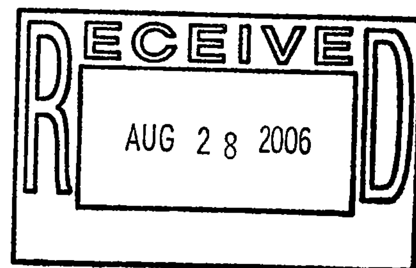
National Association of Free Clinics



August 28, 2006

Citizens Health Care Working Group
Suite 575
7201 Wisconsin Ave.
Bethesda, MD 20814

Dear Members of the Citizens Health Care Working Group:

The National Association of Free Clinics (NAFC) appreciates the opportunity to provide comments in response to the Citizens Health Care Working Group (CHCWG) interim recommendations.

By way of background, the NAFC is the only national nonprofit organization whose mission is solely focused on the needs of free clinics in the United States and the populations they serve. A "free clinic" is a community-based organization that:

- Provides medical, dental, mental health and/or pharmacy services at little or no charge to the uninsured and underinsured;
- Is a private, non-profit corporation with an independent governing body, or a program component of a private non-profit corporation;
- Is a 501(c)(3) tax exempt organization or holds a similar tax exempt status under section 501(a) of the IRS code;
- Facilitates the delivery of medical, dental, mental health and/or pharmacy services by volunteer health care professionals; and
- Generates third-party reimbursement from no more than 25% of its patients.

The NAFC estimates there are approximately 1,100 free clinics in the United States, and that these entities raise an estimated $300 million per year in *private funds* to care for the nation's uninsured and underinsured. Each free clinic is a unique reflection of the community where it is located. Free clinics receive no federal funds – yet they generate health care services worth approximately $3 billion dollars each year. They have become the "medical home" for millions who have no alternative. Free clinics represent the American spirit at its best: neighbor helping neighbor in need.

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Who are free clinic patients? They are primarily the working poor, individuals without access to health care providers, treatment or medications. The Journal of the American Medical Association recently cited reports that an estimated 61 million persons aged 19 to 64 were uninsured or underinsured in 2003, and that the number of uninsured U.S. citizens increased by 6 million between 2000 and 2004, primarily due to declines in employer coverage. Meanwhile, Medicaid cuts and increased hurdles (such as proof of citizenship) continue to erode publicly-funded health care coverage for the poor. As a result, the demand on free clinics increases to provide for those who fall through the health care "safety net." The NAFC estimates that free clinics provide care for over 4.5 million individuals each year.

Free clinics exist and continue to proliferate because of the growing sector of patients left out of the current healthcare system in this country. Unless and until there is a national health care solution that covers each and every person in our country, there will always be some number excluded – and free clinics will exist to provide for them. The NAFC is uniquely qualified to comment on the potential impact of some of the CHCWG recommendations on populations served by free clinics. We offer our comments with full respect and appreciation for the CHCWG's work thus far. We hope that our input may provide additional insight in the development of final recommendations to Congress and the President that will provide the greatest benefit for the greatest number of people in our society.

The following are the NAFC's comments on the interim recommendations presented *seriatim:*

First Recommendation: *Guarantee financial protection against very high health care costs.*

Comment: The NAFC applauds the recommended national goals to "guarantee financial protection against very high health care costs" and that "no one in America should be impoverished by health care costs." However, the devil appears in the details of this bifurcated recommendation. The proposed implementation appears simply to offer a new insurance product that would provide catastrophic coverage to "all Americans" with premium subsidies for low-income individuals. Moreover, although the term "universal coverage" is used in the context of the discussion, because of extreme coverage limitations it bears no resemblance to the universal coverage available in other industrialized nations. The lack of a definition for "high out of pocket costs" causes additional concern.

Free clinic patients cannot afford any health insurance and generally do not qualify for Medicaid. Even with an income slightly above 200% of the Federal Poverty Level (FPL), such patients typically do not have sufficient discretionary income to take care of current immediate medical needs of their households.

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Many free clinic patients are only one or two paychecks away from financial ruin, have no savings, and rely upon free clinics for care because they have no other viable alternative. This segment of the population would simply be unable to purchase catastrophic coverage - even if the cost were subsidized - and would not be "free to purchase the policy that suits their needs best."

In addition, this recommendation, like each of the interim recommendations, ignores the reality that individuals residing in the United States are not necessarily "American." Census data and estimates show the United States had 32 million immigrants (legal and illegal) in 2004, with that number rapidly increasing each year. The Pew Hispanic Center estimates the 2005 population of illegal aliens at 12 million. We urge the CHCWG not to disregard the medical needs of the millions of resident aliens, or the fact that our country's economy is increasingly reliant upon this segment of our workforce. A healthy society is to everyone's benefit. Conversely, to deny care categorically to millions is to do so at our own peril. We urge the CHCWG to address the issue of health care for resident non-U.S. citizens in its final report.

It is also of great concern to the NAFC that this first recommendation admittedly creates a new incentive for employers to drop existing health care coverage and opt to purchase only catastrophic coverage for employees. So long as any employer-based health care system remains in the U.S., any reforms implemented should not have the result of effectively eliminating primary health care coverage on which workers and their families currently rely.

Second Recommendation: *Support integrated community health networks.*

Comment: In developing this recommendation, a distinction needs to be made between free clinics and the Federally Qualified Health Center concept. Free clinics already play an important role in "integrated community health networks" and would certainly fall within the CHCWG description of "community networks of health care providers aimed at providing vulnerable populations, including low income and uninsured, and people living in rural and underserved areas, with a source of high quality coordinated health care..." Further, because free clinics are the "medical home" for millions of patients, the majority of these clinics already incorporate the "broad and inclusive" mission of providing not just care and treatment, but health promotion and education to promote wellness and health maintenance in the community.

The NAFC would gladly participate on behalf of its members in any public-private partnerships to enhance community responses to health care and strengthening the health care safety net. Free clinics offer a wealth of experience and resources in this area, and can offer their perspective on the nation's health care safety net performance and funding streams, research on safety net issues, and identifying and disseminating best practices on an ongoing basis. Free clinics are a model of efficiency in providing quality of care to uninsured, low-income

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populations at a very low per capita cost because of the donation of services and specialty care by licensed professionals.

The NAFC requests that the fourth point of this recommendation – "providing federal support for the development of integrated community health networks to strengthen the health care infrastructure at the local level, with a focus on populations and localities where improved access to quality care is most needed" – should address free clinics in the following ways:

- Increase the ability of free clinics to obtain federal benefits such as access to reduced priced prescription medications under Section 340B of the Public Health Service Act;
- Extend malpractice liability coverage and guarantee adequate funding under the Federal Tort Claims Act to include coverage of the free clinic entity and staff, so that all community funds and the pool of medical volunteers can be further leveraged to increase the amount of care provided at the grass roots level;
- Include free clinics in any available funding and all comprehensive plans for health information technology, so that there can be greater uniformity of care, increased communication, and efficiency at all levels;
- Remove all obstacles and disincentives to the direct, efficient donation to and receipt of pharmaceuticals for the benefit of free clinics, so that valuable excess medications are not shipped overseas and/or destroyed;
- Acknowledge that any limitation of health care to United States citizens or legal residents will exclude millions of people, many of whom are in the workforce, and that such limitation does not adequately address our nation's interest in a healthy population.

In addition, there is an unfortunate reality that must be addressed in any systemic changes to the U.S. health care system: Large numbers of our population may suddenly be faced with acute illness or health emergency that overwhelms the current infrastructure, such as an epidemic, natural disaster or terrorist attack. Emergency services for large numbers of patients can suddenly challenge the already overburdened U.S. health care system – as shown by the aftermath of Hurricanes Katrina and Rita. Free clinics throughout the Gulf state regions saw a tremendous increase in demand for services following the 2005 hurricanes. New free clinics, especially in heavily-damaged New Orleans where public hospitals still remain closed, started up specifically to handle the large numbers of patients who had no money, no prescription records, no physicians, and nowhere else to go. The National Association of Free Clinics, with the aid of partner nonprofit and foundation organizations, directed more than $2.5 million in pharmaceutical donations and private financial assistance to free clinics faced with sudden, increased demand – a demand which in some areas continues even a year later. Significantly, free clinics were not the only entities dependent on these private funds and donations. Federally qualified health centers were also forced to vie for private assistance because the current system was simply inadequate to address the crisis. Any health care system reforms should address not just normalcy, but

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worst-case scenarios that could affect the public health. The essential role of free clinics in these situations should be acknowledged and supported.

Third Recommendation: *Promote efforts to improve quality of care and efficiency.*

Comment: The NAFC believes that the bare recommendation to "promote efforts to improve quality of care and efficiency" sets the bar too low for both health care professionals and for our country. The recommendation offers no specific information about the "important, innovative work underway" or the "new initiatives" being tested; consequently, it is impossible to comment on the impact or promise each might offer. However, the CHCWG's specific recognition of the critical importance of health information technology and the development integrated system of electronic health records is to be applauded.

Advancements in health information technology and electronic record keeping must be available to all health care providers, not simply to those with the greatest resources. Failure to make the new technological advancements available to entities such as free clinics would undermine the stated goal of having shared access to patient information to enhance efficiency and accuracy. Similarly, the concept of public-private partnerships must be developed in a way that recognizes and supports the significant health care role played by free clinics, so that free clinic patients can benefit from the same technological advancements available to others.

Fourth Recommendation: *Fundamentally restructure the way that palliative care, hospice care and other end-of-life services are financed and provided.*

Comment: Free clinics generally do not provide palliative care, so the NAFC does not comment on this recommendation.

Fifth Recommendation: *It should be public policy that all Americans have affordable health care. All Americans will have access to a set of core health care services. Financial assistance will be available to those who need it.*

Comment: The term "Americans" is not defined in the interim recommendations, but it is our understanding that its meaning is limited to United States citizens – and thus potentially excludes millions who cannot prove that status.

The discussion of this recommendation highlights the need for "special attention to people who are now being helped by private and public programs" during the transition to a system that guarantees "core benefits to all Americans." The millions of free clinic patients are in neither private nor public programs, but are served by the non-profit sector. If "universal health care" must be limited so that it

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is guaranteed only to a certain percentage of the population, such as those who can show they are United States citizens, free clinics will remain the medical home to a large and growing sector of the resident population who would not meet eligibility requirements for those core benefits. Unless major reforms to the current health care system take into account the millions of working poor that would still be excluded from participation in a national health care program, the burden on free clinics – and the communities who support them – will continue to grow.

The "core benefit" concept is not the best or only choice for our country. The NAFC encourages the CHCWG to study carefully the health care systems of other industrialized countries before making this recommendation. France, for example, was recognized as having the "best health system in the world" in 2000 by the World Health Organization. France provides comprehensive medical care at no cost to more than 96% of its population, and the treatment costs for those who suffer from long-term illnesses are fully reimbursed. Funding for health insurance is funded by workers' salaries, by taxes on alcohol and tobacco, and by direct contribution proportionate to income. Those who are poor have free universal health care that is financed exclusively by taxes. As a result, life expectancy in France increases more than three months each year, and French women have the second highest life expectancy rate in the world. (*See* "The French Healthcare System", Embassy of France in the United States, www.info-france-usa.org/atoz/health/.asp.) Other industrialized countries also struggle with impoverished and immigrant populations, yet manage not to exclude them from the health care system. Our country should be no exception.

Sixth Recommendation: *Define a 'core' benefit package for all Americans.*

Comment: The "core benefit" recommendation presupposes that the CHCWG will not recommend complete and comprehensive health care coverage for everyone in the United States. Perhaps what is most problematic about this is that the "new" system will begin with identifiable coverage gaps, posing new problems for those whose health care needs fall outside of the specified benefit package or who do not qualify for coverage. Unintended consequences of these gaps can be anticipated, but cannot be thoroughly evaluated without more details on this "core benefit" recommendation.

The NAFC is concerned that "health care" as defined in the recommendation does not explicitly mention vision and hearing in the list that includes physical, mental, and dental health. Vision and hearing require periodic medical evaluation and care, and are obviously critical to our well being. Their impairment, if left undiagnosed, can put patient health at greater risk because of compromised ability to understand treatment and medication instructions. It is imperative that vision and hearing be included in any basic "health care" definition.

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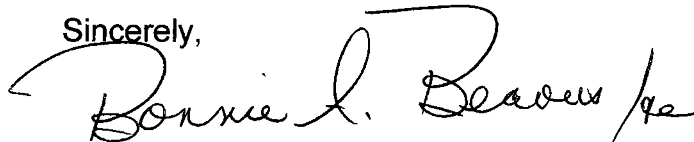
In conclusion, the NAFC would like to thank the CHCWG for taking on this important task. The NAFC supports the goal of affordable health care for everyone. Free clinics are not the answer to the growing number of uninsured and underinsured, but they most certainly function as part of the solution, and will likely remain a necessity. Thus, any reforms to the U.S health care system should support free clinics by recognizing their continued importance.

We urge the CHCWG to make further recommendations for systemic improvements that will enhance the ability of free clinics to serve those inevitably falling through the "health care safety net" – e.g., by facilitating donations of donated pharmaceuticals, including free clinics in health information technology, expanding preferential pricing of pharmaceuticals to include free clinics, and increasing liability protection under the Federal Tort Claims Act to reduce unnecessary overhead costs for these volunteer-based entities.

For Americans fortunate enough to be able to afford health care, their options should ultimately be enhanced rather than limited to a "core benefit" package. With these basic improvements, the new health care system can still maintain financial viability while also improving the quality and efficiency of care. The United States should take its rightful place among the vast majority of industrialized nations whose systems recognize the value of universal health care for all.

Please do not hesitate to contact us should you have any questions about the issues presented in this comment.

Sincerely,



National Association of Free Clinics
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cc: Amy R. Goldstein, Esq.
Director of Government Relations and Strategic Planning,
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The Honorable David M. Walker, Comptroller General

U.S. Senator Orrin B. Hatch

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