Local Access to Care Programs (LACPs): New Developments in the Access to Care for the Uninsured

LYNN A. BLEWETT, JEANETTE ZIEGENFUSS,
and MICHAEL E. DAVERN

University of Minnesota

Context: New, locally based health care access programs are emerging in response to the growing number of uninsured, providing an alternative to health insurance and traditional safety net providers. Although these programs have been largely overlooked in health services research and health policy, they are becoming an important local supplement to the historically overburdened safety net.

Methods: This article is based on a literature review, Internet search, and key actor interviews to document programs in the United States, using a typology to classify the programs and document key characteristics.

Findings: Local access to care programs (LACPs) fall outside traditional private and publicly subsidized insurance programs. They have a formal enrollment process, eligibility determination, and enrollment fees that give enrollees access to a network of providers that have agreed to offer free or reduced-price health care services. The forty-seven LACPs documented in this article were categorized into four general models: three-share programs, national-provider networks, county-based indigent care, and local provider-based programs.

Conclusions: New, locally based health access programs are being developed to meet the health care needs of the growing number of uninsured adults. These programs offer an alternative to traditional health insurance and build on the tradition of county-based care for the indigent. It is important that these locally based, alternative paths to health care services be documented and monitored, as the number of uninsured adults is continuing to grow and

Address correspondence to: Lynn A. Blewett, State Health Access Data Assistance Center, School of Public Health, University of Minnesota, 420 Delaware Street, MMC 729, Minneapolis MN 55455 (email: blewe001@umn.edu).

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these programs are becoming a larger component of the U.S. health care safety net.

Keywords: Health services accessibility, uninsured, safety net.

CURRENTLY MORE THAN ONE IN FIVE ADULTS AGED nineteen to sixty-four is without health insurance, adding up to approximately 37 million people. In 2006, there were almost 5 million more uninsured adults than there were five years ago (U.S. Bureau of the Census 2007). But few public programs, except for those for children and the elderly, provide health insurance coverage for working-age adults who do not have access to affordable, employer-sponsored insurance.

Only seventeen state Medicaid programs are available for working-age adults, particularly for those with no children (Kaiser Family Foundation 2007), and adults' eligibility for many of these programs is restricted. In thirty-five states, working adults who have children and incomes at or below the federal poverty level (e.g., in 2007, a family of three with an income of \$17,710) do not qualify for Medicaid coverage (Kaiser Family Foundation 2007). Finally, those adults who are not U.S. citizens or are recent immigrants may not be eligible for public programs because of restrictions related to their immigration status. Faced with high costs, the lack of availability of private coverage, and the new Medicaid and SCHIP documentation requirements included in the Deficit Reduction Act of 2005, many immigrant adults are likely not to have any insurance coverage (Rosenbaum and Markus 2006).

The United States' health care system has traditionally relied on safety net providers to meet the health care needs of people who do not have health insurance or who may have some coverage but still face financial barriers to getting the health care they need. A patchwork of local providers and services has developed over time to fill these gaps in health insurance coverage. The Institute of Medicine (IOM) regards these providers either as being legally mandated or mission driven to provide care for the vulnerable or as serving a substantial number of patients who are underinsured, uninsured, or Medicaid enrollees (Lewin and Altman 2000). Sixty-three percent of the care for the uninsured is estimated to be provided by direct access to community hospitals, and

another 19 percent by clinics, primarily community clinics (Hadley and Holahan 2003).

This safety net is a disparate and evolving mix of providers, programs, and services with various sources of funding. The larger, more well-established safety net providers—federally qualified health centers (FQHCs), community health centers (CHCs), and public hospitals—receive most of the formal state and federal grant funding. Yet the evidence is increasing that this traditional safety net is substantially underfunded and stretched to meet the needs of the growing uninsured population (Lewin and Baxter 2007).

Some local communities are responding to such gaps in insurance coverage and the overburdened safety net by developing new programs to give uninsured adults coordinated access to local providers at a low cost. Many of these programs grew out of local indigent care programs with histories dating back to the Elizabethan poor laws in seventeenth-century England, which deemed care for the poor to be a local responsibility. Because the counties of many states still are responsible for the care of people who are not covered by other state and federal programs, the counties have financial incentives to develop more efficient ways to provide needed primary care (Axinn and Levin 1975). Nonetheless, though growing in number, these programs are not well documented.

In this article, we examine the current structure and the nature of a distinctive subset of these new initiatives that we call *local access to care programs* (LACPs). These are locally organized and financed programs that provide a structured set of health care benefits and services to uninsured working-age adults.

After describing our research approach, we define LACPs and describe how they differ from other programs for the uninsured. We then present a typology of LACPs and an overview of the characteristics of the forty-seven LACPs we documented. Finally, we discuss recent innovations in the development of safety nets and offer recommendations for monitoring and documenting these and other initiatives.

Methods and Approach

We conducted a literature review, Internet searches, and key actor interviews, organized by state, to document the existence and characteristics of LACPs in the United States.

Literature Review

We conducted a formal search using PubMed and Ovid Medline and emphasizing terms that could be associated with LACPs, such as “safety net provider,” “three-share” (explained later), “disproportionate share,” and “care for the uninsured.” We included peer-reviewed papers from 1996 to 2006, and we searched the “gray” literature by accessing the Internet sites of all fifty states and the District of Columbia, focusing on the states’ Medicaid agencies, public health departments, and legislative offices, using key words similar to those listed earlier. We also searched the sites of federal health agencies, health services research, and policy organizations and national associations for documents related to safety net services and access to care programs, specifically the Urban Institute, Mathematica Policy Research, National Academy for State Health Policy (NASHP), Center for Budget and Policy Priorities, State Coverage Initiatives of AcademyHealth, Kaiser Family Foundation, Robert Wood Johnson Foundation (RWJF), and the Commonwealth Fund.

Internet Search for LACPs

From June to November 2005, we conducted an extensive Internet search to find existing LACPs, compiling information about each one and contacting the programs for more information when needed. We also searched the websites of public and private agencies and organizations sponsoring or compiling information about such programs at the local, state, and national levels, including the American Project Access Network (APAN), RWJF Communities in Charge, Artists Health Insurance Resource Center, National Association of Counties (NACo), the federal Health Resources and Services Administration (HRSA), and Communities Joined in Action (CJA). We collected LACP documentation and information, including annual reports, promotional literature, and other relevant materials available on the Internet.

Key Actor Interviews

Finally, we interviewed program administrators of four LACPs and four leading researchers who are knowledgeable about LACPs and their members, utilization, costs, and trends. We selected a program administrator from each of the four program models that are described next, representing programs in the Southeast, Northeast, Midwest, and Southwest, and

varied, by size and stability, the programs selected for interviews. Our interviews were semistructured. We asked about the characteristics of the LACPs, their stability, and program evaluations planned or under way. We also asked the respondents to gauge patients' perceptions of these programs as successfully providing for their basic health care needs and their possible misperceptions of these programs as insurance products.

Limitations

Our study did have some limitations. First, information about the LACPS and their characteristics was scarce, as the states and counties have no licensure or registration requirements and no centralized list of LACPs. In addition, LACPs are typically small, community-based organizations, often operating only part-time, and many are not listed on the Internet. Second, our web search used only states and the District of Columbia as search terms. We might have found additional programs if we had searched at the county level, but this was not practical. Finally, the small number of key actor interviews, though valuable, likely provided only a narrow view of LACPs and trends. Accordingly, this article should be considered a baseline for further research on LACPs.

Definition of Local Access to Care Programs (LACPs)

In this article, a *local access to care program* is a community initiative designed to facilitate access to needed health care services to the uninsured through a local organizing entity. LACPs are characterized by the following:

- An enrollment mechanism, which may or may not include a membership or monthly enrollment fee.
- Income eligibility requirements for free care or care on a sliding-fee scale for low-income individuals.
- A defined set of benefits.
- A limited local provider network.
- A contractual or agreed-upon relationship between the LACP and local providers of care, which may include an agreement by providers to provide free care or care at a reduced fee.
- Administration by nonprofit local agencies or providers.

In assessing the role of LACPs, we looked at the literature to determine how arrangements to provide access to care for the uninsured had been classified. In 2006, an issue of the journal *Health Affairs* was devoted to the safety net and described two methods for categorizing safety net initiatives. While the approaches may be sound and highlight certain characteristics of the safety net, they do not capture the unique qualities of LACPs.

The first approach, described by Taylor, Cunningham, and McKenzie (2006), used interview data collected from key informants in eight of the twelve sites in the Community Tracking Study (CTS) of the Center for Studying Health System Change. The CTS sites are a representative sample of large urban cities, and the interviewees identified different types of safety net initiatives within each site. These safety net strategies were then categorized as one of four models: managed care, donated care, discounted care, and limited-benefit coverage. The first three types were grouped as “brokered access” approaches, and the fourth involved direct health insurance coverage. The managed care models are run by public hospitals or community health clinics to better manage the hospitals’ use of inpatient care and their emergency departments. Providers participating in a donated care model agree to see a certain number of patients or to offer a certain number of free visits each year. Discounted care models are privately sponsored initiatives offering access to a network of physicians at discounted rates to those willing to pay for a discount card. The final strategy allows employers to provide a limited-benefit package authorized by the state. These packages are a lower-cost option for small employers, allowing them to purchase health insurance that is exempt from certain state mandates and regulations.

A second way of describing safety net programs was proposed by Brown and Stevens (2006) and focuses on organizations that redistribute existing resources to provide care to the uninsured. The principal redistributing organizations are (1) “mainstream” entities like government agencies, businesses, community hospitals, medical societies, and managed care organizations, and (2) “safety net” entities like CHCs, public clinics, and hospitals with a high volume of uninsured or publicly insured patients (Brown and Stevens 2006). These organizations redirect existing resources to develop new programs of care for the uninsured.

Our focus is not on the organizational entity or approach but on those components of the safety net that share the characteristics listed earlier. And while the LACPs may facilitate enrollment in public or private

health insurance plans, the LACPs themselves are not either a public or a private health insurance product. We believe this distinction is important because LACPs may look and feel like formal health plans, but unlike health insurance products, they are not subject to state regulatory oversight regarding access to needed care or the quality of care received.

A few examples may clarify our definition. Several programs that have been developed in Ingham County, Michigan, are similarly structured but are distinctive in important ways. For instance, the Ingham Health Plan's Plan A was developed through a Medicaid 1115 waiver to allow a local county health plan to cover low-income adults and thus would *not* be an LACP because it is a formal public (Medicaid) plan. By contrast, the Ingham Health Plan's Plan B is a community-sponsored program that coordinates access to care for uninsured individuals who are not eligible for public or private health insurance. This plan meets all our criteria for an LACP, including enrollment, access to a limited network of providers, and reduced fees. Still another plan is the Ingham County Advantage, which is a formal private health insurance product offered to small businesses, with employees, employers, and the county all contributing to the cost of the premium. Eligible employers are those with two or more but fewer than twenty employees, of whom at least 50 percent make \$10.00 or less an hour (Ingham Health Plan 2004). This plan is *not* an LACP as we have defined it because it offers private health insurance coverage.

We also distinguish LACPs from direct-access safety net providers (CHCs, public hospitals) from which low-income individuals may seek care. These providers may use a sliding-fee schedule but have no formal program of care, no enrollment process, and no network (of providers). In contrast, an LACP has a local organizing entity collect and maintain information about its enrollees and, in most cases, attempts to manage care over time. An LACP may contract with community-based providers, which may include a local public hospital or FQHC (federally qualified health center). The distinction is that an LACP formally enrolls its members in a program of care.

A Note on Risk and Insurance

Notwithstanding the characteristics just discussed, LACPs are not designed as insurance products. Even though their structures and financing

mechanisms vary, LACPs are not responsible for the cost of care and do not pool their risk. In traditional state-regulated insurance products, the insurers assume a “contractual duty of care” in exchange for the premiums they collect, and they are responsible for the difference between the premium revenues and claims costs. LACPs, however, do not transfer the risk from annual or monthly enrollment fees from one entity to another, and they do not adjust their enrollment fees to reflect their enrollees’ health status or potential utilization of health care services. In most cases, these fees defray the administrative costs of running the service programs or are used to make nominal payments to providers. Providers agree to take a limited number of clients, dispense limited primary or specialty care, and charge predetermined discounted fees or sliding-scale fees for their services. Although participating providers or plan administrators are not contractually obligated to provide any more care than agreed on, they may be mission driven to do more. While it can be argued that LACPs shift the “risk” to participating providers through fees at deeply discounted rates, this “risk” is not regulated, although traditional insurance risk is.

Models of Local Access to Care Programs

Using methods described earlier, we identified a total of forty-seven LACPs in twenty-seven states. As discussed later, they can be grouped into four models. Table 1 shows the number of plans in each model and

TABLE 1
Documented Local Access to Care Programs in the United States,
by Model Type

Access to Care Program Model	Number of Programs	State
Three-share programs	4	AR, FL, MI, WV
National-provider network	27	AK, CT, GA, IL, KS, KY, ME, MI, MN, NM, NC, OK, SC, TN, TX, UT, VA, WA, WV
County-based indigent care	9	CA, DE, FL, KY, MI, WI
Local provider-based programs	7	AZ, CA, FL, IN, TX
Total documented programs	47	27 states

the states in which they are located. More detailed summary information about each of these plans is in an appendix available from the authors (SHADAC 2008).

We placed the LACPs into four categories based on the type of organizing or sponsoring entity: (1) three-share programs, (2) national-provider networks, (3) county-based indigent care, and (4) local provider-based programs. The organization and financing of LACPs varies across communities according to the political climate, community leadership, drive to meet the needs of the uninsured, local demographics, state and local fiscal resources, and foundation grants (Ryan 2005).

Three-Share Programs

Three-share programs are community-based initiatives targeted to the working uninsured, in which the responsibility for the employees' cost of health care is shared by three parties, usually the employee, the employer, and the community (Silow-Carroll et al. 2001). The employee's and employer's contributions may be supplemented by community funds that include either direct subsidies or grants. Funding may come from local tax revenues or other mechanisms, including the diversion of federal disproportionate share hospital (DSH)¹ payments, foundation funds, and community matching payments (Ryan 2005). Although other programs collect premiums from employers, employees, and the city and/or county, they are organized as traditional insurance (see Ingham County Advantage, mentioned previously); the three-share LACPs are definitely not insurance (Ingham Health Plan's Plan B).

National-Provider Networks

National-provider networks offer free and discounted care through a network of local providers. The coordinated model is organized through the Physician Innovations Network, a national nonprofit organization coordinating physicians' charity care for low-income, uninsured people (Physicians Innovations Network 2007). Care coordinators assess and document patients' needs, arrange visits to specialists, and assist with needed transportation and translation (Isaacs and Jellinek 2007). The model was based on the successful American Project Access program started in 1996 in North Carolina by the Buncombe County Medical Society to meet the needs of local uninsured people.

National-provider networks have well-developed systems of patient referral, tracking of services rendered, and ongoing assessment of their effectiveness (American Project Access 2006). The benefits claimed for these plans include reduced emergency room use, fewer urgent care visits, and lower uncompensated care costs for the community.

County-Based Indigent Care

County-based indigent care programs are administered by local health departments. Besides using a limited provider network, they include case management and coordinated care services. These programs' financing comes from county indigent care resources, which may include local sales and property tax revenues, tobacco settlement funds, and/or Medicaid DSH funds that initially were intended for county hospitals.

Local Provider-Based Programs

Local provider-based initiatives are established and administered by hospitals, clinics, or local health care systems. They generally are found where a single provider network is the main source of care for residents of a specified geographic area. Low-income uninsured people obtain care from a small network of physicians, hospitals, and affiliate health centers. The patients' cost for services is based on sliding-scale fees. These plans may be financed by property tax revenues, Medicaid DSH funds, and/or federal community access and foundation grants.

Characteristics of Local Access to Care Programs

LACPs can be described in terms of the populations they serve, their size, the services they make available, and the way they are funded. In the following sections, we discuss each of these topics.

LACPs Serve Low-Income Uninsured Adults

In general, LACPs serve people who are categorically ineligible (such as non-U.S. citizens) for public health insurance programs or who have incomes that are too high to qualify for public health insurance coverage but are too low to afford private health insurance premiums. Enrollees

are likely to be working but either are not offered health insurance coverage or do not accept it because it is too expensive. In Maine, for example, people who are offered health insurance that would cost more than 5 percent of their income qualify for CarePartners, a voluntary provider network program in Kennebec County.

Most of the programs we examined had an income eligibility standard of 200 percent of the federal poverty level (FPL). For example, eligibility for the new San Francisco Health Care Access Program is as high as 500 percent of the FPL (Vega 2006). One advantage cited by several program administrators was that the providers welcomed the ease of eligibility determination; that is, when a patient comes to a clinic with an LACP card, the provider knows that this is indeed a low-income individual and eligible for free or discounted care. The provider does not need to reassess the patient to determine his or her eligibility for free care.

Most plans limit participation to residents of the plan's county or municipality, and most appear not to require U.S. citizenship as a condition of participation. Several required prospective enrollees not to have had formal public or private health insurance for a period of three months to a year.

Finally, LACPs also serve as gateways to Medicaid and other programs that provide coverage. When determining eligibility, LACPs will help people enroll in formal public or private insurance if they are eligible. For example, a program administrator at HealthCare Connect in Arizona, which has 3,400 enrollees, told us that approximately 80 percent of those screened had enrolled in a public health insurance program or other safety net program.

The LACPs Are Relatively Small with Strong Community Support

LACPs range in size from as small as eighty enrollees in the Health Care Access Program in Franklin, Logan, and Scott Counties in Arkansas, to an estimated 50,000 to 55,000 enrollees in the CareLink plan in Bexar County, Texas. All the plan representatives with whom we spoke cited strong community support. Concern for the uninsured and the underinsured, along with coordinated efforts of community leaders and local physicians, successfully transformed these plans from concepts into organized entities serving as access points for health services to the vulnerable. The Community Health Works of Georgia, the Health Flex

program in Duval County, Florida, and the Medical Society of Sedgwick County Project Access in Sedgwick County, Kansas, are a few instances in which LACPs were spawned by a communitywide problem-solving process. Other plans cited support from providers and hospitals as an important reason for their existence.

In Florida, specific legislation was passed to guide the development and oversight of LACPs, the first such legislation in the nation. In Florida, the Health Flex legislation outlines regulatory provisions for organized community-based health care programs with eligibility requirements (under 200 percent of federal poverty level), standardized grievance procedures, and oversight of Health Flex advertisement and marketing procedures (Florida Agency for Health Care Administration 2004, 2005). Health Flex was established as a pilot program in an effort to offer basic affordable health care services to low-income uninsured state residents “by encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services” (Florida Agency for Health Care Administration 2005; Florida Senate 2002).

Although most LACPs are relatively new, some programs began as early as 1991, such as the Hillsborough City Health Care Plan in Hillsborough County, Florida. One of the newest programs, Healthy San Francisco for the city/county of San Francisco, became operational in 2007. Smaller LACPs have relied heavily on the federal government’s Healthy Community Access Programs (HCAP), which as of FY 2006 is no longer a source of funding. The programs that were financially dependent on HCAP faced considerable challenges when it ended, and at least two plans that we identified during our environmental scan had closed by the completion of our project.

Most Offer Only Limited Benefits or Basic Primary Care Services

Most programs are able to offer only those services for which they can find volunteer providers, which usually are primary care services. Fewer programs offer specialty services, often resulting in long waits for specialty care. CarePartners in Kennebec County, Maine, told us that the

scarcity of specialist providers in their area limited the services that they could provide. A survey of members' satisfaction conducted by HealthCare Connect in Maricopa County, Arizona, found that enrollees were unhappy that the program did not offer discounts or a free-care arrangement with local emergency departments. Comprehensive pharmacy benefits were rare as well, and most plans' drug assistance was limited to low-cost, generic drugs with a co-pay for most prescriptions. And owing to scarce resources, few plans covered ancillary services such as physical therapy and home-based care.

Financing Mechanisms Vary

LACPs are sustained through an array of financing schemes, which include, but are not limited to, existing local, state, or federal indigent care funds (direct subsidies); leveraged Medicaid DSH funds; county and property tax revenues; and employers' contributions. Access to public funds is restricted because these plans are designed to serve individuals who are not eligible for Medicaid (Ryan 2005). As pointed out earlier, all the plan representatives with whom we spoke cited financing as a significant barrier to continued growth. Funding difficulties are often due to little political support or competing local priorities. Furthermore, models relying on donated care could not be sustained if all uninsured persons were allowed to enroll. Indeed, as we point out later, the amount of donated care appears to be decreasing while demand is increasing.

The programs' core public funding has been critical to the size and sustainability of the two largest LACPs that we documented, Health Advantage in Indiana and the Ingham Health Plan (IHP) in Michigan. Initially, Health Advantage was financed through leveraged DSH funds and it now relies primarily on a combination of city and county property taxes designated for indigent care, in addition to leveraged DSH funds. Health Advantage also received federal HCAP grants from 2001 through 2003 (Health and Hospital Corporation of Marion County 2005). Most of these funds went to refine and supplement existing programs, such as a pharmacy assistance program and an electronic application and screening system.

For the Ingham County Health Plan, Plan B, special state DSH provider payments were made to two local hospitals who agreed to turn over those payments to fund the IHP for the uninsured. In Muskegon

County, federal DHS funds were used to match local funds collected through county grants and employer contributions.

JaxCare in Duval County, Florida, had considerable community and local government financial support and was specifically targeted to low-income working adults. Financing was through the city of Jacksonville (31 percent), grants and corporate donations (20 percent), hospital contributions (26 percent), and patient and employer contributions (23 percent) (Florida Agency for Health Care Administration 2005).

Other, more recent initiatives pertain to the development of discounted fees organized around community health centers but financed by employers to increase access to primary care services. The CareNet plan in Miami-Dade County, Florida, is one example. CareNet targets employees of small businesses, hourly wage earners, students, the self-employed, and families. Enrollees are charged a membership fee of \$25 per month for an individual and \$30 per month for a family. In some cases, employers pay the monthly enrollment fee. There is a flat fee for doctor or dentist visits (\$25), laboratory tests (\$5), and prescription drugs (\$10 to \$30), with other services offered at 40 to 60 percent discounts. Currently, there are no income or residency requirements (Health Choice Network 2006).

The availability of public funds for LACPs has generally been unstable and dwindling, so most plans are facing financial insecurity. One program representative cited the need for more funding for LACPs, stating that people are falling between the cracks and “drowning in our broken health care system. . . . Whereas the federal government used to put ‘band-aids’ on the problems, they don’t even do that anymore. The wounds are gushing.”

Evaluations of LACPs

We identified very few formal evaluations of LACPs, mainly because of lack of resources, not interest. Two purposes for these plans were to reduce emergency department visits and lower the expenses to the community for uncompensated care. Some plans have calculated how much care providers have donated to treat enrollees, but they have seldom clearly shown how much communities have benefited from these programs. The Buncombe County, North Carolina, plan reports cost savings and was frequently cited as an example of how much could be saved through

such an initiative. But a study by Baker, McKenzie, and Harrison (2005) found that hospitals in the Buncombe County area avoided an average of \$3 million annually in charity care costs. Most LACPs, however, lack data that might support claims about their impact.

In talking with LACP administrators, we found that several evaluation studies were under way. The Maricopa plan, for example, had recently received results from a survey of members' satisfaction and is currently conducting exit interviews with disenrollees and tracking utilization to document cost savings. Preliminary results estimate that less use of the emergency room saved the hospital more than \$1 million in uncompensated care. The program administrator believes that this reduction can be attributed at least partially to members learning about the appropriate use of the emergency room. The plan has identified and contacted members who have used the emergency room in the past, informing them that it is not a network provider and explaining other ways of receiving care. All the other plan representatives with whom we spoke had been collecting data since the LACP's inception in order to evaluate the program, concentrating on utilization documentation—primarily reducing the use of emergency room care—but also assessing patients' satisfaction and improved health outcomes.

A Recent Development

In August 2006, Gavin Newsom, the mayor of San Francisco, announced the establishment of the San Francisco Health Access Plan, or "Healthy San Francisco," for uninsured residents of the city and county of San Francisco (Healthy San Francisco 2006). A large and visible LACP developed and administered by the San Francisco Department of Health, this program was specifically designed as a primary care plan and is not insurance. The plan provides access to "a medical home and primary physician, allowing a greater focus on preventive care, as well as specialty care, urgent and emergency care, laboratory, inpatient hospitalization, radiology, and pharmaceuticals" (Healthy San Francisco 2006). Services provided through Healthy San Francisco are limited to one hospital, San Francisco General Hospital, and twenty-seven clinics that either are run by the San Francisco Department of Public Health or are a part of the San Francisco Community Clinic Consortium (Kaiser Family Foundation 2008).

To be eligible for Healthy San Francisco, individuals (regardless of immigration status) must be residents of the city or county, must be eighteen to sixty-four years old, and must have been uninsured for ninety days. Healthy San Francisco, like most other LACPs, will not enroll individuals who are eligible for any public health insurance programs (Kaiser Family Foundation 2008). Enrollment fees are required quarterly and are based on a sliding scale. Enrollees with incomes below the federal poverty level pay nothing, and out-of-pocket fees for persons with incomes above the poverty level cannot exceed 5 percent of family income. In addition to enrollment fees, the plan is financed by contributions from the city and county of San Francisco and from employers that do not currently provide health insurance coverage.

As of January 2008, city and county employers (with twenty or more employees or nonprofit firms with fifty or more employees) were required to pay a set amount per hour for their employees' health care. This requirement can be met through either traditional employer-sponsored health insurance or direct contributions to Healthy San Francisco (Kaiser Family Foundation 2008). Mandated contributions range from \$1.17 to \$1.85 an hour (Kaiser Family Foundation 2008) per employee.

The Golden Gate Restaurant Association, representing nine hundred local businesses, has challenged employers' mandated contributions under the federal Employment Retirement and Income Security Act (ERISA), which preempts state and local regulation of employee benefits for employers who self-insure their health benefit plans.² The employers' contribution requirement was upheld by the district appeals court in January 2008, and the claim is now being considered by the state supreme court (Egelko 2008).

Despite the court challenge, the program is being implemented with phased-in enrollment. As of April 2008, 17,798 individuals were enrolled in Healthy San Francisco (Healthy San Francisco 2008), representing a potential new role for cities and counties in providing needed local access to care for uninsured residents. When fully implemented, the program is expected to reach 26,000 adults with incomes up to 500 percent of FPL (Healthy San Francisco 2006).

Conclusion

This article has provided a first look at the local access to care programs that have been developed to meet the health care needs of the

local uninsured residents. We hope it will stimulate additional policy discussion and research.

The LACPs we documented fall between the two traditional means by which care has been provided to the low-income uninsured in the United States, that is, through either publicly financed programs like Medicaid and SCHIP or direct access to safety net providers like FQHCs, CHCs and public hospitals that provide free or discounted care.

LACPs were created to fill important gaps in the increasingly overburdened safety net because the traditional methods of funding care for low-income populations are falling short. Medicaid's long-standing eligibility exclusions, including recent new barriers to enrollment for new immigrants, have only added to the growing number of uninsured adults.

Even though the number of individuals enrolled in most LACPs appears to be relatively small, there are only a few large plans (Michigan's Ingham Health, Indiana's Health Advantage, and the San Francisco Health Access Plan). Our highest national estimate of adults enrolled in LACPs would be approximately 640,000, spread across twenty-seven states. Without more secure funding, these plans are likely to remain small, grassroots efforts in certain local communities, with little assurance of their long-term viability.

But LACPs may evolve into stable and defined entities as the factors leading to their development become more unavoidable, such as the growing number of uninsured adults, the increasing costs of coverage in individual and employer-sponsored plans, higher out-of-pocket costs, and pressures on state budgets to continue to constrain enrollment in Medicaid. These factors are of particular concern to counties that bear a significant burden for funding indigent care at the local level and are questioning their investment. Is there a better way to organize and fund such care? Are we getting value for the money we are spending?

At best, LACPs are an incremental addition to the safety net for the uninsured. Although these programs may provide access to primary care, very few offer coverage for specialists or the costs of a catastrophic hospitalization. Nor do these programs address the spiraling cost of health care. At this point, little is known about how these plans actually work, how enrollees perceive their membership, and how this segment of the health care system fits into the whole system.

The results of our study highlight the importance of the LACPs as an alternative to traditional health insurance and build on the tradition

of county-based care for the indigent. We believe these programs will become an increasingly important component of the safety net as the number of uninsured adults continues to grow and the number of affordable options for health insurance continues to decline. We thus need to determine how LACPs fit into the currently fragmented safety net, by better documenting and evaluating LACPs, their costs, and their health outcomes.

Endnotes

1. Medicaid disproportionate share payments are payments made to hospitals that serve large numbers of uninsured and Medicaid patients. States have worked with hospitals to secure a portion of these funds, through intergovernmental transfers, federal matching payments, and/or a diversion of the hospital's disproportionate share payments to fund safety net programs often linked to reduced hospital inpatient and emergency room use. For more information on the use of disproportionate share funds, see Coughlin, Ku, and Kim (2000) and Silow-Carroll and Alteras (2004).
2. For additional information about the implications of ERISA in state health reform that mandates employer contributions, see Butler 2005.

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