

The Costs and Adequacy of Safety Net Access for the Uninsured Exeter and Portsmouth, New Hampshire (SeaCare)

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This report examines the SeaCare program based in south coastal New Hampshire, as part of a series of case studies whose purpose is to explore whether well-structured safety net systems are able to provide low-income uninsured people adequate access to care at reasonable cost. Safety net providers include a variety of public and private hospitals, clinics and physicians who serve disadvantaged patients, with or without health insurance (Snow Jones and Sajid 2009). While the newly enacted Patient Protection and Affordable Care Act of 2010 will cover an additional 30 million people and offer other protections to many more, at least 20 million people will likely remain uninsured, leaving many to rely on safety net care for most of their health needs (Holahan and Garrett 2010). As a result, the cost and adequacy of safety net care remain vitally important issues for health care public policy (Hall 2009).

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I. Program Structure and Access

SeaCare Health Services is a program in the eastern seacoast half of Rockingham County, New Hampshire for indigent uninsured patients, who are referred to a network of approximately 400 volunteer physicians (Isaacs and Jellinek 2006). Founded in 1992 by local physicians, with early support from the Robert Wood Johnson Foundation, SeaCare now receives the majority of its financial support from Exeter Hospital, a 100-bed nonprofit community hospital which is affiliated with Core Physicians, the largest physician group in the Exeter area.

SeaCare's service area includes Portsmouth, Exeter and Hampton, with a total area population of approximately 125,000. This population base in 2000 had a median family income of \$72,500, substantially above national and state averages (Exeter Health Resources 2008). Only about 5 percent of the population was below the federal poverty level (FPL), and only 2 percent of the population was non-white. Less than 10 percent of the area population is uninsured (with exact measures varying by year, region definition and survey source) -- again substantially better than state and national averages.

As of April 2010, SeaCare had 2,290 adult members receiving physician services, with about two-thirds located in the Exeter area. Membership is available to uninsured¹ local residents (regardless of citizenship) who are below 185 percent FPL. In addition, SeaCare arranges medication

¹ Fewer than 1 percent of members are eligible as being partially uninsured because they have "catastrophic" (very high deductible) or limited benefit insurance that is deemed inadequate for primary care access.

assistance for low-income citizens of all ages (including Medicare recipients) who lack prescription drug coverage, and it conducts a home visit program for children in need, regardless of income. For all of its members, SeaCare provides extensive care coordination for both medical and social services, to reduce barriers to care and improve health outcomes and quality of life.

This report focuses on the adult medical access component of SeaCare. These members receive an identification card renewable annually, and they are assigned a primary care home. Patients are charged \$10 or \$15 for physician visits, depending on complexity. For office-based procedures (such as minor surgeries), members pay according to a discounted fee schedule with a maximum of \$75. Laboratory and x-ray services are donated by local companies. SeaCare does not provide more complex diagnostic imaging (MRI, CT scans, ultrasound), but these are available from local hospitals through their financial assistance programs described below.

SeaCare arranges for primary care both through a community health center in Portsmouth and from community physicians elsewhere. The network of volunteer physicians covers a full range of medical specialists, who are available if patients are referred by their primary care provider. These specialists provide about half of the program's visits and well over half of the program's total value of donated services.

SeaCare does not provide prescription drugs, but its staff assists members who have ongoing prescription drug needs with applying for the medication access programs maintained by all major pharmaceutical companies. For short-term needs, physicians often prescribe inexpensive generics or provide free medication samples. SeaCare staff also provides health education and care coordination services, including referral to social services and to the limited mental and dental health services available in the area.

SeaCare does not cover hospital-based services. However, the two area hospitals, one in Exeter and one in Portsmouth, as well as Dartmouth's Mary Hitchcock Hospital 100 miles away (which provides highly specialized care), each participate in a statewide financial assistance program known as New Hampshire Health Access Network. This program, which began in 2003, adopts minimum charity care standards and a common application form that all hospitals statewide agree to follow (LaFrance 2003). Therefore, once a patient is screened at one facility, he or she can receive the same charity status at any other facility statewide for the next six months.² These statewide standards waive all charges for uninsured patients whose

income is up to 125 percent of the federal poverty level (FPL), and discount charges on a sliding scale from 125 percent to 200 percent FPL. Exeter and Portsmouth hospitals are more generous, in waiving all charges for uninsured patients up to 200 percent FPL.

SeaCare helps its members who need hospital services with applying for this financial assistance. The statewide program is especially beneficial for SeaCare patients whose physicians use Exeter Hospital. Because this hospital employs almost all of the local physicians, qualifying patients receive charity care (100 percent write-offs) for physician as well as hospital services. At

² According to one interview source, New Hampshire hospitals adopted this program in part to forestall interest by the legislature in mandating hospital charity care policies by law, as is done in Maine, for instance.

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Portsmouth hospital, in contrast, medical staff physicians have not agreed in advance to discount or waive their fees for hospital-based care.

Formal assessments have not been done of the level of access provided by SeaCare. However, its success can be seen in a 2008 community needs assessment conducted by Exeter Hospital. Its survey of 509 residents (with a response rate of 17 percent) showed that 82 percent of people below 300 percent FPL had a primary care physician, which is comparable to national norms for insured populations. Also, half of area respondents knew of a place where people without insurance could receive care.

II. Cost of Services

SeaCare reports that, in 2008, its physicians provided services valued at \$1.2 million to SeaCare’s 2,134 adult members. However, this value is based on the physicians’ reported charges, rather than the discounted rates they typically receive from large insurers. Also, not included is the value of services provided by area hospitals.

To derive a more complete estimate of the cost of services provided to SeaCare members in 2008, we focused on the sample of 1,638 patients whose primary care physicians were affiliated with Exeter Hospital through Core Physicians. This large physician group provides a full range of primary care and specialist services and uses Exeter Hospital for most institutional services. Therefore, it was possible to obtain information on the vast majority of physician and hospital services provided to this subset of SeaCare members.

For the 1,638 SeaCare adults who were enrolled in 2008 with primary care physicians affiliated with Exeter Hospital, the hospital provided uncompensated institutional services costing \$1.5 million (Table 1). Costs were measured as a percentage of full charges, based on the hospital’s overall cost-to-charge ratio.

To determine the value of physician services, SeaCare’s data were used from encounter information that its physicians submit for each visit showing normal charges for services provided. Because physicians in New Hampshire accept rates from Medicare and Medicaid that are 25 to 50 percent lower than what private insurers pay (NH Center for Public Policy Studies, Feb. 2009; NH Department of Health and Human Services 2010), half the value reported by SeaCare was used as a rough approximation of the marginal cost or lower-end market value of physicians’ services. Also, SeaCare was not able to match its records with 8.5 percent of the Core Physician patients, so the SeaCare valuation was increased to account for these missing data.

Table 1: SeaCare Members with Exeter Hospital-Affiliated Primary Care Physicians, 2008

Members	1,638
Avg. months enrolled	10.4
Physician services	\$515,218
Hospital services	\$1,457,364
SeaCare admin.	\$254,812
Total costs	\$2,227,394
Costs pmpm	\$131

Source: Data from SeaCare and Exeter Hospital

Based on these adjustments, physician services for these 1,638 patients cost an estimated \$515,218. Added to this is \$254,812 as a prorated portion of SeaCare’s administrative expenses, which includes staff expenses for care coordination and for assisting patients with enrolling in

prescription drug access programs. The Core Physician patients whom SeaCare identified were enrolled an average of 10.4 months each during 2008. Based on this, the full Exeter Hospital sample reflects an estimated 17,014 member months. This produces an average total cost of \$131 per member per month, or \$1,572 per year of full enrollment.

Data were not available to conduct formal cost comparisons with full insurance programs. However, a very rough approximation of the possible range of costs to cover this same population with insurance can be derived from statewide average costs for adults covered by private insurance or Medicaid. In 2006, insurance premiums for single coverage average \$4,622 statewide, up from \$2,790 in 2000 (NH Center for Public Policy Studies, Aug. 2009). If the same 8.4 percent inflation trend continued through 2008, the expected average premium that year would be \$5,431, or \$453 per month, which is more than triple the costs incurred by SeaCare physicians and Exeter Hospital.

Looking to Medicaid, in 2007 the average cost per person for all ages was \$6,769 (Kaiser Family Foundation 2007), but these costs varied widely by age and program type (NH Center for Public Policy Studies 2004). Costs for non-elderly non-disabled adults averaged \$3,165 statewide, but were \$17,550 for disabled adults. Not knowing the percentage of SeaCare members who might be disabled, it is difficult to estimate the correct mix for comparison purposes. But, assuming the lower bound of no disabled members, the state's cost under Medicaid would be at least double SeaCare's and Exeter Hospital's combined.

III. Implications

During the next few years, until health insurance reforms take full effect nationally, states and communities will continue to struggle with substantial numbers of uninsured people. Even after implementing federal reforms, many millions will remain uncovered by expansions in Medicaid and private insurance. These uninsured will include people for whom insurance remains unaffordable, people who are temporarily uninsured while transitioning between public and private coverage, and low-income people who do not qualify for Medicaid or public subsidies due to citizenship status.

SeaCare in Exeter and Portsmouth, New Hampshire, is an instructive example of one model to improve access to health care for people who remain uninsured both leading up to and following national reforms. By linking volunteer physicians with charitable hospital services, SeaCare has succeeded in providing two thousand low-income uninsured residents, regardless of citizenship, good access to a broad range of medical services based in primary care medical homes. The value of services provided appears to be substantially less than the cost of covering this population by Medicaid or private insurance.

Local providers in smaller communities can form effective referral networks for low-income uninsured.

Despite this success, SeaCare has several limitations. Eligibility is restricted to a fairly small geographic area. It is doubtful that all communities could provide even this extent of charity care. Nevertheless, this case study demonstrates that local providers in smaller communities could form effective referral networks for low-income uninsured, if adequate funding were available.

Learning the structures and services required to meet this population's needs might help inform efforts to develop more sustainable funding sources for the uninsured in smaller communities elsewhere.

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