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The Future of U.S. Charity Care Programs: *Implications of Health Reform*

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***AcademyHealth** is a membership organization representing the broad community of people with an interest in and passion for using health services research to improve health care. We promote interaction across the health research and policy arenas by bringing together a broad spectrum of players to share their perspectives, learn from each other, and strengthen their working relationships.*

Foreword

This paper was developed with grant funding from Kaiser Foundation Health Plan, Inc., under the direction of the Kaiser Permanente Institute for Health Policy. Kaiser Permanente currently provides no- or low-cost, comprehensive health care coverage to over 100,000 people who are unable to purchase commercially available products and do not qualify for government programs. As a major private provider of “charitable coverage,” we believe that such programs — whether sponsored by health plans, hospitals, foundations, or others — will play an important role in serving those who remain uninsured, even after major coverage expansions enacted in 2010 go into effect.

Our goal in sponsoring this work was to understand the challenges facing charitable coverage programs today and to mine these programs for important lessons that might be applicable to broader coverage expansion efforts. Finally, we hoped to explore how potential coverage expansion might affect these programs, as they struggle to fulfill their mission to serve people who do not have other options for affordable health coverage.



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I. Introduction

State, regional and local charitable coverage/care (charity care) programs run by public and private entities — including community-based organizations, health plans, health systems and state/county/local governments — have long worked to meet the needs of the uninsured through a wide range of low- and no-cost offerings. These programs are designed to reach out to the uninsured with access to health care services, often with the underlying hope that they can catch people before they get sick and need emergency care or hospitalization. Over the past two years, a weak economy, high rates of unemployment, and the loss of employer-based coverage have caused the size of the uninsured population to grow substantially.¹

While providing coverage, let alone access to care, for the nation's 46 million+ uninsured has been an ongoing challenge — with far-reaching health, social and economic consequences — a new era is upon us. Following years of contentious debate, the Affordable Care Act (ACA) passed in 2010 is expected to extend coverage to 32 million people by 2019, eventually covering 95 percent of all legal residents.² Coverage expansion will begin in 2010 with subsidies for small businesses to provide coverage to employees; a prohibition on denials of coverage to children with pre-existing conditions; a temporary high-risk pool; and a requirement that insurers permit children to remain on their parents' insurance plans until age 26. Significantly more individuals will be eligible for coverage starting in January 2014, with expanded Medicaid eligibility and the initiation of state insurance exchanges. However, most uninsured will be without coverage until 2014, and approximately 20 million individuals will remain uninsured thereafter.

Unquestionably, reform will present significant changes for charity care programs and the uninsured they have served. As these changes occur, charity care programs will have much to consider about their evolving role in the greater health care system. They will face the critical task of assessing and meeting the needs of the remaining uninsured, with implications for program delivery systems and business models, including the possibility of ceasing operations.

Key Points

As policymakers and other health care leaders consider the operational and economic implications of the Affordable Care Act (ACA), it is critical to explore how the needs of individuals remaining uninsured will be met. This paper highlights the challenges of serving this population; the role that charity care programs can play in meeting their needs; and how these programs can best be supported as ACA is implemented. Findings suggest that:

- Among the millions who will remain uninsured, it is unclear who will enroll in charity care.
- Regardless, charity care programs will remain vital and integral to the broader safety net of both service provision and coverage.
- Charity care programs have insights and experience which can benefit states and health plans as they enroll newly eligible members.
- As individuals move among coverage options and the uninsured population is redefined, the financial and operational viability of charity care programs will continue to be critical.

¹ Kaiser Commission on Medicaid and the Uninsured (February 2010). "Medicaid's Continuing Crunch in a Recession: A Mid-Year Update for State FY 2010 and Preview for FY 2011."

² "The Patient Protection and Affordable Care Act of 2009" (Public Law 111-148), and "The Health Care and Education Reconciliation Act of 2010" (Public Law 111-152).

Project Overview

This paper is the product of an effort funded by Kaiser Permanente's Institute for Health Policy. It began as a pre-reform examination of the role of charity care programs and evolved into an initial exploration of how best to serve the remaining uninsured until 2014 and for the rest of this decade. In August 2009, with the potential for federal health reform on the horizon, the Institute engaged AcademyHealth and the Center for Health Care Strategies (CHCS) to review the field of charity care programs run by health plans, integrated health care delivery systems and other community-based organizations. The intent was: (a) to explore strategies these programs were using to improve access to care, particularly primary care, for the uninsured; and (b) to understand the challenges these programs faced in enrolling, serving, and managing the health of a largely transient, culturally diverse and potentially low-literate population.

As policymakers and health system leaders consider the operational and economic implications of the new law, the report's findings can shed light on: (1) remaining challenges of serving the uninsured; (2) the role that charity care programs can play in meeting the needs of the uninsured; and (3) how these programs can best be supported during the transition. While not a comprehensive scan of the charity care field, this report helps define the range of options available in various regions — a topic that has been largely overlooked by policymakers and about which no formal study has been released since 2003.³

Study Process

From August through October 2009, CHCS and AcademyHealth interviewed numerous thought-leaders in the charity care field to identify programs meeting the project criteria. The team sought programs that: (1) take a proactive, upstream approach to reaching the uninsured; (2) are privately funded or involve a public-private partnership; and (3) attempt to measure the success of their programs.

The project team identified nine programs for potential inclusion, and interviewed operational leaders from each. Based on those interviews and subsequent assessments of each program's fit with the project criteria, the following eight were selected for inclusion in this report (see *Appendix B*):

- Access to Healthcare Network (NV)
- Ascension Health Care System (multiple states)
- adultBasic (PA)
- Healthy San Francisco (CA)
- Hillsborough County Health Care Plan (FL)
- Ingham Health Plan (MI)
- Kaiser Permanente Charitable Health Coverage programs (multiple states)
- Portico Healthnet (MN)

These programs all play a critical role in providing a safety net for thousands of individuals who do not have access to private insurance or are not eligible for publicly financed care through Medicaid/CHIP or Medicare. Because the programs vary in function, funding, scope of services, and care delivery, it is difficult to make broad comparisons. Nonetheless, they all share in the common mission to provide access to essential services for a population that otherwise would go without.

³ NIHCM Foundation (March 2003). *The Uninsured: A Study of Health Plan Initiatives and the Lessons Learned*.

II. The New Health Care Landscape

Through passage of ACA, the U.S. has embarked on a historic course of extending coverage to 32 million people. This includes a Medicaid expansion for all adults up to 133 percent of the Federal Poverty Level (FPL) starting in 2014. Consumers will have access to a more regulated insurance marketplace that will no longer allow coverage denials. Sliding scale subsidies will be available to assist families in purchasing affordable insurance. And small businesses, the self-employed and uninsured individuals will be able to access insurance through state-run health insurance exchanges. An individual mandate with penalties will encourage individuals to become and remain covered.

The estimated 20 million individuals who will not be able to take advantage of ACA will have to depend, to one degree or another, on charity care programs. This population will be composed primarily of: (1) those exempt from the individual mandate because insurance options are not affordable; (2) those who opt out of the individual mandate and face resulting penalties; and (3) undocumented immigrants and legal residents of less than five years. ACA requires recently arrived legal immigrants to wait five years to obtain Medicaid, even if income-eligible, and forbids undocumented immigrants from participating in the newly created insurance exchanges. As a result, undocumented immigrants and possibly their family members (who are often U.S. citizens or legal immigrants) may remain uninsured. Presumably, these individuals will continue to seek care in emergency rooms and other safety net programs.⁴ Clearly, some role will remain for charity care programs and their participating providers to meet the needs of this population and others.

What is the future for charity care programs? Prior to 2014, will these programs help with outreach and enrollment of many of their members into Medicaid? What new directions will these programs have to pursue as they prepare for major changes in their patient populations starting in 2014? At this time, there are far more questions than answers. For example:

- Will the focus of charity care programs be on undocumented immigrants and those exempt from or avoiding the mandate?
- Will enrollment in these programs (most of which are not bona fide insurance products) satisfy the coverage mandate?
- Will these programs face funding issues and struggle to keep their doors open, perhaps due to issue fatigue?
- Will these programs have an adequate number of primary care providers, given the influx of new patients into a system already struggling with an insufficient workforce?
- Will the health status/needs of their patient population change? Will members be healthier, or have unmet needs due to chronic conditions?
- With additional funding for Federally Qualified Health Centers (FQHCs), will charity care programs be able to partner with new publicly underwritten centers?
- How can charity care programs participate in the care coordination and delivery system redesign aspects of the new law?

To consider the above questions and many others, the following sections describe the features of current charity care delivery systems and business models. The report then offers a preliminary review of ACA's implications for these elements in the period leading up to full implementation (2010 to 2013), and in 2014 and beyond. Lastly, it presents considerations for policymakers as they develop regulations and programs in fulfillment of the new law.

⁴ New America Media, Commentary, Sonal Ambegaokar, J.D., Posted: Jan 16, 2010 http://news.newamericamedia.org/news/view_article.html?article_id=74a6e12c17a8ee1d846fa9994601b69f.

III. Overview of Charity Care Programs: The Current Environment

This section first describes the key features of charity care delivery systems, then discusses the various business models supporting these programs.

Charity Care Delivery System Features

1. *Benefit design*

The charity care programs profiled seek to be as comprehensive as possible, though funding levels limit their offerings. All provide for primary and some specialty care, prescriptions, and laboratory tests; most also cover inpatient care and emergency room use; and some provide links to social services.

Despite the breadth of their covered services, many programs report an insufficient number of providers — particularly specialists — willing to participate at the reduced payment rates they can offer. This insufficient access to specialty care can lead to exacerbations of illness and use of avoidable and more expensive inpatient services in lieu of lower-cost and more appropriate outpatient care.

2. *Eligibility and outreach*

Income eligibility levels for the charity care programs profiled ranges from ≤ 100 percent FPL to ≤ 500 percent FPL. While none of the programs requires U.S. citizenship, some either limit coverage to those in a particular geographic area or require documentation of legal residency.

In many markets, decreased access to employer-sponsored coverage and individuals' reduced ability to afford coverage have driven up demand for charity care programs. While some programs have the capacity to meet this demand, others lack resources to do so. Market penetration for most of the programs ranges from five percent to 80 percent of a given region's uninsured population. The majority of programs are meeting enrollment goals based on anticipated resources and capacity. Some have waiting lists, while others struggle to enroll members, largely because of inadequate funds for outreach.

Outreach to eligible populations varies, with use of the following channels: physician offices, clinics, and hospitals; social service agencies; community service partners; clergy; local media; toll-free phone lines; online information/enrollment; and brokers (for programs that are insurance products).

Language used to describe program costs for potential members reportedly affects the perceived value and appeal of these programs to the uninsured. For example, a number of program directors observed that the notion of a "discount" is more appealing to the target population than a "subsidy." There is a reported need for member education around enrollment/re-enrollment procedures, scope of coverage, and service availability, with some programs citing member misperceptions in these areas. Some programs try to address these challenges through face-to-face encounters at enrollment or prior to service.

Approaches to managing program demand vary, including: capping enrollment (resulting in waiting lists); disenrolling those who do not comply with program rules or are found not to be using covered services; requiring achievement of target milestones of self-sufficiency and employment; escalating member cost responsibility; and identifying and assisting with enrollment in other public or private coverage options.

Though several programs are designed to serve as bridges to more permanent coverage, many members are not eligible for or cannot afford other options. As a result, they are left without coverage if their eligibility expires.

3. Care coordination and patient navigation

All of the programs offer members some level of a medical home that coordinates care and promotes wellness; many include patient navigation. Nurse care managers or social workers are assigned to members — a service not always available through commercial health plans or even Medicaid. Some coordinate health care with social services and community resources, providing support to improve members' self-sufficiency and employability.

Across programs, there is a need to help members address both financial and non-financial barriers to accessing appropriate levels of care and using program resources cost-effectively. Program managers identified enhanced case management, disease management, and communication among providers as keys to achieving these goals.

Charity Care Business Models

1. Financing

Financing mechanisms vary both across and within charity care programs. Funds are provided by: member fees and copays; employer contributions; individual/ corporate/philanthropic donors; federal, state and county sources; provider subsidies; a sales tax levy; tobacco settlement funds; and partnering health plans and health systems (which often underwrite charity care programs to fulfill the requirements of their nonprofit status).⁵ In many cases, providers subsidize these programs by discounting their services.

The majority of the programs profiled, with the exception of Kaiser Permanente and Pennsylvania's adultBasic, are not insurance products. Operating outside of this designation affords programs a number of benefits, including:

- Exemption from cash reserve requirements mandated for insurance carriers by state insurance departments;
- Avoidance of other regulatory requirements that apply to insurance products, including mandated benefits; and
- The opportunity to operate as a government entity eligible for intergovernmental transfers (important to programs such as the Hillsborough County Health Care Plan in Florida and Michigan's Ingham Health Plan).

Accordingly, the programs generally use different language to describe their features. For example, member cost-sharing is generally not referred to as a "premium" or a "copay," rather it is deemed a "membership fee," "enrollment fee," or "reduced fee-for-service." It should be noted that as most of the programs are not insurance products, they: (a) cannot be marketed by insurance brokers; and (b) lack regulatory protection for beneficiaries.

⁵ Note: These typically are considered to be: the provision of uncompensated care; services to Medicaid beneficiaries; and specialized services that are generally unprofitable. Congressional Budget Office (December 2006). "Nonprofit Hospitals and the Provision of Community Benefits." Available at <http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf>.

2. Member cost-sharing

Charity care programs use a number of member cost-sharing mechanisms, including membership fees (some on a sliding scale, some shared by the individual and his or her employer). Three of the plans require no premium for the lowest-income enrollees; and three charge between \$24 and \$50 per member per month. One plan charges members up to \$150 per month, and another up to \$450 per month, based on income.

Most of the programs profiled require service and prescription drug copays, and coinsurance payments. These fees generally are nominal (e.g., a \$1 prescription copay); many require \$5/\$10 copays for primary/specialty care visits.

A notable example of integrating member cost-sharing and responsibility emerged from the Access to Healthcare Network, which requires members to pay for provider services in cash at the time of the appointment. Members not complying with this requirement are not seen; “repeat offenders” are asked to leave the program. These rules have led to a very high level of member payment for services: in its first four years of operation, the program disenrolled only 20 individuals for failure to comply.

4. Provider payments and incentives

Payment sources, amounts and incentives to providers participating in charity care programs vary greatly. In addition to largely nominal patient copays, providers receive funding and reimbursement from: private/public donors; grant payments (in two cases, from hospitals participating in the programs); the state; and fee-for-service reimbursement (either at commercial rates or a designated percentage over Medicaid). In some, including Ascension’s profiled programs, physicians donate their services.

Payment incentives may be used to encourage providers to pursue lower-cost, appropriate treatment options — suggesting that the “purchasing power” of charity care programs can drive these behaviors. Monitoring whether provider incentives are appropriately aligned (e.g., driving more efficient treatment rather than less treatment) is an important concern for many programs.

IV. Health Reform Considerations for Charity Care Programs

As described above, coverage expansion enacted through ACA will alter the composition of the uninsured population. While the charity care programs profiled herein are largely effective at serving their current target populations, their scalability to larger populations or adaptability to different populations is unknown.

In the face of these changes, charity care programs may pursue any of three options: (1) continue doing exactly what they are doing now; (2) re-tool to adapt to the needs of the remaining uninsured; or (3) cease operating. Given the expected number and needs of individuals who will be uninsured in 2014, option two will be the most likely. As programs explore these options, it is critical that they consider the implications of health reform measures for their delivery systems and business models, as described below (see *Appendix A*).

Charity Care Delivery System Features

As the size, demographics, and health status of the uninsured population evolve in the next three to five years, charity care programs will have to explore how their benefits, outreach activities, and care coordination may need to change.

1. Benefit design

Differences between the health status of current charity care members and those who will be enrolled following reform are unknown. For example, many of those who have chronic illnesses likely will be eager to enroll in coverage available through Medicaid or the new exchanges, if eligible. Others, including so-called “frequent users” of emergency departments, may be unwilling or unable to embrace a new system that would change the way they access care. At the same time, coverage (and the avoidance of penalties) may also be appealing to those who are healthy. Undocumented residents — a largely young and healthy population that cannot participate in the exchanges — may seek access to services through charity care programs. Without acute health needs, however, these individuals may choose to remain completely outside the system unless they need emergency care.

All of these unknowns mean that the service needs of the post-reform charity care population are unclear. It is likely that primary care and specialty providers will see an influx of newly insured individuals — either through Medicaid or subsidized coverage purchased through the exchanges. As the delivery system copes with a significantly larger covered population, access for the remaining uninsured population may suffer commensurately. Providers may be less willing to participate in charity care programs when they can receive higher reimbursement rates from private and public programs that serve the newly insured population. Charity care programs might choose, for example, to re-focus their services on specialty and high-end care, or to deliver social services that complement health care received elsewhere.

2. Eligibility and outreach

Most of the charity care programs profiled screen potential members for public-program (e.g., Medicaid, Medicare) eligibility, and many assist with subsequent enrollment. Charity care programs will need to consider what role they will play during the period of coverage expansions, as the new system manages eligibility determination. Education of current charity care participants will be needed to make them aware of these options, encourage enrollment, and facilitate their transition.

Charity care programs will have to determine their own eligibility guidelines — for example, individuals with access to coverage through the exchanges would presumably no longer need charity care services. The programs also should decide how to address those who claim they cannot afford the subsidized policies, as well as those who choose not to comply with the mandate (“mandate scofflaws”). How will their eligibility for charity care be determined?

As the average income of the non-immigrant portion of the uninsured population presumably rises with mandated eligibility for all those below 133 percent of FPL, the designation of these programs as “charitable” could even become problematic for both tax status and donor appeal. Building the case for new eligibility guidelines with policymakers and donors will be critical to ensuring the transfer of this support to the still-needy charity care population.

Additionally, as community partners may need to devote additional resources to facilitating and coordinating newly available coverage for the uninsured, they may be less able to continue supporting enrollment in charity care. Charity care programs will have to examine what resources are available and needed to compensate. This will be particularly important as identifying and enrolling the remaining uninsured in charity care programs will presumably be more difficult than it now is. The population will be smaller, more diverse, and perhaps farther “off the radar screen” due to their immigration status or fear of facing penalties for failure to comply with the mandate. Charity care programs should consider how to focus resources on reaching these populations.

3. Care coordination and patient navigation

The characteristics of the uninsured population that will remain eligible for charity care programs will have implications for care coordination and patient navigation, as well. For example, its linguistic and cultural diversity will call for parallel diversity among providers and service coordinators, with implications for health care utilization, adherence to care plans, and self-management.

As a large number of individuals transition into new coverage through Medicaid or the insurance exchanges, enrollment education and care coordination needs will be high. Those currently uninsured — particularly those with chronic and comorbid conditions — may have greater health care needs, and be unfamiliar with how to navigate the health system. Programs will have to consider whether they have the infrastructure and workforce to support this.

Charity Care Business Models

The increased accessibility and affordability of insurance coverage likely will have significant implications for program business models. Resources available to charity care programs — both from public/private funding sources and patient copays — will change, as may incentive structures that will be effective with the remaining uninsured population. Changes to the benefits package and delivery system also will affect requirements of an effective business model.

1. Financing

As health reform is implemented, financing available for charity care programs may decline. For example, charity care programs that rely in part on disproportionate share hospital (DSH) payments may see a reduction in payment levels, as funds are redirected over time to formal coverage programs. A shift of health system resources to the insurance exchanges and Medicaid, and the lack of political or social appeal of the undocumented population to both public and private funding sources may also have implications for the programs’ financial sustainability. At the same time, the new health care law may offer additional funding opportunities.

Charity care programs will also need to consider how they can help to meet the value proposition for sponsoring health plans and systems under new financing scenarios. For example, will nonprofit health systems face altered community benefit requirements in the tax code?

2. *Member cost-sharing*

The demographics of the new charity care population may have implications for member cost-sharing, as well. For example, undocumented residents with the resources to do so may choose to enroll in charity care programs. Incentives that are effective at driving appropriate service utilization in the new charity care population may be different than those used with current enrollees — due to income levels, cultural norms, or other socioeconomic factors. Programs will need to monitor how utilization changes in the new environment, and modify program structures and incentives accordingly.

3. *Provider payments and incentives*

Incentives for providers may also have to change. Individuals gaining coverage and access to care after lacking both for any period of time may have poorer health status and greater health care needs. Commercial and public payers should consider what incentives will be needed to engage providers in their care. This may have implications for charity care programs as they compete for providers to join their networks.

V. Considerations for Policymakers

This report offers a number of considerations about charity care to help guide state and federal policymakers as they develop regulations and programs in fulfillment of the new health care law. Underscoring these is the imperative: *First, do no harm*. The majority of the programs included in this analysis are very effective at caring for the uninsured in their target regions. With the infrastructure, provider relationships, and insights into the health and social needs of diverse, low-income populations, these programs are ideally positioned to serve those who remain uninsured in 2014 and beyond. Policymakers should thus consider the impact of reform measures on the financial viability and operational stability of programs that will remain critical in the new health care landscape. For example:

1. An estimated 20 million individuals will remain uninsured after ACA is fully implemented, including many who still will not be able to afford coverage.

Of those remaining uninsured — that is, either not qualifying for or choosing not to participate in Medicaid or the state insurance exchanges — only about one-third will be undocumented residents. Many in the remaining two-thirds may be higher up the economic ladder, but still unable to afford coverage options and out-of-pocket (OOP) payments.⁶ At greatest risk are those in the threshold just above Medicaid eligibility (133 percent FPL). For example:

- Those with incomes too high to qualify for subsidized coverage, but too low to afford full-price premiums (up to 400 percent FPL) — a problem that will grow as cost-sharing subsidies phase out. For example, an individual at 250 percent FPL (\$27,000) reaching the OOP maximum would spend more than 20 percent of income on copays and deductibles, plus up to eight percent of income on the insurance premium;
- Those with high medical needs who can afford the premiums, but not the corresponding service copays and deductibles;
- Low-income workers of large employers that offer coverage, but at unaffordable rates; and
- Older individuals, who may be charged more for policies in non-group markets, due to age-rating bands.

Because the new law sets subsidies to keep the share of premiums paid by the government constant over time — and medical costs have been growing significantly faster than incomes and general prices — family premium expenses are likely to grow faster than incomes.⁷ This is expected to make premiums even less affordable over time.

A real danger is that policymakers, individual and corporate philanthropists, and health system leaders will conclude that individuals not addressed by health reform can afford and access adequate health coverage and care. While there are many who will, the above factors suggest that many will not.

Providing affordable coverage and care for this population, which charity care programs are well-positioned to do, will be critical. These programs will need to consider who will be — or should be — walking through their doors in 2014, and how they can meet that diverse population's needs. Concurrently, as states redesign their health care safety net to meet new legislative requirements, they should consider the strategic and financial support that charity care programs will need to remain effective.

⁶ L. Blumberg. "Gaps in Federal Health Reform: Opportunities for Charity Care Programs." Presentation given at the *Understanding Charitable Coverage/Care Roundtable Discussion*, April 14, 2010.

⁷ Ibid.

2. *The role of charity care programs will not decline, but simply shift.*

The large number of uninsured expected in 2014 and beyond suggests that demand for charity care programs will not decline, but shift to a different population. Those without health insurance are likely to be: (1) ineligible due to immigration status; (2) of higher average wealth compared to the currently uninsured population; or (3) those choosing not to participate in Medicaid or the insurance exchanges (including those opposed to participating in any government-run program). Charity care programs may require support for the transition to serving this new population.

The expertise of charity care programs also positions them to be effective subcontractors for health plans and Medicaid as the organizations serve a newly insured population — many of whom are now served by charity care. Charity care programs could: (a) continue serving these individuals; (b) perform eligibility screening and enrollment; or (c) provide advice on effective outreach and health management strategies.

3. *Charity care programs will face new financial challenges.*

Currently available funds that support charity care programs may diminish amid health reform implementation. For example, individual, private and corporate donors may perceive a reduced need for funding, given the extensive coverage expansion. Even if they do appreciate the significant size of the remaining uninsured population, demographic perceptions (e.g., higher-income, legal/illegal immigration status) may undermine continued financial support.

Higher income levels of the remaining uninsured population relative to the current uninsured population may also hinder political attention to their needs. While perhaps perceived as less needy, many of these individuals, as described above, still may not be able to afford coverage. Policy (and charitable) efforts must be undertaken to ensure they do not “fall through the cracks.”

Furthermore, programs that rely on DSH funding may see those amounts decline as a significant portion of those funds will be redirected to subsidize coverage through the exchanges.

Another challenge may arise as Medicaid reimbursement rates for primary care increase to Medicare levels in 2013 and 2014. Programs may find it even more difficult to recruit and retain providers, who will receive higher reimbursement through Medicaid as the result of reform legislation. If charity care programs need to match those rates to preserve their networks, the drain on their resources may reduce the number of members they can serve.

4. *Enrollment and eligibility will be a challenge.*

States will have to consider what mechanisms are needed, and whether current state information systems are sufficient, to determine eligibility and facilitate enrollment in expanded coverage options. A related issue is how to provide enrollment incentives to individuals who would not be affected by tax-based non-participation penalties (i.e., those who do not pay taxes). To reach a broader population (e.g., childless adults), states may consider partnering with charity care programs that keenly understand the newly eligible population.⁸

An important consideration, and one contrary to current public program guidelines, is whether eligibility for subsidized coverage through insurance exchanges should be defined locally versus nationally. Federal poverty guidelines may not be appropriate for determining the local affordability of full-price coverage.

⁸ G. Volk and A. Jacobs. *Implementing State Health Reform: Lessons for Policymakers*. AcademyHealth, March 2010.

5. *Those opting out of the insurance exchanges to enroll in a charity care program may not be deserving of “scofflaw” penalties.*

Most charity care programs reviewed in this project are not licensed as insurance products. The question thus remains whether membership in these programs would be considered creditable coverage and would satisfy the federal individual coverage mandate. Will members be treated as “scofflaws” and face a penalty for remaining uninsured even if they pay charity care membership fees of \$200 to \$300 per month?

6. *Hospitals and health systems may need new ways of satisfying community benefit requirements.*

With ACA implementation, hospitals are expected to see an eventual decline in the number of uninsured utilizing hospital charity care services, suggesting a need to change their community benefit requirements. ACA requires hospitals to conduct needs assessments and corresponding community benefit plans, although many hospital systems already require these assessments. Many of the programs highlighted here have existing relationships with hospitals/health systems that will continue to be cultivated and perhaps transformed over time.

VI. Conclusion

Charity care programs will continue to be integral and critical to the broader safety net of both service provision and coverage: they do not, and cannot, operate in isolation. As individuals move among various coverage options, and the uninsured population is redefined under health care reform, the connectivity of these programs to FQHCs, community hospitals, and public payers such as Medicaid will be critical to minimizing the number of individuals “falling through the cracks” of a vastly improved, but still imperfect, health care system.

Appendix A: Health Reform Considerations for Charity Care Programs

I. Delivery System		
	2010 – 2013	2014 and Beyond
Benefit design	<ul style="list-style-type: none"> Anticipated higher proportion of undocumented members. Interface with temporary high-risk pools. 	<ul style="list-style-type: none"> Supply of providers willing to participate given a larger insured population. Unknown adaptability of programs to the new charity care population. Unclear health status of the new charity care population, resulting in unknown optimal benefit package and delivery system requirements. Likelihood that charity care programs (except those affiliated with insurance carriers) will not satisfy the individual coverage mandate.
Eligibility and outreach	<ul style="list-style-type: none"> Importance of maintaining current programming to address the growing uninsured population. Role in educating uninsured individuals about possible new coverage options and obligations, and how to transition to these programs in 2014. Role in expanded Medicaid eligibility screening and enrollment. 	<ul style="list-style-type: none"> Need to determine charity care eligibility of those who claim they cannot afford to participate in the exchanges, and mandate “scofflaws.” Challenges of reaching undocumented residents. Role and availability of community partners to enroll members.
Care coordination and patient navigation	<ul style="list-style-type: none"> Help in transitioning the care coordination of members as they move to other coverage. 	<ul style="list-style-type: none"> Cultural competency of providers relative to the new charity care population. System navigation needs of the new charity care population.
II. Business Model		
	2010 – 2013	2014 and Beyond
Financing	<ul style="list-style-type: none"> Anticipated reduction in DSH resources. 	<ul style="list-style-type: none"> Availability of public (e.g., DSH) and private donor funding. Continued support from nonprofit hospitals to meet their community benefit requirements.
Member cost-sharing		<ul style="list-style-type: none"> Potentially different member incentives needed, and willingness to participate in cost-sharing among the new charity care population.
Provider payments and incentives	<ul style="list-style-type: none"> Need to accommodate payment expectations of Medicaid providers now receiving Medicare rates. 	<ul style="list-style-type: none"> Competition from commercial/Medicaid plans offering higher reimbursement rates.

Appendix B: Charity Care Program Summaries⁹

Access to Healthcare Network (Nevada)

Program Design

Access to Healthcare Network (AHN) was established in 2006 as the first nonprofit, state-licensed medical discount plan in the state of Nevada (and the U.S.), offering discounted health services to under- or uninsured individuals; it is a 501(c)3 nonprofit organization. AHN is based on a shared-responsibility model that includes a comprehensive network of hospitals, clinics, primary and specialty physicians, and ancillary health care professionals, and aims to increase access to primary and specialty health care services. While the program and participating providers are based largely in Washoe County, recently received federal appropriations have allowed an expansion into rural areas of Nevada.

AHN is available directly to individuals, and as an employer-sponsored health care benefit. The program connects participating hospitals, local and state government entities, and community agencies with employers, health care providers and members. Each member chooses a primary care provider (PCP), who must issue referrals for specialist visits; the member is also assigned a care coordinator, whom he/she meets during the in-person enrollment process. The member calls the care coordinator whenever a service is needed, and is told how much the service will cost.

Participating providers offer services to members at vastly reduced rates; members must pay for these services in cash at the time they are provided. The program has a very strict rule: any member with two “no-call no shows” to any provider or any non-payment to a provider is asked to leave the network and may not return.

At the request of participating PCPs, AHN is introducing a wellness component in 2010 for members with chronic illness such as diabetes or high cholesterol. It is also launching the nation’s first individual development account (IDA) for health care. After completing required financial literacy classes, members can contribute up to \$25 per month to a savings account with Wells Fargo Bank, which the bank will match up to \$500 a year. Funds in the account can be used only to pay for provider services. Participating members will receive support from a care coordinator specializing in IDA usage.

Population Served

To be eligible for AHN, individuals must meet income guidelines according to family size: between 100 and 250 percent of FPL; not qualify for public programs such as Medicare or Medicaid, or an employer-sponsored plan; present photo identification; and confirm Nevada residency (neither a birth certificate nor a social security number is required). Individuals can qualify regardless of employment status, age or health history. There are no medical exclusions (i.e., pre-existing conditions), waiting periods, deductibles, or limits on usage. While there is no limit on the time members can remain in the program, they must confirm income eligibility annually and demonstrate after two years that they remain ineligible for employer-sponsored insurance.

Of Washoe County’s 70,000 uninsured, 3,300 are enrolled in AHN, and approximately 250 members are added each month. Since 2007, AHN has served more than 4,000 members. Demographically, 65 percent of members have annual incomes between \$10,000 and \$30,000; 55 percent are female; about half are Caucasian, and a little over one-third are Latino. The primary language is English for 73 percent,

⁹ Except where noted, all information in program summaries was derived from interviews with their respective representatives, conducted between October and December 2009. As these took place prior to passage of ACA and the Health Care and Education Reconciliation Act of 2010, program summaries do not reflect considerations of expanded coverage options, mandates and/or other provisions contained therein.

and Spanish for 26 percent. There is no clustering of ages: 22 percent are 0 to 19, 24 percent are 20 to 34, 36 percent are 35 to 54, and 20 percent are 55 to 65. Notably, 65 percent are employed full-time.

Outreach

AHN conducts a number of outreach activities to its target population, including delivery of 3,000 program brochures monthly, presentations, and radio and television public service announcements. About one-quarter of program referrals come from participating providers.

Financing and Provider Reimbursement

AHN is funded through federal, county and state funds, as well as member premiums. Individuals can join AHN in one of three ways, with associated membership requirements. Those enrolled through their employer share the monthly cost of membership at \$20 each; individuals enrolled directly pay as little as \$24 a month; and families enrolled directly pay \$35 a month. Half of AHN's operating dollars come from premiums. In addition, as members use services, they are charged reduced rates that they must pay in cash at the time of service — an arrangement that reduces providers' need to devote resources to patient billing. The plan's inpatient hospital medical charge is \$400 per day, and the outpatient rate is 35 percent of Medicaid allowable.

Since medical discount plans are prohibited from paying providers directly, AHN established a Patient Care Fund through its 501(c)3 status to accept donations and grant funding to pay providers when members cannot afford to do so (due to a long-term illness or trauma, or for services not included in the network). AHN has raised more than \$500,000 for this fund over two years from foundations, corporations, businesses, and individuals. (Only the CEO of AHN can approve payment from this fund.)

Program Measurement and Evaluation

According to Sherri Rice, executive director of AHN, response to the program has been very positive across stakeholder groups, with members complying resoundingly with program rules. The program measures success based on members' compliance with payment requirements. Against this measure, AHN has performed tremendously: since its inception, only 20 patients have been asked to leave the program due to failure to pay.

Challenges Ahead

Rice notes a number of future challenges to the program, including:

- Reluctance by many surgeons to accept reduced rates;
- Resistance from pediatricians to turn away patients who cannot pay at the time of service, despite AHN's rule to the contrary; and
- An inadequate number of participating PCPs.

adultBasic (Pennsylvania)

Program Design

adultBasic was created as a result of Pennsylvania's Health Investment Insurance Act (Act 77) of 2001, which called for a portion of the state's tobacco settlement proceeds to be invested in the health of Pennsylvania consumers. Fulfilling this requirement, the program was designed to provide basic health insurance for adults with incomes up to 200 percent of FPL who do not otherwise have health care coverage and are not eligible for Medical Assistance.

adultBasic is administered by the Pennsylvania Insurance Department, which uses program funds to purchase low-cost managed care coverage for members from private insurers operating in the state. Currently participating health plans are Highmark, Independence Blue Cross, Blue Cross of Northeast

Pennsylvania, and Unison Health Plan of Pennsylvania. Highmark serves close to half of enrollees. Members are assigned to a plan based on their county of residence; in those counties with more than one adultBasic managed care plan choice, members may choose their plan. While plan participation is voluntary, the state requires all Blue Cross/Shield (BCBS) Plans to provide a bid for participation (all participating plans, except for Unison Health Plan, are BCBS plans).

adultBasic provides for primary and specialist office visits; inpatient hospitalization; surgery; emergency accident and medical care; diagnostic services; maternity and newborn care; gynecological and obstetrical care; routine mammograms; diabetic supplies and oral agents; and organ transplants and related immunosuppressants. It does not include prescription coverage.

Population Served

To be eligible for adultBasic, an individual must be between 19 and 64 years of age; have household income no greater than 200 percent of FPL; be legally residing in the U.S.; be a resident of Pennsylvania for 90 days prior to enrollment; not covered by private or public insurance (including Medicaid or Medicare); and not covered by private insurance during the three months prior to the determination of eligibility (unless uninsured due to loss of employment).¹⁰ There is no exclusion for pre-existing conditions.

adultBasic currently has more than 44,000 members, representing less than 5 percent of the state's uninsured population. The majority of members — approximately 41,800 — are served through a subsidized, low-cost plan; while the remainder purchases the product at full-cost. This full-cost option is offered to those on the wait list for the low-cost plan. Underscoring excessive demand for the program relative to funding, the wait list exceeds 334,000 individuals, with an average wait time of more than two years. Over the life of the program, offers of enrollment have been made to almost 259,000 individuals on that list.

To ensure the program reaches the maximum number of people, the state conducts a monthly assessment of program expenditures to determine how many enrollees can be added. As funding becomes available, membership offers are made to individuals on a first-come, first-served basis.

Of those in the low-cost plan, 70 percent are Caucasian, 9 percent are Asian, and 6 percent are African-American. The majority of members are over age 35: 4 percent are age 19 to 25; 13 percent are age 26 to 35; 27 percent are age 36 to 45; 34 percent are 46 to 55; and 23 percent are 56 to 65.

Outreach

While the state does not have funding to market the program, the subcontracting health plans are required to do so; they also accept and process program applications. The state does work with community service partners to share information about the program and encourage applications. While those applying are placed on the wait list, they can enroll in the program at full cost, and may be referred to another source of coverage or service (e.g., Medicaid, FQHCs, etc.).¹¹

Financing and Provider Reimbursement

In addition to tobacco settlement funds, which are expected over the next 25 years, adultBasic is financed through payments made by Pennsylvania's four BCBS plans over six years, pursuant to the Annual Community Health Reinvestment agreement, which was entered into in 2005.¹² In 2008, these two sources of funding provided \$171.8 million to the program; it has never received any federal funds.¹³

¹⁰ Pennsylvania Insurance Department (2008). "Pennsylvania's adultBasic Program: 20087 Annual Report to the Legislature." Available at http://www.ins.state.pa.us/ins/lib/ins/chip_ab/adultBasic_Annual_Report_2008_FINAL.pdf

¹¹ Ibid.

¹² Note: The participating plans support adultBasic solely through their contributions to Annual Community Health Reinvestment fund.

¹³ Pennsylvania Insurance Department, *op. cit.*

Members share in the cost of the program through monthly premiums. The subsidized adultBasic plan requires a \$35 per month premium, plus copays (including \$5 for PCP and \$10 for specialist office visits). Those joining the full-cost plan pay a \$332 monthly premium, in addition to copays.

Most adultBasic enrollees are covered by managed care plans that pay full, commercial reimbursement rates to participating providers. A small percentage are enrolled in plans that pay Medicaid rates, which are roughly half of commercial rates.

Program Measurement and Evaluation

As the goal of adultBasic is to increase access to coverage, achievement of success has been marked by the program's full membership (despite the number of remaining uninsured). Measures pertaining to utilization, outcomes and/or costs have recently been collected; for example, the state has begun to track certain HEDIS measures and is working to build a data warehouse.

Challenges Ahead

Peter Adams, deputy commissioner for CHIP and adultBasic, Pennsylvania Insurance Department, cites a number of program challenges, including:

- Inadequate funding for the expansion of program rolls and the benefits package; and
- Challenges obtaining uniform member data across health plans.

Ascension Health Care System (multiple states)

Program Design

Ascension Health, the largest nonprofit health care provider in the U.S.,¹⁴ issued the *Healthcare That Leaves No One Behind* call to action for all of its local health systems to improve performance, cost-effectiveness, and access to local health care safety net providers. A key component of that effort is the *5 Steps to 100 percent Access* initiative, designed to lead local strategies to achieve health care access for all of a community's uninsured.¹⁵ Two notable programs supported through this initiative are the Voices of Detroit Initiative (VODI) and Seton Care Plus in Austin, Tex.

VODI was launched in 1999 through a five-year, \$10 million grant from the Kellogg Foundation to the city's four health systems, Wayne State University, and the Detroit Health Department. Its goal was to enroll and track care for 27,500 uninsured (about 14 percent of the city's uninsured population) through a demonstration model of emergency room-diversion that includes enrollment at the emergency room, followed by case and care management linked to a primary care medical home.

Seton Care Plus, administered by the Seton Health Care Network (a large, nonprofit health system) provides care through three Seton Community Health Centers (CHCs). Launched in 2002, the program is described as a "look-alike benefits package" that includes an "insurance" card, but it does not meet the definition of an insurance product. Benefits include primary care services delivered through an assigned medical home at one of Seton's CHCs; specialty care donated by local, private physicians; inpatient and outpatient services at the network's hospitals; pharmacy; care coordination; and disease management. The program applies numerous managed care principles, including pre-authorization for referrals and high-cost procedures; monthly meetings with providers to review utilization data; ongoing case management services for frequent emergency room utilizers and high-cost patients; use of a pharmacy benefits manager; and disease management for asthma and diabetes.

¹⁴ J. Webster. "One Approach to Catalyzing Community Collaboration to Improve Access to Care for the Uninsured." Presentation, May 2009.

¹⁵ Ascension Health. "Seton Healthcare Network's Application of Ascension Health's 5 Steps to 100 percent Access."

Population Served

VODI was designed to serve Detroit residents ages 18 to 64 with income below 250 percent of FPL and ineligible for any other third-party reimbursement program such as Medicaid. Through 2008, the program enrolled and provided coverage for 52,000 individuals, representing about 25 percent of Detroit's 200,000 uninsured. Among VODI enrollees, 57 percent are female, 69 percent are single, 92 percent are African-American, and 57 percent are employed. A little more than one-third have a chronic condition.¹⁶

To qualify for Seton Care Plus, an individual must have income between 100 percent and 250 percent of FPL, and be ineligible for other programs (i.e., Medicaid, Children's Health Insurance Program or Austin/Travis County Medical Assistance Program); proof of U.S. citizenship is not required.

Seton Care Plus has 4,800 active members, representing approximately 2 percent of the Austin region's 250,000 uninsured.¹⁷ Those without insurance who are not enrolled in the program typically utilize emergency care. Forty percent are ages 21 to 40; 38 percent are ages 41-60; 15 percent are age 20 or younger; and 7 percent are age 61 or older. Proof of U.S. citizenship or legal residency is not required. The majority of participants are mothers with minor children; many have limited ability to speak English; and many comprise a transient population. An estimated 60 percent of members have participated since the program's start; those who do not use the program for one year are considered inactive.

Outreach

VODI identifies and enrolls members as they utilize emergency department services and present for the first time to one of the program's safety net health centers. All new enrollees receive a one-on-one orientation, program brochure, medical home assignment with a participating health center, and ongoing support to navigate the system.

Seton Care Plus partners with the Seton Health Plan to perform much of its program outreach. Using a customized, web-based tool, Seton CHC staff screen and enroll eligible individuals into the program. Of those identified for screening, 98 percent have proven eligible.

Financing and Provider Reimbursement

Following initial funding from the Kellogg Foundation, VODI obtained support from the Healthy Communities Access Program (HCAP) federal grant, Ascension Health (which supplied a matching grant) and others that support reduction of health disparities and improved access to care for the uninsured. The participating health systems also provided an in-kind match through services delivered under their respective charity care policies.

As of April 2010, enrollees have a copay for primary care visits, ranging from \$15 to \$20 depending on the delivery site. Specialty care is free and delivered in a variety of ways — including the volunteer-based "Physicians Who Care" program, hospital-based charity care, and a university medical school — depending on the enrollee's health system. Members receive free prescriptions through manufacturers' pharmaceutical assistance programs; and hospital procedures through the facilities' charity care programs. Funding for Seton Care Plus comes equally from three sources: member copays, the Seton network, and philanthropic entities. Copays are based on patient income; there is no required membership fee or premium. As all members are mean-tested at enrollment, it is expected that they can afford the copays (collection rates are very high). The program asks participating hospitals to bill patients affordably for high-cost services that they typically would write-off, making patients accountable for their utilization.

¹⁶ Smith, L. "Voices of Detroit Initiative: Taking Care of the Uninsured: A Path to Reform." Presentation at National Congress on the Un- and Underinsured/Health Reform Congress, September 22-24, 2008.

¹⁷ Note: The small percentage of the population served by Seton Care Plus reflects that it is a pilot program.

As in VODI, Seton Care Plus members receive free specialty care through a volunteer-based physician program (St. Luke's Society), and prescriptions through manufacturers' pharmaceutical assistance programs. All services are donated by hospital-based health care providers, including inpatient hospitalizations; outpatient clinic services; diagnostics and therapeutics; and some specialty care. The program incentivizes primary care clinic providers through quality reporting and related bonus payments based on productivity, quality and patient satisfaction.

Program Measurement and Evaluation

VODI measures its impact in a number of ways. The program transitioned 55 percent of active enrollees from emergency room utilization to a primary care setting; decreased emergency room utilization by those with medical home use after VODI enrollment by 300 percent; and reduced uncompensated costs for providers by 42 percent.¹⁸

Seton Care Plus evaluates its success based on changes in a number of measures since the program's launch. These include the rate of emergency room visits per 1000 members, found to be 34 percent less than baseline, and 14 percent less than the national Medicaid average. The program has also achieved a reduction in pharmacy expenses, finding costs to be \$5 PMPM, compared to \$25 PMPM at baseline; facilitating access to almost \$14 million in free medications through manufacturers' patient assistance programs; and achieving strong compliance with formulary and generic drug use. The program also found the number of inpatient bed days and average length of hospital stay of members to be less than the Medicaid HMO average and the county's indigent care program.¹⁹ In addition, the program's disease management offering effected a reduction in average HgA1c levels to within recommended levels in participants, and a decrease in emergency department use and costs related to diabetes.

Challenges Ahead

Challenges facing VODI, as described by Cynthia Taueg, vice president — community health, include recruitment of a sufficient number of volunteer specialists to meet the growing need; reducing the increasing numbers of low-acuity emergency department visits; and, given Detroit's dire economy, rising demand for primary care services among the newly uninsured who need care.

According to Diana Resnik, senior vice president, Community Care, Seton Family of Hospitals, Seton Care Plus hopes to expand its reach, particularly to more of the vulnerable population segments that have high emergency room utilization, and to facilitate outpatient service bundling around chronic disease. She cites a number of challenges to its continued success and expanded operations, including an insufficient number of providers (particularly specialists), no available dialysis facilities, and no more capacity in current chemotherapy infusion centers to serve the region's growing population.

Healthy San Francisco (California)

Program Design

Healthy San Francisco (HSF), the nation's first county-run universal health plan, is a comprehensive medical program administered by the San Francisco Department of Public Health (SFDPH) to make health care accessible and affordable to uninsured residents. The program provides access to preventive, specialty, urgent, emergency, and mental health care; substance abuse services; laboratory services; inpatient hospitalization; radiology; and pharmaceuticals. Enrollment began in July 2007.

¹⁸ Smith, *op cit*.

¹⁹ Note: The Travis County Indigent Care Fund, supported by local tax dollars, provides an insurance-type program with care delivered through FQHCs, for residents up to 100 percent of FPL.

Each member chooses one of 30 clinics as a medical home, and receives an identification card listing that provider. The medical home provides an individual clinician (a physician or nurse practitioner) and coordinates care. San Francisco General Hospital (SFGH) and four other hospitals serve members.

A notable plan feature is its chronic care management program, “Strength in Numbers,” which supports medical home use of disease registries and rewards improvements in targeted chronic disease measures for diabetes, hypertension and high cholesterol.²⁰

Population Served

To be eligible for HSF, an individual must be between the ages of 18 and 64, reside in San Francisco, have income no greater than 500 percent of FPL (increased in February 2009 from 300 percent of FPL), be uninsured for at least 90 days, and be ineligible for a public insurance program. There are no exclusions for pre-existing conditions or immigration status. A resident may join either through an employer or individually, and must renew eligibility annually. Disenrollment may occur if eligibility is no longer met, if a member chooses to disenroll, or if the required quarterly membership fee is not paid.²¹

HSF has approximately 48,000 members, representing close to 80 percent of the estimated 60,000 uninsured adult residents. Since its inception, HSF has served close to 60,000 individuals.²² Because it is a voluntary program, enrollment by the entire eligible population is not expected.

Demographically, 11 percent of members are age 18 to 24; 40 percent are 25 to 44; and about a quarter each are 45 to 54 or 55 to 64. Forty percent are Asian/Pacific Islander, 24 percent are Latino, 18 percent are Caucasian, and 9 percent are African-American. There is an approximately even gender split. Seventy percent have income at or below 100 percent of FPL; 22 percent are between 101 percent and 200 percent; 7 percent are between 201 percent and 300 percent; and 1 percent have an income of 301 percent of FPL or greater. According to a 2009 plan study, members are sicker, older, and report somewhat greater utilization of health care needs than the general population.²³

Outreach

To help members learn about and access the program’s services, the city offers a “311” calling system, which has approximately 300 monthly callers.²⁴ Information about the program is also available through the program’s website and in local newspapers.

Financing and Provider Reimbursement

Consistent with the notion of shared financial responsibility for the health and well-being of uninsured residents, HSF has a diverse funding base comprising public funding, employer contributions, and participant fees. In FY 2008-09, HSF cost the SFDPH approximately \$126 million or \$298 per month in health care services and administrative expenses.²⁵ The majority of HSF funding, totaling \$90 million, comes from the City and County of San Francisco. The remaining \$36 million in revenue is from federal reimbursement funds (\$19 million), employer contributions (\$14 million), and participant fees (\$3 million).

Membership fees are based on income level: for the 70 percent of members whose income is below the FPL, the program is free,²⁶ while those in the highest eligible income bracket (up to 500 percent of FPL) pay \$450 every quarter. In addition, members above the FPL have copays of \$10 for primary care, \$20 for specialty care, \$5/\$25 for formulary/non-formulary drugs, and \$200 for a hospitalization.

²⁰ Healthy San Francisco (Sept. 1, 2009). “Annual Report to the San Francisco Health Commission (for Fiscal Year 2008-09).”

²¹ Ibid.

²² Ibid.

²³ Ibid.

²⁴ Ibid.

²⁵ Ibid.

²⁶ J. Barbassa. “San Francisco’s Health Care a Model During Debate.” *The Washington Post*, November 20, 2009.

In FY 2008-09, 11 percent of financing came from employer contributions.²⁷ The City and County of San Francisco have an employer mandate — the Employer Spending Requirement (ESR) — that employers spend a minimum amount per hour on health care for their employees (nonprofit employers with fewer than 50 employees and other small businesses are exempt). Businesses can meet this requirement through health insurance, direct employee reimbursement, health spending accounts, or the City Option, through which employees can apply for HSF or, if ineligible for the program, receive a medical reimbursement account. The ESR is currently under legal challenge by the Golden Gate Restaurant Association.²⁸

HSF medical homes receive negotiated payments in the form of grants. The amount paid to an individual medical home is based on the range of administrative and/or health care services provided and the number of HSF enrollees. HSF does not reimburse participating nonprofit hospitals.

Program Measurement and Evaluation

According to Tangerine Brigham, director of HSF, the program aims to improve access to, satisfaction with, and utilization of care by members. As a result, improvements in quality, outcomes and cost-effectiveness of care are expected.

HSF has assessed its impact on access in the following ways:

- Twenty-five percent of enrollees used no health care service in the previous two years;
- Since the program's start, its provider network has been expanded twice to include four nonprofit hospital systems, a private physician association, and a nonprofit health plan, broadening access to care; and
- HSF has reduced the number of uninsured by identifying approximately 6,600 uninsured residents eligible for, but not enrolled in, public health insurance.

HSF maintains a clinical data warehouse through which it examines utilization patterns, access and clinical data for participants. The program uses this data to compare utilization by participants against recognized quality standards (e.g., HEDIS measures), and assess whether appropriate and timely care is being sought by those with chronic illnesses. Data from FY 2008-09 revealed:

- Utilization of primary care services by 78 percent of participants in a 12-month period;
- A 27 percent decrease in SFGH hospital emergency department visits per 1,000 participants (216 to 157) from the first to second year; and
- Lower rates of SFGH hospital utilization and avoidable SFGH emergency department visits than found within Medi-Cal.^{29,30}

A March 2009 survey conducted by the Kaiser Family Foundation found that 63 percent of members were “very satisfied” and another 31 percent were “somewhat satisfied” with the program; 41 percent reported improvements in how well their health needs were being met; 86 percent said that they have a usual source of care; and 44 percent said that they pay less for health care than before they joined the program.³¹ Additionally, HSF found that “Strength in Numbers” led to medical homes increasing their A1c screening rates by 8.7 percent, and LDL screening rates by 7.1 percent.³²

²⁷ Kaiser Commission on Medicaid and the Uninsured, *op. cit.*

²⁸ Healthy San Francisco, *op. cit.*

²⁹ Note: Medi-Cal (Medicaid) data are for adults enrolled in San Francisco Health Plan.

³⁰ Healthy San Francisco, *op. cit.*

³¹ Kaiser Family Foundation. “Healthy San Francisco Enrollees Express High Levels of Satisfaction with City’s Health Access Program and Survey Shows Signs of Improved Access to Care.” News release, August 26, 2009.

³² Healthy San Francisco, *op. cit.*

Furthermore, initial data from the Health Access Questionnaire completed by every HSF applicant and renewal applicant indicate that those renewing their eligibility have more established relationships with a medical home, better access, fewer delays in seeking care, and perceived better quality of care.³³

Challenges Ahead

Since the debut of HSF, Brigham shares that the SFDPH has identified a number of lessons, and challenges to address in future, including:

- There is a need to manage program expectations consistently. Because HSF is a local program, it cannot address all of the problems inherent to the health insurance market or safety net delivery system driven by federal or state regulations and policies;
- Targeted strategies are needed to promote on-time renewals by members;
- Participant education is critical for any program that seeks to change health-seeking behaviors, particularly for a diverse population such as HSF's membership; and
- While there is external interest in obtaining HSF impact data, this is premature in the initial years of the program.

Hillsborough County Health Care Plan (Florida)

Program Design

The Hillsborough County Health Care Plan (HCHCP) was created in 1992 to provide state-mandated charity care more affordably to low-income, county residents. At the request of the Hillsborough County Commission and local business/civic organizations, the Florida Legislature authorized a half-cent sales tax increase to fund health care for the poor and uninsured through the plan.

As a comprehensive managed care program that contracts with providers to deliver primary care through a medical home, the HCHCP is comprehensive in scope, covering specialty care; inpatient and outpatient treatment; pharmaceuticals; and other medically necessary services. Primary care is delivered to enrollees through a consortium of four local health care systems. The plan promotes coordination across health and social service providers, with case managers employed by the county's Department of Health & Social Services facilitating access to services that can improve member self-sufficiency.³⁴

Population Served

The HCHCP was designed for employed and employable individuals who cannot afford health insurance, but do not qualify for Medicaid. For individuals who are not employable due to health, the HCHCP provides health coverage while the individual files for disability. To enroll, an individual must not be eligible for any other health care coverage; be a U.S. citizen or documented legal resident; reside in Hillsborough County; and meet income and asset guidelines that are within 100 percent of FPL. There is currently no limit on the length of time an individual can remain in the plan; the county is finalizing processes that will support length of membership no longer than 24 months.

Since 1992, the HCHCP has served more than 160,000 individuals.³⁵ As of September 2009, enrollment was approximately 17,000, with no waiting list, representing approximately 40 percent of the eligible population. In FY 2009, funding from the HCHCP paid for health care for almost 34,000 individuals. Due to the recent economic downturn and increased unemployment, the proportion of male members has increased to almost half (47 percent) and the overall education level has risen (66 percent of members have a GED, high school diploma, or higher education degree).

³³ Ibid.

³⁴ Hillsborough County (2009). "Hillsborough County Health Care Plan: Annual Report."

³⁵ Ibid.

Outreach

According to David Rogoff, Director of Health and Social Services, Hillsborough County, participating hospitals, local clergy and social services agencies have made eligible individuals aware of the plan. Given high rates of enrollment, the HCHCP itself has not conducted any direct outreach.

Financing and Provider Reimbursement

The half-cent sales tax goes into a Health Care Trust Fund that provides the financing for the HCHCP's managed health care program, as well as for Hillsborough County's funding for other state-mandated contributions to health care for the low-income population. These state mandates include a local match for Medicaid, funding for charity-qualified Hillsborough residents receiving health care in Florida facilities outside the County, and a \$3.5 million annual payment to the County's Level I Trauma Center.

HCHCP members do not pay premiums. The current \$1 copay for drugs is being phased out as the program relies more on pharmacy assistance programs to provide free access to prescription drugs.

The plan reimburses providers based on a schedule. For those providers eligible for Florida's Low Income Pool (including several participating hospitals and FQHCs), the HCHCP sends payment to the State, which provides matching funds and pays providers directly.

Most recently, the program has found savings in the State's Medically Needy Share of Cost program, through which the County pays an individual's Share of Cost, and the State pays the balance of a bill. As a result, the HCHCP has reduced its expenditures by \$4 million per year. Rogoff cites this as one of many ways that the HCHCP has identified ways to partner with the State to coordinate care.

Program Measurement and Evaluation

Rogoff defines the program's success in terms of its rate of coverage, costs per member per month, and benefits to the community and local businesses. Notably, the percentage of low-income residents without health insurance is less in Hillsborough than in many other Florida counties, and is significantly lower in the county than in the state as a whole.³⁶

Hillsborough County evaluates the HCHCP annually in a variety of ways. Between FY 2004/2005 and FY 2007/2008, for example, it found that aggregate medical and pharmacy costs PMPM increased by only 2 percent, a much lower rate than in the commercial sector; and pharmacy costs PMPM decreased by \$21. In FY 05/06, the plan's Return on Community Investment was estimated at over \$80 million, including "the improved economic impact of a healthier population, increased influx of state and federal dollars into the County, and increased non-County funded benefits for enrollees." Less tangible outcomes included a stable, healthy workforce; a financially viable local safety net; reduced financial risk and stress for low-income individuals concerned about coverage; access to a full range of social services; and a stronger provider network resulting from a decreased charity care burden.³⁷

Challenges Ahead

Rogoff, cites a number of plan challenges, including:

- Managing specialty care referrals to find the most efficient and effective balance between primary and specialty care;
- Addressing non-financial barriers to health management;
- Offering incentives — to both providers and patients — for using the most cost-effective levels of care; and

³⁶ Ibid.

³⁷ Ibid.

- Financial concerns driven by a weak economy, including: 1) reduced sales-tax revenue — \$29 million less than previously forecasted for FY 08/09;³⁸ and 2) increased program demand resulting from reduced access to employer-sponsored coverage and higher unemployment.

Ingham Health Plan (Michigan)

Program Design

Ingham Health Plan (IHP) was formed in 1998 to develop an organized system of care for the uninsured in Ingham County, Michigan. It was spurred by the desire of local medical care partners to improve access to ambulatory/primary care and decrease inappropriate use of more costly emergency department and inpatient hospital utilization.

IHP covers outpatient primary and specialty care, radiology, labs, prescriptions, and urgent care; emergency department visits or inpatient hospitalization (for which hospital financial aid may be available) are not covered. Any service which can be paid for by another public or private health care program is not covered. Each member receives a membership card, and is assigned to a medical home, which can be a PCP or an FQHC.

The program's chronic disease management efforts include the identification and care coordination of patients with conditions such as asthma, diabetes and hypertension by IHP's utilization committee. Nurse care managers work with high utilizers of care to explore alternative payment sources; direct high utilizers of emergency care to primary care settings; and authorize specialty care, outpatient hospital care and high-end radiology services.

Population Served

To be eligible for IHP, an individual must reside in Ingham County; have income at or below 250 percent of FPL; and have no other health insurance. Proof of U.S. citizenship is not required. Individuals may qualify for IHP in one of two ways. Low-income, childless adults who are eligible for the state's Adult Benefits Waiver (ABW) Program³⁹ (and not eligible for Medicaid) can enroll in Plan A during periods of open enrollment. ABW provides basic medical care with minimal to no copays. Residents who do not qualify for ABW, Medicaid, Medicare, or any other public program can enroll in Plan B, a similar offering that is community-sponsored.

IHP has approximately 13,000 members (2,000 in Plan A, and 11,000 in Plan B), representing more than 40 percent of the county's estimated 32,000 uninsured residents.⁴⁰ Since its inception, it has served more than 50,000 individuals. Among members, there is an equal split in gender, and an approximate even distribution across age groups (i.e., about one quarter each are ages 21-30, 31-40, 41-50 and 51-64). Approximately 52 percent are Caucasian, and 32 percent each are African-American or Latino. An estimated 70 percent are employed.

Annual re-enrollment is performed through an active redetermination process; those not returning yearly re-enrollment forms are disenrolled (an average of 400 members per month, who are replaced with an average of 400 new enrollees). Given concerns over the program's financial sustainability, administrators recently began disenrolling members who had not used the plan in two years, unless they notified the program that they would like to maintain membership.

³⁸ Ibid.

³⁹ Note: The ABW provides basic health insurance coverage to residents of the State of Michigan with countable incomes at or below 35 percent of FPL.

⁴⁰ Note: There are an estimated 19,000 individuals residing in Ingham County who are at or below 250 percent of FPL and uninsured.

Outreach

IHP engages in a number of outreach activities to facilitate enrollment, largely through five “Neighborhood Network” centers in the city of Lansing. Community outreach workers enroll hard-to-reach, uninsured members of the community and connect enrollees to other resources such as breast cancer screenings, exercise programs, and food security. They enroll members at the centers, as well as through door-to-door canvassing, public events and health fairs. Additional enrollment is also done through the Public Health Department, two large clinics and other social services agencies.

Following enrollment, IHP and its network centers assist with patient navigation to connect enrollees with a medical home, providing small incentives for utilization of wellness exams and appropriate use of services. The program anticipates improve its new-member orientation to provide more comprehensive education on the concept of a medical home, avoidance of emergency department utilization, and enrollee responsibilities for redetermination.

Financing and Provider Reimbursement

As of January 2010, IHP’s Plan A became funded by a Medicaid waiver; Plan B receives grants from the plan’s two participating hospitals.

IHP contracts with providers to offer a defined set of services for plan members, paying PCPs on a fee-for-service basis that is 8 percent above Michigan’s Medicaid rate. Within Plan B, medical costs are an average of \$26 per member per month. Members are responsible for provider copays of \$5 for primary care; \$10 for specialty care; \$5 for outpatient x-rays; \$5 for walk-in/urgent care; and \$5/\$10 for generic/brand-name prescriptions.⁴¹

Within Plan A, average medical costs are \$107 PMPM. This higher rate is due to the plan’s much lower enrollment and its inclusion of emergency room and ambulance services in coverage (not included in Plan B). The only copays are for office visits (\$3), prescriptions (\$1), and urgent/walk-in care (\$3).⁴²

Program Measurement and Evaluation

According to Robin Reynolds, executive director of the Ingham Health Plan Corporation, the program’s success is defined as providing a basic benefit to 13,000 (50,000 over the plan’s tenure) individuals who otherwise would not have access to care. This success is further evidenced by its replication: the model is now in place in 71 of Michigan’s 83 counties.

More specifically, IHP tracks a number of measures related to program enrollment, operation and impact. These include overall service utilization and expenditures; the number of enrollees who visit a PCP; the number who utilize an emergency department (and the number of those who do so for a non-emergency concern); the size of membership; and the number of new enrollees resulting from recent unemployment.

Challenges Ahead

Reynolds cites a number of program challenges, including:

- Financial unsustainability over the next five years due to a growing membership and increased utilization of services, both driven by high unemployment rates and an increase in the number of uninsured individuals;
- An insufficient number of participating specialists (including gastroenterologists, neurologists, cardiologists, rheumatologists, orthopedists, oral surgeons/dentists, psychiatrists, and dermatologists);

⁴¹ Health Plan Management Services (2008). “Ingham Health Plan.” Available at <http://www.communityhealthplans.org/IHP/healthplans.asp?plan=ingham>.

⁴² Health Plan Management Services, op. cit.

- The need for more intense care management;
- Members' misperceptions of services covered under the plan and ways to utilize their medical home;
- An inadequate exchange of medical information among providers and agencies; and
- Insufficient management of over-utilized diagnostic services such as x-rays.

Kaiser Permanente (multiple states)

Program Design

Kaiser Permanente's (KP's) Charitable Health Coverage (CHC) program includes 13 insurance products that serve the uninsured in communities across the country. The program represents about 20 percent of KP's Community Benefit Portfolio, designed to expand access to care and coverage for low-income individuals. Each region determines the scope of products and benefits to be offered; terms of coverage; and graduated subsidies based on need. All products are required to enroll former members of commercial KP insurance plans and those new to the company, as well as to evaluate their programs and share the findings to influence policy and practice. CHC programs are present in all KP regions, which include: Northern California, Southern California, Colorado, Georgia, Hawaii, the Mid-Atlantic States, Northwest, and Ohio.

Each CHC program offers members a set of benefits focusing on preventive rather than episodic care (though the latter is covered) through a medical home model. Benefits include primary preventive care, specialist care, labs, pharmaceuticals, hospitalizations, emergency department visits, and ambulance services; Dental coverage is provided in some programs. Two of KP's programs, the Steps Plan (California) and the Bridge Program (Hawaii), are described here.

The Steps Plan offers subsidized coverage with progressive annual increases ("steps") in member responsibility for premiums, based on family size and income, for up to four years. Designed to meet a temporary need for subsidized coverage, the program's annual premium increases aim to transition members to full-cost KP products.

KP's Bridge Program is a 100 percent dues-subsidized charity care coverage program for Hawaii residents in financial need. It is a pilot program launched in 2008 to serve as a "bridge" to permanent coverage for low-income, young adults.

Population Served

Membership across KP's 13 CHC programs grew by 10,000 in 2009, reaching approximately 115,000 individuals. Seventy percent of current enrollees are children; the remainder are adults. These members are ineligible for public coverage and have incomes below 250 percent or 300 percent of FPL. Undocumented residents are eligible. Enrollees typically remain in these programs for 12 to 18 months, in part due to member transience and difficulty paying premiums (30 percent are disenrolled due to non-payment). After leaving a KP CHC program, approximately 12 percent of members enroll in a full-cost KP program.

Across CHC programs, approximately half of members are Latino and/or African-American, and most are under the age of 45. While the population's chronic disease prevalence is no higher than the general population's, members do have more hospital inpatient days.

To qualify for the Steps Plan, an individual must be a current or previous KP member for a total of six of the previous 12 months, have family income under 300 percent of FPL, and be a California resident. The program has served 150,000 to 200,000 members since its launch in 1999. There are now approximately 15,000 members throughout California, and enrollment is closed. The majority of members are part-time

workers, self-employed or retired. The program does not track racial/ethnic demographics. About 30 percent of members disenroll after the first year, when member premium responsibility increases from 20 percent to 40 percent (see below); approximately half of those who remain for the second year disenroll at year-end, when their premium rate increases to 60 percent of full cost.

Utilization data show that members who remain in the Steps Plan and move up the premium ladder are sicker than those in their first year of membership. For example, those who have been members for more than two years have higher rates of chronic illness; presumably their pre-existing conditions prevent them from transitioning to other coverage. In addition, Steps Plan enrollees have the highest pharmaceutical utilization rates of any KP plan.

KP's Bridge Program was designed for individuals between the ages of 19 and 24 who reside in Oahu, have incomes no greater than 250 percent of FPL, and are not eligible for any other health coverage. Members are typically those who recently became ineligible for their parents' insurance coverage or are employed without coverage. While the pilot aimed to serve 200 members, enrollment in December 2009 was 50. Because of the state's universal coverage policy and employer mandates, it has been difficult to find those who remain uninsured. However, a number of recent employer eligibility audits have spurred an increase in applications. While the program had an initial one-year limit on membership, that was lifted given continuing economic challenges.

Outreach

KP seeks to enroll members in its CHC programs before the point of service, reaching out to the uninsured in partnership with community entities. The company has strong alliances with various community and social services organizations — which have a keen understanding of the target population — and provides them with grants to fund enrollment efforts.

Outreach has been a particular challenge for the Bridge Program, given the relatively small population of eligible residents. Activities have included outreach through low-impact resources such as free media and government access channels, as well as some engagement of community partners.

Financing and Provider Reimbursement

Member premiums vary across KP's CHC programs, with subsidies ranging from 90 to 100 percent; no member pays more than \$150 a month. Members who cannot afford copays may receive assistance from other KP charity programs. Coverage provided through the CHC programs represented a financial commitment from KP of almost \$221 million in 2008.

Premiums for members of the Steps Plan increase annually from 20 percent to 40 percent to 60 percent to 80 percent. Each member's premium starting point is determined based on income (a family entering at the 40 percent level can only remain in the plan for three years; one starting at 60 percent can belong for two; and one starting at 80 percent is eligible for one year only). Similarly, copays for office visits and other services increase annually. While there is no required premium for Bridge Program members, they are responsible for non-preventive office and prescription copays.

Program Measurement and Evaluation

The goal of KP's CHC programs focuses on the volume of enrollment; however, the programs also aim to manage care appropriately, particularly emergency department use. The programs monitor HEDIS-like quality measures including childhood immunizations; breast and cervical cancer screening; diabetic screening; appropriate use of asthma medications; and multiple chronic disease prevalence. Discussions are underway to determine if additional metrics will be collected to learn more about the patient population, including how individuals interact with the system and their connections with a PCP.

Challenges Ahead

Leaders in the programs cite a number of operational challenges, including:

- Enhancing chronic disease management efforts;
- Teaching enrollees how to be better consumers of health care;
- Improving administrative and clinical efficiencies;
- Implementing a centralized eligibility system;
- Improving member payment of premiums to avoid termination;
- Finding ways to transition members to other sources of coverage to overcome the “cliff effect” at termination; and
- Expanding data collection to populate program metrics.

Portico Healthnet (Minnesota)

Program Design

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 each aligned with one of the program’s nine participating hospital systems.

Portico offers care management to assist with patient navigation, health management, understanding medical bills, social services support, patient advocacy, referrals to specialty care, mental health care management, referrals to community services, and the transition to ongoing coverage (including assistance with enrollment in public programs). Each member household is assigned a social worker who performs psychosocial care management and develops a plan emphasizing prevention, chronic disease management, and optimal utilization of program services, with specific health-related goals. The social worker coordinates services across social services, health care systems, and community resources/agencies, spending approximately 80 percent of time on the 20 percent of patients with the greatest needs.

Portico does not cover emergency room utilization or inpatient hospitalization. Enrollees who have an emergent health need or catastrophic illness may automatically qualify for Medicaid.

Population Served

To be eligible for Portico, 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 1,400 individuals and is expected to rise. Currently, 70 percent of member households have at least one employed adult (the majority of whom work full-time); 90 percent have an annual income under \$35,000; and more than 60 percent live at or below 100 percent of FPL. Over 80 percent of individual members are non-white, and the program serves a largely immigrant population. A large number of members remain in Portico for only four months while they satisfy the four-month waiting period for the state’s Medicaid program. Overall, individuals most commonly leave the program as a result of finding another source of coverage.

The program is at-capacity, with a wait list of 400 to 500 individuals who face an average wait time of 18 months. Funds received in 2009 through the Health Resources and Services Administration’s State Health Access Grant Program are helping to enroll additional members off the list.

Outreach

Outreach to eligible individuals is performed in partnership with more than 100 organizations in the region, including government agencies, schools, clinics, hospitals, community agencies, and faith-based organizations. The program also utilizes events and health fairs, professional referrals, and word-of-mouth recommendations to encourage enrollment. Community health workers provide linguistically and culturally appropriate information and referrals, as well as screen for eligibility for Minnesota's Health Care Programs (including Medicaid) and assist with applications.

As a result of these efforts, in FY 2008, Portico screened more than 13,000 uninsured individuals for various health coverage options, provided over 8,000 referrals to households seeking health care resources, and helped nearly 3,800 individuals to apply for public coverage programs.

Financing and Provider Reimbursement

Portico relies on an innovative financing model with investments from all hospitals in the Twin Cities — an upstream movement of funds in the local health system. Through annual contributions totaling approximately \$1 million, participating hospitals pay for enrollee medical care at a cost of about \$1,000 to \$1,250 per person.⁴³ This investment benefits the hospitals directly by decreasing emergency room and inpatient utilization by many individuals who would require charity care and/or incur collectible charges.

Each member household pays a sliding scale, monthly participation fee of \$25 to \$50, and small copays for non-preventive physician visits. Clinical services performed in a physician's office are reimbursed at 15 percent above the Medicaid fee schedule — an attractive rate for physicians serving Medicaid patients. Reimbursement for hospital-based procedures, such as x-rays and MRIs, is at a hospital-negotiated rate (typically 110 percent of the Medicaid rate); patients pay a 25 percent coinsurance.

Program Measurement and Evaluation

Portico's mission is to reduce the number of people without coverage for health care services. The program measures its success by reduced emergency room use, lower inpatient hospitalizations, and increased use of preventive care. A 2008 survey conducted for Portico found that program enrollment leads to a 33 percent increase in PCP visits, and 33 percent decreases in emergency room visits and inpatient hospitalizations. Through cost savings from these changes and from increased enrollment in public programs, the community saw a return of \$3 for every \$1 invested in Portico.⁴⁴ Another measure of success has been the longevity of Portico's hospital partnerships: the same hospitals have participated in the program since its inception.

Challenges Ahead

Christopher Bargeron, director of operations for Portico Healthnet, cites a number of additional program needs:

- An expanded benefits set;
- A more robust care management model that addresses behavioral health; and
- More integrated clinical care management.

⁴³ D. Holmgren. "Portico Healthnet: A Local Solution for Covering the Uninsured." *MetroDoctors*, January/February 2008, 13-14.

⁴⁴ *Ibid.*