

THE AFFORDABLE CARE ACT: A PRIMER FOR HEALTH CARE CENTERS



NATIONAL ASSOCIATION OF
Community Health Centers

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INTRODUCTION

On March 23, 2010 President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) into law. The ACA includes a wide range of changes to the health care system in the United States, some taking effect in the near term and some not fully coming into place until 2015. Since being signed, the law has undergone legal challenges that were reviewed by the Supreme Court and several delays announced by the Administration. While some aspects of the law have not played out as initially intended, the ACA still presents legislated changes and business opportunities to permanently transform the way health care is delivered in the United States.

Large scale health care reform has eluded politicians for decades despite the fact that healthcare costs and chronic disease continue to increase. The ACA is the latest in a series of efforts to correct these issues and while the legislation reforms many aspects of the system, it will not singlehandedly solve all problems. Rather, the legislation provides the foundation for future reform and innovation in care delivery that would not have been possible under the previous structure.

This white paper is a primer on the ACA's impact on Health Centers across the nation. Since the law includes many changes, not all of which are pertinent for the stated audience, this paper focuses on several areas most important to Health Centers:

1. A Brief Background on the ACA
2. The Impact of the ACA to Date
3. The ACA's Impact on the Business of Health Centers
4. New Competencies Required for Health Center Success
5. Resources for Additional Help

BACKGROUND ON THE ACA

The US healthcare system has a per capita cost higher than similarly wealthy countries and had annual growth rates ranging from 6 to 10% from 2000 to 2008¹. The Centers for Medicare and Medicaid Services (CMS) estimates that healthcare costs will grow to 19.9% of GDP by 2022² from 17.2% of GDP in 2012³. Because Medicare and Medicaid are mandatory government spending, sustaining such high rates of growth would either require increased taxes to cover costs, increased borrowing to cover costs, the crowding out of discretionary spending, or large scale reform to reduce cost growth. In addition to the cost of care borne by the government, private corporations and consumers have also assumed a higher cost of care for their own coverage. Companies providing employer-sponsored health insurance have seen premium growth rates in the double digits and have offset some of this cost by increasing the portion of care paid for by the employee.

Despite the high total cost of care in the United States, not every person is insured. In a 2011 Centers for Disease Control and Prevention survey, 46.3 million Americans lacked insurance coverage. The number of uninsured fluctuates over the course of any given year due to the patchwork of insurance sources in the country, so that an estimated 58.7 million people go without insurance for at least part of any year⁴. This lack of insurance coverage combined with the high cost of care in the US makes it nearly impossible for all but the wealthiest of individuals to pay for care out of their own pocket in the event that they are uninsured. Conversely, lower income populations routinely “churn” back and forth from no insurance coverage to a variety of public insurance programs with little continuity of care.

While the US leads the world in some measures of quality when looked at in the aggregate, the US was ranked 26th in the world for life expectancy at birth by the Organization for Economic Co-operation and Development in 2013⁵. The high cost of care and comparatively poor outcomes are indicative of an inefficient system, and these inefficiencies are targeted by the ACA.

The Intention of the ACA

First and foremost, the ACA is a health insurance reform law. These reforms impact multiple groups who interact with insurers, with myriad benefits and costs accruing to each. The primary benefactors of the law are Americans who were not offered or could not afford to purchase health insurance through their employer. Insurers, care providers, and the government also stand to benefit from the reforms contained in the law, in addition to the newly insured,

The largest and one of the most complex components of the law

is the requirement for people to carry a health insurance policy or pay a tax penalty. This “individual mandate” is necessary to drive the uninsured to newly created insurance products on health insurance marketplaces and to ensure that patients do not sign up for insurance only after they have become aware of a severe illness.

Health insurers face a range of new regulations on the underwriting and benefits development within plans, but also stand to gain many new customers. The Kaiser Family Foundation estimated that up to 29 million people across America could turn to health insurance marketplaces for insurance coverage⁶. This influx of new members not only means greatly increased revenues but also expands the number of patients over which financial risk is spread. With a smaller member population, insurers could see financial losses due to a few expensive outliers; the expansion of the insured population via the ACA reduces the impact of these outliers and makes the insurance pools more stable.

Providers of health care also stand to benefit from a greater number of insured patients. Uninsured patients can lead to financial losses due to bad debt or uncompensated care. A higher rate of insured patients increases the payments for the care that is delivered. In addition to this financial improvement, Medicaid will increase payments to non-Health Center primary care physicians to match that of Medicare levels. While this change does not impact Health Centers, it may attract more providers to Medicaid.

The ACA also includes a set of benefits for payers and providers working in conjunction with one another. In the law, these two groups are encouraged to partner to manage the health care quality and cost for a designated set of patients. Any reductions in the cost of care for these patients are then split between the two groups, establishing a new degree of cooperation and a financial incentive to undertake innovations in care that would not previously have been feasible. One example of this is an Accountable Care Organization (ACO). These new entities may bring tremendous opportunities for Health Centers. Please refer to the second white paper in this series, *Accountable Care Organizations: Health Center Strategies for Success* for more information on health centers and their roles in ACOs.

The final primary beneficiary of changes via the ACA is the Federal Government itself. As the single largest payer for healthcare in the country, the government has a vested interest in seeing the growth rate of costs decline while maintaining a high quality of care. As the baby boomers age into Medicare, the government will be responsible for paying for the health care of millions more Americans. The ACA provides the opportunity for health care organizations to learn how to manage a population of patients in a high value fashion, before the impact of this demographic change is fully felt.

1 <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>

2 <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf>

3 <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>

4 <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201206.pdf>

5 <http://www.compareyourcountry.org/health/index.php>

6 <http://kff.org/health-reform/issue-brief/state-by-state-estimates-of-the-number-of-people-eligible-for-premium-tax-credits-under-the-affordable-care-act/>



IMPACT OF THE AFFORDABLE CARE ACT TO DATE

The implementation of the Affordable Care Act has occurred incrementally over the past several years. This approach was necessary in order to accommodate a high level of disruption to traditional practices and to allow adequate time for adjustment by private industry to comply with new rules and expectations.

In 2010, the Patient Bill of Rights became the first component of the ACA to be implemented. This portion established a set of protections for consumers of healthcare. It permitted children up to age 26 to stay on their parents' insurance as dependents, required that health plans on the individual market not exclude applicants with pre-existing conditions, and removed lifetime maximums on the value of benefits a member could receive from any one insurer.

In 2011, Medicare eliminated co-pays for certain preventive services such as annual wellness visits, cancer screenings, and flu shots. Additionally, beneficiaries who found themselves in the “donut hole” of Medicare Part D (outpatient prescription coverage) began to receive a 50% discount for some brand-name medications. The “donut hole” refers to a gap in coverage where a Medicare beneficiary has spent beyond a limit for outpatient prescription costs but has not reached his or her out of pocket maximum for the year.

2012 also saw the creation of Medicare Accountable Care Organizations to serve as a model of partnership between payers and providers. Organizations applied to be part of the program and, if accepted, were assigned Medicare beneficiaries that received the bulk of their care from specified providers within the ACO. The ACO accepts financial risk on the cost and quality of care for their attributed population of Medicare patients. If they meet quality and cost standards, the ACO participants share in the savings they generate for Medicare. If they fail to meet these standards, they are responsible for paying some of the cost overruns. All thirty-two Pioneer ACOs met quality standards in the first year of the program; thirteen also reduced the cost growth of care enough to share savings with CMS.

In 2013, many of the key aspects of the ACA began to take root. A number of planning and implementation activities for the health insurance marketplaces were taken at both the state and federal levels. This included finalizing the selection of Qualified Health Plans in each state, identifying benefit packages for consumers, and planning and implementing for Medicaid expansion in states that selected this option. In addition, a significant amount of resources and effort were directed at educating and enrolling consumers in new or existing health coverage programs. These programs sought to contact potential consumers via a variety of channels and Health Centers proved to be an important and effective partner in this work.

Health Insurance Expansion

The largest single component of the ACA is the expansion of health insurance, with new plans and coverage having gone into effect January 1, 2014. The ACA identified its expansion of health insurance via two major strategies: the expansion of Medicaid as a governmental payer and the creation of health insurance marketplaces to expand commercial coverage. Both of these strategies require state level decision making and therefore are varied across the country. Some states (approximately half) have opted to expand Medicaid. However, all states are required to have a health insurance marketplace and it is up to the state to decide if they would run it or default to the management by the Federal Government. Still a third group of states have opted for the partnership model where the State and the Federal government coordinate on the implementation of the Marketplace. Several states operating in the partnership model will likely transition to a state-based marketplace over time.⁷

Medicaid Expansion

State and federal governments jointly finance Medicaid with the federal government defining benefits and some components of eligibility and the state deciding the income-based eligibility requirements for adults. See the [Kaiser Family Foundation Medicaid Primer](#) for more details. The 2012 Supreme Court ruling allowed states to accept or reject an income-based expansion of eligibility to Medicaid. Despite 100% funding from the Federal government for the first three years of expansion, and no less than 90% funding beyond, 19⁸ states have opted not to expand Medicaid mainly on these grounds.

Because of this, in states that chose not to expand Medicaid, patients above the maximum income allowed by the state's current Medicaid eligibility limits and below the 100% FPL⁹ for subsidies on the health insurance marketplaces will have to purchase insurance entirely on their own or will go without coverage.¹⁰ In the event that their income falls below the state determined cutoff, they could become eligible for Medicaid.

For states that have elected to expand Medicaid, the method can take several forms. Traditional fee-for-service (FFS) Medicaid is the most straightforward way to expand care, but generally does not have the internal mechanisms to control cost and quality espoused in the ACA. Medicaid Managed Care organizations will make use of classic managed care tools to tightly manage cost and quality of care. Like health management organizations (HMOs), patients in a Medicaid Managed Care organization will

7 For more information on which states have adopted each model of Marketplace, please visit Kaiser Health Facts at <http://kff.org/statedata/>

8 This number is still in flux as state legislatures revisit earlier decisions. The most up to date information is available at <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#>.

9 For more information on eligibility based upon Federal Poverty Limits and State Medicaid programs, please visit: <http://obamacarefacts.com/obamacare-subsidies.php>

10 For information about how to calculate subsidies, please visit Kaiser Health Facts at <http://kff.org/interactive/subsidy-calculator/>



need to select a primary care provider and be subject to referral and prior authorization protocols to obtain care. In a managed care organization, the cost and quality of care is managed via a restricted network, permitting members to only receive care with a relatively small set of providers. Some states, such as California, have required that all Medicaid beneficiaries be members of a managed care organization. This mandatory Medicaid managed care trend has been growing for several years and is expected to continue to expand to more states for both the traditional Medicaid and the expansion population.

The Medicaid ACO is the newest construct that has emerged as a vehicle for Medicaid expansion. In a Medicaid ACO, Medicaid beneficiaries are assigned to a system of providers who are responsible for managing the quality and cost of care for their patients (total medical expense). Patients are allowed to use a wide array of providers from which to receive services and it is the ACO's responsibility to coordinate care across care settings. To be effective, ACOs will need to include or affiliate with providers that cover the full spectrum of care and develop the incentives and technology to enable collaborative work across this spectrum.

Lastly, some states are developing a hybrid model frequently referred to as the "private option model." In this model, states elect to expand Medicaid and use the federal funding to help beneficiaries buy insurance coverage on the health insurance marketplaces. This model is intended to expand coverage for low-income beneficiaries while encouraging market competition and reducing financial commitments at the state level. It is important to remember that in the Private Option model, enrollees retain all normal Medicaid benefits such as guaranteed access to Federally Qualified Health Center (FQHC) services. Likewise, FQHCs are entitled to Prospective Payment System reimbursement for services provided to this population.

As stated above, a large fraction of Medicaid's enrolled population qualifies through low-income eligibility standards. As members' income fluctuates they may no longer qualify for Medicaid. This presents a health management challenge as members can move on and off of insurance plans and no longer be eligible for care at their provider of choice. Providers in states with expanded income eligibility will experience less of this patient churn, but states with more limited programs may not see the cost and quality benefits associated with medical management as their neighbors.

Health Insurance Marketplaces

The health insurance marketplaces are regulated insurance marketplaces where individuals can independently shop for health insurance. The insurance plans offered on each state marketplace are tightly regulated and must fit into one of 4 different cost categories – bronze, silver, gold, and platinum. The intent of these marketplaces is to offer standardized private insurance options to families and individuals who do not qualify for Medicaid because they make too much money, but are not offered insurance through an employer. Individuals and families

making between 100% and 400% FPL will be entitled to federal subsidies to offset the cost of these plans.

The marketplaces also enforce minimum requirements so consumers can be certain that they are purchasing a high quality product. The cost categories are intended to increase competition in the health insurance market by allowing consumers to compare similar products to make an educated purchase decision.

In order to sell insurance plans on the marketplace, the product must first meet an array of requirements and be certified as a Qualified Health Plan (QHP). These requirements make sure that all marketplace plans meet a minimum set of benefits, have adequate access to providers in a region, and are not prohibitively expensive.

For 2015, all plans must provide access to at least 30% of Essential Community Providers (ECPs) in a plan's service area, of which Health Centers are one type. QHPs will be required to pay Health Centers based on PPS rates, except for cases where an alternative rate that is equal to or greater than the PPS rate is agreed to.

Further, QHPs must pay at least the PPS rate to Health Centers even if they do not specifically contract with the Health Center, i.e. the Health Center is "out of network". However, in these situations enrollees may be responsible for a significant cost share that they may not be able to afford. Further the QHP may not readily reimburse the difference to the Health Center that provided these out of network services. Finally, it is important to note that marketplace enrollees are not guaranteed access to FQHC services.

The responsibility for overseeing the marketplaces rests with different parties depending on the specific decisions of the state. Seventeen states elected to build and run their own marketplaces (state-based marketplace). These states can create additional requirements that must be met in order to sell insurance on their marketplaces. Seven states elected to run a hybrid state-federal exchange where some responsibility lies with each party (state-partnership marketplace). Twenty-seven states opted to have the Federal Government set up and run their exchange (federally-facilitated marketplace). In this case, the Federal Government is responsible for vetting individual insurance products and managing the enrollment process.

The creation of the health insurance marketplaces under the ACA opened up space for new entrants in the health insurance market. Insurance co-ops have sprung up in some regions, creating non-profit, member-owned competition for commercial insurers in the area. Insurers that have traditionally been focused on the Medicaid market have also entered into the commercial world via the state marketplaces. Since prices are tightly regulated in these markets, insurers are forced to compete on other aspects of their product. The inability to quickly raise prices also requires tighter management of patient costs via a variety of mechanisms such as managed care, narrow, and tiered networks.



THE ACA'S IMPACT ON THE BUSINESS OF HEALTH CENTERS

Health Centers have provided comprehensive health care services to vulnerable populations and communities in America for nearly five decades. While the ACA will provide new insurance and health care provider options to these populations, the range of services delivered by Health Centers will still remain vital to the overall health of these people. Health Centers will therefore need to develop plans to retain these patients while attracting new patients who have not historically received their care from Health Centers.

States that opted to expand Medicaid will see a larger shift in their payer mix as more patients are eligible for government coverage or subsidies for commercial coverage. States that have not elected to expand Medicaid will see a shift in payer mix, but not the same scale as the prior group. The business impact to Health Centers in both state-based scenarios is discussed below.

Changes in States That Elected to Expand Medicaid

Shifting Patient Populations

The ACA has the opportunity to both positively and negatively impact Health Centers. Large shifts in the number of insured patients and health plans in the market could be seen in some states, requiring Health Centers to build new relationships with payers to have access to this group of patients. Reimbursement and contracting practices will also change with the influx of managed care. Primary Care clinics will play a major role in managing a population of patients within a larger health system as payers and providers work together to manage costs. While daunting, each change presents an opportunity for Health Centers to demonstrate their value in the larger system.

The ACA represents a large shift in the number of patients and payers available to Health Centers. More people will become eligible for Medicaid in states that elected to expand the program, and more patients will be able to afford commercial coverage via the health insurance marketplaces. This shift in payer mix will also drive a shift in reimbursement. More revenue will come from commercial insurers. This move away from categorical funding to revenue based on medical activity and caring for the population will require Health Centers to revisit their administrative practices to ensure efficient operation. These new practices may take the form of care management services to guide the transition of care between settings, or enhanced coding and billing support to maximize revenue from commercial payers.

Managed Care Expansion

Medicaid Managed Care is expected to grow in prevalence as well, as states protect themselves against greatly increased Medicaid expenditures. Managed care plans will seek out care providers in rural areas where they have not previously had to contract. Managed care products function differently than fee-for-service products, requiring much closer relationships

with payers as they play an active role in deciding what care is appropriate for a patient. Prior authorization will be required for high cost services and Health Centers may wish to develop denials management teams to mitigate against non-payment for services after they are rendered.

Managed care companies frequently make use of tiered or “narrow networks” to steer patients away from high-cost providers. Clinics that provide primary care can also be high-cost if they are associated with or frequently refer into high-cost secondary and tertiary care providers. In an increasingly managed care world, high value primary care clinics are those who can provide services that are broader than traditional medical services and can manage patients across the care continuum. As a result, Health Centers must not only provide efficient quality care, they need to position themselves with specialists and hospitals providing similarly focused services.

States That Did Not Elect to Expand Medicaid

Even in states that opted out of Medicaid expansion, Americans who were eligible for the program but not previously aware of their eligibility are also expected to sign up in high numbers. While these new beneficiaries will not be the same in number as those that could have received coverage if Medicaid was expanded, they are expected to be meaningful in number. Medicaid Managed Care is likely to grow in these states as well, though potentially to a smaller degree than in other locations. Barring any political roadblocks, these states should still expect to see some patients receive insurance coverage via the health insurance marketplaces.

As noted earlier, patients between the state Medicaid eligibility cutoff and 100%¹¹ of FPL will not be able to obtain subsidies on the health insurance marketplaces and will have a harder time finding and affording coverage. While the overall proportion of patients receiving coverage will be lower than in states that elected to expand Medicaid, the same marketplaces will be in play, but with a lower intensity. These patients will likely be an area of focus for Health Centers in future community needs assessments and health planning.

Primary Care Positioning

Under both scenarios, primary care will become the new nexus of managed care. As insurers seek to manage a population's healthcare costs, they will seek to partner with primary care providers who can deliver quality care for patients without referring to higher cost providers.

In some types of risk arrangements, patient populations are defined by their primary care provider. Affiliating with primary care providers will become a prominent network growth strategy

¹¹ For more information on ACA subsidies please go to: <http://obamacarefacts.com/obamacare-subsidies.php>



as health systems seek to expand their patient base to minimize risk. Primary care providers including Health Centers will be expected to provide care management services for classic chronic diseases, but will also be asked to expand this type of management into mental health, substance use, care transitions between organizations, and other areas. For patients that do require more specialized care, these primary care providers will be incentivized to keep these patients in network where cost and quality can be managed at institutions using similar IT systems with similar incentives to work in a collaborative fashion.

Health Centers are uniquely positioned to take advantage of these shifts in the role of primary care. Health Centers have been caring for Medicaid and uninsured populations for years. They are focused on being more than providers of medical services and offer healthcare for the entire community.

The Health Center Program in recent years has focused significant resources into information technology through Health Center Controlled Networks as well as building Patient Centered Medical Home infrastructure to receive state and national accreditation. In managed care, the population of focus is not the community but the set of patients in a given insurance

product. Despite this difference, many of the competencies and resources developed by Health Centers can drive strong performance for insurers; and in the world of shared risk and responsibility, Health Centers should be well positioned to benefit financially from partnering with other organizations.

Partnering with other care providers and managed care plans will become a highly valuable competency for Health Centers moving forward; those who can prove their ability to deliver on care management programs will be strongly considered for potential partnerships. These organizations will need to develop ways to prove their value and strategies to partner with other providers and insurers in their region to form organizations capable of managing the care of a defined population of patients. Organizations that successfully undergo this type of transformation will find new opportunities to serve their patient base in a coordinated, effective fashion that minimizes cost and maximizes quality.



NEW COMPETENCIES REQUIRED FOR HEALTH CENTER SUCCESS

In order to successfully transform their organization, Health Centers will need to develop a set of competencies to allow them to partner with other care providers and health insurers. Clearly the ACA aims to change the reimbursement mechanisms from volume to value. Commercial payers have quickly followed this lead and are moving forward with even more innovative models. Health Centers not willing to embrace this change may quickly find themselves in a position where they can no longer compete for patients that had previously been theirs.

Contracting with Health Plans

Contracting with commercial insurers will require Health Centers to develop a range of skills that many do not currently possess. Health Centers will need to be able to predict the number of patients they will see from a particular insurer and demonstrate their cost and quality performance relative to other primary care providers in their region. Contract negotiations are long, data-driven processes where providers with large patient volumes from a given insurer derive leverage. In the world of managed care, providers that can demonstrate high quality while keeping costs low will be particularly attractive contracting partners. Health Centers will need to be able to predict the number of patients they will see from an insurer post-reform and be able to show their quality and cost performance compared to other providers in their region.

Revenue Cycle Management

Providers with experience with commercial insurers acknowledge the need for tight revenue cycle management. Medical billing is a massive industry on its own. Coding rules change on a regular basis and coders must hit a sweet spot with their determinations. Codes on claims should be reflective of appropriate clinical documentation and support effective and appropriate billing practices. Unfortunately, because Health Centers have traditionally billed through encounter-based billing mechanism, coding has traditionally been an area of operational weakness for many.

Commercial insurers also use a complex set of rules that vary from insurer to insurer that dictate what charges will and will not be paid for a claim, how soon a claim must be submitted after the date of service, and how claim denials must be appealed. Health Centers will need to develop capacities in this area in order to maintain cash flow as their patients move into commercial products and as they contract with a wider range of commercial payers in new arrangements.

Benchmarking and Quality Reporting

Accurate benchmarking and quality reporting will be vital in this new scenario. Using comparison data in contracting negotiations requires accurate data and collection methodologies across multiple organizations. Benchmarking against industry standards and local performance can not only provide leverage in negotiations but can also enable managerial decisions to provide better patient care in between negotiations as well as drive effective clinical quality improvement strategies.

Managing Total Medical Expense

Providers of all types will be asked to jointly manage the total medical expense of their patients with insurers. In order to create strong benchmarking and reporting, complex risk adjustment methodology must be applied to generate “apples-to-apples” comparisons. These adjustments also allow managers to compare current performance to that of a prior year and isolate “hot spots” of expense growth that require intervention. Total medical expense, by definition, includes the cost of care provided by or at multiple organizations. The more these organizations are included in an organized health system, the more data they have and the more closely they can manage quality and costs.

Integration and Use of Health IT

High functioning Information Technology (IT) is important within one organization in their current healthcare delivery system. It will become much more important as care providers band together to form larger organizations. This IT must enable both managerial and clinical activity. Provider groups will need to be able to reliably receive and analyze large claim sets from payers to actively manage total medical expense. Once a program to decrease total medical expense is designed, clinical data will need to be passed between previously segmented organizations so specialty care providers can access patient data generated by the primary care providers, and care managers can have secured communications with caregivers in the post-acute setting.



WHERE CAN HEALTH CENTERS GO TO GET HELP?

These are times of great change and growth for Health Centers and this has led to support and resource development targeted at helping Health Centers maximize their effectiveness and efficiencies in this new environment. Health Centers can access resources and knowledge from several different organizations as they try to transform the way they deliver care.

The National Association of Community Health Centers (NACHC) advocates for community health centers and provides education to their staff and boards on policy changes in the field. They also issue white papers to provide in deeper information on specific topics. More information on NACHC is available at nachc.com.

The Bureau for Primary Health Care (BPHC) is a division of the Health Resources and Services Administration (HRSA) that oversees the health center program, provides technical assistance on the requirements of the program, and aggregates data to describe the activities of its participants. A set of requirements, tools and FAQs is available at their website, bphc.hrsa.gov.

State specific primary care associations (PCAs) also provide technical assistance, policy support, and other services to member health centers at the local level. The range of services differs by state, but many can provide guidance on more tactical components of operational and clinical improvement for health centers. A state-by-state list of PCAs is available from the BPHC at bphc.hrsa.gov/technicalassistance/partnerlinks/associations.html.

State insurance commissioners can provide more detailed information on insurance reform itself. A listing of insurance commissioners is available from the National Association of Insurance Commissioners' website, naic.org.

Health Resources and Services Administration fund a number of organizations through the National Cooperative Agreements. These organization work with specific populations such as the homeless, elderly, LGBT community, farm workers, Health Centers and others. These organizations provide a number of training and technical assistance resources that may be of assistance. A list of these organizations and links to their websites can also be accessed through BPHC at bphc.hrsa.gov.



