The uninsured in Virginia: Providing health-care access for all

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The need for access to health care will not simply go away—nor will the discussion about it. Yet, while most people consider a free public education to be a fundamental right, it is hard to find legislators who advocate the right to universal health care to the extent of committing the resources that would ensure it. Perhaps that is because they are concerned about the potential cost of funding access to health care on the same level that public education is supported.

However, legislators already have a working infrastructure in place to provide health-care access for almost all Virginians: community health-care centers. The following discussion will review health care in Virginia, clarify the profile of the state’s community health centers, and present the issues facing these centers today.
Ledgers and lives: A history of health care in Virginia

Ledgers

Accountants’ books had implications for health insurance as early as World War II when, in an effort to retain workers during a period of wage freezes, employers began to offer health insurance benefits. Decades later, the 1982 recession signaled a fundamental shift in the United States economy, which transitioned from manufacturing-based to retail- and service-based. The resulting collapse of the volunteer, employer-sponsored health benefit plan was inevitable, and workers with $15 per hour wages and a $500 monthly family health insurance premium found themselves in a vastly different place from workers with $7 per hour wages and a family health insurance premium of up to $1,000 per month.

In addition to Medicare and Medicaid, costs associated with services for the homeless, the unemployed, and mothers and children began to get the attention of health service providers in all states, including Virginia. In the early 1980s, Sen. Ed Willey spearheaded a two-year study on health-care costs. Ledgers everywhere were now being closely scrutinized.

Lives

In 1992, President Bill Clinton attempted to implement a national health insurance plan. His decision to prioritize a once-shelved proposal met with much opposition, and the cost of delivering health-care services to Medicaid and Medicare recipients skyrocketed. During this period, “uninsured” essentially became a household word; since then, the number of uninsured has increased from 35 million to 45 million.

The U.S. Census reveals that in 2003, more than 19 percent of individuals without health insurance lived inside central cities, with the greatest concentration—some 18 percent—living in the South.
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(U. S. Census, Income, Poverty, and Health Insurance Coverage in the United States, 2003). Census data also show that between 1987 and 2003, the number of uninsured in the Commonwealth of Virginia increased from slightly more than 10 percent to 13 percent. During the same period, the number of Virginians with employment-based health insurance and direct-purchase health insurance decreased, while Medicare and Medicaid almost doubled.

Adding to these staggering figures, the Kaiser Family Foundation reported that in 2003, 37 percent of Virginians had incomes below 100 percent of the federal poverty level, 26 percent had incomes between 100 percent and 199 percent of the federal poverty level, and 37 percent had incomes above 200 percent of the federal poverty level (http://www.statehealthfacts.org).

Rene Cabral-Daniels, director of the Office of Health Policy and Planning in the Virginia Department of Health, reports that the lack of health insurance is, in fact, the greatest barrier to health care. After attending a national health-care conference, Cabral-Daniels, along with Cheryl Roberts, deputy director of the Department of Medical Assistance Services, and others quickly convened Virginia's first Conference on the Uninsured to celebrate the commonwealth's "Cover the Uninsured Week." According to Cabral-Daniels, the state recently completed the most comprehensive survey to date on the uninsured. (A report on the survey was expected in May to coincide with this year's Cover the Uninsured Week.)

Misconceptions about community health centers

Most legislators have heard of community health centers (CHCs), but few really understand what they are. They are not free clinics. Although the Virginia Primary Care Association (VPCA), which represents the commonwealth's community health centers, enjoys a strong and positive collegial relationship with free clinics, the two entities are very different in structure and organization.

As well, these centers are not a part
of the health department. However, community health centers are relied upon to provide services when the local health department does not.

CHCs are also not a government agency of any kind. While they do receive an annual grant from the Health Resources and Services Administration, they do not receive federal grant adjustments based on the number of uninsured or poor whom they see.

So what are community health centers? The centers serve uninsured and underinsured patients in medically underserved areas. Each CHC is a private, nonprofit corporation set up as a charity and operated by volunteer boards of directors that oversee governance and have fiduciary responsibility. The directors are representative of the patient demographics of the individual centers. Each center is managed by an executive director and employs providers and support personnel.

According to the VPCA, the three key aspects of CHCs are to provide universal health-care access, to remain cost effective, and to allow for community governance. The core services offered by CHCs include physician care, X-ray services, lab services, preventive services (such as mammograms and well-child care), immunizations, transportation for health services, case management, and specialty referrals. Some centers also offer inpatient physician care, dental care, and behavioral health services.

Each CHC charges a minimum fee—which usually ranges from $5 to $15—that is set by its board of directors based on the annual Federal Income Guidelines, similar to the way the health department determines eligibility for free or reduced-cost services. Many of the centers’ internal structures and policies are dictated by the terms of the Section 330 federal grant they receive for operating expenses. However, once a grant amount is established, increases—known as base adjustments—are rare, usually issued only if surplus federal funds are available.

The community health center program dates back to President Lyndon B. Johnson’s “War on Poverty” plan. As with the Head Start program, CHCs have survived because they work. The organizational and governance structure responds to local need, and federal performance expectations ensure that the centers operate with high-level management practice techniques.

**Who are the uninsured in Virginia?**

Barbara Willis, executive director of the Portsmouth Community Health Center, recently described the faces of the uninsured as “being no different from our own. The uninsured could be someone who has lost a job or someone in a service occupation where health insurance is not an option. It could be your child, now 20 or 30 years old, who still lives at home.” And this uninsured “everyman” can live anywhere in Virginia.
Managed care

Almost a decade ago, managed care was billed as the panacea for rising health-care costs. Today, from a provider view, managed care has managed to only control reimbursement for services. For employers and individuals, the cost of health-care benefits has risen at an average rate of 13 percent per year over the past four years. In contrast, reimbursement rates to providers have steadily declined. Providers can expect the largest insurer, Anthem (formerly Blue Cross / Blue Shield), to only pay 30 to 40 percent of the charge. While Anthem is not the only payor, overall, community health centers are writing off an average of 50 percent of their charges if they accept private insurance. Many of these insurers provide funds for special projects in health care that benefit their patients and some benefit the indigent, but those monies come nowhere near making up for the expenses insurance companies expect providers to absorb.

CHCs are the solution ...

The troubles in Virginia are compounded by the diminishing services offered by the state health department. For many years, Virginia’s local health departments provided a place for uninsured patients to get primary health care. Today, regardless of whether a county has a community health center (currently, 17 counties and municipalities do not) or even a free clinic, local health departments no longer provide primary care services. The departments’ few remaining patient-focused programs are directed toward immunizations and programs for mothers-to-be, children, and individuals with sexually transmitted diseases. Glaringly omitted are men.

Community health centers, therefore, play a vital role by providing early health care access, which reduces complications associated with late entry into the health-care system. The centers’ capacity to provide care to more than 6 million uninsured is being eroded, however, by the increasing numbers of uninsured. Nationally, CHCs care for 6 million Medicaid patients at a cost to Medicaid of $475 per patient per year, which is $250 less than the costs of the provision of services to any other segment of the health-care system. Yet, community health centers return that savings in an amount greater than $500 per person per year. Community health centers cost 30 percent less than any other segment and serve the public good.

Repeatedly, studies have demonstrated that Medicaid and Medicare expenditures are cut in half when a patient uses a community health center for chronic disease treatment. Community health centers can never turn away a Medicaid or Medicare patient as can happen in other private practices. Although CHCs are able to receive a cost-based rate of reimbursement that only strictly considers certain costs, if provisions are cut further, the burden might be insurmountable to community health centers. As a result, when conversations turn to cuts in Medicaid and Medicare, community health centers become truly frightened.
... but not without funding

In many of Virginia's community health centers, the facilities are old and do not comply with current medical center standards. Equipment has long since depreciated out of value, and instrumentation in labs needs to be updated. In every community health center in the state, there is a need for capital to purchase electronic medical record systems and practice-management software.

Problematic facilities not withstanding, the Government Accounting Office recently found community health centers to be among the top 10 most cost-effective programs in the country. President George W. Bush, in his first term of office, recognized the value of community health centers. In what is now referred to as PI1 (Presidential Initiative 1), Bush expanded the number of community health centers in the country. Now that Bush has begun his second term in office, his second initiative, PI2, is focused on the poorest of poor counties in the country. None of the counties targeted for additional funds are located in Virginia, which is really "a good thing"—or startlingly disconcerting, depending on which set of books you favor.

Nonetheless, despite all the benefits afforded by CHCs, hopes are dim for additional federal funding to provide more centers. If there are drastic cuts in Medicaid, the number of uninsured could swell beyond imagination. Now, more than ever, Virginia’s community health centers need legislative support to assist existing centers, add service sites, and establish new centers.

Hoping to find support for CHCs, the VPCA turned to the General Assembly during its 2005 legislative session. In fact, Sen. Charles Hawkins and Del. Phil Hamilton introduced budget amendments calling for a Community Health Center Capital Fund with an initial request for $5 million annually. Although the VPCA bill was not funded in this year's budget, the association will continue to pursue capital funding assistance from the commonwealth and other sources.

The VPCA has also developed a Statewide Strategic Plan to implement new health centers in 24 areas of the commonwealth. These new projects, planned through 2007, will require an investment of more than $20 million in capital funding to meet the needs of patients and the communities that community health centers serve. In addition to providing a medical home for an additional 124,145 Virginians, these new sites and services would create new jobs employing approximately 166 providers and 378 additional staff, for a total of 544 new jobs in the commonwealth.

Statewide support for community health centers is prudent. Savings from such a move could be converted to resources for the uninsured. These savings would become the stuff of legend, the basis for ledgers, and the hope for healthy lives for years to come.

Together, we can do this

Although many problems plague community health centers, they continue to be the providers of the most accessible primary health care in this state. Community health centers have well-managed and well-governed organizations built at the grassroots level and guided by the best medical protocols in the country. For the past four decades, community health centers have shown strong commitment

to access to care.

Legislators cannot continue to expect uninsured Virginians to turn to charities such as community health centers for basic primary health care without providing meaningful financial support. A single new policy or piece of legislation will not resolve the issues of health care in Virginia, but by developing a partnership with health centers, the state could take advantage of an existing, sophisticated resource for improving health care. The benefits of doing so include quality health-care access for local communities, the opportunity to match the federal government's commitment to accessible health care, and the ability to leverage the dollars already supporting community health centers. If the state were to provide support for community health centers, the expense would be modest compared to the wealth of programs Virginians would be able to access. [VIA]

Resources


Falik M., et al. “Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers,” 2001 Medical Care, 39(6):551-56. This published report is based on the findings from Falik M.