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Health Care PULSE

E-Magazine

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Health Care PULSE E-Magazine

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Navigating Through The Health Care Maze

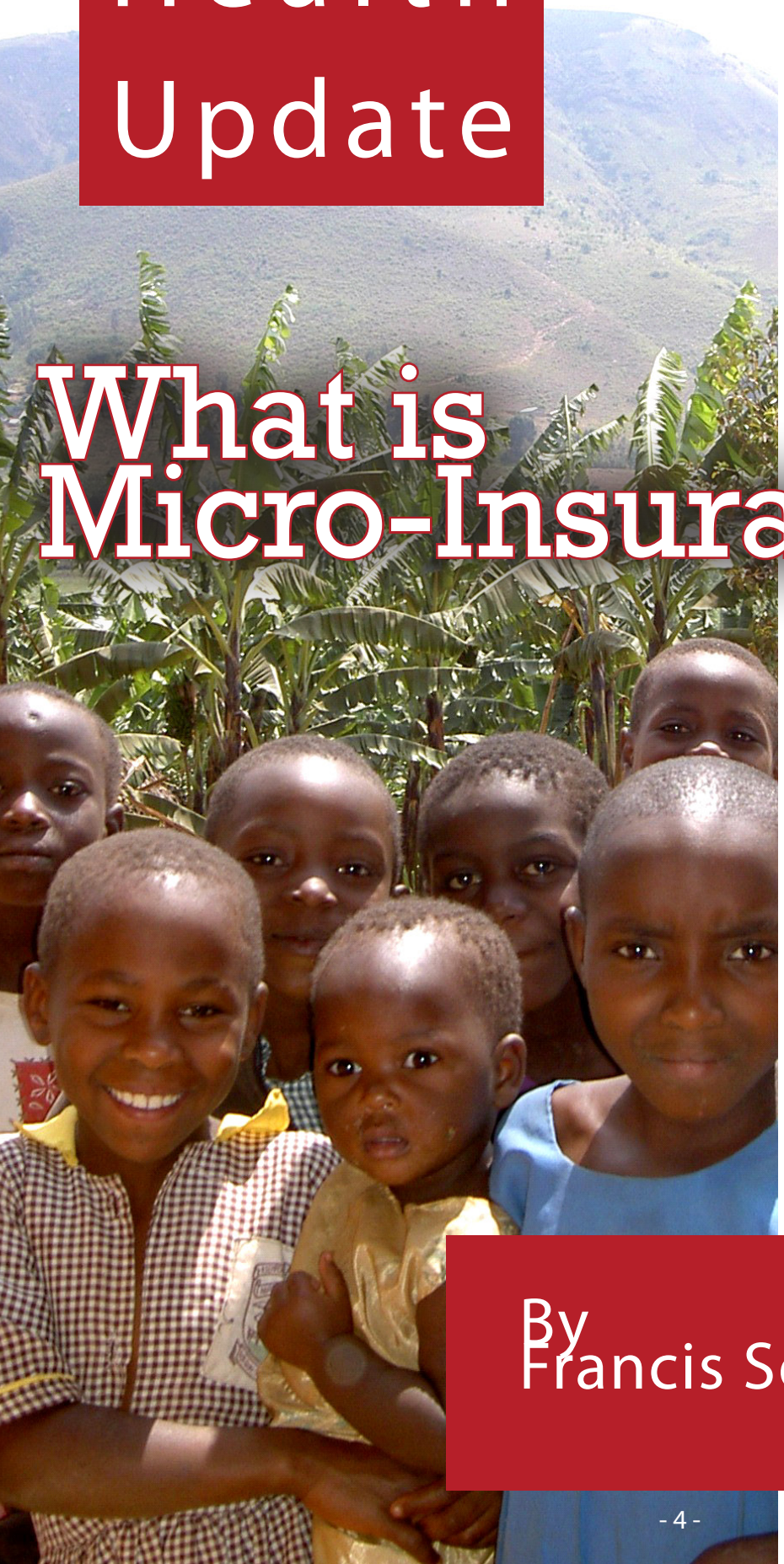
What Are Health Care Navigators?

By: Beatriz Arroyave

Early in the summer of 2009, when lawmakers were starting work on what would become the largest health care reform in decades along came the birth of the name "navigators." The new law called for state and federal governments to hire these «navigators», which are members of various organizations such as CBO's, Social Services and patient advocacy group to help people use an online marketplaces created by the law to choose among insurance plans and enroll in coverage.

Navigators have a vital role in helping consumers prepare electronic and paper applications to establish eligibility and enroll in coverage through the Marketplaces and potentially qualify for an insurance affordability program. They also provide outreach and education to raise awareness about the Marketplace, and refer consumers to health insurance ombudsman and consumer assistance programs when necessary. Navigators play a role in all types of Marketplaces, are funded through state and federal grant programs, and must complete comprehensive training.

Global Health Update



What is Micro-Insurance?

Microcare is an innovative organization involved in developing insurance program for the low income earners in Uganda. The structure of low income varies in rural and urban area. So the affordability for any insurance has got a vast difference. The difference between the developed and underdeveloped countries is that the low income earners in the developed countries do have insurance facilities to cover the risks like life, health, retirement properties and mortgages. Unfortunately such insurance are not available in the underdeveloped countries. The reason is that, the income patterns of these venerable populations are too low to design any reasonable insurance cover.

Microcare has taken the challenge to develop insurance for these low income (micro-income) populations through "affordable" basis. Affordability from one community to another community varies. So the larger volume is inevitably needed to design micro-insurance program. The challenge here we see is the sensitization of the product and to make the people understand about the insurance concept takes time. Poor people value money more than the richer people by comparing the utilization of the cover then the security concept of the insurance. Any program designed for Micro insurance need to have a long term commitment. Many NGOs

By Francis Somerwell

and short term projects fail to achieve this because the market absorption time in the micro-insurance is much longer than any commercial insurance products. Although microcare started as a not for profit donor dependent organization, soon taken the direction to become self sustainable by taking the commercial approach. The strengths of microcare are the unique and innovative research and development approach as the micro-insurance is a new concept to the world and with its technical capacity which

developed computerized database management system effective and efficient ICT system

control of fraud and abuse specifically customized to suit the low income population

innovative preventive health care program to provide proactive healthcare which in turn controls treatment cost

our insurance program is specific to pre-existing community, micro-finance, agricultural, association etc groups

Microcare aims to convert most of the uncertainties like health, debt, death, properties, income source (agriculture) of the poorer population into an affordable Micro-insurance program.

With the innovative capacity, microcare has elevated itself by penetrating into the commercial sector of the market for its own sustainability. The main reason the commercial companies could not come down to meet the requirements of the low income population and consider a viable market population. In the micro-insurance, the gravity flow model of higher level population flowing down on the gravity towards the low income market may not work successful because understanding the mindset of the poor people is difficult, administrative cost to serve micro-income people are higher and the market penetration takes longer time. Microcare started its operations to provide health care to the low income population and elevated as a "capillary force" model, micro-insurance works better. Microcare quickly expanded its operations into the commercial market by becoming the leading health insurance company in Uganda within three years from venturing into the commercial approach but never failed to fulfill the commitment of the original aim to provide health insurance program for the low income market. Without donor support, depending on the income from the commercial side, has decided to contribute its administrative work towards the low income market.

Microcare has started its operations in two remote locations namely Kisoro and Kisiizi. In order to transfer the data to the head office from the remotely located offices we use satellite connectivity. To have an optimum cost utilization for the connectivity charges, microcare called each location as a cost centre and created an Internet café and secretarial services where the rural area people could not access such facilities before. This cost centre generated income to meet the local administrative and personnel costs.

The premiums collected from the rural area like Kisiizi is too low in any insurance terms but that is what the people could afford say about $15 per family

Microinsurance is the protection of low-income people (those living on between approximately $1 and $4 per day[1]) against specific perils in exchange for regular premium payment proportionate to the likelihood and cost of the risks involved. This definition is exactly the same as one might use for regular insurance except for the clearly prescribed target market: low-income people. The target population typically consists of persons ignored by mainstream commercial and social insurance schemes, as well as persons who have not previously had access to appropriate insurance products.

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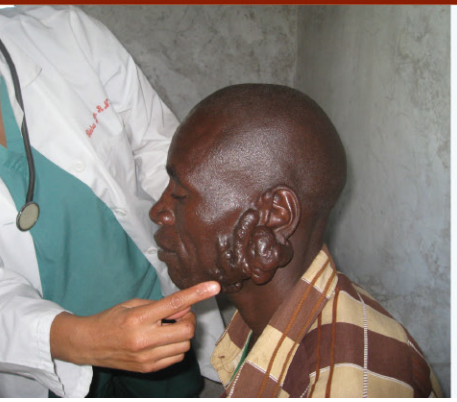

of five people per year. With such premium only mission hospital can provide the services even within the mission hospitals the slag of the administrative capacity makes the poor people not to access the outpatient treatment. The costs of outpatients are higher because the different departments like admissions, surgical, maternity, orthopedic are mixed with the outpatient cost. If the inter-departments in the mission hospital are decentralized, using outpatient as a separate cost center, administrative cost for outpatient will come down. The poor people can access essential outpatient services like, malaria, typhoid, pediatric cases and maternity complications without fumbling to collect money for treatment. Increasing medical cost is also another threat like recently the malarial drugs has gone higher by 600% without considering the affordability of the people. Only with the mass volume of population sharing the cost through group solidarity model can alone deliver such micro-insurance services. This has been a challenge for us to upscale the Micro-insurance program to other target markets. The new market takes time to adapt insurance and with our experience any group takes about eighteen months to maturely use the insurance product. With increasing drugs costs any intervention to reduce drug cost will bring poorer population to access health insurance.

Kisiizi

Rurial society, lasting over forty years called 'Engozi' meaning stretcher. This stretcher society is formed to carry dead bodies initially later used to carry sick person to hospitals and brides on wedding ceremonies. These Engozi societies have their village names with family size varying between fifty to one hundred and fifty, collect money from all villagers when someone within the community dies, also collect money to accumulate a solvency fund to use in times of emergencies.

The healthcare plan started as an initiative to meet the healthcare uncertainties during 1997 as a part of community based healthcare program, the number could not raise as it had many challenges like, proper actuarial calculation, control of abuse, increased healthcare cost, lack of medical data collections, effective marketing, health wellbeing awareness etc.

In 2000 this community approached Microcare as Francis and Gerry was involved with them during early 1998/99 project. Microcare brought

in contributions, in effective marketing, negotiating service cost with the hospital, put in database management system, put in magnetic and micro-chip smart card to control fraud and abuse, preventive healthcare initiatives like mosquito bed-net and water sanitation program. With such participatory model along with the community gained confidence over Microcare, the number grew from 4,500 to 21,000 over four year period. Also community requested Microcare to design a burial insurance for them. This is a mile-stone. The traditionally maintained burial society hands over their burial program, now it is being insured with an affordable burial insurance program.

The under-privileged poorer community people like widows, orphans and the poorest of the poor people with the communities are identified and microcare has planed to design a further subsidized program. So far Microcare doesn't believe in subsidy of services as it will limit the existing strategy, and can not make the community people to increase the premium thus causing dependency on donor funds.

first ever health insurance program for Micro-finance groups. Microcare has some groups for the past seven years. In the microfinance groups, mainly targeted the women who are the loan borrowers also the primary caretaker of the family. These women understand the health needs of their children and other family members. One of the key factors we identified during the sensitizing process is that women worry a lot about the well being of the children while concentrating on their day to day micro-businesses. Selling the peace of mind concept with the group methodology model workout very effective thus client retention is good in this business. Most of these women talked about microcare to their other colleagues who are not part of the microfinance groups. Now there is already a created demand for micro health insurance among the market vendors and the other low income populations like taxi drivers.

More information on Micro-Insurance and Microcare can be seen in next months issue of Health Care Pulse E-Magazine.

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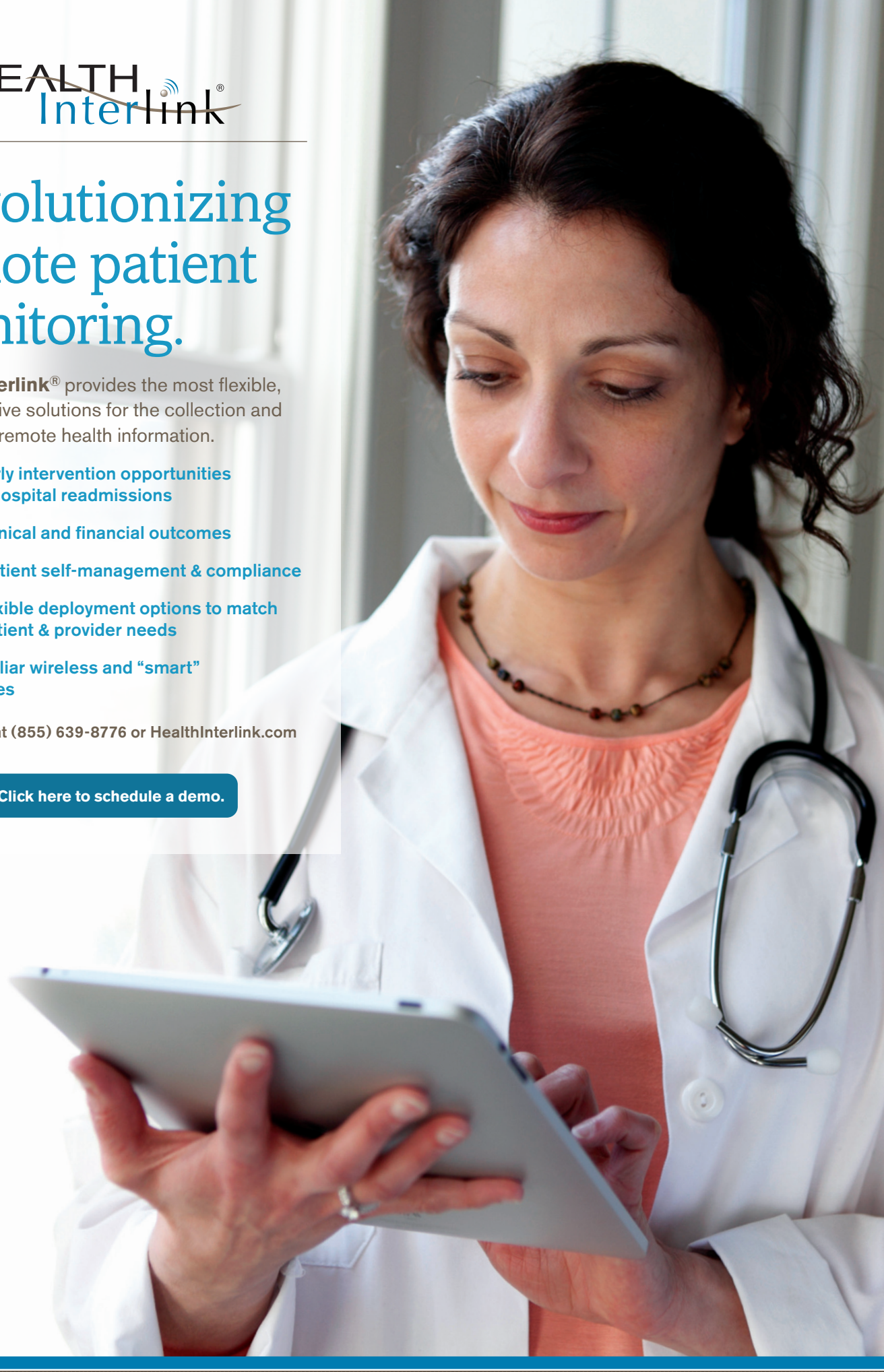

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What is Obamacare?

President Borack Obama explains **The Patient Protection and Affordable Care Act (PPACA)**, or more commonly known as **»Obamacare«**.

The full 906 page PDF text of the PPACA can be seen here.

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Looking Back

On March 27, Health Care Pulse was on the scene to report on the 2012 Health Quality Awards to individuals that highlight the need for drive and health care improvement. Past recipients include former Pennsylvania Governor Edward Rendell, former California Governor Arnold Schwarzenegger, the Honorable Hillary Rodham Clinton, former U.S. Surgeon General David Satcher, Senator Edward Kennedy of Massachusetts, actress and advocate Mary Tyler Moore and The Cystic Fibrosis Foundation.

The NCQA Hor

Health Quality Awards 2012

The recipients were **Dr Atul Gawande, MD, MPH** author; Dr. Gawande has contributed enormously to public understanding of the paradoxes and complexities affecting health care quality. Dr. Gawande is the author of numerous New Yorker articles and the books Complications, Better and The Checklist Manifesto. Helen Darling President and CEO of the National Business Group on Health know for her sustained leadership promoting health care quality as an issue of commercial competitiveness. **Patricia Gabow, MD** the CEO of Denver Health and Hospital Authority, Dr. Gabow's pioneering use of "lean" management techniques has assured high-quality care for some of Denver's most vulnerable and at-risk residents. **Paul Grundy, MD, MPH** the global director of Health Care Transformation at IBM, a champion of one of health care's most important innovations, the patient-centered medical home.

The event proved to be one of enlightenment and insightfulness with shared visions from each recipient on their projection of the future of health care models throughout the USA and global communities. Health Care Pulse EZINE would like to congratulate all the honorees and commend NCQA on an outstanding ceremony and time of reflection.

http://www.ncqa.org/tabid/1500/Default.aspx

http://www.ncqa.org/Sponsorship/2012HQALookback.aspx

nors

Reporter Dr. Clishia Taylor RN, MBA, DMIN

Tobacco-Free

Tobacco use remains the single largest preventable cause of death and disease in the United States. Cigarette smoking kills more than 440,000 Americans each year, with an estimated 49,000 of these deaths from exposure to secondhand smoke. In addition, smoking-related illness in the United States costs $96 billion in medical costs and $97 billion in lost productivity each year.

- http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a3.htm

What is Smoking

Really Costing You?

Smoking harms nearly every organ in the body and causes the vast majority of all deaths from lung cancer. In addition, smoking is a major cause of heart disease, cerebrovascular disease, chronic bronchitis, and emphysema. Smoking is a known cause of cancer of the lungs, larynx, oral cavity, bladder, pancreas, uterus, cervix, kidney, stomach, and esophagus. Despite these devastating consequences, more than 1,000 kids per day become regular smokers while another 4,000 kids try their first cigarette. Cigarette smoking is the single most preventable cause of death in the United States. It causes premature death in more than 440,000 people in America each year. Lifelong smokers have a 50 percent chance of dying from a smoking-related disease.

It is never too late to quit smoking. Smoking is a strong

e Living

By Dr. Clishia Taylor RN, MBA, DMIN

addiction for both the body and mind, which contributes to the difficulty people experience when they try to stop the habit. Despite the challenges, many people succeed in breaking this addiction. Since 1965, more than 40 million Americans have quit smoking. People who smoke, but desire to make a healthful change, can take the first step by making the conscious decision to stop smoking and by getting rid of all cigarettes. Furthermore, one can gather information through self-help books, brochures, or by calling 1-800-QUITNOW.

Individual or group counseling or a support group could be beneficial as a person addresses this preventable health risk. Exercise, even just five minutes, can help reduce the craving for a cigarette. One can find encouragement during this transformational time by creating a strong support system—ask a friend to stop smoking at the same time and talk to one's doctor.

How Much Will You Save?

Smoking cigarettes is expensive. Use our calculator to find out how much of your money is going up in smoke. For reference, the average price of a pack of cigarettes is $5.31 in the United States.

How many cigarettes do you smoke per day? *

How much do you pay per pack?

$

Calculate...

*This Savings Calculator and other useful tools to help you or a loved one quit smoking can be found at www.SmokeFree.gov

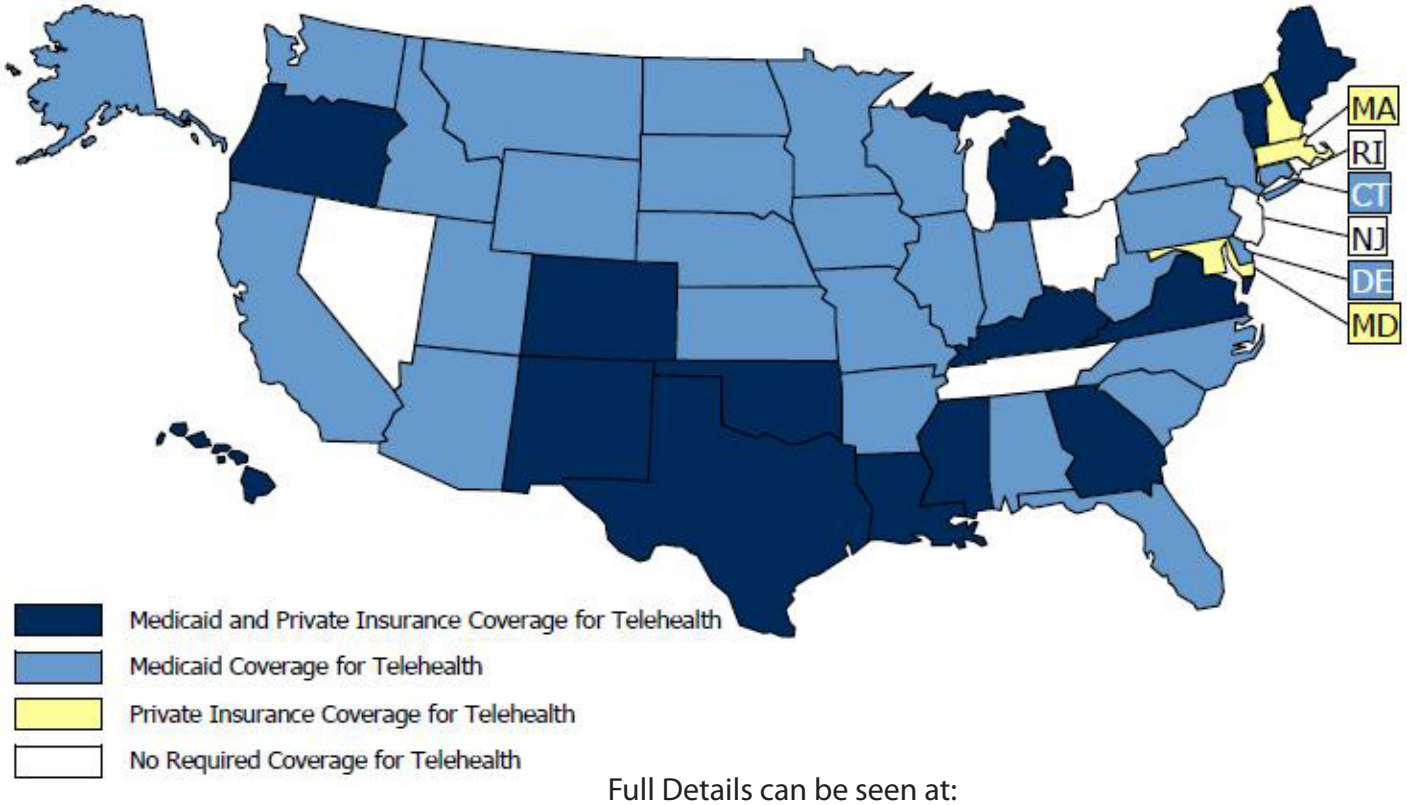
Telehealth Expansions

By- Cyle Taylor

Starting January 2014, the Centers for Medicare and Medicaid Services announced recently approved changes expanding coverage of Telehealth services to Medicare beneficiaries. This is a significant victory for all those working to push for Telehealth expansion.

The new rule will Expand the geographic areas where telehealth service can be provided into the fringes of metropolitan areas; Adding coverage for transitional care management services (CPT codes 99495 and 99496) and making explicit that coverage includes the Evaluation and Management portion of these services; Adding coverage for chronic care services (CPT codes 99487-99489) for patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; and Slightly increasing the fee for originating (patient) sites to $24.63 from $24.43 The proposed changes can be found at http://www.ofr.gov/OFRUpload/OFRData/2013-28696_PI.pdf. The telehealth section may be found on pages 536-557 and for chronic care management, pages 589-632.

US Map Of Telehealth Coverage



Full Details can be seen at:
http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx

Dig A Little Deeper

-H.R. 3077: TELE-MED Act of 2013

On September 10th 2013 Rep. Devin Nunes [R-CA22] Introduced Bill (H.R. 3077).
This comes after the The Telehealth Promotion Act of 2012 (H.R.6719) ,
The VA Act (H.R. 2001 for Veterains) and
The STEP Act of 2011 (H.R. 1832 for government service members) that were all introduced with efforts made to improve reimbursement and physician licensure issues dealing with telehealth.

Find out more about H.R. 3077 in next months Telemedicine Today section of Health Care PULSE.

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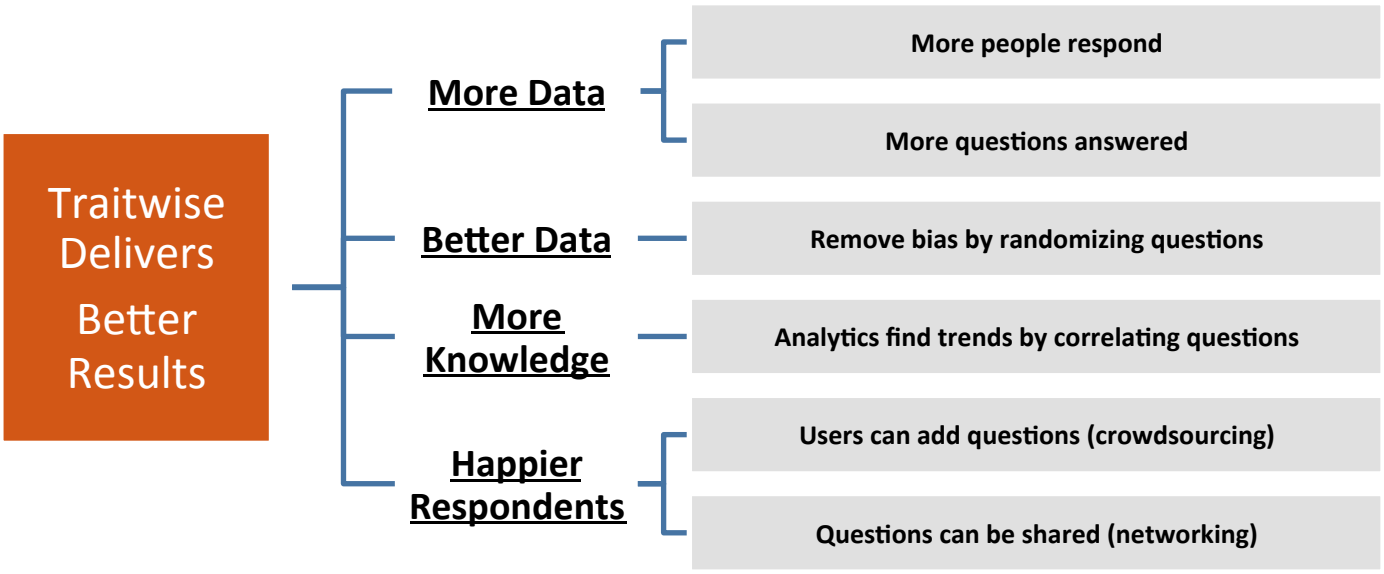

Traitwise: The Next Generation of Survey Technology
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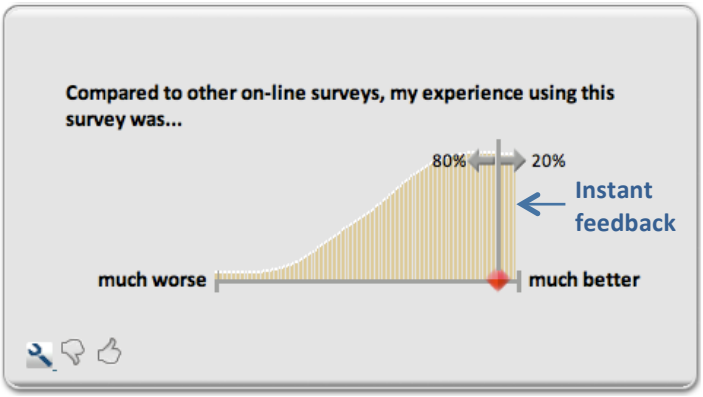

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