



What You Can Do to Help Your Uninsured Patients

Here's how to make your care more accessible to patients who might otherwise miss getting the services they need.

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According to the latest U.S. Census Bureau estimates, 45.7 million people in the United States are uninsured.¹ This exceeds the number enrolled in Medicare (44.8 million)² and approaches the number enrolled in Medicaid (58.7 million).³ After a combined total of 23 years in private practice, we decided to do something to help the growing number of uninsured patients in our own community. In 2004 we founded a novel practice, in which we spend half our time providing primary care to the uninsured (“Recipients”) at no charge and support ourselves by spending the other half of our time providing outstanding access to our paying patients (“Benefactors”) for an annual lump sum. We receive no government funding, and we do not bill any insurance. (To learn more about our practice, see “A New Model of Charitable Care: The Robin Hood Practice,” *FPM*, February 2008; <http://www.aafp.org/fpm/20080200/12anew.html>.)

We've now provided more than 10,000 free outpatient visits to uninsured patients in our community and done so on a shoestring budget. As the uninsured population continues to grow, we would like to share what we've learned about caring for these patients cost-effectively. There is no one-size-fits-all approach, but perhaps a few of these tips will work in your community too.

1. Confirm that the patient is really uninsured.

Many people who think they are uninsured – or uninsurable – aren't. We require patients who say they are uninsured to go through the eligibility and qualification process at the local office for Medicaid and our county's Medically Indigent Adult Program. Some who say they don't qualify for government assistance have never tried, or at least haven't tried recently. Often we learn that individuals don't qualify because they haven't provided the necessary pay stub or birth certificate. Once these clerical hurdles are cleared, voila! There is one less uninsured patient in America. Others may qualify for services they are unaware of, such as veterans benefits, special cancer screening programs, worker's compensation or state disability insurance.

2. Talk openly with patients about the cost of your services.

Many uninsured patients hesitate to go to the doctor's office for fear of expense. However, primary care cognitive services are a bargain. Help them understand the cost of an office visit by comparison to the cost of an emergency room visit, laboratory testing, diagnostic radiology, pharmaceuticals, specialty consultation and diagnostic procedures, or hospitalization that may result from unattended

health problems. If possible, tell them exactly what you will charge. You can offer discounts to uninsured low-income patients, even in traditional practices that accept insurance and Medicare. The article on page 26 describes how to do this without violating fraud and abuse regulations, and it includes a form your practice can use to assess financial need.

3. Make the most of your cognitive services.

In primary care, sometimes we feel pressed to make a perfect decision very quickly. In our previous practices, when confronted with an overwhelming problem we had no time to deal with appropriately, we might have suggested to the patient a plan like this one: “Let’s get an ECG, a treadmill, a chest X-ray, a Chem 2000 and a total body scan, and I’ll see you for a physical in six weeks after the tests are complete.” That is an exaggeration, but you get the idea. Though the patient might be happy that we were “really doing something” for him or her, this is a very cost-insensitive way to practice medicine, and it’s poor patient care.

In our current practice, we try to allow ample time for visits and make the most of our opportunity to provide cost-effective cognitive services. Objective lab and X-ray data are sometimes essential, but often the smarter thing to do when things don’t make sense is to explain to the patient why their limited funds might be better spent on our cognitive services than on tests, and then do a complete history and physical. It is gratifying how often this leads us to the correct diagnosis and plan.

4. Reduce polypharmacy.

One of the best ways to slash drug costs is to eliminate unnecessary medications. This includes not only medications that you and other health care providers may have prescribed but also over-the-counter medications, herbs, vitamins and complimentary treatments. Many patients spend a lot of money every month on treatments of dubious value.

5. Choose generic drugs whenever possible.

Our practice is cash-only. Senior “benefactors”

pay an annual fee of \$1,700. More than once we have saved one of these patients the entire annual fee on their first visit by eliminating medications or substituting generic drugs in their regimen. For example, we saw an overweight patient with diabetes who was taking a brand-name angiotensin receptor blocker, a thiazolidinedione, a calcium channel blocker and a statin, even though he had never had an adverse reaction to any medication. By switching him to generic lisinopril-HCT, metformin and simvastatin, plus adding aspirin 81 mg daily, we not only saved the patient hundreds of dollars at the pharmacy each month but also provided better evidence-based treatment and reduced his risk of morbidity and mortality.

6. Take advantage of low-cost formularies.

We have become very familiar with the \$4 formularies offered by several large retailers. In our community, many of the smaller pharmacies will match these prices. The tricky part is knowing what drugs are available. If you do not use the correct quantity or milligram strength, patients may incur a significantly higher cost. At first, we tried making the formularies available in each exam room, but at four pages of fine print each, these lists were hard to use. The biggest improvement came when we modified our electronic health record system so that the names of the formulary drugs, their dosages and covered 30-day and 90-day quantities were highlighted in a different color. This made the information more accessible, and our formulary compliance soared.

7. Be patient with patient assistance programs.

The first few times we used drug manufacturers’ patient assistance programs, we found them to be frustrating and time-consuming, mainly because each company has its own web site. But these programs are very valuable for eligible U.S. citizens, particularly those who need expensive medications such as atypical antipsychotics, antidepressants, angiotensin receptor blockers and thiazolidinediones. We have found that using one web site (<http://www.helpingpatients.org>), sponsored by the Partnership for Prescription Assistance,

■ Establish a protocol for confirming that patients who say they are uninsured or uninsurable really are.

■ Talk with patients about the value of cognitive services, and don’t underestimate the ability of a complete history and physical to lead to the correct diagnosis and plan.

■ Review medication lists, opt for generics and rely on low-cost formularies when possible, and learn to use patient assistance programs.



Article Web Address: <http://www.aafp.org/fpm/20090900/21what.html>

makes the process much more efficient. We've learned how to use this web site well, and it has paid great dividends. Most of the forms can be completed by a clerical person relatively quickly. The patient is responsible for the sometimes burdensome work of collecting the necessary financial data. We have found manufacturers to be very generous with some very some expensive medications.

8. Do some things yourself that you might otherwise refer.

Caring for uninsured patients with diabetes is challenging, but without objective laboratory data it is almost impossible. Blood glucose test strips are expensive, and uninsured patients usually can't afford frequent monitoring. Sending these patients to the lab for A1C testing was often an exercise in futility. They incurred a significant cost, and the delay between the office visit, receiving and reporting the lab result, and recommending a new treatment sometimes frustrated our efforts to provide the best care. We solved the problem by purchasing CLIA-waived A1C test kits and providing this service ourselves. The efficiency improvements more than compensated for the hassle of performing the tests. Simply telling the patient that the test kits cost \$11 sometimes results in a free-will donation that covers the expense.

9. Don't generate bills.

One key to our practice is that we keep overhead low, primarily by not billing insurance. We recommend adopting a policy for uninsured patients of "cash pay at time of service." Make it clear that though you will work with uninsured patients to keep their expenses down, you cannot bill for payment later.

10. Shop around for the best lab prices.

Become familiar with the cash-pay rates for the 10 to 20 lab tests you order most often. The results may surprise you. In our community, lab services are provided by a small company,

two major chains and two local hospitals. Some are eager to accept cash-pay business, while others are not. Most provide a 50 percent or better discount for cash-pay at the time of service. We participate in a group purchasing program for non-profit organizations (<http://www.councilconnections.com>) that provides steeply discounted lab and medical supplies. For example, we have seen the cash-pay rate for a comprehensive metabolic panel vary from our contracted rate below \$5 up to \$150 at a local emergency department.

11. Shop around for the best radiology prices.

We have found similar variation in pricing for diagnostic radiology services. Some offices are willing to provide discounts for cash-pay at the time of service. One local provider has favorable rates for plain films, CT and MRI; another has lower prices for ultrasonography. Again, consider checking the cash-pay price of the 10 to 20 procedures you order most often. Your familiarity with these prices will help when discussing options with your uninsured patients.

"Older" procedures are lower-priced alternatives that uninsured patients may prefer to more "modern," higher-priced technologies. Maybe we're showing our age, but it wasn't too many years ago that an upper GI series and a CT brain scan were pretty good tests. For instance, if our clinical concern is to rule out a gastric malignancy, endoscopy might be the best single test, but it can be very costly. Typically it includes an initial gastroenterology consultation, the cost of the prep, the procedure room fee, the professional component, the pathology report, and a follow-up visit with the consultant to discuss the results. An uninsured patient might choose an upper GI series (about \$120) first, and then an endoscopy later if the findings are suspicious or the situation doesn't improve.

12. Use the Web to aid decision-making at the point of care.

We have Internet access in our exam rooms and frequently use it to find clinical information and the reassurance we need to avoid unnecessary referrals and improve treatment plans. We often visit these sites: <http://www.epocrates.com>, <http://www.ahrq.gov>, *American Family Physician* at <http://www.aafp.org>, and <http://www.UpToDate.com>. ➤

■ Taking a do-it-yourself approach to services such as A1C testing can yield quality and efficiency gains that offset the costs.

■ Requiring uninsured patients to pay at the time of service reduces overhead and may enable you to charge lower fees.

■ You might be surprised by the variation in cash-pay rates for certain lab and radiology services; your familiarity with these prices will save money and inform care plans.

About the Authors

The authors founded St. Luke's Family Practice in Modesto, Calif.; <http://www.stlukesfp.org>. Author disclosure: nothing to disclose.

13. Talk to your consultants.

Our community is relatively underserved. Every physician is busy. In our previous practices, where we often saw 35 patients per day, if in doubt about whether the patient required specialty consultation, we were sometimes quick to refer the patient and have the consultant figure it out. Now we take the time to call our consultants directly about urgent or “borderline” cases. We don’t charge our patients for this time, although you might choose to. We believe these calls would be an effective use of uninsured patients’ limited funds. In addition to promoting cost-effectiveness, these conversations also improve patient care, build collegiality and help us improve our knowledge-base and understanding of the appropriate evaluation beyond the typical scope of primary care.

To further improve relations with your consultants, consider these two suggestions: Send your referrals with a concise cover letter and the appropriate lab and office notes. Give your personal cell phone number to the consultant to make it easier for them to reach you when they return your call.

And remember that your radiology colleagues are consultants too. They are usually readily available by phone, and we have been very impressed with their ability to guide us to more expeditious and cost-saving ways to evaluate our clinical concerns.

14. Ask a consultant for a reduced fee or no charge once in a while.

If you provide a steady source of well-prepared referrals for your consultants, they may consider seeing an uninsured patient occasionally at low or no charge as a special favor. Let them know that you are already making a special effort to help the uninsured in your community, and that you are treating the patient on a shoestring budget as well. In return, consider offering to accept an uninsured patient who no longer requires specialty care from the consultant.

15. Keep in touch with your community’s social service resources.

Making contact every year or two with our local social service organizations helps us keep abreast of new health programs that may be of interest to our patients and of programs that

have lapsed. We have set up appointments at our county’s Medicaid and Medically Indigent Adult Program offices, the hospital social services departments, the local psychiatric emergency service and charitable organizations to find out what services they offer, and to offer our assistance when they need the help of an office-based physician. In our experience, these folks are flabbergasted by the offer and will in turn bend over backwards to help our patients.

16. Chart appropriately.

Many physicians feel apprehensive about offering anything less than state-of-the-art medical care to all of their patients. While this standard is admirable, it may not always be practical. For instance, if you feel an endoscopy would be the best test to rule out gastric malignancy, say so, but don’t hesitate to offer the option of the lower-priced test (upper GI series). Make sure your medical record reflects the range of diagnostic and treatment options that you discuss. If a particular test is not chosen because of its cost, chart accordingly. We have a “phrase” function in our electronic health record that allows us to add this phrase to the note in two clicks, “Recommended to the patient but declined for financial reasons.”

Though all of our patients appreciate our effort to provide them great primary care, none are as appreciative as our uninsured patients who have no other option. Caring for the uninsured not only helps them but also helps us remember what being a family physician is really all about. **FPM**

Send comments to fpmedit@aafp.org.

1. DeNavas-Walt C, Proctor BD, Smith JC. U.S. Census Bureau, Current Population Reports, P60-235: *Income, Poverty and Health Insurance Coverage in the United States: 2007*. Washington, DC: U.S. Government Printing Office; 2008. <http://www.census.gov/prod/2008pubs/p60-235.pdf>. Accessed July 31, 2009.

2. The Kaiser Family Foundation, statehealthfacts.org. Data Source: Mathematica Policy Research analysis of CMS State/County Market Penetration Files, July 2008. <http://www.statehealthfacts.org/comparemappable.jsp?ind=290&cat=6>. Accessed July 31, 2009.

3. The Kaiser Family Foundation, statehealthfacts.org. Data Source: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2009. <http://www.statehealthfacts.org/comparemappable.jsp?ind=198&cat=4>. Accessed July 31, 2009.

Using web-based resources may help you avoid making unnecessary referrals and develop cost-effective treatment plans.

Open, proactive relationships with consultants can save money and time for all your patients.

Make sure that you document the range of diagnostic and treatment options you discuss and, if appropriate, the reason for choosing a lower-cost approach.