

**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.

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**Option 1: Enhancement of Lincoln Community Health Center’s Network**

This category refers to communities that have engaged in collaborative efforts among health care providers to 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 also increase that availability of primary care and/or specialty care. These expansion activities are typically funded by foundation grants and certain federal programs, such as the “Health Communities Access Program” of the federal Bureau of Primary Care (though the future of this program is in great doubt – it was de-funded by Congress in FY 2006).

<b>Pros</b>	<b>Cons</b>
<ul style="list-style-type: none"> <li>▪ Efficient use of existing resources</li> <li>▪ Simple way to introduce more specialty care into existing safety net providers</li> <li>▪ One-stop delivery of care – reduces problems of transportation, knowing how to use unfamiliar health care resources</li> <li>▪ Builds on well known and trusted sources of care for the uninsured and medically underserved</li> <li>▪ Safety net providers such as Lincoln Community Health Center are already aware of and responsive to the needs of the uninsured and medically underserved</li> </ul>	<ul style="list-style-type: none"> <li>▪ May be difficult for existing safety net providers such as Lincoln Community Health Center to recruit physician specialists</li> <li>▪ Expanded services at Lincoln Community Health Center may require physical plant expansion and significant capital expenditures for specialty-related medical equipment and supplies</li> <li>▪ Unlikely to get small businesses to help share financial costs of expansion (i.e. not tied to an employee benefit)</li> <li>▪ Further segments care for the uninsured – no opportunity for non-safety net providers to participate in a solution</li> <li>▪ Some individuals may feel labeled (stigma) when using this centralized system of care.</li> <li>▪ Does not address the lack of coverage for emergency and inpatient care</li> </ul>

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**Option 2: Free Clinic**

A free clinic is an organized set of health care services offered mostly by volunteer health care professionals to persons who have no health insurance and cannot afford to pay for their health care. A free clinic may be a stand-alone, permanent clinical facility operated by a non-profit organization, or it may operate out of an existing facility during evening and weekend hours, such as a hospital outpatient clinic or a health department. Free clinics focus on short term health needs and primary care. Free clinics may offer pharmacy services (including on-site licensed pharmacies), health education, case management, specialty medical care, vision care and dental services. Free clinics are staffed mostly by volunteer health care providers, but typically have paid support and administrative staff.

<b>Pros</b>	<b>Cons</b>
<ul style="list-style-type: none"> <li>▪ Cost efficient – can make use of existing facilities such as Lincoln Community Health Center, Durham Regional or a community-based private clinic</li> <li>▪ State and Federal statutes offer malpractice coverage or protection for physicians and other health professionals who volunteer their services, i.e. Federal Torts Claims Act Coverage of Free Clinic Volunteer Health Care Professionals</li> <li>▪ Funding needed only for free clinic administrative and support operations, not for provider reimbursement</li> <li>▪ Clear mission and value to the community drives local support</li> <li>▪ Evening hours make care accessible to many day time workers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Local physicians or clinic/practice lawyers may be unaware of free clinic malpractice protections</li> <li>▪ Unclear whether Duke-affiliated physicians are encouraged or allowed to offer free care outside of Duke University Health System (DUHS) facilities</li> <li>▪ Specialists not as comfortable or effective in an outside facility – away from customary equipment, supplies, etc.</li> <li>▪ Free clinics generally do not offer specialty medical care</li> <li>▪ Recruiting and retaining professional health care volunteers can be challenging</li> <li>▪ Continuity of care may suffer – patients with chronic conditions often do not see same provider</li> <li>▪ North Carolina Association of Free Clinics has been unsuccessful in facilitating the opening of a free clinic in Durham County</li> <li>▪ Ensuring access to affordable prescription medications can be challenging without a dedicated prescription assistance program or on site pharmacy</li> <li>▪ Does not address the lack of coverage for emergency and inpatient care</li> </ul>

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**Option 3: Project Access**

Project Access is a way for health care providers in a community to organize and deliver a coordinated system of free care to persons who have no health insurance and cannot afford to pay for their health care. 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 as a physician-led initiative. Participating physicians make a commitment to see a certain number of uninsured patients or accept a certain number of referrals each year. Project Access uses a “fair share” principle in organizing these commitments, wherein each physician agrees to help out so that care for the uninsured is distributed evenly through the local health care system. Local hospitals typically make their own commitments for free services (inpatient, laboratory and radiology) for Project Access patients, either as a capped dollar value (charge or cost) of services or as an unlimited amount. Project Access initiatives vary in terms of whether and how they help patients obtain prescription medications and whether or not they are focused on primary care and or specialty access.

<b>Pros</b>	<b>Cons</b>
<ul style="list-style-type: none"> <li>▪ Physicians able to practice in their own clinic, where they are most comfortable and well equipped</li> <li>▪ Funding needed only for administrative and support operations, not for provider reimbursement</li> <li>▪ Gives professional associations of physicians a way to give back to the community and a way to be recognized for charitable efforts</li> <li>▪ Addresses the issue of a lack of access to specialty care among uninsured</li> <li>▪ Utilizes “fair share” principles to ensure that physicians share responsibility to care for the uninsured</li> <li>▪ Primary care providers can see more patients once the specialty referral system is in place, because they no longer have to manage repeat visits of patients with chronic conditions that could more appropriately be cared for by a specialist. This creates more primary care capacity.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Unclear whether Duke-affiliated physicians could make their own free care commitments or would need departmental, practice or institutional approval</li> <li>▪ No current physician association champion for Project Access in Durham</li> <li>▪ Ability and/or willingness of physicians to donate care is vulnerable to changes in third party reimbursement and other market forces and conditions – not a sustainable solution</li> <li>▪ Getting physicians to donate their time means that the practice or clinic donates its overhead allocated to the care of the uninsured, which may not be financially viable for some practices or clinics</li> <li>▪ Need a broad network of participating physicians, especially if primary care is offered</li> <li>▪ Increased patient load may affect medical malpractice coverage without any compensation (no coverage under Federal Torts Claims Act)</li> <li>▪ Ensuring access to affordable prescription medications can be challenging without a dedicated prescription assistance program</li> <li>▪ Does not address the lack of coverage for emergency and inpatient care</li> </ul>

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**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 who would be working under a physician-approved and supervised protocol. 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, and complemented by some arrangement for specialty care, pharmacy, laboratory and radiology, and/or care management. Probably would require a great deal of patient education, selection, and support mechanisms such as 24-hour telephone triage to ensure appropriate use.

<b>Pros</b>	<b>Cons</b>
<ul style="list-style-type: none"> <li>▪ Possibly make use of donated space in existing facilities such as the Department of Health, Latino Community Credit Union, Emily K Family Center</li> <li>▪ Sitting ‘clinics’ in nontraditional community-based sites such as the ones above could make them more accessible</li> <li>▪ Could adapt the focus/expertise/hours to the needs of particular population served by a particular site (eg. school-based clinics)</li> <li>▪ Transformative – can have separate express care mini-clinics that use advanced access principles, and more traditional clinics with scheduled visits specifically for chronic care</li> <li>▪ The clinics might relieve some of the pressures on existing safety net providers and emergency departments (EDs), particularly by redirecting less-urgent acute complaints to more</li> </ul>	<ul style="list-style-type: none"> <li>▪ These clinics would not offer full-service primary care</li> <li>▪ Separate arrangements for higher level lab work, radiology would be needed</li> <li>▪ Would require unified electronic medical record to be effective Likely more confusing to consumers and providers than the other options and would require significant education</li> <li>▪ EMTALA – unclear if emergency departments could legally send non-emergent patients to these clinics instead, but it is being done to some extent in Wake County with the Open Door Clinic</li> <li>▪ Does not address the lack of coverage for specialty care, emergency and inpatient care</li> </ul>

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**Option 5: Community Health Plan**

Community health plans (CHPs) represent a novel way to finance and deliver health care for lower-income uninsured residents in a community. Regional institutions (employers, insurers, county government, and healthcare institutions) all contribute to a centralized plan (nicknamed “4-Share”). Patients themselves also contribute. CHPs provide coverage for a variety of benefits that closely mimic commercial plans – outpatient preventive, primary and specialty medical care, inpatient care, emergency services, radiology, etc.

CHPs can be financed in a variety of ways. In Hillsborough County, Florida, for example, a CHP is financed primarily by a half-cent sales tax. In Jacksonville, Florida, the JaxCare program is financed with a mix of public and private dollars including local, state and federal government, participating employers, foundations, and patients themselves, who pay modest monthly premiums. Like other CHPs, JaxCare also relies on physicians in its network that agree to accept below market reimbursement rates and hospitals that donate inpatient care. In some instances, hospitals participating in CHPs have received approval from state and federal government to re-direct Disproportionate Share Hospitals (DSH) Medicaid and Medicare payments into CHPs in an attempt to finance care at the “front end” – to offer access to care in earlier, less expensive stages.

CHPs use managed care delivery models and principles to control costs – chronic disease management protocols, provider networks, specialty referral gate keeping, health education, etc. However, CHPs are not insurance products – they are exempt from state regulations concerning solvency and mandatory coverage requirements. As such, they do not guarantee coverage of services for enrollees as they depend on annual budgets, not actuarial reserves. Exemption from insurance regulations required passage of a new state law in both Florida and Michigan where CHPs exist.

<b>Pros</b>	<b>Cons</b>
<ul style="list-style-type: none"> <li>▪ Numerous examples from other communities about how to create feasible cost-sharing arrangements among local, state and federal government, insurance providers, health care providers, businesses and patients</li> <li>▪ Plans offer a menu of benefits similar to commercial insurance plans</li> <li>▪ Provides small businesses unable to afford group plans a way to help cover their employees</li> <li>▪ Offers a sustainable approach to increasing health coverage for the uninsured by providing acceptable reimbursement to providers</li> <li>▪ Potential to reduce uncompensated care costs incurred by Duke and Durham Regional Hospitals</li> <li>▪ Potential to relieve some demand for services at Lincoln Community Health Center</li> <li>▪ If Lincoln Community Health Center were part of the provider network, negotiated contracts</li> </ul>	<ul style="list-style-type: none"> <li>▪ State legislation is probably needed to allow a community health plan to exist outside of state insurance regulations concerning mandatory coverage policies and solvency requirements</li> <li>▪ May require new local government revenue source to help finance</li> <li>▪ Developing a community health plan product can be a lengthy and complicated process to reach cost-sharing agreements, develop a provider network and adequately market to local businesses and individuals</li> <li>▪ Potential risk for Lincoln Community Health Center to lose patients now with health coverage to participating providers in a community health plan, leaving an even greater proportion of uninsured patients</li> </ul>

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<b>Pros</b>	<b>Cons</b>
<p>could increase revenue for care delivered to covered patients who retained Lincoln as their provider</p> <ul style="list-style-type: none"><li>▪ Plan can contain several cost containment strategies similar to managed care plans</li><li>▪ Plan can be marketed in a similar fashion as insurance products to attract enrollees</li><li>▪ Not charity – enrollees have to pay premiums and co-payments</li></ul>	<ul style="list-style-type: none"><li>▪ No guarantee of coverage – finite amount of dollars financing care vs. reserve funds of insurance companies</li></ul>

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**Option 6: Modified Private Insurance**

Some insurance companies have developed managed care plans that target uninsured individuals who cannot afford premiums for their individual plans. 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 (a percentage of federal poverty guidelines). 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 an annual deductible). 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.

A managed care plan may have restrictions, such as Blue Cross and Blue Shield of Kansas’ Value Blue plan, which limits office visits to five per benefit period. Another managed care example is First Plan, offered by FirstCarolinaCare, Inc., a plan affiliated with First Health Carolinas, a non-profit health system. First Plan is tailored to the needs of small businesses that cannot afford commercial group plans and includes subsidies for lower wage workers, paid for by FirstCarolinaCare and by outside grants and discounted reimbursement rates.

<b>Pros</b>	<b>Cons</b>
<ul style="list-style-type: none"> <li>▪ Insurance companies can create more affordable products by working with health care providers to accept lower reimbursement rates to target plans to the uninsured</li> <li>▪ The most sustainable option of all if funding available – an insurance product to provide coverage – not donation of care or payment for care with finite resources</li> <li>▪ High deductible individual plans coupled with health savings accounts (HSAs) could provide small businesses with a more affordable way to contribute toward employees’ health care costs through matching account contributions</li> <li>▪ No stigma because not considered a “hand out”</li> <li>▪ Can add preventive services to a basic package of health care services</li> <li>▪ If Lincoln Community Health Center were part of the provider network, negotiated contracts could increase revenue for care delivered to covered patients who retained Lincoln as their provider</li> </ul>	<ul style="list-style-type: none"> <li>▪ Response is completely up to private insurance companies, which thus far have shown no inclination to offer affordable individual health plans (i.e. market has not responded)</li> <li>▪ Blue Cross Blue Shield unlikely to offer discounted plan(s) since they must accept pre-existing medical conditions</li> <li>▪ High deductible plans coupled with a Health Savings Account:               <ul style="list-style-type: none"> <li>➢ Considerable consumer education would be necessary</li> <li>➢ Persons most likely to participate because of premium affordability will be the younger and healthier uninsured who need care the least</li> <li>➢ even if premiums were affordable, many lower-income persons may not have sufficient income to pay deductibles beyond what their employers contribute to their HSA</li> <li>➢ some provider require that patients pay for medical expenses up front and then file for reimbursement later</li> </ul> </li> </ul>