CHCS Center for Health Care Strategies, Inc.

Policy Brief

Impact of the Affordable Care Act on Charity Care Programs

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Charity care programs (CCPs) have long played a critical role in the health care safety net – providing access to low- or no-cost health care for individuals without access to affordable health insurance due to eligibility or affordability barriers. CCPs connect the uninsured and underinsured to preventive and early treatment services to help reduce more expensive and acute care and ultimately improve long-term health outcomes and control costs.

These organizations operate on a state or regional basis, serving individuals who meet eligibility criteria that may incorporate: (1) income guidelines, with limits ranging from 100 to 500 percent of the federal poverty level (FPL); (2) residency/citizenship requirements; and/or (3) the ability to participate in cost-sharing via premiums and/or co-pays. Most CCPs are available only through direct consumer enrollment, though some use employer channels to reach employees who are either ineligible for or cannot afford to purchase employer-sponsored coverage.[1]

Business models and financing mechanisms vary both across and within CCPs. Funds are provided by a variety of sources, including: (1) member fees and copays; (2) employer contributions; (3) individual/ corporate/ philanthropic donors; (4) federal, state, and county sources; (5) provider subsidies; (6) sales tax levies; and (7) partnering health plans and health systems. In many cases, providers also subsidize these programs by discounting their services. CCPs are typically not insurance products, but use a variety of member cost-sharing mechanisms, including membership fees (some on a sliding scale, some shared by the individual and his or her employer). Also, they often require nominal service and prescription drug co-pays, and coinsurance payments.

State Medicaid Expansion Decisions and the Implications for CCPs

In June 2012, the U.S. Supreme Court ruled that the Medicaid expansion mandate of the Affordable Care Act (ACA), which threatened non-compliant states with the loss of all existing Medicaid funds, was unconstitutional.[2] This ruling made state participation in the Medicaid expansion optional by limiting the federal penalty to a loss of Medicaid expansion funding, instead of a state's entire Medicaid funding. Since the Court's decision, states have explored whether to expand Medicaid eligibility for legal residents up to 138 percent of the FPL, with implementation beginning in 2014. Although not all states have made their decision public, to date, 26 states[3] and Washington, DC, have stated their intention to participate in the expansion and 13 announced that they will not expand.

There is no federal deadline for states to declare their intentions; however, those expanding in later years will not benefit from the full (100%) federal match in the first three years (2014 through 2016) – an incentive to opt-in sooner.

IN BRIEF

Although up to 33 million individuals could still gain health coverage following full implementation of the Affordable Care Act in 2014, 23 million or more will remain uninsured. The need for charity care programs (CCPs) – which provide the uninsured with access to preventive, primary, and specialty care – will remain. These organizations must consider the implications of the size, health care needs, demographics, and expected utilization of the remaining uninsured population. This brief, informed by an affinity group of CCPs supported by Kaiser Permanente Community Benefit, examines options that CCPs are considering. These include: (1) serving as a consumer assister in their state's health insurance marketplace (formerly known as an insurance exchange); (2) operating in a marketplace as a Consumer-Operated and Oriented Plan (CO-OP); (3) continuing to provide the uninsured population in their regions with access to affordable care, albeit with program modifications; and/or (4) providing complementary services to those newly eligible for health insurance.

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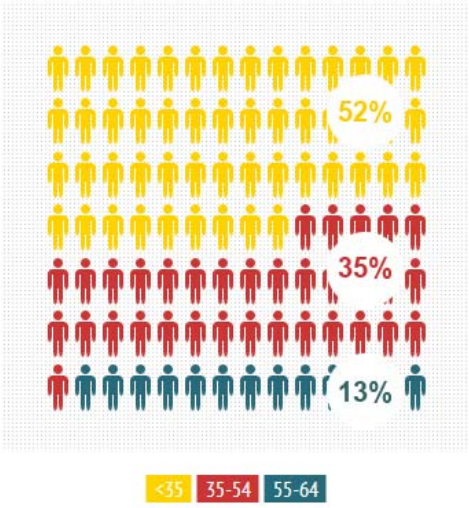
Exhibit 1: Age Distribution of Medicaid Expansion Population



SOURCE: *Opting in to the Medicaid Expansion under the ACA: Who are the Uninsured Adults Who Could Gain Health Insurance Coverage?* Urban Institute, August 2012.

Although the number of uninsured in 2014 and beyond unknown at this point, state decisions regarding Medicaid expansion will impact upwards of 21 million uninsured adults in that year. Of those, almost 12 million have incomes below 100 percent FPL and would not qualify for other ACA-based health coverage options if their state does not expand Medicaid. Many of these individuals will continue to depend on CCP options to meet health care needs.

Who would become eligible for Medicaid and who would remain uninsured?

Nationally, the uninsured are diverse in age and race/ethnicity. If states choose to expand Medicaid eligibility under the ACA, it is estimated that among the newly eligible:

- About half will be under age 35; 35 percent would be between the ages of 35 and 54; and over 10 percent between the ages of 55 and 64.[4]
- Just over half will be white, male, childless adults, although race and ethnicity estimates will likely vary greatly across states.
- There will be about 4.6 million women of reproductive age.[5]

Estimates of the uninsured population that will be newly eligible for coverage in individual states are expected to largely resemble national estimates.[6]

The Remaining Uninsured Post-ACA Implementation

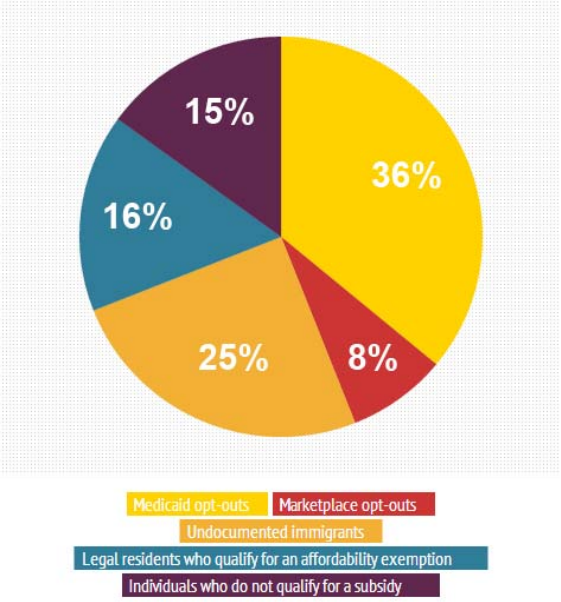
States have started to predict the demographics, size and health needs of their populations that are expected to remain uninsured in 2014. For example, California estimates that between three to four million individuals will remain uninsured; the majority of this population will be eligible for coverage through the state's insurance marketplace or Medicaid, but will remain uninsured for a variety of reasons[7] (e.g., affordability, reluctance to enroll in a public program). The remaining one million will be ineligible to receive coverage because of their immigration status.

National studies project that 23 million individuals will remain uninsured under the ACA; of those, 18.6 million are nonelderly adults.[8] Nonelderly uninsured adults will include:

1. ***Medicaid opt-outs:*** A group likely to remain uninsured includes individuals who become eligible for Medicaid but do not enroll, perhaps due to: inadequate outreach by the Medicaid program; their unfamiliarity with or disinclination to enroll in a government-sponsored program; or the perceived stigma of being a Medicaid beneficiary. It is expected that these Medicaid-eligible individuals -- mainly low-income, young single adults without dependents -- will compose roughly 36 percent of the uninsured.[9]

2. ***Marketplace opt-outs:*** Almost eight percent of the estimated remaining uninsured individuals would qualify for coverage in the marketplace, but will opt to not fulfill the requirements of the individual mandate. These individuals would be mostly younger (median age of 33) single adults without children (61 percent), with moderately low incomes (median 280 percent of FPL).[10]

Exhibit 2: Distribution of Remaining Uninsured Post-ACA



SOURCE: *M. Buettgens and M. Hall. Who Will Be Uninsured After Health Insurance Reform? The Robert Wood Johnson Foundation, March 2011.*

3. ***Undocumented immigrants:*** Undocumented immigrants would make up roughly 25 percent of the remaining uninsured. In 2007, this population accounted for one in seven of the uninsured, but going forward it will represent a larger proportion of the total uninsured population due to the overall decline in the uninsured.[11] More than half (54 percent) of families in this group will have incomes under 138 percent of FPL.[12]

4. ***Legal residents who qualify for an affordability exemption from the individual mandate:*** Legal residents of fewer than five years who are not eligible for Medicaid qualify to purchase coverage in a marketplace if their income is below 400 percent of the FPL and they do not have affordable coverage under their employer. Many of these individuals will be exempted from the individual mandate because the premiums associated with purchasing coverage will exceed eight percent of their family income. It is expected that 16 percent of legal residents will not have an affordable insurance option.[13]

5. ***Individuals who do not qualify for a subsidy:*** The remaining 15 percent would not qualify for a subsidy in the marketplace, but would have an affordable private insurance option. Those who do not qualify for subsidies would come from higher-income families.

6. ***Other uninsured exempt from the mandate for other reasons:*** Others who may be exempt from the individual mandate requirements include those with qualifying religious exemptions, those in a health care sharing ministry, and incarcerated individuals.[14]

Nationally, almost half of the remaining uninsured will be single adults with no dependents with median gross income of 130 percent of the FPL and median age of 37.[15] Although many will fit these demographics, it is expected that they will vary in individual states depending on geographic characteristics, rates of Medicaid uptake, and prevalence of specific populations.

CCPs at a Strategic Crossroads

Given the expected declines in the number of uninsured, and the shifting demographics of who will be in the remaining uninsured population, CCPs are at a strategic crossroads. These programs need to consider which populations they want to continue serving, and decide how their missions, delivery systems, and business models must correspondingly evolve.

This is not a simple task. To begin, it is unclear what the health care needs and utilization patterns of the remaining uninsured population will be. Individuals in this remaining uninsured subset will likely be harder to reach (i.e., enroll and subsequently engage in preventive care) if they are from populations with barriers related to language, culture, and immigration status. Variation is likely to exist among states in determining the magnitude of the uninsured populations, utilization patterns, and the health care needs of those without coverage.

Adding to the complexity of the challenges they will face, CCPs may also see a decline in available financial support. Because of potential shifts in federal funding, and a misperception that the ACA will eliminate the need for

Overview of the Charity Care Affinity Group

Given the absence of any membership association to connect CCPs across the country, Kaiser Permanente Community Benefit funded the Center for Health Care Strategies to lead an affinity group of CCPs to: (1) share best practices and address challenges in redefining program roles, delivery systems, and business models for serving the remaining uninsured population in 2014; (2) consider potential roles in their state's Medicaid programs (e.g., outreach) or insurance marketplaces (e.g., as navigators or CO-OP insurers); and (3) "build the case" for their continued existence in 2014 and beyond.

Members of the group are:

- Access to Healthcare Network, Nevada;
- CareLink, San Antonio, Texas;
- Healthy San Francisco, County and City of San Francisco;
- Ingham Health Plan, Ingham County, Michigan;
- Kaiser Charitable Health Coverage (CHC) Program, Northern and Southern California, Colorado, Georgia, Hawaii, Mid-Atlantic states, Northwest, and Ohio;
- Portico Healthnet, Dakota, Hennepin, Ramsey, and Washington Counties, Minnesota;
- Project Access, Buncombe County, North Carolina; and
- Seton Care Plus, Austin, Texas.

Of the states in which the affinity group's eight CCPs operate, four -- California, Nevada, Michigan and Minnesota -- have opted to expand Medicaid, although some of them face legislative opposition.

charity care, especially in states that decide to expand, many CCPs face the possibility of losing important sources of donations and other philanthropic financing. Programs that receive state funding might see reductions in these dollars post-2014, especially in expansion states, where the uninsured population will shrink. Federal changes in Disproportionate Share Hospital (DSH) payments, which reflect the volume of uninsured that use hospital-based care, will likely also influence the financing of CCPs. As federal funding for the uninsured gradually declines, states will be unlikely to replace those funds on their own, especially if they expand Medicaid.

CCPs that qualify for health center designation also need to consider how recent and future federal reductions may impede their ability to provide low-cost or free coverage. For FY2011 and 2012, there were reductions in health center funding totaling $600 million, cuts that are projected to continue in subsequent years. Furthermore, as millions of individuals become newly eligible for coverage and demand health care services, there is concern about available provider capacity to serve both the newly insured and the remaining uninsured. Many CCPs already face provider capacity challenges that may be magnified if a large proportion of these providers are being recruited to serve the qualified health plans (QHP) or newly eligible Medicaid populations. It is reasonable to expect a trickle-down effect on available care for those served by CCPs – likely to be an even less-desirable population to serve. Contending with this challenge will be another strategic imperative.

Lastly, while considering the above challenges, CCPs must communicate to key stakeholders that they will continue to be critical to the health safety net. Without access to health care services, the still-sizable uninsured population will pose a fiscal burden on states through costs for uncompensated care.

Options that CCPs are Considering

As CCPs consider how they will evolve when states implement the ACA – with or without Medicaid expansion – in 2014, they are exploring a number of options, including:

1. Continuing to serve the uninsured in their catchment areas;
2. Providing complementary services to those newly covered by Medicaid or a QHP in their state marketplace;
3. Serving as a navigator, in-person assister, or certified application counselor in their state marketplace; and/or
4. Forming a CO-OP to be offered in their state marketplace.

1. *Continuing to Serve the Uninsured*

While the number and faces of the uninsured may change in 2014, the mission of many CCPs will stay the same: connecting the uninsured to affordable, quality care. As described earlier, the approximately 23 million individuals who are expected to lack coverage despite the ACA will face a health care marketplace that is even less favorable to their needs than the current system, suggesting that efforts to connect them to care will require CCPs to change their outreach and delivery systems. This is a particular challenge given that it is unclear what the health care needs and utilization patterns of this population will be.

That said, CCPs may consider the following for those individuals remaining uninsured:

a. ***Medicaid and insurance marketplace "opt-outs":*** While CCPs typically screen their own program applicants for Medicaid eligibility – to avoid allocating limited program resources to those who can access low- or no-cost care elsewhere – their role in this capacity may need to be more assertive. CCPs will need to decide whether to offer coverage to those who opt out of Medicaid or marketplace coverage. CCPs can play a role in "selling" the value of Medicaid and marketplace enrollment.

b. ***Undocumented immigrants:*** Reaching and enrolling these individuals in a charity care organization may be more difficult given linguistic challenges, cultural barriers, and/or individuals' fears of deportation.

Given the growing predominance of immigrants in the uninsured population, CCPs may need to enhance their workforce (e.g., Spanish-speaking outreach and enrollment coordinators, providers, etc.) to meet the above-described needs and concerns. CCPs will also need to consider a tailored advocacy and communications strategy to ensure appropriate funding of efforts to serve this group. Outreach to stakeholders should emphasize the ethical obligation to provide health care access, and the large costs that will accrue to public systems if patient health is allowed to deteriorate.

c. ***Individuals exempt from the mandate:*** As with undocumented populations, these individuals will still have health needs that may lead to increased utilization of the emergency department. CCPs can play a role in

mitigating this avoidable, high-cost utilization by providing this population with a coverage alternative.

d. ***The "churn" population:*** For those moving in and out of eligibility for Medicaid or for marketplace-based premium subsidies, CCPs can provide "gap coverage." The relatively small increase in income that can move an individual out of Medicaid eligibility is often not enough to cover the additional costs of marketplace-based coverage, leading to the risk of a coverage gap. Within six months of enrollment, an estimated 35 percent of low-income adults could be expected to move from Medicaid to a QHP in a marketplace, or vice versa; the number rises to 50 percent over 12 months.[16] Gaps or changes in coverage can also threaten access to consistent primary care and specialty providers, a particular issue for individuals with chronic illness requiring ongoing management.

   A CCP interested in providing "gap coverage" for individuals (whose incomes rise beyond the Medicaid eligibility ceiling, but for whom enrollment in a QHP is not affordable) could engage its state Medicaid agency to provide outgoing beneficiaries with enrollment information about the CCP. This would be in addition to any other mechanisms the state has implemented to minimize coverage disruptions such as the Medicaid bridge plan, premium assistance programs, or wraparound benefits.

2. *Providing Complementary Services to those Newly Covered by Medicaid or a QHP*

For currently uninsured individuals who gain coverage through Medicaid or an insurance marketplace in 2014, CCPs can play many important roles. The programs' experience serving this population – and the direct relationships they have formed with current members – confers an expertise in the needs, cultural nuances, and health literacy levels of low-income individuals in their catchment areas. Accordingly, CCPs are well-positioned to promote appropriate utilization and optimal health outcomes among the newly insured:

- Reaching out to current members to make them aware of and help them navigate new coverage options, including determining eligibility for Medicaid and/or premium subsidy assistance (an informal navigator role);
- Providing enrollment assistance for those eligible for coverage;
- Developing and providing complementary services such as case management and/or care coordination, which can help the newly insured use their new coverage most effectively and efficiently; and
- Providing social services to improve self-sufficiency.

Through the above roles, CCPs can apply their expertise and community relationships to contribute to the coverage and health outcomes gains achieved under the ACA.

3. *Providing Consumer Assistance*

The ACA requires that state insurance marketplaces establish a grant program to fund navigators to assist consumers in using the marketplaces. Navigators are required to: (a) maintain expertise regarding the marketplace; (b) provide information to consumers in a fair, accurate, and impartial manner; (c) facilitate QHP selection; (d) refer consumers to other resources; and (e) provide information in a culturally diverse and linguistically accessible manner. The law requires that each marketplace select at least two types of entities to be navigators, at least one of which must be a community- or consumer-focused non-profit.

States operating a state-based marketplace or participating in a partnership model will have the option of designing an in-person assister program. Assisters will have the same role as navigators, but are not required under the law. Marketplaces also have the option of using certified application counselors to help people understand and enroll in health options. The key difference is that this option does not have a funding mechanism. Given their familiarity with low-income, diverse populations, CCPs are well-positioned to play these roles.

4. *Operating a CO-OP*

Another choice for CCPs has been to form or become part of a Consumer-Operated and Oriented Plan (CO-OP), a coverage mechanism established by the ACA. CO-OP programs can offer low-interest loans to eligible private, nonprofit groups to help set up and maintain health plans. CO-OPs are directed by their customers and designed to offer individuals and small businesses affordable, consumer-friendly and high-quality health insurance options. Starting January 1, 2014, CO-OPs will be able to offer health plans either within or outside of a marketplace.[17]

Over the past two years, the federal government awarded nearly $2 billion in loans to 24 proposed state CO-OPs, including Charity Care Affinity Group member Ingham Health Plan (see case study on the following page).[18] While the CO-OP program is no longer open to applicants, it has allowed some CCPs to apply their expertise in the needs of the population.

Case Study: Portico Healthnet (Minnesota)

Minnesota-based Portico Healthnet offers prevention-based coverage that includes: primary and preventive medical care; specialty and urgent clinic care; outpatient mental health services; prescription medications; and interpreter services for medical appointments. Services are delivered through networks of providers that are aligned with nine hospital systems.

To be eligible, an individual must: be a resident of Minnesota's Dakota, Hennepin, Ramsey, or Washington County; have an income at or below 275 percent of FPL; and be uninsured. There is no limit on the length of time eligible individuals can remain in the program. Portico's membership is currently 1,200 individuals, with a wait list of about 1,000 individuals who face an average wait of 18 months. Many individuals remain in Portico for only four months while they satisfy the four-month waiting period for Medicaid. Annually, the program helps about 10,000 additional residents with public-program enrollment.

Portico is funded by contributions totaling approximately $1 million from all hospitals in the Twin Cities, covering enrollee medical care at a cost of about $1,000 to $1,250 per person.[19] Each member household pays a sliding scale, monthly participation fee of $25 to $50, and small copays for non-preventive physician visits. Services performed in a physician's office are reimbursed at 15 percent above the Medicaid fee schedule. Patients pay a 25 percent coinsurance for hospital-based procedures, billed at a hospital-negotiated rate.

Minnesota will participate in the Medicaid eligibility expansion to 138 percent of FPL, and will establish its own insurance marketplace by October 2013. Portico is seeking to serve as a navigator in Minnesota's state insurance marketplace. This role is a natural fit, since a large portion of Portico's operations include helping individuals to: (1) enroll in public programs; (2) access care; and (3) identify/secure resources for immediate care needs.

Portico is seeking to expand to meet the needs of the remaining population, including those who will fall through the cracks of coverage in 2014. It is working with the organization's hospital partners to pursue opportunities for growth, and is exploring new sources of funding. The organization is also recruiting community health workers to increase outreach staff capacity.

Portico is involved in a pilot with its hospital partners through which Portico staff work in emergency departments and primary care clinics to provide enrollment support. The hospitals would like Portico to play a navigator/assistor role for the uninsured individual who visits their emergency departments – channeling him or her to Medicaid or enrollment in Portico, and/or providing help to find an immediate source of follow-up care.

Portico is facing a number of challenges, including:

- While opportunities to test the navigator role, expanded outreach, and a modified coverage program exist, corresponding funding is not yet available;
- Concerns that funding for marketplace navigator/assistor roles may not be adequate, especially after the first year of the program; and
- Competition among safety-net organizations.

Case Study: Ingham Health Plan (Michigan)

Ingham Health Plan (IHP), formed in 1998, serves uninsured residents of Michigan's Ingham County with incomes at or below 250 percent of FPL. U.S. citizenship is not required. IHP provides: primary and specialty care; outpatient labs; limited outpatient hospital services; and prescription drugs for small co-payments (emergency department and inpatient services are typically hospital charity or uncompensated care). IHP also links enrollees to a medical home.

IHP is funded by a Medicaid waiver, and by grants from two hospitals. Of the county's estimated 32,000 uninsured residents, approximately 11,500 are served by IHP. Since its inception, it has served more than 60,000.

IHP's strategic planning efforts included forming the Michigan Consumer Healthcare CO-OP, known as Consumers Mutual of Michigan. Organized by a coalition of 15 Michigan non-profit corporations that are county health plans,[1] Consumers Mutual of Michigan is a consumer-oriented, integrated delivery system. It includes several plans offering the same benefits (essential health benefits), but with variations in member co-pays and deductibles.

Consumers Mutual of Michigan is a statewide plan, targeting individuals who are likely to fluctuate between eligibility for Medicaid and the marketplace. The program will offer plans on and off the marketplace. A particular focus will be on individuals with incomes above the Medicaid ceiling who might experience affordability issues despite the availability of marketplace-based premium subsidies.

IHP will also act as the HUB for Michigan Pathways to Better Health (MPBH), a Pathways Community HUB Model funded by the Centers for Medicare and Medicaid Services, will serve adult Medicaid and/or Medicare beneficiaries with two or more chronic conditions. As the HUB for MPBH, IHP will be the project's central data collection site; serve as a center of accountability to ensure that community agencies work through the pathways according to established guidelines; receive referrals from the community and assign individuals to community health workers; and present outcome reports to the county. In later years, IHP's role in facilitating case management is expected to expand.

IHP will work to make changes along the following timeline:

- **2013:** Increase provider rates to encourage participation in IHP's network; build provider capacity to serve the newly insured and remaining uninsured; and continue to enroll eligible uninsured residents in IHP.
- **2014:** Help navigate IHP members to Medicaid or the marketplace.
- **2015:** Build provider capacity, perhaps offer a premium assistance program to help residents afford marketplace-based coverage; and continue to offer basic benefits to those who remain uninsured in the county.

Conclusion

CCPs will face numerous challenges in the years to come, and they are all working to determine their paths going forward. For many, strategic directions hinge on their respective state's decisions regarding implementation of the ACA, especially the Medicaid expansion. Delays in these decisions have been fueled in large part by fiscal issues, politics, and uncertainty associated with insufficient federal guidance. Many states still have a "wait and see" attitude about the outcomes and implications of federal executive and state legislative decisions.

While this uncertainty continues, it is clear that CCPs will need to evolve both operationally and fiscally in preparation for 2014. They have numerous options for change that will allow them to stay true to their missions and play critical new roles in securing the health care safety net.

Endnotes

[1] For a discussion of the specific delivery systems and financing models of selected CCPs, see: S. Chazin, I. Friedenzohn, E. Martinez-Vidal, and S.A. Somers, *The Future of U.S. Charity Care Programs: Implications of Health Reform.* Center for Health Care Strategies, Inc., August 2010; available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261141.

[2] National Federation of Independent Business (NFIB) v. Sebelius. 567 U.S. ___ (2012), available at http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

[3] The District of Columbia and the following states will participate: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, West Virginia.

[4] G. Kenney, S. Zuckerman, L. Dubay, et al. *Opting in to the Medicaid Expansion under the ACA: Who are the Uninsured Adults Who Could Gain Health Insurance Coverage?* Urban Institute, August 2012.

[5] Ibid.

[6] Ibid.

[7] K. Jacobs, D. Graham-Squire, G. Kominski, et al. *Remaining Uninsured in California under the Affordable Care Act: Regional and County Estimates* UC Berkeley Labor Center and UCLA Center for Health Policy Research, June 2012.

[8] M. Buettgens and M. Hall. *Who Will Be Uninsured After Health Insurance Reform?* The Robert Wood Johnson Foundation, March 2011.

[9] Ibid.

[10] Ibid.

[11] S. Zuckerman, T. A. Waidmann, and E. Lawton. "Undocumented Immigrants, Left Out of Health Reform, Likely to Continue to Grow as Share of the Uninsured," *Health Affairs,* 30, no. 10 (2011): 1997-2004.

[12] Buettgens and Hall, *op cit.*

[13] Ibid.

[14] J. Mulvey and H. Chaikind. *Individual Mandate and Related Information Requirements under the ACA.* Congressional Research Service, July 2, 2012.

[15] Buettgens and Hall, *op cit.*

[16] S. Rosenbaum, S.A. Somers, and S.M. McMahon. *Strategies for Building Seamless Health Systems*, Center for Health Care Strategies, February 2012.

[17] Healthcare.gov. "Consumer Operated and Oriented Plans (CO-OPs)." For more information, visit: http://www.healthcare.gov/law/features/choices/co-op/index.html.

[18] State Health Facts. *Consumer Oriented and Operated Plan (Co-Op) Loans Awarded, 2012.* Kaiser Family Foundation. http://www.statehealthfacts.org/comparetable.jsp?ind=1027&cat=17&st=6&sort=2775&rgnhl=7

[19] D. Holmgren. "Portico Healthnet: A Local Solution for Covering the Uninsured." *MetroDoctors*, January/February 2008, 13-14.

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