

Guiding Principles for a Collaborative Response to Provide Health Coverage for Uninsured Adults with Limited Incomes in Durham County

We believe that everyone should have access to an affordable range of health care services. We believe that federal and state programs should address the growing needs of the uninsured. However, until these programs are created, we should respond to the needs of the uninsured at the local level. We have identified that:

- The number and percentage of Durham County residents lacking health insurance (including Medicaid or Medicare) continues to grow;
- Lincoln Community Health Center faces significant challenges in meeting this need;
- Specialty medical care* remains difficult to access for the uninsured; uninsured residents do not have the full range of essential health services;
- Charity and uncompensated care amounts continue to increase for local hospitals.

These principles and observations do not constitute a plan for such a response, but serve as a guide for creating a collaborative, local plan:

1. Providing emergency care is required by law and professional ethics. Non-emergent care that is delivered in the emergency department is very expensive, poorly coordinated care that is extremely inefficient and leaves many residents of Durham County without the health care they need.
2. No single entity bears the sole responsibility of financing the cost of care for the uninsured. Health care providers and institutions, local, state and federal government, local employers, insurance companies, philanthropy and the patients themselves ought to share this responsibility.
3. Our plan should build upon, not weaken, the existing health care safety net, including Lincoln Community Health Center and its affiliated and satellite clinics.
4. Our plan should focus on financing and delivering a range of services for uninsured adults ages 19-64 in Durham County with limited incomes (family income at or below 200% of the federal poverty level).
5. Our plan might include a role for small businesses that are unable to afford group health coverage and have lower wage, uninsured employees. However, a solely employer-based benefit may not be the best option.
6. Our plan should include: preventive, primary and specialty care, behavioral health services, laboratory, pathology, and radiology services, surgery, hospitalization, emergency services and pharmacy services.
7. Our plan should be delivered through models that control costs and improve health by using a network of local providers and institutions with a medical home for each patient, promoting preventive health services and managing chronic conditions and illness.

* Specialty care: Services provided by medical specialists, such as cardiologists and dermatologists, who generally do not have first contact with patients

Note: These documents (and a more detailed discussion of the six options), and a glossary of terms are available at www.healthydurham.org or you can call (919)560-7833 to reach the office of the Partnership for a Healthy Durham.

8. Health care must include help for patients to navigate and use services from participating health care providers and institutions. Depending on patient needs, such services might include transportation assistance, patient education and translation assistance for non-English speakers.
9. It is not reasonable or sustainable to ask health care providers and institutions to provide more charity or uncompensated care than what they are currently offering as the sole solution. Nonetheless, health care providers and institutions ought to be willing to accept discounted rates and, wherever possible, offer free care for qualified individuals.
10. A solution to increasing health coverage for the uninsured should include avenues for resident and small business participation in the design to ensure that it will meet resident and small business needs.
11. A solution should be:
 - a. Efficient (make the best use of resources)
 - b. Equitable (fair or proportionate sharing of resources and burdens based on financial capability)
 - c. User-friendly (addressing patient perspectives concerning freedom, stigma and satisfaction with care)
 - d. Feasible over the long term.

Options for Increasing Access to Care for Uninsured Adults with Limited Incomes in Durham County

The models below are being explored for local use, alone or in combination. In addition to the options listed, other ways to improve care for the uninsured might include expanding pharmacy services, care management, and the availability of electronic medical records.

Option 1: Lincoln Community Health Center's Network Enhancement

This would expand and/or better coordinate services for the uninsured in an effort to strengthen the local health care safety net. As a federally qualified healthcare facility, Lincoln CHC receives favorable reimbursement rates from Medicaid and Medicare and other beneficial pricing contracts (e.g. for medications). However, 82% of current patients do not have insurance (public or private). Expansion could literally mean physical expansion or using existing space in different ways. This expansion could increase that availability of primary care and/or specialty care.

Weaknesses: Some individuals may feel labeled (stigma) when using this centralized system of care. Employers may not support this focal point of care and community providers cannot partner as easily to provide care. Offers no coverage for hospitalizations.

Option 2: Free Clinic

This is an organized set of health care services offered by volunteer health care professionals. A free clinic may be a stand-alone, permanent facility operated by a non-profit organization, or it may operate out of an existing facility (such as a hospital or private clinic, or a health department) during evening and weekend hours. Free clinics focus on short-term health needs and primary care. Free clinics may offer pharmacy services, health education, case management, specialty medical care, vision care or dental services. Free clinics are staffed mostly by volunteers, but typically have paid support and administrative staff.

Weaknesses: Requires a large and continuing contribution from local health professionals. Relationships between patients and providers may be difficult to establish with rotating volunteers. Institutional support for administration and logistics is needed, and clinical services are usually available after hours. Separate coverage would be needed for medications, specialty care (especially medical procedures), and for hospitalizations.

Option 3: Project Access

This model allows health care professionals to donate in-kind support of the established "safety net" within their own office and schedule. Contributed professional time is efficient, since primary and specialty care occurs in its usual setting. Project Access is usually organized and run by a local medical society. Participating providers make a commitment to accept a certain number of referrals each year. Local hospitals typically make their own commitments for free services (inpatient, laboratory and radiology) for Project Access patients.

Weaknesses: Creating a medical home and continuity of care could be challenging depending upon provider participation. If this is the only option, it may overload participating providers. In Durham,

the largest provider network and the medical society are separate entities with limited history of collaboration or overlapping membership. Offers no coverage for hospitalizations or medications.

Option 4: Express Clinics

This option to create a network of “mini-clinics,” some possibly housed in less traditional community-based settings, would seek to increase availability of less intensive care while reducing overall medical costs. These clinics would be staffed predominantly by Nurse Practitioners and Physician Assistants. Express clinics would provide a limited array of preventive care and chronic illness care/monitoring. To be effective, these clinics would be connected by an electronic medical records system with an entity such as Lincoln.

Weaknesses: Innovative but has not been tried yet. Data systems are not yet linked. Professional and public education about its limitations would be required. Specialty care, medications, and hospital needs are not addressed.

Option 5: Community Health Plan

Community health plans (CHPs) provide coverage for a variety of benefits that are similar to commercial insurance. Regional institutions (employers, insurers, county government, and healthcare institutions) all contribute to a centralized plan (nicknamed “4-Share”). Patients themselves also contribute. CHPs try to manage care in order to help control costs. However, CHPs are not insurance products – they are exempt from state regulations. As such, they do not guarantee coverage of services for enrollees as they depend on annual budgets.

Weaknesses: Unlike insurance with a financial guarantee, Community health plans can only enroll members and support care while its specified funding is still available. Prior to starting, requires agreement by all funding parties and regulatory changes.

Option 6: Modified Private Insurance

Some insurance companies have developed insurance products that target uninsured individuals. To qualify, an individual must not have had health insurance for a certain amount of time (six to twelve months), not have access to a group health plan through their employer, and have family income below a certain amount. Four categories exist: Managed care, Low- and High-deductible plans (covering a wide range of services at different levels of individual cost-sharing); and Catastrophic-only plans (covering hospitalization and surgery after a large annual deductible). The managed care plan may have restrictions, such as limiting office visits. The high deductible plans can include a few preventive services and be coupled with a tax-free health savings account. Enrollees pay premiums, co-pays, deductibles and co-insurance like other plans, yet premiums are discounted. Participating providers and institutions may accept below market reimbursements rates. In essence, the “4-Share” model of funding can be applied to providing private insurance.

Some definitions
<u>Premium</u> : what an individual must pay (usually monthly) to participate in a plan
<u>Co-pay</u> : set fee an individual pays for care
<u>Co-insurance</u> : percentage of a fee that an individual pays for care
<u>Deductible</u> : costs an individual must pay before health care is provided (usually annually)
<u>High- and low-deductible plans</u> : cover a wide variety of medical services after the individual pays their deductible
<u>Catastrophic plan</u> : cover hospitalization and surgery after the individual pays a large deductible
<u>Managed care</u> : controls costs by offering a network of providers and reviewing the medical necessity of care

Weaknesses: Depending upon benefit design, there may be limitations on what services are provided. Stakeholder negotiations would be critical.