist in their transition of care between hospital, nursing home, and other settings
- Medical-Legal Program – Access to a Lawyer to assist patients with health-harming legal issues

ENABLING SERVICES EITHER OFFERED ON-SITE OR THOUGH A REFERRAL AGREEMENT

- Access to dietary services
- Access to dental services
- Access to optometry
- Access to specialty care
- Access to lab, diagnostic and inpatient services
- Offer Medication Assisted Treatment Clinics or Access to Substance Abuse Services

HOW ARE THEY FUNDED:

- Federal grant for each health center is $650,000 annually
- Increased cost-based reimbursement rate for Medicaid and Medicare

Medicaid patients –

$130 for Medical Visit

$104 for Dental Visit

$59 for Behavioral Health Visit (LCSW or LCPC)

Medicare patients –

$150 for Medicare Visit

$250 for Medicare Wellness Visit

$61 for Chronic Care Management

- Private Insurance
- Fund Raising Efforts

HEALTH CENTERS NOW

- Health centers play a critical role in the U.S. health care system, delivering care to **over 25 million people** today.
- Across the country, health centers produce positive results for their patients and for the communities they serve.
- Assuming they have the continued resources to do so, they stand as evidence that communities can:

1. improve health
2. reduce health disparities
3. deal with a multitude of costly and significant public health and social problems – including substance abuse, HIV/AIDS, mental illness, and homelessness.

Health Centers Serve

1 in 13

people in the US, including:

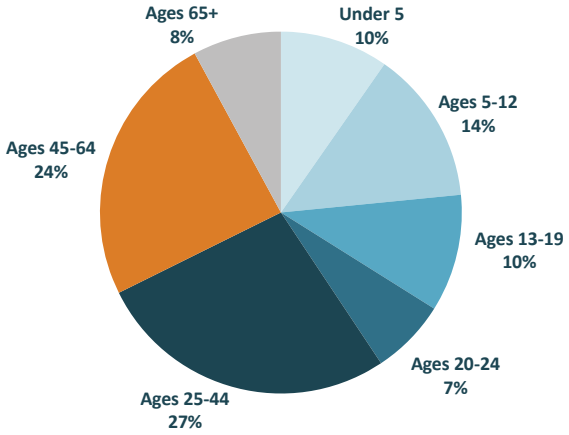
1 in 6 people receiving Medicaid

1 in 3 low income uninsured

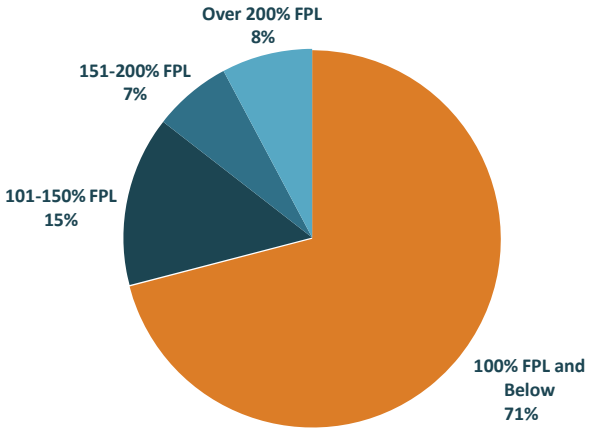
1 in 3 individuals living below poverty

1 in 4 rural Americans

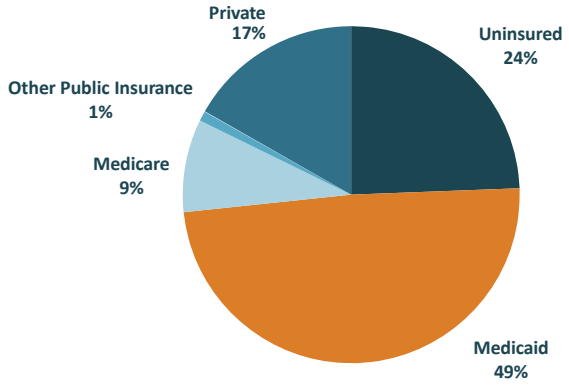
Health Centers Serve Patients Throughout the Life Cycle



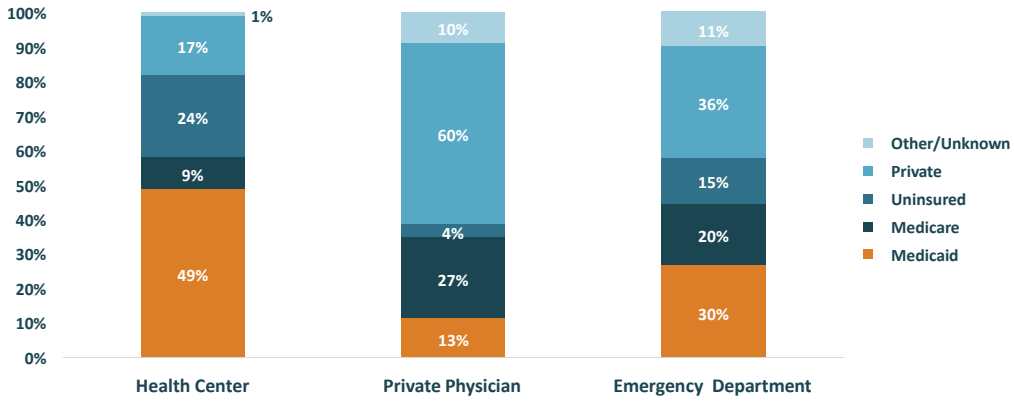
HEALTH CENTER PATIENTS ARE PREDOMINATELY LOW INCOME



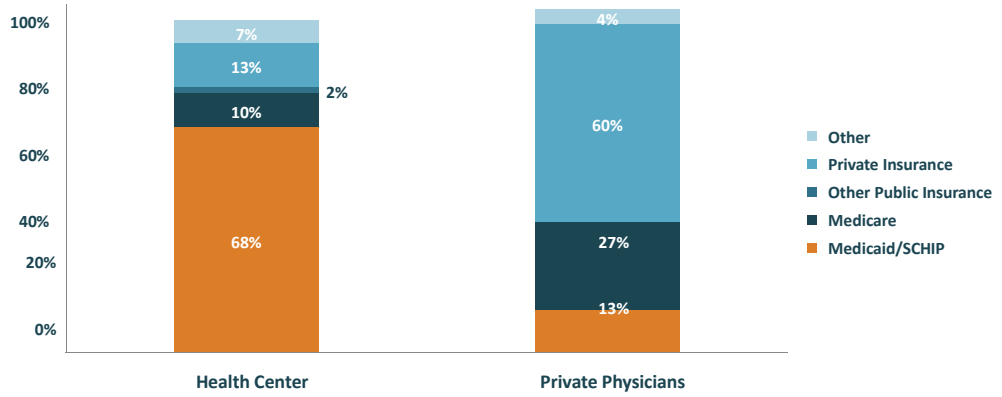
Most Health Center Patients are Publicly Insured or Uninsured



Health Center Patient Mix is Unique Among Ambulatory Care Providers

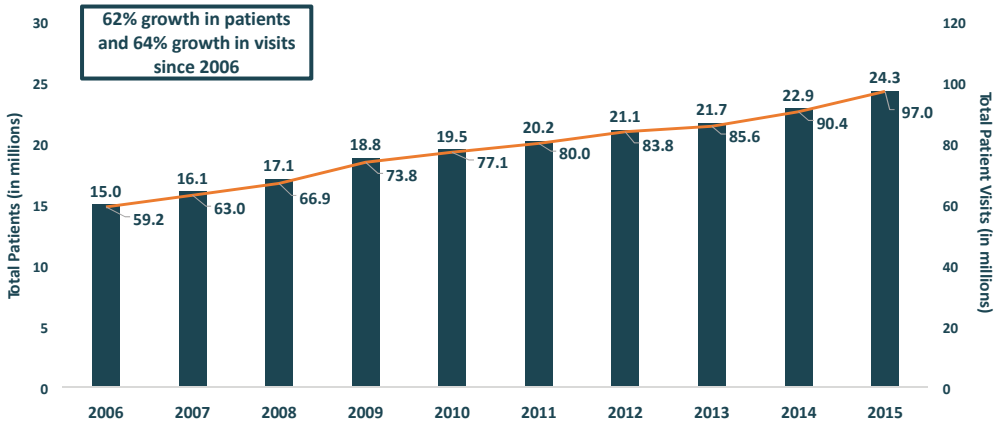


HEALTH CENTERS' INSURANCE REVENUE SOURCES DO NOT Resemble Those of Private Physicians



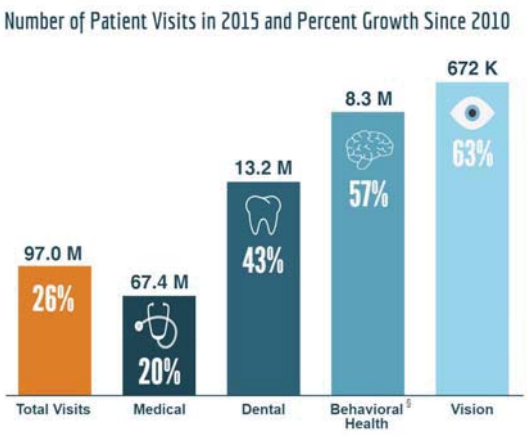
States, 2013.

THE NUMBER OF HEALTH CENTER PATIENTS AND VISITS Continues to Increase



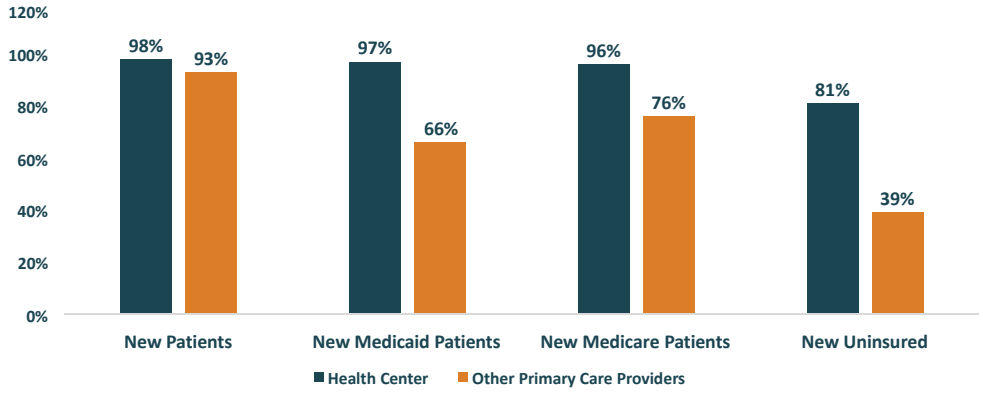
HEALTH CENTERS HAVE EXPANDED THE BREADTH OF SERVICES

Offered to Both New and Existing Patients

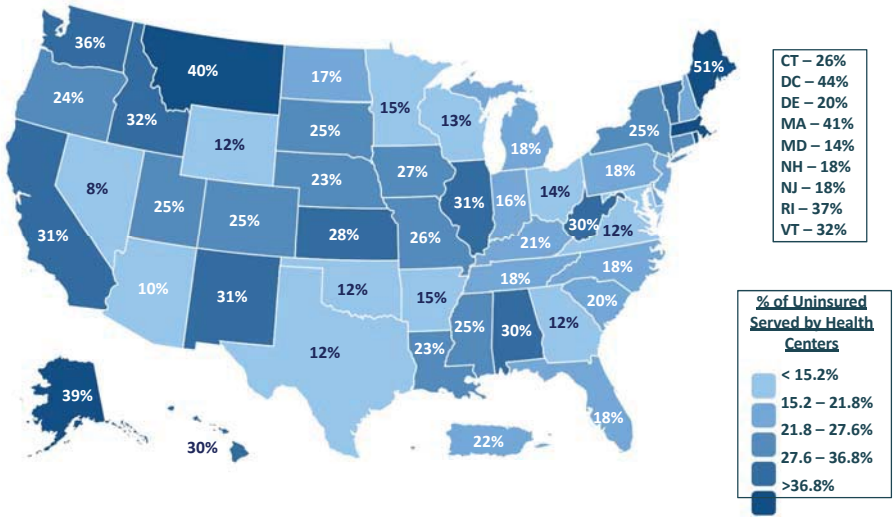


HEALTH CENTERS HAVE EXPANDED THEIR CAPACITY TO PROVIDE MORE SERVICES BY EMPLOYING A WIDER VARIETY OF STAFF TYPES AND INTEGRATING CARE

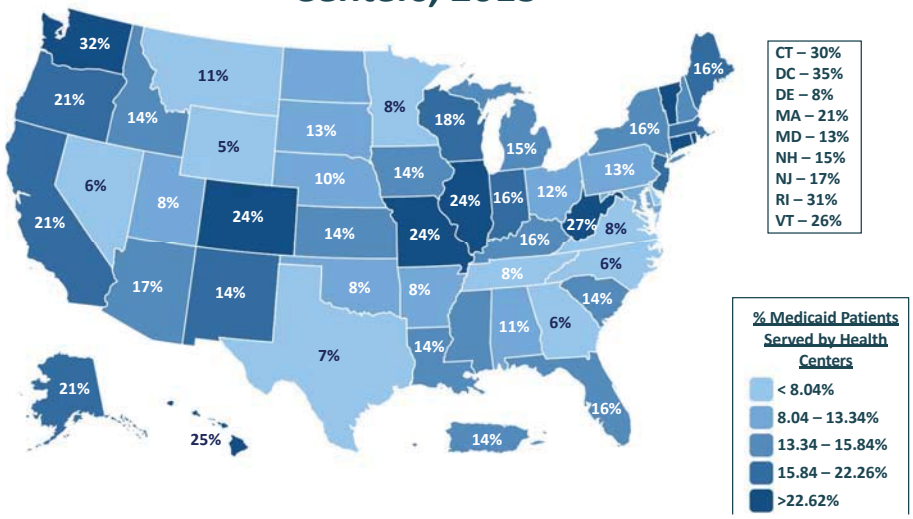
HEALTH CENTERS HAVE HIGHER RATES OF ACCEPTING NEW Patients Compared to Other Primary Care Providers



PERCENT OF UNINSURED SERVED BY HEALTH CENTERS, 2015

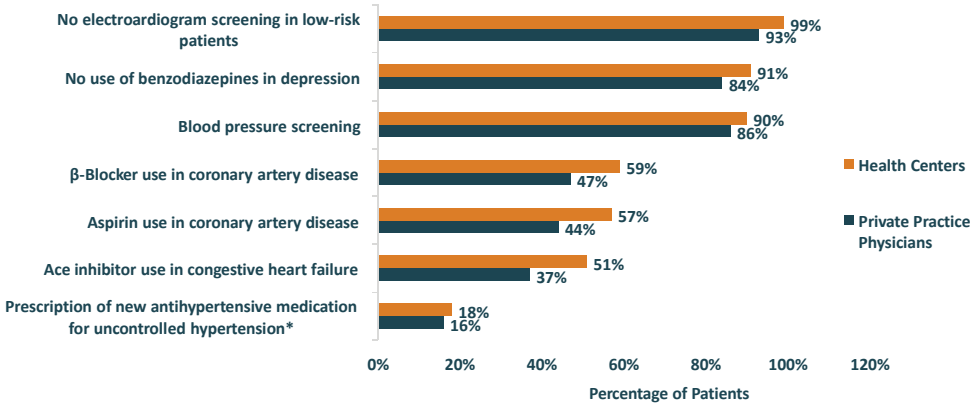


PERCENT OF MEDICAID BENEFICIARIES SERVED BY HEALTH Centers, 2015

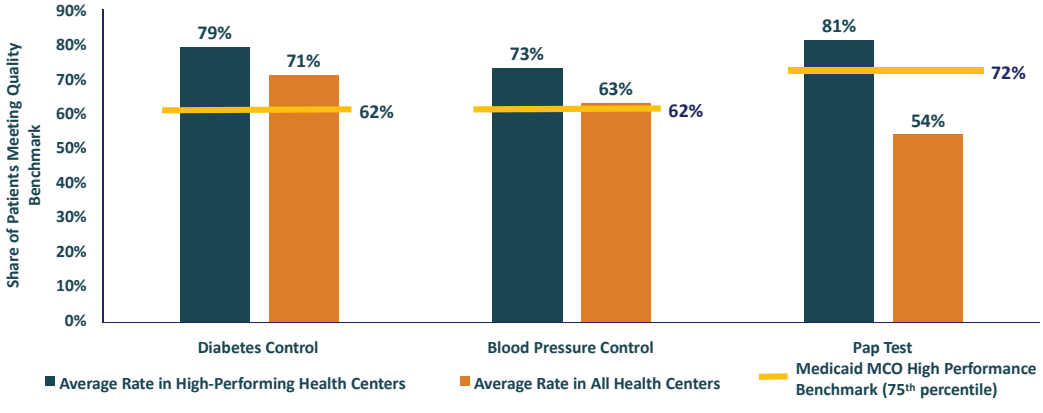


Health Centers are required to report clinical outcome measures on an annual basis to HRSA with the goal of Providing High Quality Care and Reducing Health Disparities

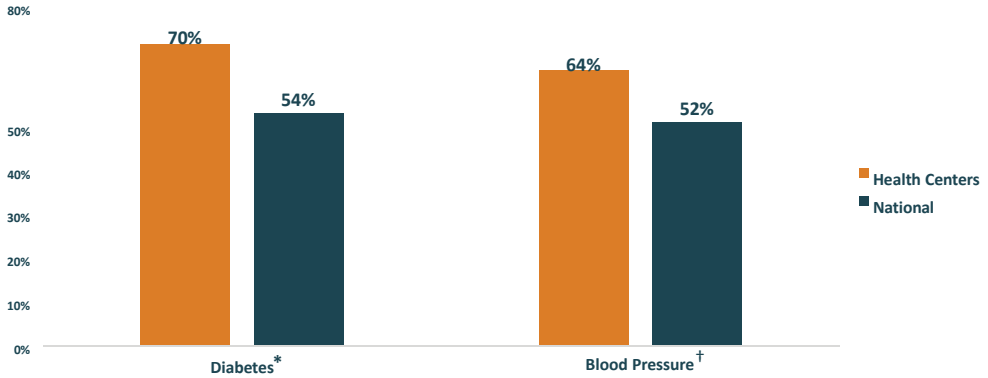
Health Centers Perform Better on Ambulatory Care Quality Measures than Private Practice Physicians



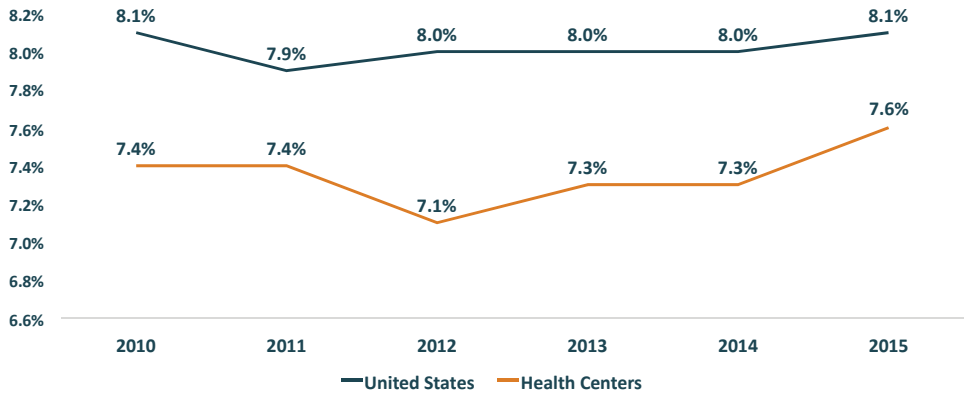
HEALTH CENTERS EXCEED MEDICAID MANAGED CARE Organization High Performance Benchmark Scores



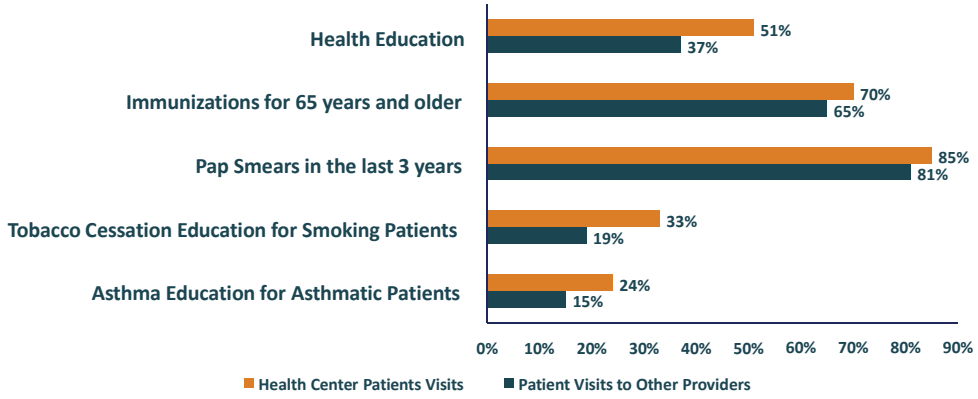
HEALTH CENTER PATIENTS HAVE HIGHER RATES OF DIABETES and Blood Pressure Control than the National Average



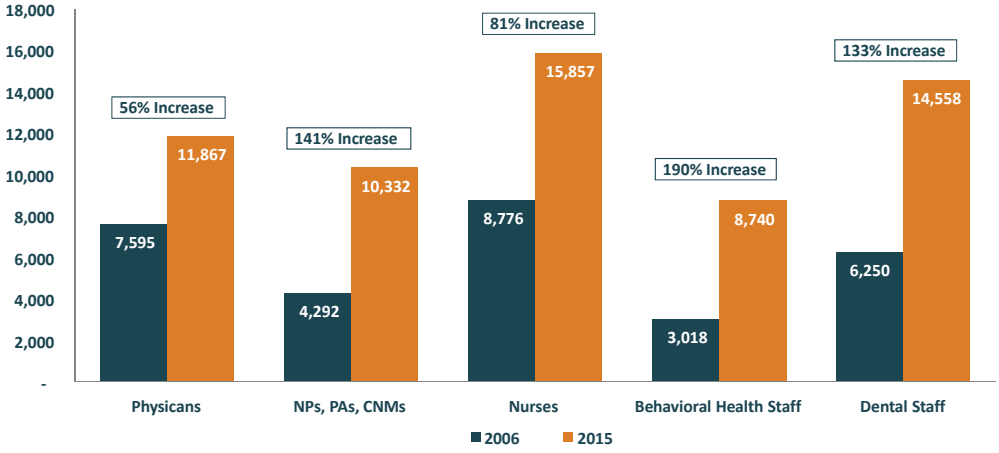
HEALTH CENTER PATIENTS HAVE FEWER LOW BIRTH WEIGHT Babies than the US Average



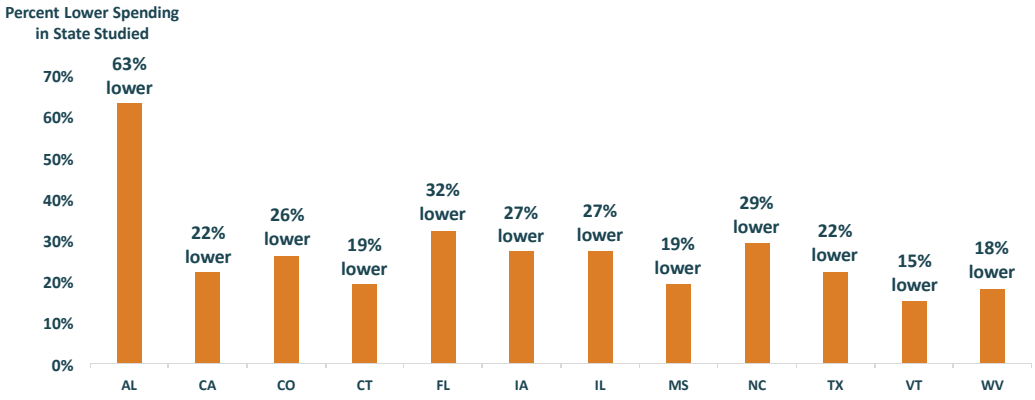
HEALTH CENTERS PROVIDE MORE PREVENTIVE SERVICES THAN Other Primary Care Providers



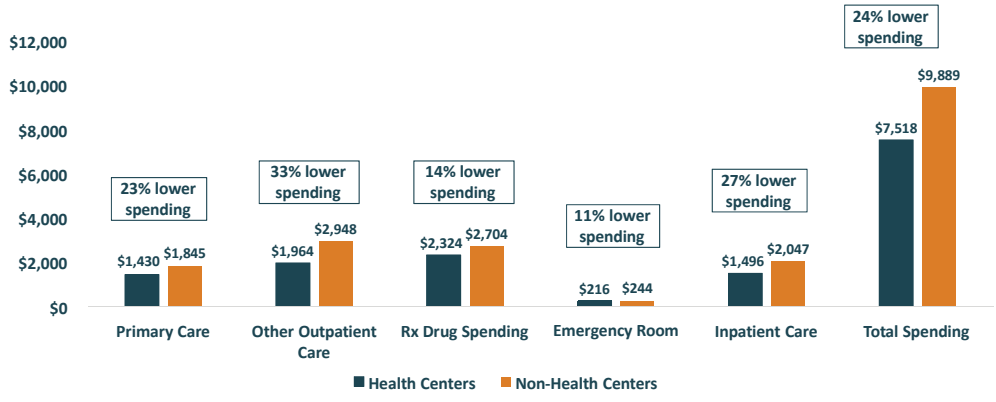
GROWTH IN HEALTH CENTER MEDICAL PROVIDERS 2006 - 2015



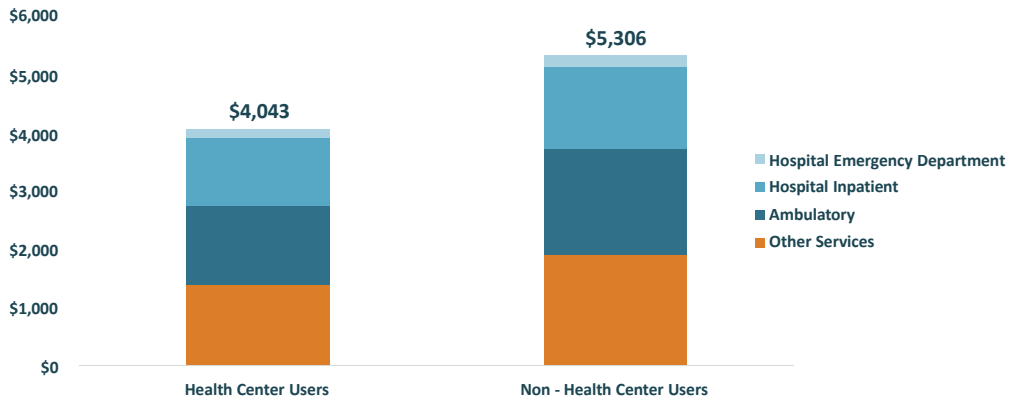
HEALTH CENTERS HAVE LOWER TOTAL SPENDING PER Medicaid Patient Compared to Other Providers



HEALTH CENTERS SAVE 24% PER MEDICAID PATIENT Compared to Other Providers



HEALTH CENTERS SAVE $1,263 PER PATIENT PER YEAR



IN SUMMARY, HEALTH CENTERS CAN AND SHOULD BE A PART OF THE SOLUTION FOR HEALTHCARE IN THE US GOING FORWARD BECAUSE THEY PROVIDE CARE THAT IS:

- Comprehensive
- Integrated
- Patient Centered and Community Oriented
- Includes enabling and wrap-around services
- Lower Cost
- High Quality

THANK YOU AND PLEASE FEEL FREE TO VISIT ONE OF OUR HEALTH CENTERS IF YOU HAVEN'T ALREADY IN:

Springfield

Lincoln (includes dental)

Jacksonville

Quincy (soon to include dental in Feb 2018)

Decatur