

Local Coverage Initiatives: Solution or Band-Aid for the Uninsured?

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OVERVIEW — *This issue brief surveys health coverage expansion initiatives that are operating on the county or local level, often without the benefit of federal funding. The paper explores the circumstances that have made these initiatives possible and considers the ongoing barriers that local policymakers face in sustaining the programs. Descriptions of four initiatives illustrate the range and variety of programs in operation today and offer both best practices and lessons learned for other communities. The paper also includes a brief analysis of the key elements that make up a successful coverage initiative. Finally, this issue brief considers the role of local and county-based initiatives in the context of overall health care delivery in the national policy framework, highlighting the prospects for sustainability and replication on a broader scale.*

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With the ranks of the uninsured continuing to increase each year—reaching a total of 45 million (17.7 percent of Americans under age 65) in 2003—policymakers continue to grapple with the question of what, if anything, can be done to ensure that more people have access to affordable health care coverage. Large-scale proposals for varying forms of national health insurance have been proposed, debated, and rejected repeatedly over the past 70 years. Americans continue to say that the rising cost of health care is a major concern in their daily lives, yet other priorities continue to take precedence.

In the absence of major solutions that are national in scope, many communities across the country have taken it upon themselves to provide health care options for their citizens. These options range broadly from small indigent care programs to major expansions of health insurance coverage financed by foundations, health plans, local tax revenues, and special earmarked funding sources. Some of the programs have been in operation for more than a decade, while others are just getting started. The structure of these initiatives varies according to the political climate, the extent of community leadership, the state and local fiscal situation, and the overall demographics of the target population, yet they all share the common goal of increasing access to health care in their respective communities.

Some initiatives have had more success than others, and all have had to adjust to changing political tides over the years. In addition, the economic downturn that has driven state health policy since the beginning of the 21st century has taken its toll on the viability of many of the initiatives. However, the presence of what one state policymaker calls “willing co-conspirators” has enabled many of the more creative and resourceful programs to persevere even in tight fiscal times.

ALL OVER THE MAP

Just as states’ Medicaid and State Children’s Health Insurance Program (SCHIP) efforts differ widely across the country, county or locally based health initiatives vary significantly in structure, size, and overall approach. Over the past 15 years, several distinct strategies have emerged, each using a different approach to achieve the same basic goal—to increase access to health care services. This issue brief highlights the following four approaches:

- Insurance coverage expansion (California)
- Small business/employer buy-in program (Michigan)

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- Managed care plan/public hospital–driven approach (Indiana)
- Provider-driven efforts/physician volunteerism (North Carolina)

The first approach builds on existing public insurance programs like Medicaid and SCHIP by expanding coverage to families with higher incomes and to individuals who do not otherwise qualify for federally funded programs. The second approach uses cooperation between the public and private sectors to offer health coverage to the uninsured. In what has become known as the “three-share model,” the employer, the employee, and the community each contribute a portion toward the cost of coverage. The third approach is to use the existing public hospital system in a community to provide health coverage through managed care. This strategy has offered a cost-effective and organized alternative to a faltering safety-net infrastructure. Finally, this issue brief discusses one county’s mobilization of the provider community to strengthen the safety net through physician volunteerism. While these are only a sampling of the strategies being tested in communities across the country, they do represent some of the most popular and time-tested approaches used to date.

County-Based Expansions in California— Health Coverage Laboratory for the Nation?

“From the get-go, we said we are covering all kids. We didn’t care whether they had a green card, a blue card or whatever color card—a kid is a kid.”

— Leona Butler, Chief Executive Officer, Santa Clara Family Health Plan¹

The state of California is distinctive in many ways, including its geographic size, its large population, and the ethnic and economic diversity of its residents. California is also a state whose governance is strongly determined by its counties. These factors make California an interesting laboratory for the entire country, while at the same time a case study unto itself. This may be particularly true with respect to health coverage. Although nearly a quarter of the population is covered by Medi-Cal or Healthy Families (California’s Medicaid and SCHIP programs), the state continues to suffer a 20 percent rate of uninsurance.² This health coverage crisis has prompted the largest trend of locally driven, county-based health coverage expansions in the nation.

Over the past decade, California’s counties have assumed primary responsibility for providing health care to uninsured individuals. The state provides funding to the counties, which in turn ensure the delivery of public health services and medical care to the uninsured and low-income. Counties must agree to supplement, rather than supplant, these state funds with county funds and maintain specified levels of access to care. The state and the counties formalize this relationship through standard agreements between government agencies; the corresponding funds are commonly referred to as realignment funds.³

To date, 30 of California’s 58 counties, accounting for 75 percent of the state’s uninsured children, have in place or are planning to pursue a county-based

health coverage initiative designed to reach out to low- and middle-income children and their families.⁴ The first wave of expansions occurred in counties with either a “Local Initiative” health care plan or a county-operated health system under the state’s “Two-Plan” Medicaid managed care model.⁵ Several more recent coverage expansion programs have contracted with commercial plans to administer a new subsidized health insurance product. These coverage expansions are almost all modeled after the Children’s Health Initiative (CHI) that was spearheaded by a key group of stakeholders in Santa Clara County, located in the San Francisco Bay area.

Thirty of California’s 58 counties have in place or are planning to pursue a local coverage initiative targeted at children and families.

Santa Clara County’s CHI has been studied and publicized extensively because of its innovation and its success. The program was launched in January 2001 in an attempt to provide “universal” coverage to all children in Santa Clara county. Technically, the new insurance product, Healthy Kids, was available to all children with family incomes up to 300 percent of the federal poverty level, or FPL (\$58,050 for a family of four in 2005), including both legal and undocumented immigrants. Because the vast majority of Healthy Kids enrollees are immigrant children, the program was by definition not eligible for federal Medicaid matching funds, so alternate financing streams were identified.⁶ The CHI secured funding from the county and the city of San Jose’s tobacco settlement dollars, state Children and Families Commission (“Proposition 10”) grants, private foundations, and the local initiative health plan.⁷

The Santa Clara Family Health Plan (SCFHP)—the administering agency and the local initiative plan—is run by Leona Butler, one of the key architects of the overall CHI in the county. Healthy Kids has expanded over the years and now serves 13,000 children. In fact, the outreach efforts have been so successful that interest in the Healthy Kids program has exceeded its capacity. The SCFHP was forced to start a waiting list for the program in 2004. However, Healthy Kids will potentially receive federal funding through a SCHIP section 1115 waiver that was approved in 2004.⁸

All of the county-based expansions have committed to first screening children for Medi-Cal or Healthy Families eligibility in order to ensure appropriate coverage, as well as to reserve funds only for those children who are not eligible for programs funded by the state and federal governments. This is done using a facilitated, in-person, application process that has been shown to result in a higher application success rate than using mail-in applications, mainly due to the hands-on assistance that the enrollment specialists provide.⁹ As a result, CHI outreach workers have helped more than 60,000 children enroll in Medi-Cal and Healthy Families since 2001.¹⁰

A recently released evaluation of the Santa Clara Children’s Health Initiative found that the Healthy Kids program has reduced unmet medical and dental need by 50 percent and nearly doubled the percentage of children with a usual source of health care. Access to dental care increased nearly three-fold. In addition, parents’ confidence in their ability to access care for their children increased from 43 percent to 75 percent, according to the

recent survey. And parents overwhelmingly reported being satisfied with the care their children are receiving through the SCFHP.¹¹

With Santa Clara as a model, many other counties have followed suit over the past four years, developing Healthy Kids programs of their own. A total of 15 counties have coverage initiatives in place serving children and/or families (Table 1) and many more have plans under way.¹² In addition, several counties have also developed expansions for adults. A recent poll indicated that a large majority of California's residents support these health coverage initiatives, suggesting that the programs could have statewide appeal among likely voters and serve as the platform to expand health coverage to all of the state's low-income residents.¹³

TABLE 1
County-Level Insurance Coverage Expansions in California

Children		Adults	
In Place (15)	Proposed (15)	In Place (11)	Proposed (6)
Alameda(Healthy Kids)	Colusa	Alameda	El Dorado
Del Norte (Cal Kids) ^a	El Dorado ^c	Contra Costa	Lassen
Kern (Healthy Kids) ^b	Fresno ^c	Los Angeles	San Bernardino
Los Angeles (Healthy Kids)	Kings	Napa	Santa Barbara
Marin (CalKids) ^a	Mendocino	Sacramento	Sutter
Orange (CalKids) ^a	Merced	San Diego	Tuolumne
Riverside (Healthy Kids)	Napa	San Francisco	
San Bernardino (Healthy Kids)	Sacramento	San Joaquin	
San Diego (Child Health Plan-1, ^c FOCUS ^d)	San Luis Obispo ^e	San Mateo	
San Francisco (Healthy Kids)	Santa Barbara ^e	Santa Clara	
San Joaquin (Healthy Kids)	Sonoma ^c	Solano	
San Mateo (Healthy Kids)	Tulare ^e		
Santa Clara (Healthy Kids)	Ventura		
Santa Cruz (Healthy Kids)	Yolo		
Solano (CalKids) ^a	Yuba		

^a These counties have CalKids expansions in place that provide coverage for children ages 2 to 18 with incomes up to 300 percent of the federal poverty level (FPL). Planning for Healthy Kids expansions is underway, with implementation expected in January 2006.

^b Kern county started enrolling children ages 0 to 5 in March 2005; enrollment for older children will begin in the fall of 2005.

^c Child Health Plan-1, a Kaiser Permanente program available to children with incomes between 250 and 300 percent of the FPL, is accepting enrollees from San Diego County.

^d The FOCUS program is unique in that it receives no public support and is an employer-based health insurance program for low-income employees and their families. The program is closed to enrollment at this time. San Diego county is in the early stages of planning a Healthy Kids program.

^e Implementation is expected within the year.

Source: Institute for Health Policy Solutions – California, Child and Family Coverage Technical Assistance Center, "Coverage Initiatives," available at www.ihaps-ca.org/localcovsol/cov_initiatives.html and "Overview of Local Children's Coverage Expansions," updated June 9, 2005, available at www.ihaps-ca.org/localcovsol/_pdfs/WebsiteTableDocument060905.pdf; and Annette Gardner and James G. Kahn, "Assessing County Capacity to Meet the Needs of California's Uninsured: 2004 Survey Findings," California HealthCare Foundation, Oakland, CA, September 2004, available at www.chcf.org/documents/insurance/AssessingCountyCapacity2004SurveyFindings.pdf.

Spotlight: San Francisco County—As noted, many of California’s counties have adopted the Santa Clara model in designing coverage expansions, but San Francisco stands out both in its unique city/county jurisdiction and in the level of innovation and energy being exhibited there. The San Francisco Health Plan (SFHP) was created by the local health authority in the mid-1990s and began enrolling members in January 1997. Serving more than 50,000 members in the San Francisco area, SFHP is focused primarily on low- and moderate-income families. The plan offers four health insurance programs—Medi-Cal, Healthy Families (SCHIP), Healthy Kids and Young Adults (the local expansion program), and Healthy Workers (providing health coverage to home health care workers).

Healthy Kids–San Francisco (HK–SF), which began enrollment in January 2002, currently serves more than 4,000 children. The program enjoyed strong support from former mayor Willie Brown and the San Francisco Coalition for Healthy Kids. As in Santa Clara county, the program is administered by the SFHP and targeted primarily at undocumented immigrants who are not otherwise eligible for public health coverage through Medi-Cal or Healthy Families. The benefit package, premium and cost-sharing structure, and provider network were adapted from Healthy Families to provide consistency where possible, and the program uses a short, two-page application. When the program began, there were an estimated 9,000 uninsured children in the city and county of San Francisco.

After an extensive media campaign to generate interest and name recognition, the SFHP followed the example provided by Santa Clara and Alameda (Oakland) counties in developing “in-reach” campaigns, targeting uninsured children who were already accessing public hospitals, health clinics, and community health centers to inform families about the new program. SFHP also did outreach through schools, health facilities, and community-based organizations.¹⁴

The county-based programs have learned from each other’s successes and challenges and have made specific strides in improving program retention rates. HK–SF has a premium assistance fund available to subsidize families who have difficulty paying their portion of the monthly premium. The program also provides a two-month grace period before disenrollment for failure to pay the premium. During that time, outreach workers attempt to contact the family to try and establish the reason for nonpayment and to offer premium assistance. As of June 2005, 26 percent of the program’s enrollees were receiving financial assistance with their premiums. In addition, the SFHP has implemented an annual billing system that requires families to make a \$48 annual premium payment upon enrollment rather than making monthly payments of \$4. Program administrators found that too many people were being disenrolled for failure to pay the premium each month and determined that the administrative costs actually exceeded the value of the premium payments.¹⁵

HK–SF is funded exclusively through city general revenue, a grant from the San Francisco Proposition 10 Commission, and a small grant from the

California Endowment to assist with the premium subsidies. The program's total initial budget was \$5.7 million, but in June 2003, the SFHP received an additional \$4.8 million in city funds to continue HK-SF through 2004.¹⁶ SFHP has paid particular attention to longer-term sustainability by relying on county general funds and Proposition 10 funds rather than the more time-limited tobacco settlement funds. San Francisco's combined city/county governance structure has helped shore up the commitment for the program by avoiding the competing priorities that can result from a more loosely structured relationship.¹⁷

In July 2004, San Francisco's mayor, Gavin Newsom, included \$1.9 million in the city's budget for SFHP to expand health coverage to young adults and parents aged 19 to 24.¹⁸ The new program, designed as an extension to Healthy Kids, has been named Healthy Kids and Young Adults and began enrollment in late December 2004. It targets the estimated 14,000 uninsured low-to-moderate-income young adults living in San Francisco through two pilot programs: the first provides coverage through age 24 for those who are aging out of existing Medi-Cal, Healthy Families, or HK-SF and do not have employer-sponsored coverage; the second offers coverage to parents aged 19 to 24 who have children enrolled in Medi-Cal, Healthy Families, or HK-SF and are not otherwise eligible for Medi-Cal or covered by employer-sponsored insurance.

Healthy Kids and Young Adults provides a comprehensive benefit package that includes preventive care as well as dental, vision, mental health, and prescription drug benefits for an annual premium of \$48 per year and \$5 copayments for certain services. This unprecedented expansion of a county-based program is designed to help families with incomes just high enough to exceed the limits for other federal and state-funded programs and families whose immigration status disqualifies them from such programs. The program hopes to help "young adults [who] are cut off from health care coverage at the very time when they are trying to establish themselves in the workplace and in college."¹⁹ The new program has already been heralded a success, with 1,365 young adults and 109 young parents enrolled after only six months of operation.²⁰

Under Jean Fraser, its chief executive officer, the SFHP works constantly to find ways to keep the program fully funded and to look for further opportunities for expansion. San Francisco has been in discussions with the state and the federal Centers for Medicare & Medicaid Services about the possibility of getting dedicated federal funding for San Francisco to cover all parents of children enrolled in Healthy Kids. However, the state has not yet formally submitted the waiver proposal and new concerns have been raised because California is now spending all of its SCHIP funding, so the funding source for a parental expansion is no longer clear. In addition, the SFHP has recently begun work on an initiative that would use the existing regulatory structure as a vehicle for generating funds that would subsidize health coverage for taxi drivers.²¹

Muskegon County, Michigan—The Three-Share Model

Muskegon County, Michigan, is providing health care through a three-way financial commitment among employers, employees, and a community-owned health plan, Access Health. Through the leadership of the Muskegon Community Health Project, Access Health began in 1993 with a partnership grant from the W. K. Kellogg Foundation and the Community Foundation of Muskegon County. Chosen as one of the foundation's three "Comprehensive Community Health Models of Michigan," the project was initially tasked with assessing the needs of the community of 172,000, approximately 8 percent of whom were uninsured. The Community Health Project convened a county-wide workgroup that ultimately led to the development and implementation of Access Health. The program began with \$125,000 in start-up funding provided through the tobacco settlement and a \$132,000 loan. Access Health has since received \$900,000 in total through two direct federal appropriations that form a reserve pool to help ensure the program's solvency. Through community collaboration and the leadership of Vondie Woodbury, executive director of the Muskegon Community Health Care Project, the program has grown in size as well as substance over the years.

As in many communities, the uninsured population is composed of groups of individuals that have distinctive health and social needs (Figure 1). For example, in Muskegon county there are efforts designed to serve the lowest income "indigent" population through the existing safety net. This portion of the uninsured population is made up primarily of adults who are not eligible for Medicaid and who are unemployed. These individuals are more likely to have chronic and sometimes severe health issues (such as substance abuse and the complicating conditions that can result) which require attention. Therefore, the workgroup determined that Access Health should be targeted specifically at meeting the needs of the higher income working uninsured, who tend to be healthier overall and are already connected with the employer system. These individuals also have a greater ability to contribute to the cost of their care.²²

Today, Access Health has become a community-owned health plan that helps small and mid-sized businesses provide health coverage to employees and their families. Under the plan, which began enrollment in 1999, 430 businesses now provide coverage to some 1,500 individuals. Eligibility is limited to small and medium-sized businesses with full or part-time employees. Seasonal, contract, and temporary employees, as well as employees who have other insurance, are not eligible. The median wage of the employees must be no more than \$11.50 per hour and the business must not have been offering another health insurance product for the past 12 months.

FIGURE 1

Muskegon, Michigan: Distinctive Populations with Distinctive Needs

Commercial Plans [96,900 individuals]
Working Uninsured [13,700] (Access Health Targets)
Medicaid and/or Medicare [56,000]
"Muskegon Care" Safety Net Coverage [3,400]

Source: Based on PowerPoint slide from presentation by Vondie Woodbury, "Access Health: Closing the Gaps Between Public and Private Insurance Coverage," 17th Annual State Health Policy Conference, National Academy for State Health Policy, St. Louis, MO, August 2, 2004.

Young adults aged 19 to 23 can be covered as part of the plan and dependent coverage is also available (although rarely utilized). As part of the enrollment process, families are screened for eligibility for Healthy Kids (Medicaid) and MICHild (SCHIP) programs for the children. Access Health distributes several Medicaid/SCHIP applications per week, resulting in hundreds of children being enrolled in the programs. Consequently, only about 100 children are actually receiving dependent coverage through Access Health.

Outreach efforts have been targeted to restaurants, day-care centers, hair salons, and other small businesses. In addition, the program does outreach to pools of employers and larger businesses that offer some commercial coverage but cannot afford to offer health coverage to all of their employees. Because the organization is a county health program that has the look and feel of a cooperative, rather than an insurance product, Access Health has been able to avoid state insurance regulations and fees.²³

The program is financed by a three-way partnership in which the employer and employees each pay 30 percent of the cost (\$46 per month) and Access Health covers the remaining 40 percent (\$56 per month), for a total of \$148 per month. The community share (Access Health) is made up of a combination of local government, community, and foundation funds, as well as federal disproportionate share hospital (DSH) funds. This “three-share” concept has been well received both by employers and by the broader community. The idea of individuals paying for a portion of their care helps to avoid any association with the “welfare stigma” that Medicaid programs have suffered over the years.

The benefit package includes local physician services, inpatient hospitalization, outpatient services, emergency care, behavioral health care, prescription drugs, diagnostic laboratory and x-rays, home health, and hospice care. There is no preexisting condition exclusion. Members choose their own primary care providers and typically pay a \$7 copayment for each office visit. They access prescription drugs through a pharmacy network of 12 sites across the county. Copayments for generic prescriptions (that are listed on the plan’s formulary) are \$7; however, 50 percent coinsurance is required for brand-name prescriptions.²⁴

Access Health has executed a successful campaign to elevate awareness of the product and now has a professional sales staff who market the product to eligible businesses. The plan contracts directly with providers and has secured participation from 97 percent of Muskegon County’s physicians and both of the health plans.²⁵ Several local insurance brokers have also included Access Health as part of their portfolios. The combination of the success of the program and the charismatic leadership that is behind it has led other states and communities to pursue adopting this three-share model and has garnered broader attention for the concept as well.

The “three-share” concept has been well received both by employees and by the broader community.

In fact, Michigan's governor, Jennifer Granholm, announced in early 2004 that the state would begin pursuing a "Third-Share Partnership," which would make a similar health coverage package available throughout the state, and several other states have passed enabling legislation to test the concept. Despite the fact that the three-share concept is designed to limit financial exposure, the state budget crisis has hindered the expansion of the program. Michigan's legislature introduced the authorizing provisions in June 2004, but the proposal did not pass.²⁶ Although Access Health's cost increases have remained below the average trend, continued pressures around funding the community share of the premium remain. And the federal government's renewed scrutiny of states' sources of state matching funds have raised additional concerns about the continued availability of DSH funds.²⁷

At the same time, the three-share concept has recently received national attention. Access Health has served as the model for the Affordable Health Care Act (S.16), introduced for consideration by Sen. Edward M. Kennedy (D-MA). A companion bill is under development by a bipartisan group in the U.S. House of Representatives.²⁸

Marion County, Indiana— Managing Care through Health Advantage

As with many locally driven initiatives, a program initially called Wishard Advantage was the result of a confluence of events in the mid-1990s that included the nationwide trend toward Medicaid managed care and the merger of two of the three major hospitals in the Indianapolis area. The area's public hospital, Wishard Hospital, became concerned about its capacity to provide care to the uninsured in the wake of new competition from the larger Clarian Health system that was created by the merger.²⁹ The governor, the mayor of Indianapolis, and the Marion County Health and Hospital Corporation (HHC) shared this concern. As a result, the HHC worked with the community and with Wishard Hospital to develop a managed care plan to provide health coverage to low-income and uninsured county residents. Established in 1997, the program was largely modeled after the statewide Medicaid managed care program. The initial goals of the program were to improve the financial efficiency of the hospital and to shift emphasis away from episodic, hospital-based care toward primary and preventive care. By establishing a managed care approach, the HHC also hoped to more effectively integrate the hospital system into the community at large.³⁰

Now called Health Advantage, the managed care program provides health coverage to all Marion County residents with incomes below 200 percent of the FPL (\$38,700 for a family of four in 2005). Once enrolled, individuals remain eligible for a 12-month period. More than 30,000 active members receive services at some 20 provider sites, including Wishard community health centers, and from physicians who are on faculty at the Indiana University Medical School.³¹ Comprehensive benefits are provided and cost sharing, on a sliding-scale basis, is required only for individuals with incomes between 150 percent and 200 percent of the FPL.

The HHC initially used \$20 million in DSH funds to get the program started. It is now financed by a combination of city and county property taxes and federal DSH funds provided through the HHC.³² Having reduced inpatient days by 50 percent and emergency room use by 30 percent, the program has proven successful in meeting its overall goals.³³

Buncombe County, North Carolina— Physician Volunteerism Makes Its Mark

The fourth approach that has been highly successful and studied extensively over the past ten years is an initiative that was spearheaded by the provider community in Buncombe County, North Carolina. The planning for Project Access began in August 1994 and was initially financed through the Robert Wood Johnson Foundation's Reach Out initiative. The Buncombe County Medical Society (BCMS) took on the task of improving health care delivery to the underserved in its community. The BCMS began by creating a planning group, known as Health Partners, that was made up of physicians, local health and service agencies, county commissioners, local business groups, and the uninsured themselves. The group discussed the problem of overuse of emergency departments and the critical role of free clinics and community health centers, and subsequently conducted several research efforts designed to better understand the needs of the uninsured population in the county. The Health Partners coalition decided to focus its efforts on organizing a system supported primarily by physician volunteerism. The idea was to increase access to both primary and specialty care for the uninsured, who often ended up in the emergency room for lack of access to comprehensive care. Project Access became a program that matches needy patients with free physician services and connects them with additional specialty care as needed. A second goal was to promote more efficient use of primary care clinics and support the creation of additional neighborhood clinics offering primary and preventive care and case management services.³⁴

The program got up and running in 1996. Project Access provides uninsured individuals with incomes below 200 percent of the FPL with free physician visits, laboratory and radiology services, inpatient care, and subsidized medications (\$4 copayment per prescription). Pharmacy services are supported by funding from the county commissioners and discounts from the Pharmacy Network National Corporation. Emergency room visits are not covered unless the visit results in a hospital admission. Patients receive insurance cards and prescription drug cards that are similar to those of private insurance. To address some of the concerns that have been raised about no-show rates among the uninsured population, Project Access also offers patient appointment reminders and transportation services as needed. Individuals may be disenrolled from the program for failure to show for two appointments.³⁵

Project Access matches needy patients with free physician services and connects them with additional specialty care as needed.

The physician response in the community has been extraordinary: 90 percent of physicians participate in the program, whereas only 25 percent had been volunteering their time before the program's inception. Volunteering physicians pledge to see a minimum of 20 specialty patients or 10 primary care patients from Project Access in their offices each year and some also donate time at the free clinic. The BCMS reports that the community's capacity to see primary care patients has doubled over the past ten years, without significantly increasing costs to the health department. Time previously spent trying to arrange for specialty care for indigent patients is now used to provide care directly to those patients. In addition, the overall cost of service per patient has decreased by 22 percent. Finally, the local hospitals have experienced a significant savings of at least \$120,000 per year in uncompensated care costs, in large part due to a 20 percent decrease in self-reported emergency department use.³⁶

ANATOMY OF A LOCAL COVERAGE INITIATIVE

Although each state, county, and locality is unique in the composition of its population, its problems, and its politics, some common themes have emerged in studying successful health care access programs.

Leadership

As with any community-driven initiative, health coverage and access expansions would not be possible without the presence of several key players who ensure that the concepts and goals of the initiative come to fruition. First, there must be a group within the community that coalesces around the issue of health care and raises it to the larger community and government structure. These groups—ranging from locally based access coalitions to more formal and well known organizations like Health Care for All in Massachusetts and California—have played significant roles across the country and often collaborate to move their agendas forward.³⁷

A second key element of a successful local initiative is buy-in from elected officials, ranging from county boards of supervisors to mayors to state legislators. Elected officials can be particularly helpful by securing financing for the programs and drawing attention to them by speaking on their behalf at public events and in the state legislature. In addition, these elected officials play a crucial role in ensuring the programs' sustainability over time—a key challenge.

The role of other community players, such as foundations, public hospitals, and other safety-net providers has also been noted as instrumental. For example, the physical presence of charitable foundations in certain communities has been a key factor in getting several of the local coverage initiatives off the ground. Particularly in states like California and Michigan—where foundations have identified health care as a funding priority—large-scale expansions would not likely have taken place without their support.

A recent study also noted that counties with public hospitals were more likely to have success in launching coverage expansions than those that did not. This could be due to the established role that these hospitals were already playing in supporting the health care safety net in those areas.³⁸ Conversely, in a number of communities, innovation was tied to the closure or conversion of a public hospital. This action-forcing event created a shift away from reliance on a central safety-net provider and a move toward developing a broader community-based health care network. This effectively spread the responsibility among a greater number of providers and created an opportunity to emphasize the importance of primary and preventive care. However, in these cases the loss of the centralized safety-net “provider of last resort” did have an impact on the already fragile patchwork of care and may have hindered access.³⁹

Finally, it should be noted that behind the success of nearly every local or county-based coverage initiative seems to be a dynamic and committed leader who has made it his or her personal priority to ensure that the program accomplishes its goals and continues to provide access to care in the absence of other broader-based (for example, federally funded) solutions. Leaders such as Leona Butler, Vondie Woodbury, and Jean Fraser have clearly played a major role in the success and sustainability of their programs. These individuals use their creativity and charisma to keep the community coalitions focused and moving forward and to motivate and even inspire their staffs.

Behind the success of nearly every local or county-based coverage initiative seems to be a dynamic and committed leader.

Knowledge of the Community

Another key element of a successful coverage initiative is to design a program that fits appropriately with both the identified health care needs and the capacity of the community to meet those needs. For example, some areas with extremely high insurance coverage rates may only need a small and targeted program to meet the needs of the small percentage of uninsured in that community. Such a program can be easily designed and implemented and provide results. Conversely, in an area with low coverage rates and a frail safety net infrastructure, an incremental approach might be safer and more feasible than a sweeping program expansion. Marketing and outreach practices must be designed accordingly. Too little outreach can lead to a failure to connect with the target populations, while marketing blitzes can result in so many people wanting to sign up for the program that budgets are exceeded or strained.⁴⁰ A delicate balance is needed.

Economic factors also play a key role. Individuals’ ability to afford health insurance depends on the relationship between their income and the cost of living and the price of health care in their area. As noted in a recent *Health Affairs* article, “Moderate-income residents of states with high health care costs might find insurance just as unaffordable as do lower-income

residents of states with low health care costs.”⁴¹ Some areas that have high rates of uninsurance may be more likely to have weaker economies and perhaps even differing philosophies about the role of government in providing access to health care, which changes the political dynamics of getting buy-in for a program. And the shifting political tides that can accompany a change in a state’s administration or a change in the makeup of the state legislature can have implications at the local level as well. All of these factors can directly affect the sustainability of a program.

Financing

Identifying viable financing sources is integral to the establishment and success of any health care access initiative. It is also the main barrier to sustainability of these programs.

Many of the local initiatives were conceived in the late 1990s when state and federal budgets were at a surplus and the economy was on an upward swing. These circumstances gave community leaders a strong sense of security and a willingness to try out innovative ideas for dealing with the uninsured. It was easy for many communities to ride on the coattails of the success of SCHIP, which brought new light to the concept of expanding coverage and using marketing and colorful advertising to reach out to families who could benefit from the new program. The welfare stigma so often associated with publicly financed health care programs began to fade into the past, and many groups used this opportunity to change the way health coverage programs could be perceived.

Foundations were some of the first organizations to get on the bandwagon. Several major national foundations got involved by providing millions of dollars to states and communities across the country; locally based foundations were similarly enthused. Many communities and nearly every state were benefactors of the Robert Wood Johnson Foundation’s (RWJF) Covering Kids and Families program and used that funding as a springboard for getting their SCHIP programs off the ground. This type of funding has also been combined with support from local foundations to form a financial base for the first years of operation of county-based coverage initiatives. RWJF also created the Communities in Charge program, which has provided \$16.8 million to help 12 communities design and implement approaches to improving health care delivery and financing for the uninsured.⁴²

In 1998, the W. K. Kellogg Foundation established Community Voices, a broad-based initiative dedicated to improve access to all types of health care. The program was initially implemented in 13 demonstration sites across the country and has now focused its efforts in eight localities, all with different goals, including expanding health care coverage, improving oral health care, eliminating health disparities, and bringing more attention to mental health and substance abuse treatment needs and to men’s health. The program is now managed by the National Center for Primary Care at the Morehouse School of Medicine in Atlanta.⁴³

For some states, the physical presence of a foundation's headquarters helped create a laboratory for health coverage and access initiatives. California has experienced this phenomenon with the Packard Foundation, the California HealthCare Foundation, and the California Endowment; Michigan has benefitted similarly from having the W. K. Kellogg Foundation headquartered there. The continued replication of the Santa Clara Healthy Kids concept in California would not have been possible without the support of its foundations, and the W. K. Kellogg Foundation's keen interest in the health of Michigan's residents has made the state another important laboratory for innovation.

Although foundations have dedicated significant dollars to supporting the health care safety net and the Medicaid and SCHIP programs in every state, these commitments cannot be relied on to completely finance the new programs. Communities with successful initiatives have also had to seek other existing or new sources of funding. Most communities have successfully leveraged some form of state and/or local tax dollars, either through the general fund or through special appropriations like tobacco settlement funds or other funds dedicated to health care. For example, the passage of California's Proposition 10 referendum in 1998 created a \$700 million annual discretionary fund dedicated exclusively to children's services. These "Prop 10" funds, as they are commonly called, are generated through an increase in the statewide tobacco tax and are governed by the Children and Families Commission. Overall, California counties have leveraged an average of 5.5 funding streams to operate their health coverage initiatives.⁴⁴ Programs in other states have similarly cobbled together a variety of funding sources in order to begin and sustain operation.

For some states, the physical presence of a foundation's headquarters helped create a laboratory for health coverage and access initiatives.

Many communities have also leveraged federal grants whenever possible. The Health Resources and Services Administration (HRSA) has been a key financing source. HRSA's Healthy Communities Access Program (HCAP) grants have been helpful in supporting local initiatives in 158 communities in urban and rural areas and on tribal lands. HCAP has provided \$360 million in grants since 2000.⁴⁵ The State Planning Grants (SPG) program began in 2000. SPGs were designed by Congress to support states in collecting data and analyzing their uninsured populations and the health care marketplace. HRSA has distributed nearly \$50 million over four years, providing SPGs to nearly every state. In addition, in September 2004, the Department of Health and Human Services announced a new type of grant to be made available to SPG grantees. The Pilot Project Planning Grants are intended to support the design and planning of coverage expansions targeted at the uninsured. The pilot projects give states the option of testing the strategy on a county or multiple-community level. Eight states and one territory have received as much as \$400,000 each for use between September 2004 and August 2005. Although the prospects for actual implementation are not very strong in light of the continued state budget crisis, these grants have helped lay the groundwork for

expansion options similar to those discussed in this issue brief. And the availability of these grants has spurred innovative thinking in communities that previously did not have many options for improving the health of their citizens.⁴⁶

Some counties and localities have also been able to work with the public hospital system in their areas to gain access to some of the federal Medicaid DSH dollars that are specifically for the purpose of helping cover some of the costs of providing uncompensated care to the uninsured. For example, the financial viability of Denver Health—well known as the principal source of care for the uninsured in the Denver area—was essentially saved by a large infusion of DSH funding in the 1990s. The Denver Health system includes a 350-bed hospital, 11 federally qualified community health centers, 12 school based clinics, and the local health department. After receiving \$320 million in DSH funding, Denver Health was able to pull out from a \$40 million operating deficit in 1991; by 1999, they were able to provide nearly \$75 million in care for the uninsured.⁴⁷

Medicaid DSH funding is particularly helpful to efforts that provide health care services to low-income communities as a whole. However, because most of the coverage initiatives are designed to cover specific individuals who are not otherwise eligible for the Medicaid or SCHIP program in the state, access to federal funding is limited. As described earlier, many of the initiatives target higher-income families, undocumented immigrants, single adults, and other low-income working individuals who cannot be covered by Medicaid without a waiver, therefore precluding federal funding of any kind.

Barriers

The task of launching and sustaining health coverage initiatives is not without its challenges. In addition to the need for leadership, large-scale political buy-in, and sustainable financing sources, communities must overcome barriers such as resistance from the provider community and the potential for public unwillingness to increase taxes or expand the scope of public programs. As illustrated by the recent fiscal crisis that has affected every state in the nation, the status of health coverage programs has slipped in comparison with education and homeland security.

There are other factors that must be dealt with when implementing a program. Advertising and generating interest in a new program can be difficult at first, creating a slow “take-up” rate that can lead to premature criticism of the program’s effectiveness. Other logistical factors can be problematic. For example, in rural areas, communities must deal with lack of transportation systems and weaker safety-net infrastructures that can impede individuals’ ability to access the care they need. While these

Medicaid disproportionate share hospital funding is particularly helpful to efforts that provide health care services to low-income communities as a whole.

types of problems are not uncommon, a great deal of creativity and innovative thinking is required to address them and challenges remain in many areas.

PROSPECTS FOR SUSTAINABILITY AND REPLICATION

While all of the approaches discussed above have been highly successful in their respective communities and sociopolitical situations, each has had to confront the challenge of sustainability over time. Each of the programs started with dedicated funding sources to be used for development and implementation, but the financing for long-term service delivery has not been certain. The leader of the pack in California, Santa Clara County, was forced to establish a waiting list that now numbers more than 1,500 children, and program administrators have had to resort to fundraisers to enable them to pull these children off the list. While the absence of federal funding offers a great deal of flexibility, it also creates significant limitations on the scope of the program.

On the other hand, tailoring programs to meet the needs of an individual community also helps ensure the long-range commitment of the various stakeholders. For example, advocates for Buncombe County's Project Access argue that, even though physicians have provided charity care for decades, the program offers a way to organize the delivery of that care and keep the volunteers committed. And while physician volunteerism cannot realistically offer more than a partial solution to the problems created by uninsurance, the concept could certainly be replicated in other places and the prospects for sustainability are good.

Hybridized strategies like the three-share model in Michigan are increasing in popularity. The concept of a joint effort by the employer, the employee, and the government appeals to a broader range

of interest groups and philosophies, and the overall cost to the community is lower than the traditional publicly funded coverage expansion. However, administrative complexities make effective operation of these types of programs more challenging, and best practices need to continue to be developed before wide-scale replication is possible. This point has been illustrated by the slow uptake in premium assistance programs that states have developed as part of SCHIP and Medicaid. Although nearly a dozen states have received federal approval to develop premium assistance programs, only a handful have actually implemented them, with limited success.

Each of the locally based approaches has experienced its successes and challenges. The efforts have all proven to be worthwhile in improving the overall access to health care for their respective communities, but translating these successes to the national level continues to be difficult. The scope of the initiatives is still very small in comparison to the rising numbers of

Tailoring programs to meet the needs of an individual community also helps ensure the long-range commitment of the various stakeholders.

uninsured, and increasing premiums coupled with the slow but steady erosion of employer-sponsored coverage will only exacerbate the situation. However, the examples provided in this paper and in the large body of research on state and local health coverage efforts is a testimony to the reassuring presence of a rich group of innovative thinkers who are sprinkled in communities across the country. Committed to improving health and persevering in the face of budget deficits and changing political tides, these individuals provide hope for a workable solution.

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