Community Approaches To Providing Care For The Uninsured

Community engagement and sources of funding are critical preconditions for efforts to address uninsurance.

by Erin Fries Taylor, Peter Cunningham, and Kelly McKenzie

ABSTRACT: Faced with rising uninsurance rates and little response at the state or federal levels in recent years, communities have developed various strategies to provide care for uninsured people. This paper profiles local strategies in the Community Tracking Study sites, focusing on efforts that go beyond traditional safety-net access. Our findings suggest that more-recent community efforts—which tend to be privately sponsored—are relatively modest in scope compared with more-mature programs that enjoy public financing. Although local strategies can fill some holes, communities often do not have the resources necessary to fully address the problems of the uninsured on their own. [Health Affairs 25 (2006): w173–w182 (published online 11 April 2006; 10.1377/hlthaff.25.w173)]

Many communities across the United States are experiencing increases in the number of uninsured citizens, in part because of state budget cuts in public programs, rising costs of private health insurance, and declines in employersponsored coverage. Increases in the number of uninsured people often strain local safety nets and health systems, and they generate concern among community leaders about the effect on the health of the community and workers’ productivity. With the current federal and state policy environment focused more on cost containment than on expanding public coverage programs, as was the case in the late 1990s, many community leaders are no longer expecting major assistance from the state and federal governments in addressing the problems of their uninsured populations.

Some communities have taken the initiative to at least partially address these problems. In the absence of coverage or an organized program to coordinate their care, the uninsured—most of whom come from households with incomes under 200 percent of the federal poverty level and at least one full-time worker—often seek care at community health centers (CHCs), free clinics, and in some cases, emergency departments (EDs). Therefore, more-traditional strategies to increase capacity to care for the uninsured include expanding the number of free-care clinics or increasing local subsidies to major safety-net providers.

Based on site visits to twelve nationally representative communities, this paper focuses on several strategies that attempt to provide the uninsured with health care that is more coordinated, better organized, and some-
times more comprehensive than traditional approaches. These strategies range from coordinating and promoting charity care provided by physicians, to offering limited-benefit coverage products, to better coordinating care using managed care safety-net models. We show how these efforts vary in terms of their target populations, scope, services provided, funding, administration, and relative emphasis on care delivery versus coverage. We also discuss the limitations of these programs and their potential for having a noticeable impact on access to care for the uninsured.

Study Data And Methods

Data for this analysis come from the Community Tracking Study (CTS), a longitudinal study conducted by the Center for Studying Health System Change (HSC) every two to two and one-half years. The CTS’s Round Five site visits occurred between January and June 2005 and included interviews with more than 1,000 health care leaders from a wide range of organizations across twelve randomly selected markets: Boston, Cleveland, Greenville (South Carolina), Indianapolis, Lansing, Little Rock, Miami, northern New Jersey, Orange County (California), Phoenix, Seattle, and Syracuse.²

For this analysis, we interviewed more than 150 respondents, including community program administrators and others who could provide a perspective on the programs we wished to study, such as representatives from safety-net hospitals and health systems, CHCs, state and local government entities, and advocacy organizations. Semistructured interview protocols included open-ended questions on approaches or strategies designed to increase access to care or expand coverage in the community and closed-ended questions on program details. This paper is based largely on data obtained in the Round Five interviews but also incorporates information from previous rounds.

Although the twelve CTS sites are representative of all large U.S. communities, the strategies described in this paper do not necessarily cover all possible approaches and might or might not be representative of similar approaches elsewhere. This analysis should be viewed as in-depth case studies of a number of different community programs identified in our site visits. The fact that the communities were randomly selected and vary by region and size helped ensure that a broad range of program types were identified.

Study Findings

Community strategies in the CTS markets. The most traditional community approach to providing care to the uninsured is through traditional safety-net providers such as CHCs and free clinics. However, communities may also provide care through some centrally administered process—often with a greater degree of care coordination than traditional safety-net access can attain—which we refer to as "brokered access.” Alternatively, communities can offer health insurance coverage for the uninsured to obtain services on their own. We observed a range of approaches in the CTS sites; however, this paper focuses on the subset of local approaches that represent either brokered access or coverage, given that much literature already exists on access through traditional safety-net channels.

In eight sites, we identified a variety of strategies developed at the local level that provide either brokered access or coverage (Exhibit 1). These different strategies can be categorized into four general types: managed care safety-net programs, donated care models, discounted care models, and limited-benefit coverage. The first three types represent brokered-access strategies, while the fourth is a coverage strategy.

Managed care safety-net models. In these models, a safety-net system that is already serving the uninsured organizes to coordinate and manage their care.³ This approach attempts to manage the use of inpatient and ED care while promoting more preventive and primary care.⁴ Typically, enrollees of these programs are already using the safety net; enrollment often provides them more-coordinated care and better access to certain services, such as prescription drugs. Boston, Indianapolis, and Lansing have all had managed care programs.
## EXHIBIT 1
Community Strategies And Selected Characteristics In Twelve Community Tracking Study (CTS) Sites, 2005

<table>
<thead>
<tr>
<th>CTS site</th>
<th>Program name</th>
<th>Eligibility criteria</th>
<th>Financing</th>
<th>Year began</th>
<th>Enrollment&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Community uninsurance rate (2003)&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Donated-care programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greenville</td>
<td>Medwell Access (Greenville County Medical Society)</td>
<td>Income &lt;165% FPL; working 30 hours/week; citizenship</td>
<td>Grants from foundations</td>
<td>2001</td>
<td>200</td>
<td>12%</td>
</tr>
<tr>
<td>Indianapolis</td>
<td>Project Health (Indianapolis Medical Society)</td>
<td>Income &lt;300% FPL</td>
<td>Each of 5 hospitals contributes $20,000/year; grants from foundations</td>
<td>2004</td>
<td>300</td>
<td>12%</td>
</tr>
<tr>
<td>Little Rock</td>
<td>Arkansas Health Care Access Foundation</td>
<td>Income &lt;100% FPL; citizenship</td>
<td>Some state financing</td>
<td>1989</td>
<td>=&lt;sup&gt;c&lt;/sup&gt;</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Discounted-care programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phoenix</td>
<td>HealthCare Connect</td>
<td>Income 100–250% FPL; county resident</td>
<td>Enrollment fees; grants from foundations; former HCAP grantee</td>
<td>2004</td>
<td>1,700</td>
<td>19%</td>
</tr>
<tr>
<td>Miami</td>
<td>CareNet</td>
<td>None</td>
<td>Enrollment fees</td>
<td>2005</td>
<td>=&lt;sup&gt;d&lt;/sup&gt;</td>
<td>23%</td>
</tr>
<tr>
<td><strong>Managed care safety-net programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boston</td>
<td>Boston CareNet&lt;sup&gt;a&lt;/sup&gt; (Boston Medical Center)</td>
<td>Income &lt;200% FPL</td>
<td>State uncompensated care pool; HCAP grantee</td>
<td>1997</td>
<td>22,000</td>
<td>6%</td>
</tr>
<tr>
<td>Indianapolis</td>
<td>Health Advantage&lt;sup&gt;d&lt;/sup&gt; (Health and Hospital Corporation of Marion County)</td>
<td>Income &lt;200% FPL; county resident</td>
<td>County property taxes; former CAP grantee</td>
<td>1997</td>
<td>52,000</td>
<td>12%</td>
</tr>
<tr>
<td>Lansing</td>
<td>Ingham Health Plan—Plan A and B</td>
<td>Income &lt;250% FPL; county resident</td>
<td>DSH, county, and state medically indigent funds</td>
<td>1998</td>
<td>15,000</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Limited-benefit coverage programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lansing</td>
<td>IHP Advantage (third-share model)</td>
<td>Employees of small employers (2–20 workers); no insurance for 1 year</td>
<td>Employer, employee, and county each pay portion of premium</td>
<td>2004</td>
<td>25</td>
<td>7%</td>
</tr>
<tr>
<td>Little Rock</td>
<td>Community Health Alliance (offered through QualChoice)</td>
<td>Employees of small employers (&lt;100 workers)</td>
<td>Premiums (paid by employer and/or employee)</td>
<td>2004</td>
<td>120</td>
<td>13%</td>
</tr>
</tbody>
</table>
in place since the mid- to late 1990s. However, no new programs like these have emerged among the CTS sites recently.5 

In the past five years, enrollment in the managed care safety-net programs in Indianapolis and Lansing has more than doubled, with each now enrolling roughly half of their community’s uninsured population (in stark contrast to other approaches’ relatively small enrollment levels). The capacity of these programs is based largely on their ability to garner substantial public funding, as discussed later.

Donated care. In this model, participating physicians (and sometimes other providers, such as dentists) agree to see a certain number of patients or provide a certain number of visits pro bono each year. This approach, which emerged as an outgrowth of the free-clinic movement, was created to coordinate and formalize the provision of charity care by local providers. Donated-care programs are often administered through a local medical society. The objective of these programs is to provide some structure to the charity care that physicians provide, encourage more physicians to participate in charitable activities, and provide a central point of contact for medically indigent patients.

Donated-care models became more prevalent in the mid- to late 1990s. One of the earliest programs to use such a model is Project Access of Buncombe County, North Carolina, which began in 1996 and has received considerable media attention.6 Similar approaches are now being used in at least forty U.S. communities, making donated care one of the more prevalent local strategies. Among the CTS sites, Greenville and Indianapolis have recently started donated-care programs; Little Rock has had a program in place since 1989.

Donated-care models in the CTS sites have fairly limited capacity and enrollment. For ex-

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**EXHIBIT 1**
Community Strategies And Selected Characteristics In Twelve Community Tracking Study (CTS) Sites, 2005 (cont.)

<table>
<thead>
<tr>
<th>CTS site</th>
<th>Program name</th>
<th>Eligibility criteria</th>
<th>Financing</th>
<th>Year began</th>
<th>Enrollmenta</th>
<th>Community uninsurance rate (2003)b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miami</td>
<td>FlexCare (Jackson Health System)</td>
<td>Income &lt;200% FPL; no coverage for 6 months; state resident; under age 65</td>
<td>Premiums and cost sharing; county’s public health trust subsidizes premiums for those &lt;150% FPL</td>
<td>2004</td>
<td>830</td>
<td>23%</td>
</tr>
<tr>
<td>Orange County</td>
<td>CaliforniaKids</td>
<td>Income &lt;250% FPL; parent must work for participating employer</td>
<td>Parent, employer, and foundation each pay a portion of premium</td>
<td>1998</td>
<td>6,300 (children only)</td>
<td>16%</td>
</tr>
</tbody>
</table>

**SOURCE:** Community Tracking Study, Round Five, 2005.

**NOTES:** FPL is federal poverty level. HCAP is Healthy Communities Access Project. CAP is Community Access Project. DSH is disproportionate-share hospital.

a Enrollment is as of spring 2005 unless otherwise noted.
c The program does not enroll per se but rather refers patients to physicians; the program received 16,000 telephone calls in 2004.
d The program was just starting in mid-2005 and did not yet have enrollees.
e This program was formerly known as Boston HealthNet.
f This program was formerly known as Wishard Advantage.
ample, Greenville’s Medwell Access has served about 400 enrollees since its inception in 2001. Because these programs rely on physicians who volunteer their time, financing is usually limited to support program administration and referral services.

Discounted care. A new variation on the theme of donated care that has emerged in the past few years in the CTS communities is the discounted-care model, in which participating safety-net and private providers agree to provide certain health care services at discounted rates to those willing to pay for a discount card. For example, specialty physicians participating in HealthCare Connect’s network in Phoenix charge enrollees 50 percent of the Medicare rate; one respondent referred to the program as the “Costco of health care.” Discounted care programs generally are privately sponsored and administered by a nonprofit organization that is at least loosely affiliated with the area’s CHCs. Only a few programs exist in the country, although some communities are in the process of starting such programs (for example, Miami’s CareNet program).

HealthCare Connect grew out of an existing strategy implemented by advocates in nearby Tucson and was propelled by state legislative support and outside grant funding. In contrast, CareNet in Miami was developed internally by a group of community clinics with the capacity to expand their services to a wider patient population and an interest in generating greater revenue for their centers. The two programs partner mostly with community clinics, although Phoenix’s program has worked over time to build a base of private-practice physicians. However, given the current size of its physician network, the total capacity of the Phoenix program reportedly is only about 4,000 people, and with 1,700 enrolled in the first eight months of the program, demand may soon outstrip capacity.

Discounted-care programs see themselves as attracting the working uninsured, given that care provided through these programs still requires substantial out-of-pocket cost sharing. (Although being employed is not an explicit eligibility criterion in HealthCare Connect, CareNet specifically targets employees of small businesses.) To ensure that enrollees are able to meet their financial obligations, HealthCare Connect targets working uninsured people with incomes of 100–250 percent of poverty, excluding those with incomes under 100 percent. Administrators of discounted-care programs believe that a selling point of this approach to the community is that discounted care “is not charity.”

Limited-benefit coverage. A more recent development is a community strategy that provides limited-benefit coverage, rather than access or brokered access, and often works through employers. This strategy can take several forms. One is a local limited-benefit program facilitated by state policy changes. Community Health Alliance in Little Rock and FlexCare in Miami developed after their respective states passed legislation allowing for the creation of small-group limited-benefit products that are exempt from state mandates and other insurance regulations on coverage; therefore, these products have more-limited benefits than those subject to full regulation. Although these products originate from state law (the “health insurance purchasing group” law in Arkansas and the HealthFlex law in Florida), they are administered at the local level, rely on insurers’ willingness to offer the product in a given locality, and essentially represent a private coverage product. For instance, the effort in Little Rock was spearheaded by the North Little Rock Chamber of Commerce, and its coverage products are sold by QualChoice/QCA, an Arkansas health insurer. The most basic product under this program is a high-deductible ($5,000) plan that includes some fully covered preventive services.

Another local employer-based approach receiving increased attention recently is the third-share or multishare model, in which the cost of insurance premiums is split among employer, employee, and a government entity. Lansing’s third-share program, known as IHP Advantage, is the sole example from the CTS sites. This product is offered by the Ingham Health Plan, which, as described above, also uses a managed care safety-net approach.
Advantage covers up to $3,500 for outpatient services and $35,000 for all benefits annually. Ingham Health Plan’s addition of a third-share model targeting workers and small employers was seen as essential to sustaining community support among those promoting public-private partnerships.

To date, enrollment in community limited-benefit coverage programs has been small. FlexCare in Miami, for example, has relatively few enrollees; in fact, statewide enrollment in HealthFlex plans (of which FlexCare is one) is reportedly fewer than 1,200 people.

**Trends in strategy.** Newer strategies in the CTS communities—such as the discounted-care and limited-benefit coverage programs—tend to be privately sponsored, in contrast to the managed care safety-net programs, which originated in the 1990s and leveraged substantial public resources. The fact that no new managed care programs have successfully been launched recently could reflect the growing scarcity of new public funds specifically devoted to programs caring for the uninsured, compelling local communities to leverage the private sector to a greater extent when considering new initiatives. In general, newer programs seem to see themselves as having a narrower mission—such as serving the working uninsured—in contrast to more mature managed care safety-net programs, such as Ingham Health Plan, which has the ambitious goal of eventually reaching all uninsured people in Lansing. (Although most of the uninsured come from working families, more programs now include employment as an explicit eligibility criterion.)

**Factors influencing community strategies.** Although community response to the uninsured is idiosyncratic to local-market characteristics and other factors, certain community characteristics might influence the development, and ultimately the sustainability, of these programs. We only observed programs across twelve sites and could not discern whether these factors are causally related to the approach taken (and, in fact, some communities use multiple approaches). However, we highlight a few possible associations between community factors and the strategy taken, but we note the need for additional evidence to confirm them.

**Stable funding.** The availability of dedicated funding streams, defined as stable and ongoing funding earmarked specifically for a given community-based effort, is one of the most important factors in any effort’s viability and sustainability. For example, Health Advantage, operated by the Health and Hospital Corporation of Marion County, Indiana, has found a stable source of funding in local property tax revenues. Lansing’s Ingham Health Plan has been able to successfully draw down disproportionate-share hospital (DSH) funding for a number of years. The dedicated funding streams available to the managed care safety-net programs make them unique among the approaches profiled in their stable access to funding.

**Number of uninsured people.** The size of a community’s uninsurance problem, measured through its uninsurance rate, might also be related to the approach used (see Exhibit 1). For example, two of the three managed care safety-net models operate in the CTS communities with the lowest uninsurance rates (Lansing and Boston). Implementation of the more expansive managed care approaches in these communities could reflect the strong tradition they (and their states) have in emphasizing coverage either through expansive public programs or through high levels of job-based health benefits negotiated by strong labor unions.

In contrast, the more limited discounted-care programs have emerged in the two CTS sites with the highest uninsurance rates. These sites are located in the South and West, which generally have not had public coverage programs as expansive as those in the Northeast and upper Midwest. The emergence of discounted care could be related to a greater emphasis in some communities on private charity as opposed to large government programs to address the needs of indigent populations.

**Safety-net strength.** Strong safety-net infrastructure—illustrated through the presence of stable and financially viable CHCs and safety-net hospitals—is another factor that could in-
fluence the type of approach a community takes. In sites with strong safety-net infrastructures, we observed both managed care safety-net programs and discounted-care models. Other approaches appear to occur in sites with both strong and weak safety-net infrastructures.

Several factors converge in those sites with the most expansive efforts. The communities with managed care safety-net programs—Boston, Indianapolis, and Lansing—have dedicated funding, state and local politicians and advocates who are supportive of their mission, and stable safety-net infrastructures to deliver care to sizable portions of the uninsured in their communities. Moreover, despite increasing budget pressures in recent years, political support and program leadership remain strong, and cuts to these programs are not considered a viable option. Although other communities pursuing local strategies might share one or two of these characteristics, it could be the combination of several factors that unites those communities whose local efforts have had the greatest success.

Discounted-care models are present in Phoenix and Miami, both of which have strong safety-net infrastructures. Both programs share the goal of increasing revenues for clinics and providing care primarily to the working uninsured. In terms of financing, discounted care programs are somewhat less reliant on dedicated funding streams—since care is paid for by enrollees themselves—but still involve substantial costs to set up the provider network and continued administrative costs to sustain it over time.

Donated-care models might require the presence of fewer community conditions. Of the three CTS sites with these models, Little Rock and Greenville do not have strong safety-net systems; in fact, there is some question among respondents in these sites as to whether hospitals have fully embraced their safety-net mission. Moreover, to the extent that this approach focuses only on physician services, donated-care programs typically require less financing than other approaches. Clearly, donated-care models require advocacy support, but this advocacy often takes place through well-established medical societies. These relatively small start-up costs are likely an important driver of this approach's prevalence across the country. However, these models sometimes provide less comprehensive or more time-limited care (for example, enrolling patients for only a few months); have limited capacity (given that participating physicians take on a certain number of patients and specialists' participation is often hard to get); and face the issue of retaining physician support over time.

Finally, communities that pursue limited-benefit coverage programs—the only approach studied that actually provides insurance coverage rather than access—vary greatly. Because employer-based strategies typically are not dependent on the safety net, they arise in communities with relatively strong safety-net systems as well as those with relatively weak systems. This approach requires less in the way of direct financing; with the exception of third-share models (in which a government entity pays part of the premium), these products typically are financed through premiums paid by employees or employers, or both. However, the political will clearly must exist to create legislation allowing for these products or programs. Moreover, as suggested by low enrollment levels, implementation necessitates substantial resources to engage employers and their employees, and it requires that enrollees can pay (at least part of) the premium.}

**What community approaches do and don’t deliver.** Tailoring to local conditions. One important advantage of community approaches is their ability to tailor efforts to local needs and desires, such as addressing care for certain subgroups or providing specific services. For example, the discounted-care pro-
gram in Miami was created after small employers approached CHCs “looking for something [they could] offer their employees.” Similarly, the medical society in Indianapolis assessed local health care needs and realized that although Health Advantage provides care to a large number of the community’s uninsured citizens, access to specialty care was still problematic (waiting times for specialty appointments are often several months). Consequently, the medical society recently formed Project Health, a donated-care model focused on specialty care.

Support of other community resources. Another strength of certain community models—for example, managed care safety-net models and discounted-care models, depending on their funding mechanisms and care delivery processes—is their ability to provide strong financial support to a community’s public clinics and safety-net systems. By channeling new patients to clinics and paying these clinics for care they might otherwise have provided for free, managed care safety-net programs can provide financing to community clinics; one administrator identified one of his program’s explicit goals as finding “a way to flow more money to our county primary care clinics.” Similarly, discounted-care models in which community clinics are the centerpiece of the provider network are viewed as a potential new revenue source for clinics, given that many enrollees might be higher-income patients who typically do not seek care at community clinics.

Limited reach. Although community approaches can be responsive to local needs, they often face several major challenges. Program reach is typically limited to a small fraction of the community’s uninsured residents, for several reasons. First, community programs are often constrained by limited resources available for outreach, relatively little capacity to serve, and lack of financial and other means to take these models “to scale.” Second, program eligibility criteria are often restrictive—in some cases, intentionally so because of limited capacity—targeting very specific groups that fall into narrow income bands and meet several other criteria.

Finally, enrollment could be small because there is little demand for the product offered. Several program administrators and community advocates noted that limited-benefit coverage sometimes has limited appeal, even among the uninsured; according to one respondent, “The target population is looking for health insurance for about $50 per month, including hospital and doctor visits.” Potential enrollees in Miami’s FlexCare program might see little added value in the program, given the presence of a large, well-known safety-net hospital (Jackson Memorial) and an extensive network of CHCs. In other parts of the state, products offered through Florida’s HealthFlex program cover only outpatient care; they have fewer than 400 enrollees statewide after three years. One respondent attributed this result to “not getting bang for your buck.”

Limited services. For those who do enroll, it is important to consider what services are not provided by the program or product. For example, Little Rock’s Community Health Alliance offers a high-deductible product, so most services are not covered until $5,000 is spent. Ingham Health Plan in Lansing does not provide inpatient care; therefore, the country still bears the brunt of uninsured patients’ hospital costs. Similarly, while discounted-care programs likely improve enrollees’ access to the health care system, access might still be limited, given the high out-of-pocket costs associated with obtaining care.

Difficulty engaging community partners. Another challenge for community programs is engaging community partners, which range from community advocates to private physician practices to employers. Donated-care programs report difficulty in attracting and retaining physician volunteers—especially specialists—to their networks, a result that is not particularly surprising, given increased financial pressure related to low Medicaid reimbursement rates, growing malpractice concerns, and reports of “donor fatigue” among some physicians who feel overloaded with patients. Consequently, access to specialty care often remains difficult. Donated-care programs also
have experienced some push from participating physicians to include drug coverage; physicians suggested that donating their time to treat patients has little value if patients do not have access to needed medications.

Similarly, administrators of managed care safety-net models reported difficulty in recruiting enough specialists to meet demand and therefore end up with long waiting lists for specialty services (as in Health Advantage). Also, when Ingham Health Plan—which already serves 15,000 uninsured people in Lansing—implemented its third-share program targeting small employers recently, it found that reaching out to small employers is difficult. Moreover, these employers might have few resources to devote to a coverage product for their workers.11

Administrators’ own accounts of their programs offer an important perspective on the limits of community models. While community-based programs provide access to care to those who they are able to enroll and serve, many administrators think of the community programs they run as incremental measures rather than complete solutions to the problem of the uninsured in their communities. Moreover, administrators are keenly aware of the issue of sustainability, given that many local programs lack a dedicated funding stream to rely on over time.

**Discussion And Policy Implications**

Numerous community-based approaches exist for providing care to uninsured people. These programs are often invaluable to those who are able to enroll; however, almost all of the programs studied serve only a small proportion of their community’s uninsured residents, barely making a dent in the overall problem. Therefore, communities considering such strategies should be realistic about what such programs can achieve.

Community programs in the CTS sites increasingly are clustered around private-sector strategies, likely because public resources targeted specifically to programs for the uninsured have become more constrained in recent years, especially new funding that would expand existing programs. Greater reliance on the private sector seems to be limiting the scope of these programs in terms of the numbers of uninsured people served, compared with the managed care programs of the 1990s that could tap into substantial public funds and pursue ambitious enrollment goals.

Community programs also are increasingly focused on the working uninsured, apparently at the behest of local health care leaders, providers, politicians, or the community at large. The advent of discounted care programs in the past two years embodies the increased focus on working people, coupled with the underlying notion that health care shouldn’t be free. However, because enrollees with relatively low incomes might still face high out-of-pocket costs even with the discounts, these programs might be associated with greater financial risk than enrollees realize.

Although our case-study analysis allowed us to make in-depth comparisons of different programs that we observed in the CTS communities, our results may not reflect the experiences of all programs of a certain type. For example, many communities have implemented donated-care programs (often using the Project Access model), and it is possible that some have had more of an impact on access to care than have those in the twelve CTS sites.12 Nevertheless, most donated-care programs will face the challenge that charity care provided by physicians has been declining for at least the past decade, as physicians struggle with increased financial and time pressures.13

In sum, many of the community programs we studied—especially the more recent programs—were initiated in response to communities’ concerns about their growing uninsured populations and the perceived lack of
action by state and federal governments. Local communities often play an important role in organizing and coordinating services, programs, and providers for the uninsured; however, local public and private resources are often too small for community-based efforts to provide care to all or most uninsured people in the community. Community approaches are often more vulnerable to funding streams and community support than state programs are; when either one fades, sustainability is difficult. Yet without major policy change, community programs are likely to remain a primary vehicle for chipping away at the problem of uninsurance in the United States.

The authors gratefully acknowledge the contributions and insights of the Community Tracking Study’s interview respondents as well as the work of the study’s research teams. They thank Laurie Felland, Robert Hurley, and Paul Ginsburg for helpful comments on a draft of this paper. The Robert Wood Johnson Foundation provided support for this research.

NOTES


2. These markets were selected to be representative of U.S. metropolitan areas with populations of more than 200,000 and also to ensure a diversity of markets in terms of region and size. For more details, see C.E. Metcalf et al., “Site Definition and Sample Design for the Community Tracking Study,” Technical Publication no. 1 (Washington: Center for Studying Health System Change, 1996).


5. TrustCare, a managed care safety-net pilot program in Miami, began in 2001. Jackson Health System (whose funding for indigent care comes from local property tax revenues and a half-cent sales tax) provided financing for TrustCare through its general operating revenue. Given available financing, TrustCare enrollment was capped at 2,000 members. Because the system did not believe that the program was scaleable to the thousands of uninsured people in the Miami area for financial reasons, Jackson moved TrustCare enrollees into a limited-benefit product called FlexCare in 2004.


8. CaliforniaKids in Orange County is a variant of the multishare model, using foundation funding (rather than government support) to subsidize insurance premiums.

9. Unlike its counterpart in Muskegon, which has 1,500 members (see Ryan, “Local Coverage Initiatives”), Lansing’s third-share program had only about thirty enrollees as of December 2005.

10. Ingham County places money in a county trust fund that is passed to the state Medicaid agency. The state then draws down DSH matching funds from the federal government, which are then passed through two community hospitals to Ingham Health Plan.

