

Appendix D

Local Initiatives to Expand Care and Coverage of the Uninsured

Charles Begley, Alpna Agrawal, and Heather Draper

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Prepared by Charles Begley, Alpna Agrawal and Heather Draper
Center for Health Services Research
School of Public Health
The University of Texas Health Science Center – Houston

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I. Introduction

Local health care safety nets help meet the health care needs of the large number of uninsured people that Medicaid, Medicare and other federal and state safety net programs do not reach. These populations primarily include lower-income working families, adults with and without children, and undocumented immigrants but they also include large numbers of low-income children and parents, pregnant women, and the disabled who are targeted by federal and state programs but for various reasons are not covered. Local governments, private providers and other partners have taken on the responsibility of creating local health safety nets by directly providing services or indirectly purchasing services or coverage in the private sector. With rising numbers of uninsured and no significant expansions in federal and state coverage programs, demand for local health care safety nets is growing, increasing the burden on local governments and communities.

Meeting the health care needs of the uninsured is an important public policy issue in Texas, both for public health reasons because of the consequences for individuals and communities of untreated diseases and for fiscal reasons, as health care providers are asked to absorb unpaid costs. Public responsibility to care for the low-income uninsured is delegated to Texas counties and minimal requirements for eligibility, service coverage, and public financing, were established by the Indigent Health Care and Treatment Act (IHCTA) passed in 1985 and amended in 1999.ⁱ To meet their obligation, counties choose to either create a hospital district, operate a public hospital or form a County Indigent Health Care Program (CIHCP).

The legal requirements for safety net care are not well-monitored or enforced and are set well below the need.ⁱⁱ Many counties do more than their legal requirement and rely heavily on partnerships with hospitals fulfilling mandatory benefit obligations, to more adequately address the need. Other counties provide the minimum leading to uneven access for the uninsured and unevenness in the burden on local taxpayers. Local safety net systems differ by the extent to which they rely on publicly provided services to meet their obligations to the uninsured or to public financing of privately provided services. They also differ in the reliability and sources of funding available to support safety net services and the strength of their commitment to provide a high standard of care.

To cope with the increasing burden to provide or pay for expensive health services for the uninsured, local governments and communities around the country and in Texas are pursuing a variety of resourceful and innovative strategies. Many communities are finding ways to expand access by enrolling uninsured individuals and families into organized health plans

with more coordinated services that promote preventive care and reduce inappropriate utilization of emergency and inpatient services. Others are concentrating more on extending coverage to gap populations by working with various partners to expand the availability of and/or directly provide low-cost insurance products for the uninsured. The purpose of this paper is to review local initiatives to determine what approaches are being used to effectively expand the safety net and/or reduce the number of uninsured, with the goal of identifying successful models for replication in other communities and to inform state and local policymakers.

II. Profiles of Local Models for Expanding Access

One major strategy being followed involves expanding safety net care by developing better-organized and coordinated systems of comprehensive care. This strategy has important features designed to provide enrollees with a medical home, offer some form of case management that enhances early detection of problems and promotes appropriate treatment, produce patient information that can be shared among providers working within the system, give providers some incentives to serve low-income patients, and promote the dignity of enrollees. Selected models illustrating this strategy are profiled in Section IIa below. Their features are summarized in Table 1 at the end of the paper.

A second common strategy is to develop low-cost insurance products that extend public and private coverage to larger portions of the population. This can be accomplished by developing and offering private plans to small businesses and individuals; mandating small business coverage; or developing cooperatives that allow small employers to join larger employers. With this strategy, some of the issues that must be addressed include financing, marketing, benefit design, target population, provider choice, program duration and transition populations of individuals between jobs. Models of this strategy are profiled below in Section IIb, and summarized in Table 2 at the end of the paper.

IIa. Models for Expanding Care

General Assistance Medical Program

Milwaukee County

(Milwaukee, Wisconsin)

Start Date: 1998

Overview

Milwaukee County created a program to shift care from a primary public hospital to private primary care clinics. The program formed a provider network, such that each primary clinic is affiliated with a hospital, specialty provider and pharmacy. The county shifted from being a provider to purchasing care from private providers, and developed an integrated patient record system with primary care assignment. As a result the county was able to provide a more continuous care system over a larger area.

The GAMP program was created after the 1995 closure of Doyne Hospital -- the county's public hospital -- in an effort to redirect the indigent and uninsured population². Froedert Memorial Lutheran Hospital agreed to provide care to uninsured and indigent patients for \$60 million a year for two years.ⁱⁱⁱ During these two years, Froedert developed a pilot program with five community-based primary care clinics that would bill for services provided to a limited number of GAMP clients. By April 1997 a total of 2,100 GAMP patients were in the pilot program and at this time the county voted to expand enrollment in the program and to include Medical College of Wisconsin clinics in the purchasing model. The program went county-wide in July 1997 adding other hospitals besides Froedert as preferred providers and several FQHCs and other local clinics began serving as gate-keepers and primary care providers.^{iv}

Currently, Milwaukee County purchases health care services for all of its uninsured low-income population through the GAMP. The program places the uninsured into a provider network that includes 15 community clinics, 10 local hospitals, 240 specialty providers and approximately 25 pharmacies. In total there are about 30 sites which include an array of federally qualified health centers (FQHCs), FQHC look-alikes, private practices, community health agencies and community hospitals. GAMP covers primary care, specialty care, inpatient hospitalization, pharmaceuticals, diagnostics and laboratory services. Mental health, routine dental services and substance abuse treatment are not covered. Emergency dental extractions are covered.

Each clinic must have an affiliation with at least one hospital, specialty provider and pharmacy. The program includes integrated patient record-sharing among all network providers and standardized eligibility screening for the GAMP and other public assistance programs.

GAMP participants enroll when a medical need arises. They select a participating clinic in which to receive services. The chosen clinic is then required to meet the participant's primary medical needs and coordinate all specialty services. When specialty care is needed that is not offered by the clinic, it is up to the clinic to obtain a provider in the GAMP network to provide the needed service.

Eligibility

GAMP serves adult county residents who are not eligible for other public programs (Medicaid, BadgerCare, W-2), have incomes up to 125% FPL, depending on family size, and have a medical need. The majority of the participants are adults aged 22 to 65 years. Residency is established after 60 days of living in Milwaukee County.

In 2003 a total of 24,000 participants were enrolled in the program with 10,000-12,000 enrolled at one time. There is an estimated population of 80,000 indigents who may need GAMP services.

² Doyne hospital was closed and was privatized for several reasons only after state legislative approval to do so. A nearby non-profit hospital, Froedert Memorial Lutheran Hospital, was opened in 1980 and consequentially the two hospitals shared medical school staff and services which compromised Doyne's revenue. In 1995 state funding towards the General Assistance funds was capped and reduced thus creating a significant financial deficit. Finally, some of the Doyne facilities were considered obsolete and the hospital generally provided higher cost specialty services which created one of the highest cost per person in the state. These were all factors surrounding the closing of Milwaukee county's public hospital in 1995.(Norton & Lipson, Portraits of the safety net: The market, policy environment, and safety net response. Assessing the New Federalism: Occasional Paper Number 19; Nov 1998 (pp. 31-32)).

Financing

Sources of revenue include a county property tax levy and state funding from the Relief Block Grant Program (RBGP) and intergovernmental transfer (IGT). The RBGP funding originated from legislation enacted in 1996 to convert the state's mandatory general relief program into a block grant program to counties.^v The legislation allowed Milwaukee County to shift from being a provider of health care to becoming a purchaser of health care. The block grant program is capped at \$16.6 million and consists of federal Medicaid DSH funds and general revenue funds allocated to the county. Each year the county applies for the block grant which the county matches with at least \$20 million, \$13 million in county tax revenues and \$7 million from the IGT. The GAMP budget was \$38.4 million in 2003.

Cost Sharing^{vi}

There is a \$20 copayment for emergency room visits, \$1 copayment for generic prescriptions, and \$3 copayment for brand name drugs on the formulary. Also, there is a \$35 application fee for each six-month enrollment period which is waived for homeless individuals.

GAMP reimburses clinics on a fee for service basis at Medicaid rates. Hospitals are reimbursed at 80 percent of their costs. If the total cost of the program exceeds the program budget, providers are responsible for the additional costs.

Administration

The Milwaukee County Division of County Health Programs, Office of Related Health Programs administers the GAMP.

Health Advantage^{vii,viii}

Marion County

(Indianapolis, Indiana)

Start Date: 1997

Overview

Faced with the loss of a contracted private safety net provider, Marion County chose to restructure their care system by acquiring community clinics, and securing a contract with a physicians group for staff. A managed care program was created, with a designated set of benefits, a network of providers, and each primary care provider responsible for referrals. Providers are reimbursed through capitation and other performance-based methods.

Historically, Wishard Memorial Hospital was the primary safety net provider for Marion County through a contract with the Health and Hospital Corporation of Marion County (HHC). In 1990s, The University Hospital, which also had a role in providing indigent health care, merged with Methodist Hospital of Indiana and reduced its commitment to indigent care. The task force responsible for the merger also created the Indiana University Medical Group (IUMG), a physician group sponsored by the Indianapolis medical school. Concerned about meeting its indigent care obligations, the HHC worked with Wishard Hospital to expand its health care safety net by taking over several community clinics of the Marion County Health Department.

HHC also developed a contract with the IUMG to staff Wishard Hospital and its primary care clinics.

Wishard Advantage was created in the late 1990s to increase coordination between primary and specialty care in the Wishard Hospital system. It is a managed care medical assistance program for low-income, uninsured residents operated by the HHC. The provider network is comprised of the IUMG, the Wishard Hospital, and its seven primary care clinics. The medical assistance program offers a comprehensive benefits package including primary and preventative care, inpatient and specialty care, prescription drugs, laboratory services and mental health services. Vision and dental services are limited but dental check ups, vision screening and discounted eyeglasses are included.

At enrollment, patients select their primary care physician from a list of providers in the network. Although there is no official gate keeper, the chosen physician is responsible for offering primary and preventive care, and for specialist referral and hospital admission. The health clinics contain pharmacies and other social services, and are available during daytime hours. There is one after-hours clinic next to the hospital and a 24-hour consultation hotline.

The primary care physicians receive capitated payments per member per month covering primary care, specialty and inpatient referrals. Specialty care funding is pooled through the dean of the medical school, who distributes these funds to specialists based on a relative value unit (RVU) payment schedule. The HHC provides payments for inpatient services on a fee-for-service basis and also provides prescriptions free of charge to patients via the clinic pharmacies.

Eligibility

All uninsured Marion County residents with incomes at or below 200% FPL are eligible. Participants must not be eligible for other public programs including Medicaid or SCHIP.

Financing

Wishard Advantage is financed through city and county property tax levies as well as federal DSH matching funds at amounts of \$56 million and \$20 million, respectively. The HHC has the authority to levy taxes at its own rate but has to seek state legislative authority. The HHC tax levy generates a total of \$70 million with \$56 million going towards Wishard Advantage and the rest for Marion County Health Department and the HHC staff. The property tax levy rate of 79.1 cents per \$100 property valuation has remained the same since 1992. Medicaid DSH payments also contribute a significant percentage of the hospital budget.

Cost Sharing

There is no charge for services to enrollees with incomes less than 150% FPL. Participants with incomes between 150%-200% FPL are required to pay a \$5 copayment on office visits and 20-60% of the cost of other care based on income. Providers bill patients for services and there is no cap on out-of-pocket payments.

Administration

The Health and Hospital Corporation (HHC) of Marion County is a municipal (non-profit) corporation that operates Wishard Advantage and the Marion County Health Department. The HHC is governed by a seven-member board consisting of members appointed to four-year terms. Three of the members are appointed by the Mayor of Indianapolis, two are appointed by the County-City Council, and another two are appointed by the County Commissioners. Funding for the HHC comes from local property tax dollars and HHC has legal responsibility to provide health care to all who become ill or injured within Marion County.

Carelink^{ix,x}
Bexar County
(San Antonio, Texas)
Start Date: 1997

Overview

Carelink utilizes the maximum family liability concept (MLC), or the amount a family can be expected to contribute based on their income, to help offset the costs of a designated set of benefits that it offers to the uninsured in Bexar County. The program uses a provider network that includes medical school and private practice physicians, pays providers on a fee-for-service basis, and collects payments from the family over an extended period of time. An integrated patient record system has also been developed allowing for a system-wide quality assurance program.

Carelink is the Bexar County Hospital District's (now called University Health Service) indigent care program, and can best be described as a financial assistance plan with managed care features. Carelink began in 1993 as CostShare when UHS officials introduced the concept of maximum family liability (MFL)³, which was an amount used to determine a monthly repayment schedule for services received. The plan is administered by the UHS with a provider network that consists of one hospital, six ambulatory centers, five Federally Qualified Health Centers (FQHCs), and one private physician. The plan purchases health care for enrolled participants who use the UHS network. The hospital and physicians are reimbursed on a fee-for-service basis. Families with incomes below 200% of the FPL who reside in Bexar County are eligible and make monthly membership payments and service co-payments based on their income level. Benefits include primary and specialty physician services, hospital care, prescription drugs and mental health services. Another potentially valuable service is a 24-hour nurse-staffed hotline that serves to help refer patients appropriately, help make doctor appointments and deter misuse of the emergency room.

All low-income uninsured families in the county are encouraged to enroll. At enrollment, families select a primary care provider and clinic site as their usual source of care and must seek all their care through that provider. Non-Carelink patients receive services but may be asked to pay, in advance, for primary and preventive care.

³ Maximum Family Liability (MFL) = (11%) * (annual family income) * (FPL index).

Eligibility

The target population equals about 300,000 uninsured in the county at or below 200% of the FPL. In addition to the income requirement, eligible families must be current residents with the intent to live in Bexar County. Families apply for enrollment at the main CareLink office or at one of the seven ambulatory centers or FQHC sites.

If a family member is determined to be potentially eligible for Medicaid or CHIP, a 60-day enrollment period into CareLink is allowed during which the individual must apply to the Medicaid and/or CHIP program. If the family member is eligible for the other public assistance program and fails to apply, the entire family may be disenrolled from Carelink. Family members will be billed full charges and regular collection methods will be utilized.

Financing

A county hospital district tax levy, equaling 25 cents per \$100 valuation, is the primary funding source. Medicaid DSH funds are also used to help fill the funding gap in health care delivery. The annual budget/revenue is currently about \$95 million. Annual collections from enrollees is around \$11 million.

Co-payment

There is no cost for those with incomes at or below 75% of the FPL while those with income above 75% of the FPL make monthly payments and service co-payments based on family size and income. A formula was developed to determine the patient's Maximum Family Liability (MFL). This value is used then to determine monthly payments over a 48-month period for services rendered. A family's MFL for the four years is calculated at the time of enrollment and is re-evaluated annually. Members of CareLink only pay after health care services are rendered and a charge incurred.

Administration

CareLink is governed by the UHS. University Hospital System has a contract with the University of Texas Medical School in San Antonio to provide physicians to UHS's facilities. It also has contracts with Community Medical Associates for hospital staff as well as the FQHCs.

Denver Health^{xi, xii}
Denver County
Denver, Colorado
Start Date: 1997

Overview

Denver County created a hospital authority that is independent from other city government and links public hospitals, FQHCs, schools, clinics and the health department into a unified safety net system. The program also offers insurance products for public employees and small businesses, and utilizes a patient payment plan based on an income and assets rating system.

Until 1993, Denver Health (DH) was a component of city government. At that time, a mayor-appointed panel consisting of community and business leaders met to determine new organizational structures for DH: a not-for-profit corporation, a public benefit corporation, a hospital district, or a hospital authority. The hospital authority structure was recommended in order to enable DH to exist as a more independent public entity. In 1994, Denver Health officially became a hospital authority with the intent to ensure the delivery of health care to the indigent and uninsured. In 1997, the Denver Health and Hospital Authority became an independent entity governed by a nine-member board appointed by the mayor and confirmed by the council. Another board that exists to govern the Neighborhood Health Program has 13-members board, of which 51% are DH patients in order to maintain federal funding.

DH is a vertically and horizontally integrated health care system for indigent and uninsured populations in Denver. The system is centrally organized and consists of an acute care hospital, an ambulatory center, 11 FQHCs, 13 school-based clinics and the local public health department. There is an integrated system-wide eligibility and referral system to help guide patients to the appropriate health care services including public health, primary, specialty and inpatient services. The system offers several different health care products. Colorado Access is a managed care product in which DH partners with several private providers in an effort to maintain revenue from Medicaid patients. The Denver Health Medical Plan (DHMP) is marketed to public employees and employees of small businesses. The DHMP also serves the CHIP population. DH also offers a program of inpatient and outpatient services to the prisoners located in federal and state correctional facilities in the Denver area. It provides a 911 emergency response service, a locked forensics unit, a women's care clinic, a 100-bed nonmedical detoxification unit with nonambulance transport service, and the regional poison control center.

Eligibility

Potential enrollees must meet residency, income and asset standards. Income must not exceed 185% of the FPL. After eligibility is determined, the participant is assigned to a payment rate category based on their income and assets.

Financing

DH relies on a variety of funding sources for its programs but the primary source is the County Indigent Care Program (CICP). The CICP is a state program that reimburses participating providers for a portion of the costs of treating eligible individuals. The participating providers must follow state-established limits for acceptable amounts to charge the eligible individuals. Thus the program aims to help reduce provider costs when administering care without compensation while also limiting the amount the low-income patient is required to pay for their care.

For the fiscal year 2003-2004, the Colorado State General Assembly set aside \$255,976,646 to reimburse the CICP providers. Three sources of funding for the program are federal funds (\$128,000,000), cash funds exempt (\$115,400,000), and the General fund (\$12,576,646). Cash funds exempt refers to the DSH and Medicare Upper Payment Limit funding. The CICP reimbursement to providers is based on previous year's write-off costs which are inflated for the upcoming year. For the fiscal year 2003-2004, the DH reimbursement from CICP was \$64,704,089 and \$38,037,301, respectively.

Cost Sharing

Patients are required to make co-payments for inpatient facility and physician services, outpatient physician services and prescription drugs. The co-payments vary by income category and there is an annual cap on co-payments of \$120 per year for the lowest income category (families below 37% of FPL).

Administration

Denver Health is governed by a nine-member board that is appointed by the mayor and is also city/county council approved. To help protect the board from political pressures, members can only be removed by a confirming vote of the council. A chief executive officer is appointed by the nine-member governing board. DH has the authority to issue debt.

Hillsborough County HealthCare Plan^{xiii,xiv,xv,xvi}

Hillsborough County, Florida

Start Date: 1992

Hillsborough County pursued legislation to create funding to purchase a managed care plan for the uninsured. The managed care plan offers four benefit packages to different types of eligible individuals. Participating providers are reimbursed on a fee-for-service basis at a percentage of Medicare payments.

In the late 1980s, volunteer professionals met to discuss the problems of the main public hospital, Tampa General, and the safety net in Hillsborough County. They concluded that a health advisory board should be created to give recommendations to the County Commissioners of Hillsborough County. Around the same time, a group of health care experts envisioned a managed care plan to deliver health care to the uninsured and indigent. The intent was to save money by decreasing inappropriate emergency room care and increasing primary and preventative health care services through the managed care model. An attempt was made by the County Commissioners, the local medical society, the recently created health advisory board, and several business and community leaders to lobby the state legislature to allow the adoption of a sales tax for the purpose of financing the managed care plan. The new tax legislation did not receive enough support and the proposal was rejected. In 1991, the County forces united again and the state approved legislation which permitted counties with a population of 800,000 or more to tax up to one half of one percent of its infrastructure sales tax towards uninsured and indigent health care.⁴ With the revenues from this tax the Hillsborough County HealthCare Plan (HCHCP) was created.

The HCHCP offers staff model managed care provider networks to uninsured and indigent residents with incomes up to 100% of the FPL. The plan divides the county into four zones and contracts with one preferred provider network in each zone using a competitive bidding process. In 1999, the Board of County Commissioners gave permission to the HCHCP to negotiate with current providers rather than undergo a competitive bidding process. Four

⁴ Section 212.055, Florida Statutes. From the state approval, the Hillsborough Board of County Commissioners enacted Ordinance 91-19, allowing a half-cent sales tax. The \$26.8 million per year on property taxation mandated by the State legislature would continue in addition to the new taxing scheme.

different benefit plans are offered.⁵ Plan A covers all services that the plan offers to individuals while Plan B is for Medicare recipients and covers medical services and supplies not covered by Medicare. Plan C is also designed for Medicare recipients and covers deductible and co-payments for inpatient facility costs and home health care costs not covered by Medicare. Finally, Plan D offers benefits that are defined to meet the special health care needs of individual members. Several limitations and exclusions exist in the services provided by each plan.⁶ Also, certain outpatient and inpatient services require patients to obtain authorization from their primary care provider.

Physicians are paid on a FFS scale. Specialty care physicians receive between 80-85% of Medicare reimbursement depending on the network zone. Outpatient hospital surgery physicians are either paid 20% of the bill up to a cap ranging from \$700 to \$1,250 depending on the surgery and the network zone. Physicians providing inpatient care are reimbursed at the Medicare DRG rate.

Eligibility

To be eligible for HCHCP, an individual must be a Hillsborough County resident, have no other form of health insurance coverage, and have an annual income at or below 100% FPL. One can be eligible for the program if medical expenses would result in an income equating to the poverty level.⁷ Enrollment usually occurs via a medical provider or social worker when medical care is sought. The county social workers are located at each hospital and the primary care sites of each network and play a significant role in assisting in the enrollment process and in providing case management services.

Financing

A .5 cents local sales tax and property tax are used to finance HCHCP. In 2004, the HCHCP received about \$94 million in revenue from the sales tax, general fund and other revenues, respectively. The projected sales tax revenue in 2005 is estimated to total \$94.7 million.

Cost Sharing

Participants in Plan A are required to make co-payments for pharmaceuticals (\$1 for generic and \$5 for brand name) regardless of income threshold. Those in the Medical Crisis Intervention program also make co-payments of \$5 for services.

⁵ Participants had eleven insurance health care plans to choose from before October, 1999. After this date only five plans were available. Currently only four plans are administered by the HCHCP plus the Medical Crisis Intervention plan. Services like eyeglass coverage, hearing, and dental services are being cut due to financial constraints.

⁶ For further information about the exclusions and limitations, Adrulis and Gusmano give a clear list of exclusions and limitations under the HCHCP.

⁷ Previously individuals could enroll in the HCHCP or the Medical Crisis Intervention procedure with an income threshold of up to 400% FPL. Cost share existed for those individuals higher than the 100% FPL. Financial constraints have led the HCHCP to only include individuals at the 150% FPL or 100% FPL for the Medical Crisis Intervention and HCHCP, respectively.

Administration

The County's Department of Health and Social Services is responsible for operating the HCHCP. The Board of County Commissioners determines the policy of the HCHCP while the 15-member Health Care Advisory Board makes recommendations to the commissioners regarding issues of fund allocation, coordination, planning and monitoring of the health care delivery system.

PlusCare^{xvii}
Wayne County
Detroit, Michigan
Start Date: 1992

Overview

Wayne County purchases health care services for the uninsured from local managed care plans and uses several federal/state/local match arrangements for funding. Enrollment in PlusCare may occur through an outreach worker placed in hospitals, the public health department and in other community health agencies. Potential participants may also enroll upon receiving health care services at emergency rooms, safety net providers or the public health department. Once enrolled, each patient is enrolled in one of four health plans and one dental care plan. The services covered include primary and preventative care, inpatient care, outpatient care, dental services, pharmacy services, emergency care, ambulance services, immunizations, family planning, laboratory services, radiology services and physical therapy. There are coverage limits on these services due to budget restrictions. Patients needing mental health and substance abuse treatment are referred to the Detroit-Wayne County area Substance Abuse Treatment Programs that are administered by the Detroit-Wayne County Community Mental Health Agency.

Eligibility

Adults residing in Wayne County between the ages of 19 and 64, not eligible for any other type of medical coverage are eligible for PlusCare. The income threshold is \$250 per month but family size is taken into consideration as PlusCare eligibility is determined on an individual basis. A \$90 standard work expense is omitted from the monthly net income and neither child support nor Social Security payments are considered as income. Enrollment lasts for one year.

Financing

The primary source of funding is federal/state/local match funds generated through an upper payment limit (UPL) and other arrangements. Wayne County and the state contribute to an indigent health care fund. An intergovernmental transfer from Wayne County is used to designate the indigent health pool for federal matching funds. These funds are distributed to qualified hospitals in the county based on each of their estimated Medicaid outpatient payments. A total of seven hospitals qualify to receive these funds. Providers in the health care networks are reimbursed on a capitated per member per month basis. The dental provider is also reimbursed in this manner, however the payments are based on the total number of patients served each month.

Cost Sharing

Patient cost-sharing is limited to pharmacy co-payments.

Administration

PlusCare is managed by the PCMS.

Project Access^{xviii,xix,8}
Buncombe County, North Carolina
Start Date: 1995

Overview

Project Access is a collaborative initiative administered by the Buncombe County Medical Society (BCMS), connecting existing public and philanthropic primary care centers with private practice physician volunteers. Providers volunteer specialty and chronic health care services to patients below 200% of FPL. The flow of patients from primary to specialty care services is additionally supported by pharmacists providing pharmaceuticals at cost, hospitals providing free inpatient and outpatient services, and allocation of county indigent care funds to provide medications for patients and ongoing operating support to sustain the initiative.

Project Access began with the support of a Robert Wood Johnson Foundation planning grant provided from 1994 to 1998. Community partners in Project Access include BCMS, Buncombe County Health Department, local volunteer clinics, area hospitals, the area health education center, local pharmacists and the county human/social services. Physicians donate their services to Project Access by pledging to see 10 enrolled patients per year (20 patients if they are medical specialists). Most physicians (80%) in private practice in the area have committed to the program. Physicians see Project Access patients at their practices or volunteer at a clinic. Physicians can limit their participation and/or withdraw at any time. Area hospitals provide all needed ancillary services free of charge, and the county contributes to the cost of prescribed drugs.

Project Access operates in six safety net clinics in the community including the county's health department clinic, a federally qualified health center and an urgent care center. Eligibility services are provided at all sites and enrollees are centrally managed at BCMS' office. BCMS is "headquarters" for the program and does provider recruitment, promotion and communication. Since Project Access' inception, primary care sites have been able to serve more primary care patients without increasing costs because patient care has been coordinated and continuous. For example since patients are able to readily access needed specialty care, appointments previously consumed seeing patients repeatedly for unresolved specialty care needs are now available for new patients and for proper management of existing patients' chronic primary care conditions.

⁸ Personal Communications with Alan McKenzie and Kristen Neel, Buncombe County Medical Society, May 2005

Eligibility

Patient eligibility and enrollment is performed within the primary care clinics where the County Department of Social Services has out-posted its Medicaid and CHIP eligibility and enrollment staff. Eligible patients are residents of Buncombe County, ineligible for federal programs, and below 200% of FPL. The program staff matches qualifying patients needing specialty physician care or chronic primary care with volunteer physicians through an online database linking county care clinics to a central server at the Buncombe County Medical Society. For its recordkeeping, the Buncombe County Medical Society keeps online clinical and demographic records gathered via patient enrollments, physicians' no-charge invoicing and hospital service reports. Patients sign responsibility agreements and use "Access" cards for visiting physician offices and for prescriptions obtained through pharmacies at cost.

In 2004, 27,000 Buncombe County residents were eligible for Project Access. Project Access served 26,000 of these residents and 3,000 of the 26,000 were provided with advanced primary care services and/or specialty care services.

Financing

Pharmacists provide pharmaceuticals at cost; patients pay a \$4 co-pay, and county funds managed by the Medical Society are used to pay the difference. All lab tests, inpatient and outpatient services are donated by the hospitals. Referrals and appointments for specialists are made through "on-line, real time" connections with the CARES system at each primary care site based upon availability of physician appointment slots. The community clinics pay the local match (5%) to pull-down state and federal funds which then pay for out-stationed eligibility and enrollment workers. Each year, over \$3.5 million in services are donated by private practicing physicians and other healthcare providers at no charge to low-income, uninsured patients.

Cost-Sharing

Health care services are provided free to enrollees.

Indigent Care Collaboration^{xx,xxi,xxii,xxiii,9}

Austin, Texas

Start Date: 1992

Overview

Safety net providers in three counties came together to form the Indigent Care Collaboration (ICC) in Austin, Texas in order to promote coordinated implementation of local initiatives to better serve the indigent population of Central Texas. ICC's members include the local public health department, ambulatory medical center, FQHCs, and major hospitals. ICC functions to help providers in developing tools and initiatives that make service delivery among providers more efficient and cost effective including its integrated patient record system (I-Care) and eligibility system (Medcaider). The I-Care system creates an electronic medical record for a patient that is then accessible at any ICC member facility, but it tracks patient utilization of health care services across the ICC system and facilitates the development of disease

⁹ Personal Communications with Sandy Coe Simmons, Indigent Care Collaboration, April 2005

management programs. I-Care promotes continuity of care, provides better management of pharmaceuticals, provides access to a wider range of therapeutic ancillaries and increases physician efficiency. The Medicaider online eligibility tool is used to determine uninsured patients' eligibility for a variety of assistance programs available at the federal, state and local levels. Medicaider helps providers identify third party reimbursement sources and thereby obtain previously uncaptured revenue.

In addition to I-Care and Medicaider, a number of other initiatives have taken place within ICC to improve health care delivery to the uninsured. ICC formed a purchasing group to negotiate pharmacy discounts for all its members, while maximizing participation in the 340B discount program. ICC replicated Project Access in Buncombe County, North Carolina by working with the local medical society to recruit physicians to volunteer primary and specialty care services to the uninsured. ICC developed a disease management online tool in conjunction with agreed-upon protocols to manage chronic disease and to improve patient outcomes. Finally, ICC has carried out two studies related to the safety net health care system in the region – a Primary Care Use and Capacity Study for Travis County and a Regional ED Use Study. The studies provide an overall picture of the demands placed on the safety net care system in the region.

Eligibility

There are no eligibility criteria for the ICC system as there is no ICC program. Rather there are a variety of financial assistance programs that patients may be eligible for when they visit one of ICC's members. Patients may be eligible for federal programs, state programs or local charitable programs. Some of the state and local charitable programs include the City/County Medical Assistance Program (MAP), Seton Care Plus and Project Access.

To determine patients' eligibility for a given program, ICC has developed an automated, on-line screening tool known as Medicaider. With Medicaider, members are able to find potential payment sources for uninsured patients. First, Medicaider determines whether patients are eligible for federal programs such as Medicaid and CHIP. In addition, Medicaider screens for Title V, Title X, and Title XX programs, the state Primary Health Care Program, the City/County MAP program, Seton Care Plus and Project Access. If a patient is not eligible for any of these programs, ICC members will see any patient on a sliding fee scale basis. The sliding fee scale and fee schedule varies from member to member.

For the City/County MAP program, patients at or below 150% of FPL, not eligible for other programs, and residents of Travis County are eligible. Similarly, Project Access serves uninsured residents in Travis County with incomes at or below 150% of FPL. The Seton Care Plus program at the Seton Community Clinics serves patients up to 250% of FPL who are not eligible for other programs.

Financing

ICC cites the following four grants and awards as significantly contributing to the development of its collaborative:

1. A Robert Wood Johnson Foundation Communities in Charge grant of \$700,000 that supported general system development from 2000-2003.

2. A HRSA CAP/HCAP grant of nearly \$2 million that supported the development of I-Care and Medicaid programs from 2000-2003.
3. A grant from Ascension Health of \$900,000 that matched the first HRSA HCAP grant.
4. A second HRSA HCAP grant of \$2 million to support pharmacy initiatives from 2003-2006.

Travis County and the City of Austin primarily finance indigent health care in Central Texas. In FY 2002, the City of Austin budgeted \$45 million and Travis County budgeted \$6.3 million for indigent health care. The following diagram shows the flow of funds from the City of Austin and Travis County to support indigent health care in Travis County.

Cost Sharing

There are no cost sharing arrangements for the ICC system as it varies by program.

Administration

At its inception, ICC was organized as a Texas Uniform Unincorporated Nonprofit Association (TUUNA) and created a regional Health Financing District. These two formal structures facilitated ICC's ability to coordinate activities among its member groups and draw long-term funding for its initiatives. The TUUNA structure enabled ICC to create a more formal structure for itself in order to implement and monitor its efforts. In addition, the TUUNA permitted ICC to participate in the Robert Wood Johnson Foundation (RWJ) *Communities in Charge* grant project. The creation of the health financing district permitted ICC to attract funds and finance initiatives it planned to develop in the areas of primary care, mental health, ER/trauma, specialty services and general infrastructure. At present, ICC has an executive director, research and administrative staffs, a board consisting of its members, and an advisory board.

Healthcare Options (formerly known as Primary Care Plan)^{xxiv,10}

El Paso, Texas
Start Date: 1999

Overview

Healthcare Options (HCO) is a managed care program that links primary and specialty care services for low-income, uninsured residents of El Paso County and was modeled after the Hillsborough program. HCO was originally known as the Primary Care Plan (PCP) and was developed by a collaborative of safety net organizations in El Paso. The program is administered by the El Paso First Health Network (EPFHN) which also serves the Medicaid and SCHIP populations and is owned by the El Paso County Hospital District.

Initially, coverage in HCO included outpatient primary and preventive care, laboratories, X-rays and limited in-network specialty care services. Pharmaceutical coverage was provided through the indigent pharmacy plan for Thomason Hospital. Hospital care was not officially covered by HCO, but enrollees qualified for charity care at Thomason Hospital. Once HCO was integrated into the Hospital District in 2003, covered services were extended (particularly for specialty care, inpatient hospital and other ancillary services) to match those provided through

¹⁰ Personal Communications with Bill Schlesinger, Project Vida, April 2005

the county indigent care plan. Benefits extended to HCO enrollees included: case management services, more diagnostic tests, emergency room services, gynecological services, immunizations, prenatal care and well patient annual exams. Dental care and mental health services are not covered benefits. The provider network includes two federally qualified health centers, Thomason hospital outpatient clinics and some private physicians.

Eligibility

HCO enrollment no longer takes place at community health centers since it reached 7,000 enrollees in 2004. Additional patients are only referred to HCO by Thomason Hospital's ER department. Eligible enrollees are adults over the age of 19 with incomes below 100% of FPL, residents of El Paso County, and ineligible for other publicly supported programs.

HCO enrollees select a primary care provider, nurse practitioner or primary care clinic from the EPFHN to serve as their medical home. Case management services are offered to enrollees with special health care needs.

Financing

Through its initial grant from the W.K. Kellogg Foundation, HCO was able to develop its infrastructure, staffing and daily office operations. At present, the program is administered by the hospital district which assumes full responsibility of its financing. The Hospital District's annual budget for primary care reimbursement is \$850,000. Reimbursement rates to providers under HCO equal Medicaid fee-for-service reimbursement rates plus 5 percent.

Cost Sharing

For HCO enrollees there is a \$10 co-pay for physician office visits. The remaining cost of care is subsidized by the hospital district.

IIb. Models for Expanding Coverage

Chamber Choice^{xxv,11} Kansas City, MO

Overview

In 1994, the Greater Kansas City Chamber of Commerce began marketing Chamber Choice for small and low-wage businesses in the area. Chamber Choice is a non-subsidized plan that offers a rate cap of two years to enrollees.

Chamber Choice was a revised version of an existent small group plan already offered by BCBS of Kansas City. Chamber Choice and BCBS of Kansas City's existing small group plan only differed in that the small group plan at the time was not open to businesses with 50 employees or less, did not offer any kind of rate stability, and was not marketed aggressively. However upon receiving the Chamber's endorsement of Chamber Choice, BCBS of Kansas City simply expanded administration and staffing of its existent small group plan to Chamber Choice.

¹¹ Personal communications with Jeff Nelson, BCBS of Kansas City, November 2004

Since Chamber Choice's launch, 11 additional local chambers of commerce have joined the Greater Kansas City Chamber of Commerce to endorse Chamber Choice. And Chamber Choice has expanded its eligibility criteria to small businesses with up to 50 employees. The actual enrollment in Chamber Choice is 80,000 members as of 2004.

Eligibility

Small businesses with up to 50 employees located in Kansas City, which includes Jackson, Clay, Platte, and Cass counties in Missouri and Johnson and Wyandotte in Kansas are eligible for Chamber Choice. Rather than establishing a target enrollment for the program, BCBS of Kansas City set a target growth rate of 15% per year. The actual enrollment in Chamber Choice is 80,000 members as of 2004. Approximately 30% to 35% of businesses were not offering health insurance prior to joining Chamber Choice (2001). Four out of ten employees were uninsured prior to enrollment (2001). The retention rate is 82% to 86% per year. Staffing of Chamber Choice is the same as the staff for other BCBS of Kansas City products.

Benefits and Services

Chamber Choice offers comprehensive services and a flexible benefit design. Employers choose among five different plan arrays that range from limited to comprehensive benefits. Each array consists of a PPO, a traditional HMO and an open network HMO product. Employees then choose one of the three products within the array. The basic plan benefits include: physician visits at \$15 to \$25 per visit; inpatient and outpatient hospital procedures; hospital stay at \$100 to \$500; a \$5/\$20/\$40 to \$10/\$30/\$50 three-tiered prescription drug plan; life insurance; dental benefits; and accidental death and dismemberment benefits. Chamber Choice also provides rate stability for two years to enrollees.

Financing

Chamber Choice is financed by member cost-sharing and premiums identical to conventional commercial insurance products. Co-payments range from \$15 to \$500 depending on the plan. Monthly premiums are group and member specific with average premiums of \$125 for healthier, lower-risk groups and \$208 for extremely high-risk groups. The average premium per member per month is \$166.56. The average price of Chamber Choice is generally lower than other commercial products offered by competitors (except for those in the high-risk groups). Approximately 87% to 88% of the total overall cost of the product is used for health benefits, 12% to 13% for administration, and 0.5% for profit. The profit margins for other BCBS of Kansas City products are four to six times greater than for Chamber Choice. (2001 numbers cited)

Marketing

BCBS of Kansas City's multifaceted marketing approach includes print, radio and television ads as well as direct mail to very small employers. All materials illustrate the local Chamber of Commerce's endorsement. A broker community of around 1,000 brokers recruits 96% of the members through direct contact with Chamber businesses. Marketing is integrated with the Chamber of Commerce's resources as well. Chamber Choice is marketed on the Internet through the BCBS of Kansas City and Chamber websites. Employers may obtain information by calling the Chamber's or BCBS of Kansas City's toll-free numbers.

Overview

FirstPlan is a private, partially subsidized, small group coverage product with choice of open or closed network. Premiums are based on a shared contribution among employers, employees and health care providers. Unlike the “3-share model” seen in Muskegon County and other communities, FirstPlan is sponsored by a local safety net health system. It provides subsidies when necessary, and uses an actual insurance vehicle that is obligated to meet all state insurance requirements. The plan emphasizes disease management for high-risk enrollees, and has an educational component that teaches new enrollees how to access the system.

Eligibility

In 2005, over 1,375 workers in 132 businesses were enrolled in FirstPlan products; including dependents, there were over 2,000 members, nearly 380 of whom were previously uninsured. Members receiving premium subsidies numbered 218 and 63 businesses received premium discounts in the form of “CareCredits” through First Plan. “Care Credits” was developed by FirstCarolinaCare.

FirstPlan does not specifically target the uninsured. Rather all small businesses with 50 employees or fewer are eligible to purchase FirstPlan products. Premiums may be subsidized for workers earning \$9/hour or less, if the business has 100% employee participation and the employer contributes at least 50% of the premium. The amount of the subsidy is based on the employer’s perception of the employee’s ability to pay. The employee contributes around \$50 per month for employee only coverage and the subsidy amount makes up the difference of the full premium.

FirstPlan premiums for a business may be reduced up to 20% as permitted by North Carolina Department of Insurance. FirstPlan utilizes CareCredits based on criteria related to: employer contribution rate for employees and dependents; participation level among workers; and coverage history. Using these criteria, FirstCarolinaCare is able to look at the final rates more favorably. A firm that had not offered coverage before, for example, could get a 5% premium reduction. So far, reduced group premiums average 7% to 10%.

FirstCarolinaCare has given 40 businesses CareCredits to date. All insurers in NC have a flexibility of 20% higher or lower with their filed rates. FirstCarolinaCare plans to enroll 500 previously uninsured members annually, and can subsidize up to 1,000 low-wage workers.

Benefits and Services

When designing FirstPlan, FirstCarolinaCare considered an HMO product with limited choice, but analysis indicated it would bring only minor price savings compared with more flexible plans. As a result, FirstCarolinaCare offers health plans similar to those offered to other businesses. The health plans have the choice of open or closed network. Benefits include preventive care, physician care, inpatient and outpatient care, lab/X-ray, OT/PT/chiropractic

¹² Personal Communications with Rebecca Ballard, Community Voices Project, May 2005

care, behavioral health, and other services. A variety of co-pay and deductible options are available. Prescription drug coverage is available at a co-pay for three tier levels.

New enrollees are assessed through health risk appraisals and health screenings and those deemed high-risk for certain conditions are referred to the FirstCarolinaCare disease management program. The case manager develops care plans and arranges for additional services not available within the network. Further, FirstCarolinaCare nurses and case managers visit the businesses to discuss potential health problems and how to address them, and a telephone nurse helpline is available.

Financing

The subsidies are financed through FirstHealth and outside grants, including a one-year federal appropriation of \$490,000. In addition, community physicians have agreed to accept reduced reimbursement (tied to Medicare 2001 rates) for subsidized patients. The planning and development for FirstPlan was supported by a Community Voices grant from the W. K. Kellogg Foundation.

Marketing

After the initial phase of FirstPlan, local advertising began in September 2003. Developing partnerships with the community were a key strategy for communications and marketing. A FirstCarolinaCare salesperson contacts businesses that, according to a previous survey, have not provided coverage and employ low-wage workers. The salesperson meets with the employer and workers, describes the product, and addresses the workers' questions and possible concerns. While the subsidy program does not exclude previously insured groups, FirstCarolinaCare targets uninsured businesses.

HealthChoice^{xxvii} Wayne County, Michigan

Overview

HealthChoice was created in 1994 and is a private, three-share health insurance program for businesses with up to 99 employees in Wayne County, Michigan. The program is administered by the Patient Care Management System, a management corporation created by the Wayne County Executive and Wayne County Board of Commissioners. HealthChoice originates from the "One Third Share" project originally funded by the Robert Wood Johnson "Health Care for the Uninsured Project."

Eligibility

In 2000, the program served 1,977 businesses or 19,019 employees. Employers were eligible if 90% of the business was in Wayne County; if at least 3 employees qualified for coverage; if 50% or more of all employees qualifying for coverage had an average wage of \$10 an hour or less; and if the employer had not offered health benefits in the last 12 months. Employees were eligible if they were anticipated to work in the future for at least 5 months; if they worked at least an average of 20 hours per week; if they had been without health insurance and were not eligible for other programs.

Benefits and Services

Enrollees can choose from five health plans that cover a full range of inpatient, outpatient, emergency, diagnostic and prescription drug services. The provider network consists of private physicians. Enrollees are assigned a PCP/gatekeeper who authorizes access to specialty care. The co-payment for physician visits and prescription drugs is \$5. Supplemental riders are available for an additional premium charge. For example, vision and exam coverage is available for an additional 6 cents, dental for \$3.29, and unlimited hospitalization for \$1.86.

Premium costs are divided equally (one-third each) among the employee, the employer, and the HealthChoice program. The employee's share of the cost of coverage for single coverage is \$42; for employee and spouse is \$90; for employee and one minor dependent is \$70; for employee and two minor dependents is \$78; and for employee, spouse, and one to three minor dependents is \$120.

Financing

The program is financed through enrollee premiums, employer contributions and the HealthChoice program. HealthChoice's share of the cost of coverage is funded through a hospital indigent care pool, which is financed by state Medicaid funds, federal Medicaid matching funds and county general funds. The annual budget, based on premiums for basic health coverage for a projected 20,000 enrollees, is \$16.8 million.

Marketing

Radio and television advertisements and some direct marketing are funded by the program. Each participating plan employs a sales staff that targets the plan to small and midsize businesses.

Access Health^{xxviii,xxix,xxx}
Muskegon, Michigan

Overview

Access Health is a private, subsidized, small to medium-sized group coverage program with a closed network. The program is financed through a three-way shared buy-in where employers, employees and the community each cover a portion of the cost.

Eligibility

Businesses with up to 150 employees are eligible to participate in Access Health if they have not offered health insurance to their employees for the past year and the median wage of eligible employees is \$10 per hour or less. Access Health encourages Medicaid-eligible adults to enroll in Medicaid, but allows them to participate in Access Health if they do not want Medicaid coverage. In addition, employers must offer dependent coverage, although families are encouraged to enroll Medicaid- or CHIP-eligible children in Medicaid or MICHild (Michigan's CHIP program).

The program targets up to 3,000 full- or part-time working uninsured individuals and up to 500 small to medium-size businesses in Muskegon County. By 2004, the program was serving more than 420 employers and 1,150 employees and dependants.

Benefits and Services

Access Health covers physician services, inpatient hospital services, outpatient services, emergency services, ambulance services, prescription drugs (formulary), diagnostic lab and X-ray, home health, and hospice care. Individuals are not excluded or rated according to pre-existing conditions. The program does not cover any care received outside of Muskegon County. Co-payments are required for most services. For example, PCP office visits require a \$5 co-payment and specialist visits require a \$20 co-payment. The co-payment rates were designed to encourage primary and preventative care. Access Health members are required to select a PCP and have an office visit within a year.

The cost of coverage is shared among the employee (30%), the employer (30%), and the community (40%). In 2004, the employee's share of adult coverage was \$46 per month. The employee's share of dependent coverage was \$29 per month.

Almost all Muskegon physicians participate in Access Health. Access Health services are paid for on a negotiated fee-for-service basis.

Financing

The program is financed according to a three-way "shared buy-in" among the employer, employee and community. The employer pays 30% of the cost of coverage, the employee pays 30% and a community match pays the remainder. The community match is unique in that it is comprised of federal DSH funds as well as local government, community and foundation funds. In addition, 10% of provider fees are donated back to the program for ongoing administrative costs.

Marketing

In 1999, Access Health began a public relations marketing campaign (including billboards, and TV, radio and newsprint ads) that was designed to establish the program's identity. Aggressive enrollment began in 2000 and a full-time sales person was hired to sell the product to eligible businesses.

Alliance Group Care^{xxxi,13} Alameda County, California

Overview

The Alliance Group Care was created to provide coverage to the county's home care workforce, who generally do not have access to employment-based insurance. It is a subsidized product with funding from public and private sources.

¹³ Personal Communications with Luella Penserga, Community Voices Project, May 2005

Eligibility

As of 2005, enrollment in Alliance Group Care was approximately 4,400 individuals. Outreach activities are conducted via the IHSS union in collaboration with the Alliance and the Public Authority, the employer of record. There is no income eligibility requirement, but enrollees must work in Alameda County as an IHSS home care worker for the prior two months, be authorized to work a total of 70 hours or more during those two months, and continue to be authorized to work at least 35 hours per month thereafter. Alliance Group Care does not provide dependent coverage.

Benefits and Services

The Alliance Group Care benefit package includes preventive care, physician services, hospital inpatient and outpatient care, laboratory and X-ray services, emergency room care, pharmaceuticals, and limited mental health, substance abuse, acupuncture, chiropractic care and other services. Dental care was added as a benefit and negotiations for vision care are underway. Enrollees are responsible for an \$8 per month premium. Physician services, preventive care visits and some pharmaceuticals do not require a co-payment, while hospital, ER, brand name and generic drugs, and some other services require a \$5 point-of-service co-payment.

As with Alliance Family Care, Alliance Group Care enrollees choose a primary care provider located at one of the participating care sites. The provider network consisted of local safety net providers.

Financing

For its Group Care program, the Alliance secured a combined total of \$1.5 million annually from the tobacco settlement funds as well as county-based social service agency dollars. This money was then used to draw down \$5.5 million in state and federal matching dollars through a variety of programs and intergovernmental transfers. The Alliance used funding from the W.K. Kellogg Foundation's Community Voices Initiative to support a Group Care evaluation.

Alliance Family Care^{xxxii,14} Alameda County, California

Overview

In 2000, The Alameda Alliance for Health (the Alliance), and its local community partners created a coverage program to help the working uninsured with income below 300% of the FPL. Alliance Family Care utilizes the local health care safety net system as the provider network to offer an affordable, family-centered, comprehensive health plan. Enrollment in Family Care is combined with publicly funded programs provided in the county and thereby provided families with a seamless system of enrollment.

Initial expectations were that the Alliance would enroll 2,000 members over five years. Instead, they reached their current membership after only 3 years. Alliance Family Care

¹⁴ Personal Communications with Luella Penserga, Community Voices Project, May 2005

provider sites, Asian Health Services and La Clínica, have gained the trust of the community and are the health care sites of choice of many program enrollees. Concerns do still exist among undocumented immigrants that they may face public charge penalties, but the Alliance and their local partners are working with outreach workers and health care staff to educate these individuals that they can obtain coverage without public charge concerns.

An evaluation of Alliance Family Care conducted by the University of Michigan found that Alliance Family Care enrollees used a higher number of preventive services once they were enrolled than prior to enrollment. In addition, 2003 HEDIS results showed high child immunization rates for Family Care enrollees and high screening rates for diabetics.

Eligibility

Alliance Family Care targets uninsured family members with children who are enrolled through the Alliance in either Medi-Cal, Healthy Families or Alliance Family Care, and who do not qualify for other public health programs. To be eligible, a family must have an annual income no greater than 300% of the FPL, live within Alameda County, and enroll all children in their household in whichever of the three above-mentioned programs for which they are eligible. When designing the program, the Alliance found that over half of the uninsured immigrants in the county have at least one family member who is an undocumented immigrant. This understanding of the mixed immigration status that is common among immigrant families led to the decision to not make immigration status a qualifying factor for coverage.

As of July 1, 2003, just over 7,300 individuals were enrolled in Alliance Family Care and 2,500 family members were on a waiting list. As noted above, early enrollment was higher than estimated, which justified the Alliance's decision not to implement a formal outreach strategy. Rather, as part of a long-standing, county-wide enrollment program, community clinics and community-based organizations conducted most of the enrollment. Asian Health Services and La Clínica, in particular, coordinated outreach efforts. At Asian Health Services, four community health workers who speak Cantonese, Mandarin, Vietnamese and Korean conducted outreach in the Asian community. They made presentations on health care coverage options and public charge issues at nail salons, sewing factories, churches, etc. La Clínica hired a Spanish-speaking enrollment specialist to enroll individuals. The county also included Alliance Family Care in several successful enrollment events and initiatives.

In terms of retention, there has been a consistent re-enrollment rate of over 97 percent annually. Enrollment is currently capped and will remain so until the Alliance can tap into an increased and sustainable funding stream.

Benefits and Services

Alliance Family Care offers coverage for a comprehensive set of health care services that specifically were designed to mirror the Medi-Cal and Healthy Families benefit packages provided in Alameda County. This enables enrolled families to have a "seamless" health care experience whereby all family members can access similar benefits (including vision and dental), use the same providers, and get care in the same locations. In addition, if a family member becomes ineligible for Medi-Cal, there is an easy transition to Alliance Family Care. Such seamless coverage is particularly important since the Alliance currently has the highest Medi-Cal enrollment in the county (Blue Cross is the only other provider). Families are responsible for a monthly premium, which varies according to age. Children age 18 or younger (or up to age 23 if a full-time student) pay \$10 per month, while adults between 19 and 64 pay

between \$23 and \$120 per month. There are no co-payments for primary and preventive care services, nor for hospital-based services. Physician visits, pharmaceuticals and emergency department visits require nominal co-payments.

In addition, Alliance Family Care enrollees choose a primary care provider located at one of the participating care sites. Specialty care is covered but, as is typical in the safety net system, is often difficult to access.

Financing

Through a combination of private and public funds, the Alliance is able to subsidize care for Alliance Family Care enrollees, thereby keeping cost-sharing at a more affordable level. The bulk of the funding comes from the Alliance itself, which provides almost \$15 million out of its reserve funds. Grants from the California Healthcare Foundation (\$1 million), The California Endowment (\$400,000) and the county tobacco settlement fund (\$2 million) provide the balance of funding. Another \$950,000 is pending. The Alliance used funding from the W.K. Kellogg Foundation's Community Voices Initiative to support a Family Care evaluation. Finally, a county-wide enrollee satisfaction survey was conducted, for which the Community Voices grant provided \$50,000 and in-kind staff time for management and oversight.

HealthPass^{xxxiii,xxxiv,xxxv}
New York, New York

Overview

In 1999, New York City Mayor's Office and the New York Business Group on Health (NYBGH) developed HealthPass, a health insurance cooperative for small businesses. HealthPass is administered by the New York Health Purchasing Alliance, a subsidiary of NYBGH, and provides access to a range of health plans and prescription drug and dental options. The cooperative does not provide premium subsidies, but does offer small businesses a rare combination of choice and administrative simplicity. It utilizes the "defined contribution" approach, in which employers pay a set amount of each employee's premium and employees can choose more expensive plans and pay the balance themselves. Hence while there is no substantial price advantage relative to the regular market as a consequence of joining HealthPass, the cooperative makes shopping for health insurance relatively simple and provides many health benefit choices to employees.

HealthPass is considered to be a relatively successful cooperative not only because of the administrative simplicity it provides and the flexible benefit plans it offers, but also because of the initial support it received from local government and its close ties to the broker community. The New York City Mayor's Office contributed money to HealthPass during its start-up phase and lent personnel to assist in managing the cooperative. The cooperative's close interaction with the broker community has also benefited HealthPass as brokers have been the main source of enrollment. HealthPass' major drawback has been its inability to achieve financial self-sufficiency as of 2004.

Eligibility

In 2004, 1,000 small businesses were a part of Health Pass and 9,111 persons were covered through the cooperative. In Health Pass, there is no minimum payment requirement for employers, and the employer may also provide commercial coverage. Adverse selection is addressed by a 75% participation requirement for employers with at least two employees in Health Pass.

Benefits and Services

The cooperative offers a variety of plans that range from limited to comprehensive coverage. The plans are operated by four insurers: Group Health Incorporated, Health Insurance Plan of New York, Horizon Healthcare and HealthNet. Initially, each of these four carriers offered five identical benefit packages, for a total of 20 plans that differed from carrier to carrier according to the size and perceived quality of the participating physician networks. As HealthPass evolved, the plans offered by the four carriers have diverged somewhat. In addition, six new plans have been added by the four original insurers.

Ultimately, there is no price advantage over the regular market as a consequence of joining Health Pass. Though the cooperative has worked with the participating insurers to develop leaner benefit packages, the benefit packages are constrained by state mandated benefit requirements. However, small businesses have been attracted by the choice of health plans afforded through the program and simplicity of shopping for health insurance.

In 2004, the average employer contribution for individual coverage was \$197 per month, and for family coverage, \$383 per month. The percent of the premium that these amounts represent varies based on family size and choice of benefit plan. The average contributions in HealthPass are considerably lower than the average New York employer contributions reported in a 2001 statewide Commonwealth Fund survey of small employers (\$242 for individual coverage and \$467 for family coverage).

Financing

During the program's planning phase and first two years of operation, \$2.7 million in start-up funding was provided from the New York City Department of Health and the Economic Development Corporation. In addition, participating insurers and general agents contributed \$129,000 plus significant in-kind contribution. By 2004, the program had not yet achieved financial self-sufficiency.

Marketing

HealthPass leadership devoted extensive efforts and resources to the development of an active network of brokers and general agents. HealthPass maintains strong person-to-person relationships with brokers, provides brokers with support services, and allocates increasing proportions of their marketing budget to outreach to the broker community. The broker community has been the main source of enrollment for HealthPass. The cooperative does not exceed the market commission but provides sales promotion support to the brokers and agents. Overall, marketing costs have been high.

Healthcare Accountability Act^{xxxvi,xxxvii,xxxviii,15}
San Francisco, California

Overview

In 2001, San Francisco's mayor introduced the Healthcare Accountability Act (HCAO) requiring contractors that provide services to the City and County to either (option 1) offer health plan benefits to all employees or (option 2) make payments to the City and County for use by the Department of Public Health to help partially offset the cost of services for uninsured workers.

Impact

An estimated 16,050 uninsured workers were projected to benefit from HCAO. This included 1,900 for-profit contractors, 2,650 non-profit contractors, 5,750 Airport tenants, and 5,750 tenants of City property.

Mandate

A city/county contractor has one of two options in order to abide by HCAO.

Option 1: The employer must offer the covered employee a plan that is as good or better than what is outlined in the Minimum Standards. HCAO's Minimum Standards require employers to offer at least one health plan that is a Health Maintenance Organization (HMO). Employers may not require employees to pay a monthly premium contribution toward the HMO plan. This HMO must not charge employees a deductible of any amount for any services or benefits covered in the package. Co-payments for office visits (including PCP, perinatal and maternity, preventive care, and family planning) shall not exceed \$15 per visit for a Closed Panel HMO; and \$20 per visit for all other HMO models. The employee's annual out-of-pocket maximum shall not exceed \$2,500.

Each plan must be comprehensive and provide coverage for the following services:

- Office visits (including PCP, perinatal and maternity, preventive care and family planning)
- Hospital inpatient
- Prescription drugs
- Outpatient services and procedures
- Diagnostic services (X-ray, labs, etc.)
- Perinatal and maternity care
- Emergency room and ambulance
- Mental health services, outpatient and inpatient
- Alcohol and substance abuse care, outpatient and inpatient detox
- Rehabilitative therapies
- Home health
- Durable medical equipment
- Hospice care
- Skilled nursing services

¹⁵ Personal Communications with Anne Kronenberg, San Francisco Department of Public Health, May 2005

Option 2: Employers must pay a fee of \$2 per employee/per hour, with a weekly maximum of \$80 or \$320 per month. The fee is higher than the current HMO average premium for 2003 (\$222/month). It also compares favorably to the premiums for Kaiser, Blue Shield and the PacAdvantage plans. A fee of this level ensures that both providing insurance and paying the fee remain viable alternatives for employers.

Exemptions/Waivers

Businesses may be exempt from HCAO for a number of reasons. Some reasons include the following: (1) if the business employees too few employees (20 or fewer employees for for-profits, and 50 or fewer employees for non-profits); (2) if the contract is with a public entity, (3) if the contract was entered before 2001, (4) if the contract duration is less than a year.

Financing

The City/County estimated that HCAO would cost approximately \$4 million annually. This is based on the assumption that one-third of all contracts would be renewed or modified. These additional costs were to be funded through the City's General Fund.

III. Lessons Learned

Innovative Strategies for Expanding Care

Our review suggests that there are design features that can be used to expand systems of local safety net care including: new organizational forms that allow for community-wide planning and coordination, standardized eligibility processes to identify and limit patient populations and assign them to a medical home, integrated data systems to make patient eligibility and medical information readily available to providers, provider networks that offer access to comprehensive services, case management services to encourage care coordination, and provider payment methods that create incentives to serve low-income uninsured patients.

Existing governance structures often present difficulties when trying to operate a coordinated health care safety net system involving multiple agencies, public and private providers, and different sources of financing. One of the ways that safety nets have extended care is to make organizational changes that establish relationships among community-based safety net organizations and ensure commitments to work toward common goals, such as community-wide planning and service coordination. The actual form taken to achieve these organizational improvements may include:

Consolidation - When health care agencies merge for policy, administration and delivery of services. The main intent is to centralize authority and provide a more efficient and accountable system.

Collaboration - When health care agencies develop arrangements to take joint responsibility for policy, administration and delivery of services.

Coordination - When health care agencies develop arrangements for joint responsibility of the delivery of services.

Safety nets are extending care by developing integrated eligibility systems. These systems include a defined screening, eligibility and enrollment process that limits eligibility, defines the eligibility period and service restrictions, and encourages stable participation. Outside funding is maximized by ensuring that persons meeting eligibility criteria for local, state and federal programs become enrolled in those programs.

Innovative safety nets are also using primary care assignment to expand capacity, improve continuity of care and reduce costs. In these systems patients are assigned to a specific medical home where they have expanded access to primary care and through which they go for referrals to specialty care. Reimbursement methods for providers often include risk arrangements and incentives for performance but do not normally utilize “aggressive” payment methods.

Specialty care is an important component of delivering an effective local health care initiative. Meeting the costs involved in maintaining an adequate supply of specialty care providers can be challenging. Local health care initiatives have involved specialty care providers during the design and beginning phases of developing a local initiative and work towards the development of adequate reimbursement rates and performance-based payment methods.

Another common feature is the development of a structured referral network with a defined network of providers and procedures for coordinating care between ambulatory and hospital settings. It may involve structured protocols in clinics, hospitals and ERs for patient referrals to the most appropriate and least expensive settings for care. Additional features may include after-hours hot lines and navigators to assist patients in accessing services.

Safety net initiatives also focus on the development of integrated patient record systems. Integrated eligibility and patient record systems (IPRS) link ambulatory, hospital and specialty care sites in the system. An IPRS tracks eligibility, health history and movement of patients as they obtain services. These systems are used for enrolling patients in third-party programs, improving access to and better coordination of services, and saving costs through reduced duplication.

Innovative safety net models have invested resources in the development of quality assurance programs with patient care guidelines and case management programs. Such programs require integrated eligibility and patient record systems that allow monitoring of patterns of care and outcomes. Resources from the community for quality assurance activities, measurement strategies and performance targets should be determined early in the development of new programs. Periodic evaluations that permit public accountability are important for the overall success of a program.

Safety net programs rely completely on local funds or on a combination of local, state and federal funds. They rarely have sufficient funds to adequately serve the target population. Those without a substantial portion of funds from a regular source such as Medicaid or commercial insurance often have the most difficulty. A diversified funding stream enables local safety nets to stabilize their budgets and protect themselves from unanticipated changes.

Finally, several of the safety net models are taking a broad view of health-related services that are necessary to meet the array of medical, social, behavioral and financial needs of the uninsured. Explicit linkages to social services, transportation and local public health services allow coordination between treatment and prevention programs. The linkages range from consolidation, to sharing of facilities, to referral arrangements.

Innovative Coverage Initiatives

The issues that must be addressed by local initiatives to extend public and private coverage include benefit design, cost, target population, financing, marketing, provider choice, program duration, enrollment and operations, and transition.

Benefit Design: The level of benefits and services offered by the health plans varied significantly, reflecting different approaches to creating affordable products. Some of the health plans offered comprehensive services with limited cost-sharing, patterned after products available to other commercial members. In an effort to reduce the cost of coverage, others provided more limited benefit packages and greater cost-sharing. Several health plans conducted extensive market research to develop the optimal benefit package. Regardless of which strategy was followed, plans that were stable and reasonably adequate to meet most basic needs of the patient population seemed to attract more enrollees. The reason a particular product attracted its intended audience was more attributable to a combination of the benefit package with product price, marketing approach, and/ or target population.

Cost and Financing: Lack of affordable products is the reason many are uninsured and innovative health plans attempt to find methods to lower product premiums. Several products have been made available at 50% of commercial rates. Some have premiums of less than \$100 (for individuals), with most offering some variation of the product at less than \$50. These ranges reflect the results of market research, which have consistently shown that \$50-\$100 per month is the maximum price low-wage workers are willing to pay for health coverage.

The health plans used numerous methods to reduce premiums, through negotiated discounts with providers, rate stability, limited benefit packages, plan subsidies, enhanced cost sharing, lower profit and administrative fees, and premium alternatives. Despite lower premiums, some plans found that their products did not attract the anticipated number of customers, because (a) the premium remained out of reach; (b) the product's benefits were viewed as insufficient for its price; or (c) the product seemed less desirable in comparison with the company's other offerings. Low-priced products do not necessarily attract the anticipated number of customers.

All of the products charged co-payments to lower premiums, ranging from a low of \$2 for primary care office visits to a high of \$500 per day for a hospital stay. Products that used increased cost sharing mechanisms experienced good enrollment, but no data exists to determine if cost sharing has deterred members from seeking necessary health care.

Some small business and individual products have become break-even or profit-making. Others must be financed in part by moderate to heavy subsidies. The presence or absence of plan subsidies does not appear to be a defining factor in attracting the uninsured. But health plans may find some advantages in subsidizing products such as enhancing the provider-plan relationship through partial reimbursement for services which would otherwise be uncompensated. Also, some health plans recognized the uninsured as a potential future market for individual or group coverage, since most people do not remain uninsured permanently. Plan-

subsidized initiatives offer exposure to the plan and may build loyalty when the individual or family is in a position to obtain commercial health insurance.

Products with varied financing mechanisms provided employers and individuals with greater choice and may have enhanced value. Nevertheless, giving the uninsured such choices did not have consistent appeal in every market.

The initial offering of some new products had higher than normal administrative costs. Outside sources may scrutinize the percentage allocated to administration, but must also realize that plans usually need enhanced infrastructure to support new initiatives.

Target Population: Many uninsured initiatives restricted program eligibility due to limited funds to support the product or in order to avoid duplication with other coverage for the uninsured. Most of the individual products that were reviewed established income eligibility limits. Some of the private sector products with more restrictive eligibility criteria than others experienced mixed results on enrollment. Two health plans which did not reach desired membership in their products had conducted preliminary assessments before initiating their programs, but attracted many applicants who were not eligible. Regardless of the target population, most new health insurance products took time to attract members. Some successful initiatives did not achieve enrollment goals until one to two years after product launch.

Marketing: This is a critical feature to the success of private initiatives. The mere existence of a quality product at a low cost does not guarantee that the target population will purchase it. For small group products, a multifaceted approach to marketing is generally associated with higher enrollment. Successful small group initiatives that attracted more than 10,000 members used direct mail, brokers, the Internet, toll-free telephone numbers, and television, print, and radio advertisements. Among these different strategies, health plan representatives indicated that brokers were essential in securing new members. Indeed, programs that had difficulty with enrollment either did not use brokers or worked with a limited number to recruit customers. Brokers are not only a bridge between health plans and consumers, but also educate employers about the value of health insurance and the different options available for purchase.

Among individual products, a greater number of marketing strategies did not necessarily translate into a higher number of enrollees. Health plans offering individual products were more likely than those selling small group products to use direct approaches such as distributing flyers and holding community events as part of a marketing campaign. The three health care organizations that managed to enroll more than 10,000 relied on a variety of marketing techniques, but few were common among the three. The use of the Internet and toll-free numbers is common among the three individual products, but it is also shared among nearly all programs examined in this study. All three individual products did, however, conduct extensive market research to determine which channels would most effectively reach their target population.

Providers: Provider choice affected program marketability and price, as networks were a factor for some applicants in assessing the product's value. Nearly all the health care organizations that developed insurance products used the same network as used for their other products, concluding that product success depended in part on having a network identical to that of other commercial coverage. While a broad network did not guarantee that consumers would purchase a product, a restricted panel did have negative consequences on enrollment.

Four health plans negotiated discounts with providers as a means to keep premiums low. Products that utilized provider discounts coupled with restricted panels experienced more difficulty attracting enrollees than products that used discounts and the usual provider network. One health plan reimbursed primary care services in full while specialty care services were partially reimbursed to provide incentives for preventive care for the uninsured.

Program Duration: Several of the initiatives were either time-limited pilot programs or intended to serve as short-term insurance. Among the new, shorter-term programs, enrollment has been lower than anticipated, as some pilots with limited availability due to service area, income, or number of potential members experienced marketing difficulties. Long-established programs were better able to meet membership targets. One health plan indicated that pilots not supported by senior management may have problems achieving their goals. A pilot launched in competition with another commercial product could garner less investment and less aggressive marketing. Short-term pilots provide only temporary coverage for the uninsured since the closing of a program marks the end of health benefits. Also, some employers who have made the commitment to join a short-term pilot may face a predicament: once the program terminates, they must maintain coverage without plan subsidies, find another affordable product, or discontinue health benefits.

Nonetheless, under certain circumstances, a pilot may be desirable. Pilot programs allow plans to try new, unproven or otherwise risky approaches to coverage. Plans are able to make changes on a small scale and refine their products over time, before investing significant resources in major program modifications. To overcome the barriers inherent in pilot programs, one health plan created a product intended for those currently covered as well as the uninsured to replace its existing programs. By rolling over its current members into new individual and small group products, the plan mitigated the risk that initial enrollment projections would not be met. Over time, however, a health plan has no guarantee that every member will prefer the new product over the old or that all members will choose to renew. Moreover, the replacement products still face obstacles similar to pilots or other new programs in attracting the uninsured.

Transitions: Recognizing that many people become uninsured as a result of transition issues, some health plans designed products for those who (a) lose status as a dependent on another's policy but are unable to secure one's own coverage; (b) change jobs or become unemployed; and (c) lose eligibility for public programs but are unable to secure private coverage. Five products addressed these age, income and public/private transitions by: allowing over-aged dependents to remain on their parents' policies; guaranteeing rate stability for the near-elderly; providing subsidies to pay for a percentage of one's premiums for a fixed amount of time; and bridging the divide between the public and private sectors through cross-referrals. Some of the transition efforts conflict with other plan strategies; for example, seeking relief from community rating to pursue age banding versus directing products to the uninsured who are near-elderly. In general, products attempting to address transition issues have generated higher enrollment than those that have not.

Enrollment and Operations: Innovative health plans acknowledged enrollment and operational problems as major barriers to obtaining health coverage since applicants must go through a multi-step process prior to obtaining coverage. A failure in any step of this process can result in lack of coverage. Several products examined in this study addressed enrollment issues by streamlining applications, allowing self-declaration of income, and providing multilingual application materials. These products attracted a greater percentage of the uninsured than others. Those health plans with less success had problems upstream in the enrollment sequence such as in marketing. Because some people are unable to obtain care due to language or cultural

barriers, two health plans attempted to increase access by using multilingual case managers to help new members navigate their way through the health care system. Members received case managers as long as the focus was on health, rather than social or career issues.

IV. Conclusions and Recommendations

Texas is faced with significant challenges in providing access to health care for the state's uninsured. To help develop local initiatives that address these issues, we have reviewed a number of features of local programs that have expanded care and coverage for the uninsured. The state should consider creating a program to provide support of local effort for producing more coordinated and collaborative health care systems, including direct financial support and/or other financial-related incentives for innovations, such as Medicaid payment for navigator services, technology grants for electronic record systems, or tax credits for private insurance plans that integrate coverage with Medicaid. State level support is also needed as seed money to support the development of community-based health insurance plans and to expand existing successful plans to broader populations and geographic areas.

To address the fragmentation and inequity in the existing system will call for broader solutions such as raising and making more uniform the eligibility and service standards of local safety nets across the state. Given the regional nature of health care markets and the desire for local control, basic services, funding, and eligibility levels could be standardized at the regional level.^{xxxix} Under the regionalization approach, urban counties with more sophisticated medical centers would be grouped with smaller surrounding counties to build a more coordinated health care infrastructure dispersing primary and secondary care more broadly.

One of the easiest things the state could do to begin to improve the performance of safety net systems is require standardized reporting from all county safety net programs so that state and local officials could more accurately understand the features of existing programs, monitor performance, assess unmet needs, and identify the potential impact of innovative strategies.

Texas has limited underwriting requirements for small businesses, which is a major reason for the gap in coverage of small employers compared to the rest of the country. Until these regulations are changed, including movement towards community rating and making cooperatives a realistic alternative, the number of commercial products available to small groups and individuals will not be adequate, even with community-based efforts to expand their availability. Current law is skewed against small employers, who comprise the majority of Texas employers and are also the majority of employers not offering health insurance.

Some of the best safety nets in the country that are also featured in this report do not have programs to assist individuals in families with incomes above 200% of the FPL. Hence, local initiatives that target services or coverage to this fastest growing segment of the uninsured population should be emphasized. This is also an opportunity to offer programs to people who have money to make a significant contribution to the cost of their own care.

It is clear from our review that innovative models of community-based care and coverage have the potential to significantly expand access to care. Since Texas has maintained a broad statutory obligation for counties to provide medical care to low-income uninsured persons in the state, it seems that a comprehensive approach to expanding these models in Texas is warranted.

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Table 1. Local Care Initiatives				
Location	El Paso, TX	San Antonio, TX	Denver, CO	Detroit, MI
Local Care Initiative	Health Care Options	CareLink	Denver Health	PlusCare
Start Date	1999	1997	1994	1992
Overview	Health Care Purchasing with Managed Care	Health Care Purchasing with Managed Care	Consolidated Safety Net Plan with Managed Care Features and Vertical Integration	Managed Care Plan
Organizational Form				
Consolidated	No	No	Yes	No
Coordinated	No	Yes	Yes	Yes
Collaborative	Yes	No	No	Yes
Administrative Authority	Community Voices Collaborative and First Health Network	Bexar County Hospital District	Denver Health and Hospital Authority	Patient Care Management System
Delivery System				
Coordinated Features *	IES, PCA, SR, CM	IES, IPRS, PCA, CM, QA, SR	IES, IPRS, QA, CM, PHDL	IES, PCA, QA, SR
Services Provided **	A,C	A - E	A - F	A-F
Community Partners	CHCs, FQHC, Hosp Dist, Other	UTSA Med School, Comm Medical Assoc, FQHCs,	All Public Safety Net Providers	FQHCs and other Safety Net Providers
Patient Cost Share (y/n)	Yes	Yes	Yes	Yes
Provider Payment	FFS	FFS – Physicians % Charges, DRG- Other	Varies by Program	Capitation PMPM
Eligibility				
Children	No	Yes	Yes	County, State, Medicaid Matching
Adults	Yes	Yes	Yes	\$44 million (2004)
Income Threshold	100% FPL	200% FPL	Varies by program	\$250/month/person
Other	Residents not eligible for other programs	Residents not eligible for other programs		\$90 work expense deducted from income
Total Enrolled/Served	7,000 (2004)	53,000 (2004)	155,000 (2002)	25,000 (2004)

***Features**

IES Integrated Eligibility System(w/ local safety net)
PCA Primary Care Assignment
RPR Reduced Provider Reimbursement
CM Case Management
QA Quality Assurance
SR Structured Referral network
BC Broker Collaboration
MC Marketing Campaign
RC Rate Cap

****Services Provided**

A Primary and Preventative Care
B Inpatient care
C Specialty Care
D Pharmacy Access
E Behavioral Health Care
F Dental
G Vision

Table 1 (Continued). Local Care Initiatives

Location	Indianapolis, IN	Tampa, FL	Milwaukee, WI	Austin, TX	Buncombe Cty, NC
Local Care Initiative	Health Advantage	Hillsborough County HealthCare Plan	General Assistance Medical Program	ICare System	Project Access
Start Date	1997	1992	1998	1997	1999
Overview	Health Care Purchasing with Managed Care	Health Care Purchasing with Managed Care	Health Care Purchasing with Managed Care	Integrated Eligibility And Patient Records with Pub/Priv Provided Service System	Providers volunteer health care services
Organizational Form					
Consolidated	Yes	No	No	No	No
Coordinated	Yes	Yes	Yes	No	Yes
Collaborative	Yes	Yes	Yes	Yes	Yes
Administrative Authority	Health and Hospital Corporation	County Dept of Health and SS	Milwaukee Cnty Div of Health Programs	Indigent Care Collaboration	Buncombe County Medical Society
Delivery System					
Coordinated Features *	IES, CM, QA, SR, PHDL	IES, PCA, QA	IES, PCA, IPRS, CM, QA, SR	IPRS, IES, PHDL	IES, CM, QA, SR
Services Provided **	A - F	A - E	A - D	NA	A, B, C, D, E
Community Partners	Med School, FQHCs, Other Safety Net	Med School, FQHCs, Other Safety Net	Med School, FQHCs, Other Safety Net	All Safety Net Providers	CHCs, FQHC, Hosp Dist, Private Physicians
Patient Cost Share (y/n)	Yes if Income > 150%FPL	Yes	Yes	NA	No
Provider Payment	Capitation-PC Physicians FFS- Other	FFS	FFS- Physicians 80% Charges- Hospitals	NA	NA
Eligibility					
Children	Yes	Yes	Yes	NA	Yes
Adults	Yes	Yes	Yes	NA	Yes
Income Threshold	200% FPL	100% FPL	115%-125% FPL based on family size	250% FPL depending on program	200% of FPL
Other	Not eligible for other programs	Not eligible for other programs	Medical need required		Residents not eligible for other programs
Total Enrolled/Served	47,000 (2004)	29,000 (2004)	25,000 (2004)	83,000 [∞] (2002)	26,000 (2005)

***Features**

- IES** Integrated Eligibility System(w/ local safety net)
- PCA** Primary Care Assignment
- RPR** Reduced Provider Reimbursement
- CM** Case Management
- QA** Quality Assurance
- SR** Structured Referral network
- BC** Broker Collaboration
- MC** Marketing Campaign
- RC** Rate Cap

****Services Provided**

- A** Primary and Preventative Care
- B** Inpatient care
- C** Specialty Care
- D** Pharmacy Access
- E** Behavioral Health Care
- F** Dental
- G** Vision

Table 2. Local Coverage Initiatives						
Location	Kansas City, MO	Moore County, NC	Wayne County, MI	Muskegon, MI	Alameda County, CA	Alameda County, CA
Local Coverage Initiative	Chamber Choice	First Plan	HealthChoice	Access Health	Alliance Group Care	Alliance Family Care
Start Date	1994	2002	1994	1999	2000	2000 – 2004
Overview	Private, unsubsidized, small group coverage with choice of open or closed network	Private, partially subsidized, small group coverage with choice of open or closed network	Private, subsidized, small to medium sized group coverage with choice of open or closed network	Private, subsidized, small to medium-sized group coverage with closed network	Private, subsidized, workgroup specific coverage with closed network	Private, subsidized, family coverage with closed network
Organizational Form						
Administrator	Blue Cross Blue Shield of Kansas City	FirstHealth of the Carolinas	Patient Care Management System	Access Health	Alameda Alliance for Health	Alameda Alliance for Health
Public/Private	Private	Private	Private	Private	Private	Private
Delivery System						
Features*	RPR, BC, MC, RC	RPR, MC, CM, QA	PCA, SR, CM, QA	RPR, CM, BC, MC, QA	RPR, CM, QA	IES, RPR, CM, QA
Basic Services Provided**	A – D	A - E	A - D	A – D	A - E	A - G
Provider(s)	Private physicians	FirstHealth of the Carolinas, private physicians	Private physicians	Private physicians	Local safety net	Local safety net
Patient Cost Share	Yes	Yes	Yes	Yes	Yes	Yes
Financial						
Funding Sources	Private, Cost Share	Federal, Cost Share	County, Cost Share	Grants, County, Federal, Cost Share	Private, Grants, County, State, Federal, Cost Share	Private, Grants, County, Cost Share
Funding Model	Private insurance plan	Private insurance plan	Three way shared buy-in	Three way shared buy-in	Heavily Subsidized	Heavily Subsidized
Eligibility/Enrollment						
Children	Yes	Yes	Yes	Yes	No	Yes
Adults	Yes	Yes	Yes	Yes	Yes	Yes
Income threshold	250% of FPL	N/A	N/A	N/A	N/A	300% of FPL
Other	Businesses with up to 50 employees	Businesses with up to 50 employees	Businesses with at least 3 employees	Business with up to 50 employees	In-home supportive services workers	
Total enrolled	80,000 (dependants not inc, 2004)	2,000 (2005)	19,019 (dependants not inc, 2000)	1,150 (2004)	4,400 (2005)	7,400 (2004)
% previously uninsured	40%	19%	100%	100%	100%	100%

***Features**

- IES** Integrated Eligibility System(w/ local safety net)
- PCA** Primary Care Assignment
- RPR** Reduced Provider Reimbursement
- CM** Case Management
- QA** Quality Assurance
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****Services Provided**

- A** Primary and Preventative Care
- B** Inpatient care
- C** Specialty Care
- D** Pharmacy Access
- E** Behavioral Health Care
- F** Dental
- G** Vision

Table 2 (Continued). Local Coverage Initiatives		
Location	New York, NY	San Francisco, CA
Local Coverage Initiative	Health Pass	Healthcare Accountability Ordinance
Start Date	1999	2001
Overview	Private purchasing cooperative for small businesses	Public, health insurance mandate for government contractors
Organizational Form		
Administrator	New York Business Group on Health	San Francisco Department of Public Health
Public/Private	Private	Public
Delivery System		
Features*	MC, BC	N/A
Basic Services Provided**	A – D	A - E
Provider(s)	Private physicians	Private Physicians
Patient Cost Share	Yes	No
Financial		
Funding Sources	Grants, Cost Share	Public
Funding Model	Cooperative	Government
Eligibility/Enrollment		
Children	Yes	Yes
Adults	Yes	Yes
Income threshold	N/A	N/A
Other	Businesses with up to 50 employees	City/County contractor
Total enrolled	9,111 (2004)	N/A
% previously uninsured	56%	100%

***Features**

- IES** Integrated Eligibility System(w/ local safety net)
- PCA** Primary Care Assignment
- RPR** Reduced Provider Reimbursement
- CM** Case Management
- QA** Quality Assurance
- SR** Structured Referral network
- BC** Broker Collaboration
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