

Increasing Health Insurance Coverage at the Local Level: The Communities In Charge Program



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Editors' Introduction

Increasing access to health care has been a goal of the Robert Wood Johnson Foundation since its very beginning. In Volume IX of the *Anthology*, Robert Rosenblatt reviewed the 30-plus-year history of the Robert Wood Johnson Foundation's efforts to expand health insurance coverage to all Americans and concluded that the Foundation's initiatives had oscillated between trying to bring about major change at the national level and working with states and communities to find ways to insure people locally. The *Communities In Charge* program is an example of the latter approach; it supported 14 communities' efforts to expand insurance coverage within their limited geographic area.

As Mary Nakashian observes in this chapter, the Communities In Charge grantees ran into many obstacles. These ranged from expected sources of revenue drying up to onerous insurance regulations, and from lack of administrative know-how to September 11th derailing planned activities. As the program unfolded, the communities showed a great deal of ingenuity in meeting the challenges, even if it meant deviating from their original plans. Though the number of people who obtained coverage under the program was disappointing, some of the sites developed strategies that could—and are—being replicated. Communities In Charge and other programs that look to generate local solutions for expanding insurance coverage raise the question of whether efforts to address lack of insurance coverage are best done at the community, state, or federal level, or some combination of the three.

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Nearly 46 million Americans currently lack health insurance coverage, and the number is rising. Between 2000 and 2004, as health insurance premiums escalated and employers cut back on employee coverage, the number of uninsured Americans rose by 6 million.¹ Lack of insurance has serious consequences for health and well-being. Uninsured people often delay getting needed medical care, are in worse health than those with insurance, and encounter financial difficulties paying their medical bills.^{2,3}

Four out of five uninsured individuals are employed or live in a family in which the household head is employed, largely in service establishments such as restaurants, hotels, and retail stores. Although two-thirds of uninsured people are White, higher percentages of ethnic and racial minorities lack health insurance. In 2004, 34 percent of Hispanics, 21 percent of Blacks, 19 percent of other races and 13 percent of Whites lacked insurance.⁴ Similarly, middle- and upper-class Americans are more likely than low-income people to have health insurance.⁵

More and more people who are employed or who are self-employed find themselves uninsured. People like Sandra Fleming, a self-employed massage therapist from Boulder, Colorado. With income from her massages supplemented by occasional work preparing magazines for publication, Sandra has been able to meet basic expenses. But she cannot afford health insurance. For a while, she was eligible for care at a clinic at a cost of \$25 per visit. “I had a mental profile of the people I thought would be at the clinic, but when I walked in, they were different. There were a lot of people who looked like they came to the clinic from work.” As her massage practice grew, the clinic had to adjust her fees. “They tell me now I have to pay \$73 per visit, and I don’t know if I can do that. My payment almost tripled, but my income only went up a little bit.”

Over the years, the federal government has taken steps to cover certain groups and to expand coverage. In 1965, Congress passed Medicare, a federal program that covers people over 65 and with disabilities, and Medicaid, a federal and state program that insures poor people. In 1997, it passed the State Children’s Health Insurance Program, or SCHIP, a federal-state program that covers children living in low-income families. Proposals for large-scale health care reform surfaced in the Nixon, Ford, and Carter administrations. All of them failed. President Bill Clinton’s Health Security plan, proposed in 1993, failed as well.

The Development of the Communities In Charge Program

In the mid- to late-1990s, with the failure of the Clinton health plan and national health care reform off the table, the Robert Wood Johnson Foundation turned its attention to states and localities. In contrast to the void at the federal level, states and communities offered promise. State economies were strong, employment was up, and welfare rolls were at historic lows. Anticipating revenue from settlements with tobacco companies, state governments were interested in using those funds to support new health programs in their communities. “Increasingly, the challenge of providing health care to the uninsured was falling disproportionately to local communities,” said Judith Whang, the former Robert Wood Johnson Foundation senior program officer who helped develop and monitor the Communities In Charge program.

In attempting to expand health insurance coverage at the local level, the Foundation built upon its experience dating back to the 1980s and a program called Community Programs for Affordable Health Care. This program supported community coalitions in devising ways to manage care and keep medical costs down. Results were disappointing, and in 1990 Foundation officials concluded that the program's central flaw was its misguided assumption that cost containment could be achieved through intervention at the community or local level when the true levers of power existed at the national and state levels of the health care system.⁶

In 1985, the Foundation funded the Health Care for the Uninsured Program to test strategies for making health care coverage more available and affordable to small businesses. Under this initiative, 14 states either developed new insurance products for businesses or subsidized existing ones. One lesson from this program was that "health insurance, even if heavily subsidized, was unaffordable for small businesses."⁷

In looking for promising community strategies in the mid-1990s, Foundation staff members were encouraged by what they saw emerging in Hillsborough County, Florida, which includes Tampa and surrounding areas. In 1993, the county reorganized the way it financed and delivered health care services to its low-income residents. With a half-cent increase in the county sales tax that had been authorized by the Florida legislature two years earlier, the county government was able to finance Hillsborough HealthCare, a managed care program that emphasized prevention and early detection of health problems. Each year, about 27,000 people received care through one of four networks that operated clinics under contract to the county government. Enrollees received primary and specialty care, hospital services, prescriptions, and vision, dental, and home health care. In 1996, the program won the Ford Foundation Award for Innovations in American Government.

Hillsborough HealthCare interested the Foundation staff because it was an organized system based on primary care and prevention that operated on a large scale and was available to people based on their income rather than on characteristics such as employment or family status. Furthermore, it appeared to be sustainable through ongoing public financing.

As staff members at the Foundation considered how a new program should look, they debated the extent to which it should replicate Hillsborough HealthCare. Although staff members were impressed with the Hillsborough program, they understood that other communities would have different circumstances and priorities and might not be able to replicate what Hillsborough County had done. "We studied the Hillsborough County model to death," recalls Judith Whang. "Early on, we talked about whether it could be replicated. But we decided to focus on strategies that engaged community leaders in designing their own solutions rather than on replicating specifically what happened in Hillsborough County."

In 1997, the Foundation's board authorized \$16.8 million for a four-year national program called Communities In Charge. The call for proposals, released the following year, specified that the program was "designed for local communities interested in improving access to care for low-income uninsured individuals by rethinking the organization and financing of local care delivery." It went on to specify that during a one-year planning phase, communities would be expected to:

- Create a process to build consensus regarding funding and service delivery.
- Assess the scope of the problem and resources available to address it.
- Design an actuarially sound financing approach that identifies dedicated and sustainable funds.
- Plan an infrastructure and an information system to administer the development and operation of a managed care system.

To receive three-year implementation grants, communities would be expected to:

- Establish comprehensive delivery networks emphasizing primary care.
- Create detailed implementation plans to operate their projects.
- Design and launch outreach, marketing, and enrollment programs.
- Enroll members and provide services to them.
- Collect baseline and operational data for program management and evaluation.

In 2000, 20 communities received up to \$150,000 planning grants. In 2001, 14 of those communities received up to \$700,000 for three years to implement the projects they had planned. Two of the sites (Birmingham, Alabama and Spokane, Washington) later withdrew from the program.

Table 4.1 Communities In Charge Programs and Grantees

Project Name	Location	Program Design
Alameda Health Consortium	Oakland, California	Coverage product for low-income children and their families; new managed care products for low-income adults
District of Columbia Primary Care Association	Washington, D.C.	Expand Medicaid eligibility and enrollment into a D.C.-sponsored coverage program
JaxCare	Jacksonville, Florida (Duval County)	Managed care coverage product with donated hospital services
Community Health Works/Medcen Community Health Foundation, Inc.	Macon, Georgia	Donated care model providing case management for uninsured with high-risk medical conditions
Project Access/Central Plains Regional Health Care Foundation, Inc.	Wichita/Sedgwick County, Kansas	Donated care model coordinates medical care, prescription drugs and services
getCare Health Plan (Louisville-Jefferson County Communities In Charge Coalition) (getCare closed in 2005.)	Louisville, Kentucky	Donated care model coordinates access to existing safety net and voluntary specialty care
CarePartners/MainewHealth	Greater Portland, Kennebec, Lincoln and Cumberland counties, Maine	Donated care model provides access to health care services, care management and low-cost or free pharmaceuticals

Jackson Medical Mall Foundation/ Hinds County Health Alliance	Jackson, Mississippi	ER redirect/disease management program
Brooklyn HealthWorks/ Brooklyn Alliance, Inc.	Brooklyn, New York	Insurance subsidy program
HealthforAll of Western New York, Inc. (HealthforAll closed in 2005.)	Buffalo/surrounding counties, New York	Insurance subsidy program
Multinomah County Health Department/Tri-County Health Care Safety Net Enterprise	Portland, Oregon	Regional public corporation for safety net system management and governance
Indigent Care Collaboration	Austin, Texas	Web-based regional information system creation of health financing district

The implementation awards required a dollar-for-dollar match from communities. Virtually all of the communities secured some of their matching funds from the federal Health Resources and Services Administration’s Healthy Community Access Program or the W. K. Kellogg Foundation’s Community Voices program.

Medimetrix, a health care consulting firm located in Cleveland, directed the program nationally and provided technical assistance to grantees.

Program Implementation

Even though the Foundation had not required potential grantees to replicate the Hillsborough model, staff members hoped that at least some communities would do so. However, the program diverged from that idea almost from the start. According to Nancy Barrand, one of the original Communities In Charge program officers at the Foundation, “We did not want to say we were replicating the Hillsborough model *per se*—we didn’t want to say we were asking communities to pass a sales tax. When the proposals came in, things really morphed. It is common that a program attracts what is out there, not necessarily what you want. For example, we hoped communities would really examine and change the way they financed existing health care and explore ways to reallocate money and reorganize services to make them more effective. But when proposals came in, they suggested more limited initiatives, and we ended up supporting approaches that focused on improving coverage or coordinating care for targeted groups of people such as low-income workers and high users of care. Later, the program morphed even more because of changes in the national economy and fiscal crises in the states. These changes are not necessarily negative, but you should understand why you are getting what you are getting.”

The proposals suggested a range of initiatives. Some communities planned to create managed care systems as specified in the call for proposals; some proposed to enroll thousands of new people in existing safety net programs; and some proposed to create new insurance products for working people. In 1999, when community representatives were writing their planning grant proposals, the economy was booming and grantees assumed they would receive approval from the state government to use

tobacco-settlement funds for their projects or to tap new funds resulting from a provision in federal law that allowed states to collect higher levels of reimbursement for hospitals that served disproportionate numbers of low-income people. These assumptions generally proved false.

During 2000, after communities received their planning grants, the economy began to deteriorate. By 2001, when projects began their implementation phase, the high employment rates and robust state budgets that characterized the 1990s had evolved into gloomy reports of increasing joblessness and dwindling revenues. After the September 11, 2001 attacks, homeland security became the priority at all levels of government and health care all but disappeared as a concern. These changes forced communities to scale back their original ideas.

As is often the case when community groups attempt to implement new programs, everything took more time than expected. Local grantees did not hire project directors until 2001 when the implementation grants were awarded. Therefore, planning was conducted on a part-time basis by staff members generally employed by one of the health care agencies affected by the project. In some communities, safety net providers were in competition with each other for patients or funds. According to Terry Stoller, the national program director at Medimetrix, “Sadly, the overall funding environment creates a situation where you have local agencies fighting over any community-designated funding crumbs, and you have communities fighting one another over state funding crumbs. Given this mindset, it is not difficult to imagine how challenging it is for these competitors to come together on a project whose goal was to rethink local health care financing and delivery.”

Despite tanking economies and nerve-wracking delays, most Communities In Charge projects took hold: As of December 2004, when Foundation support ended, 12 of the original 14 were still operating. Collectively they leveraged \$81 million in public and private funds, enrolled 50,000 people in existing programs such as Medicaid and SCHIP, and another 30,000 people in programs that were created or expanded through Communities In Charge. One year later, in December 2005, 10 of the 12 were still operating.

Three Communities

Reflecting on the disparate Communities In Charge sites, Anne Weiss, the Foundation senior program officer currently overseeing the program, says, “If you have seen one program, you have seen one program. Each community put its own mark on how it approached and handled everything.” While this is certainly true, an examination of Communities In Charge projects at three locations illustrates issues that many sites had to address and the solutions that they adopted. Two of the sites—Brooklyn, New York and Jacksonville, Florida—attempted to make insurance affordable to small business owners and their employees. The third site—Austin, Texas—used new technologies to improve the efficiency of safety net programs.

Brooklyn HealthWorks

Brooklyn is the most populous of New York City’s five boroughs with nearly 2.5 million residents. Howard Golden, Brooklyn’s powerful borough president for 25 years, secured the Communities In

Charge planning grant on behalf of his borough. When Golden left office in 2001, one of his parting actions was to hand Brooklyn's nascent Communities In Charge project to the Brooklyn Chamber of Commerce, where it landed on the desk of Mark M. Kessler, the vice president for member services.

Kessler is a former teacher and Peace Corps volunteer. "I'm an incrementalist. I learned to work with what you have, to move the pieces around to make things work. Even so, when we started this, we were not sure we could pull it off, but we wanted to try." Kessler's boss, Kenneth Adams, president of the Chamber of Commerce, adds, "We didn't see this as a health care initiative as much as a product that would be useful to our members. We are not health care professionals, but we do know what our members worry about and what they want."

From the start, Brooklyn had two goals for its Communities In Charge project, Brooklyn HealthWorks: first, to create an affordable commercial health insurance product for uninsured businesses with two to 50 employees; and, second, to enroll enough members to ensure its economic sustainability. By the end of 2005, Kessler observed, "Could a local consortium build an affordable, localized commercial health insurance product to meet the needs of its small business community? Obviously, yes. But if such a product was brought to market, would the local small businesses buy it? Not necessarily. We learned that they would not buy products that are 'cheap' but don't work for them. There is a difference between 'cheap' and 'affordable'."

Rosalie Rance runs Viking Hospitality Marketing & Media in Brooklyn. "We develop strategic plans for cultural institutions like museums and tourist destinations like Brooklyn." When she started her business, neither Rosalie nor her sole employee had health insurance. "I was scared to be without coverage and I wanted to offer it to my employee, but it was daunting. I am my own everything—cleaner, secretary, scheduler—and I didn't have time to research and figure out what kind of care I should have, what it costs, where I should get it. I was worried about not having care, but I didn't know what to do about it. I am a member of the Chamber of Commerce and when I found out that the Chamber offered insurance I called Mark. In about ten minutes I understood my options and selected a program. But when I started filling out the paperwork, I learned that there was a lot of other documentation I needed for my business but did not have. This made me go through mounds of paper and work with my accountant to be sure that all my business affairs were in order. Now it is. I have insurance, and I can pay for my employee's health insurance, too. This helps because I want to bring my values to my company, attract good employees and create a stable, supportive working environment."

The Chamber of Commerce took control of Brooklyn HealthWorks early in 2002, began enrolling employers in April 2004 and by December 2004, when the Communities In Charge project ended, had enrolled just 25 companies covering 104 employees. When asked about the low level of interest, business owners said the program offered too few providers and those providers who did participate were not located near where workers lived. In August 2005, the Chamber brought Brooklyn HealthWorks into Group Health Incorporated, or GHI, a not-for-profit health insurer that has a network of more than 72,000 providers in New York, New Jersey, and Connecticut. This change

solved the provider problem and raised enrollment rates to about 70 people per month. As of February 2006, 157 employers had enrolled, covering 730 workers. “Because it includes a range of providers, the new program offers a better product than our first try. Even though it meant we had to raise premiums, people are buying it because it gives them what they need,” says Kessler. While this spike in enrollment is promising, 730 enrollees in a borough with more than 475,000 uninsured people still leaves a lot of people without coverage.

Businesses are eligible to enroll in Brooklyn HealthWorks if they are located in Brooklyn, have between two and 50 employees, 30 percent of whom earn \$34,000 or less per year, and have not provided health insurance to employees within the previous 12 months. At least 50 percent of eligible employees must enroll. Brooklyn HealthWorks participants receive an insurance card that entitles them to services through GHI. Employers pay between \$177 and \$188 per month per employee, about one-third the cost of standard health insurance premiums in New York City. Funds from Communities In Charge and the federal Healthy Community Access Program pay the difference between the employer premium and the full premium cost. Overall, Brooklyn HealthWorks leveraged \$2.2 million from other funding sources.

Brooklyn HealthWorks provides coverage for inpatient and outpatient hospital services, physicians’ services, maternity care, adult and child preventive health care, x-ray and lab services, emergency services, and other named services. For companies that choose the more expensive premium, employees pay a co-payment from \$10 to \$20 a visit. The prescription drug program has a \$100 deductible per year and a \$10 co-payment per generic drug.

Jonas Kyle and Miles Bellamy, owners of Spoonbill and Sugartown Booksellers, purchased Brooklyn HealthWorks for themselves, their spouses, their children, and two of their three employees. “For a while, my kids got care through Child Health Plus”—New York State’s health insurance plan for children—“but then when my wife went back to work, we didn’t qualify for that anymore, and no one had insurance. This has been especially important for my kids. My daughter got hurt and we had a doctor who would see her, and now we have a regular doctor,” says Kyle. “She would not have had care if we didn’t have Brooklyn HealthWorks.”

People who participate in Brooklyn HealthWorks love it, so why did it take so long to launch a program that serves only 730 people? It certainly wasn’t for lack of hard work. Among the things that happened were the following:

- While the events of September 11th rippled across the country, they virtually halted life as usual in New York City for some time.
- The Chamber of Commerce had to satisfy a complex maze of New York State Insurance Department regulations and secure approval to become part of a larger New York State health insurance initiative, Healthy New York. In the end, these systems fell into place and actually improved Brooklyn HealthWorks, but the administrative work took more than one year.
- After state regulatory issues were resolved and despite GHI’s commitment to Brooklyn HealthWorks, negotiations over premium rates, benefit packages, and claims processing systems took an additional 15 months.

- When the Chamber of Commerce initially approached businesses about purchasing health care for their employees, most were interested. When it came time to enroll workers, however, both employers and workers were less enthusiastic, partly because the roster of providers participating in Brooklyn HealthWorks was so small before the program became part of GHI’s provider network. Also, according to Kessler, “While many employers tell us they are interested in providing coverage to their employees, when it comes time to make a decision, many simply cannot afford to do so and may not want to admit it.”
- Moreover, employees in the lowest-wage jobs (less than about \$11 an hour) asked that employers give them the value of the health premium in the form of wage increases rather than health coverage. This caused some tensions between business owners who thought they were being generous in purchasing health care for employees and the employees who felt that their need for additional income outweighed their need for health insurance.
- Fifth, because New York City has a strong public health system, people have health care options that low-income people in other parts of the country generally do not have.

The Brooklyn experience appears to reinforce the lessons learned from the Foundation’s earlier programs aimed at small businesses—they don’t work. So, why try again? National program director, Terry Stoller notes, “We were worried about projects that focused on small businesses because we knew about earlier, unsuccessful efforts to interest business owners to purchase insurance. But we also knew that Brooklyn had a lot of the elements that seemed to be lacking in other places. It had a strong political champion, an attractive and comprehensive product costing one-third the price of competing products, solid project management, a smart marketing campaign, and a small geographic area that included thousands of potentially eligible businesses and employees. The fact that, even with all of these powerful attributes, Brooklyn had so few employers in its program should dissuade other communities from using this approach.”

Kessler and the Brooklyn HealthWorks staff are not so sure. “One thing we learned through this is that you can’t innovate on a schedule. What breakthrough ever happened in the timetable people set at the outset? We had a lot of design and start-up problems, but since August 2005, we have been steadily enrolling more than 70 people per month, and there is no reason, except for funding, that won’t continue. If we expanded Brooklyn HealthWorks citywide, based on our current enrollment of more than 70 people a month in Brooklyn, we estimate we could enroll more than 10,000 additional people.

“Kessler may have a point. In July 2006, the New York State Legislature appropriated funding of \$2 million annually to expand HealthWorks in New York City and to add a new HealthWorks initiative elsewhere in the state.”

JaxCare

With a population of 774,000 spread over 758 square miles, Jacksonville looks very different from Brooklyn, but it also has its share of uninsured people. Nearly 14 percent, or more than 100,000 Jacksonville residents, lack health insurance.

As was the case with most Communities In Charge locations, Jacksonville entered the planning phase with a noble vision and great hopes. It used its Communities In Charge planning grant to

prepare to add 10,000 people to an existing low-income health care program. The planning group intended to pay for this expansion with \$10 million in new city funds and newly designated state funds available for hospitals that provide a disproportionate share of services to people without insurance coverage. But the group was not able to secure city and state buy-in for such a significant investment and was forced to abandon this strategy just as the Communities In Charge implementation phase was due to begin.

Enter Rhonda Davis Poirier, a health care consultant with a doctorate in public health and a reputation for getting things done. According to John Delaney, Jacksonville's mayor at the time, "She is a 'never-say-die' person. I think most of us who were involved were really skeptical, but she wouldn't give up."

Under the sponsorship of the Jessie Ball duPont Fund, headquartered in Jacksonville, and Communities In Charge, Poirier co-convened a series of eight health policy forums. These forums were created to educate key city leaders about health care issues concerning the uninsured in Jacksonville and to secure consensus about JaxCare's design. The mayor and the presidents of all of Jacksonville's hospitals personally attended these three-hour meetings and the monthly working sessions in between. By the end, all were convinced that the policy forums were the key to making JaxCare work. A. Hugh Greene, president and chief executive officer of Baptist Health and the chairman of JaxCare's board of directors, says, "What the forums did was to 'create the table.' The table is the engagement of key stakeholders. I was amazed that everyone kept coming. We had our disagreements. Once, one of the very important leaders got up and walked out. I literally ran after him, caught him at the elevator, and convinced him to come back. I think if he had gotten on that elevator and left, we would have lost the others too." Sherry Magill, president of the Jessie Ball duPont Fund adds, "This was a serious project for our community and for my organization. Neither of us wanted to fail, and we did not want to fail in front of the Robert Wood Johnson Foundation."

Poirier notes, "Through these meetings, we built a common understanding of the facts and challenges of providing care to uninsured people in Jacksonville. The forums provided an opportunity and a framework for community leaders to communicate candidly with each other about these issues. And JaxCare's current board of directors includes many of these same people who are still actively engaged and regularly attend board meetings."

By the end of 2002, forum members had reached agreement on a pilot program that would serve 1,600 low-wage workers. The City of Jacksonville committed \$2.5 million, which local hospitals matched with in-kind services or funds. JaxCare also received a federal Healthy Community Access Program grant and funds from local corporations and foundations. In all, JaxCare leveraged \$6.5 million in outside funds.

JaxCare was ready to go, pending final confirmation from the state that the program was exempt from regular state insurance requirements. Despite earlier assurances to the contrary, this turned out to be a problem. State officials ruled that JaxCare had to secure an insurance license and comply with all state requirements governing health insurance—requirements that the project could not meet. Everything stopped. Finally, after Governor Jeb Bush intervened, Duval County, in which

Jacksonville is located, was added to Health Flex, a state program for low-income people that operated outside of regular insurance regulations. Waiting for the State's initial decision and then applying for approval under Health Flex rules delayed JaxCare's implementation by nine months.

In 2003, JaxCare became a non-profit 501(c)(3) organization headed by Poirier. It provides health care to low-income workers between 19 and 64 years old living in Duval County who have been uninsured for at least six months, have been working for the sponsoring business for at least 90 days, have household incomes less than 200 percent of the federal poverty level, and are not eligible for government-sponsored health insurance programs.

Between 50,000 and 60,000 workers are eligible for JaxCare coverage, which includes primary and specialty physician care, generic pharmaceuticals, inpatient and outpatient hospital care, diagnostic services, and disease-management services. Businesses pay \$50 per month for each enrolled employee, and the employees pay a \$15 monthly premium. This is about 20 percent of the actual cost of the JaxCare premium. Enrollees are assigned a primary care physician from among the more than 900 physicians who participate in the program, and they receive hospital services from the hospital where their primary care physician has privileges.

Henry Osborne left a career as an aide to former Florida Senator Lawton Chiles and the Secretary of the Department of Business and Professional Regulation to return home to Jacksonville where he purchased North Florida Scrap Metals, a company that buys discarded machinery, extracts metals from them, and resells the metals. "I didn't know the business when I started, but I learned. I'm so much happier using my hands and I'm fitter than I've ever been!" Early in 2004, Henry secured health care for his three employees through JaxCare. "When I came here, no one had insurance. I asked an insurance agent about purchasing care for my employees, but I couldn't afford it. I heard about JaxCare and called right away, and all of my guys qualify for it. To me it was a no-brainer."

JaxCare began enrolling businesses in March 2004 and by December 2005, 122 employers and 389 employees had signed up, far short of the 1,600 goal. At the beginning, JaxCare focused only on small businesses—those employing three or four workers. In order to increase enrollment, the program launched a marketing blitz aimed at large employers who already covered some, but not all, of their employees. The theory behind this strategy, which has not been widely tested, is that the chief executive officers of these companies have already made a decision to provide insurance as a matter of policy and will be amenable to extending coverage to all their employees. Floyd Willis, a family practitioner at Jacksonville's Mayo Clinic, president of the Duval County Medical Society and a member of JaxCare's board of directors, notes, "Sometimes when we call company leaders, they have no idea that some employees don't have coverage. We are the ones telling them their employees are showing up in emergency rooms because they can't get care elsewhere because of the lack of coverage. We learned that often, when we talk directly to the CEOs, they motivate and give direction to their staff. It didn't work when we started with mid-level management in the companies."

Like Brooklyn HealthWorks, JaxCare has struggled to gain enrollees, and for many of the same reasons. "Start-up was a lengthy process and when we thought we were all set, the state's decision regarding our insurance status meant we had to abandon implementation and focus exclusively on

getting state approval. We lost a lot of momentum when that happened,” says Poirier, echoing the experience described by Mark Kessler in Brooklyn. “Even now, with the program up and running, we have to navigate a complicated maze of state regulations and adhere to state policies that limit our ability to enroll people. For example, we have enrolled 122 businesses, but two to three times that number have chosen not to enroll because we can’t offer JaxCare to all of their employees, only the ones who meet all our eligibility guidelines. Because small business owners know each of their employees, they are just not prepared to offer a benefit like this to some but not other employees who need it just as much. Changing the income guidelines requires state legislation. The Florida legislature has shown little interest in amending these laws for us, despite the fact that there is no state money involved and we have the support of our local health care and health insurance industries.”

Poirier, however, is still a believer. “We have all the necessary systems in place and are fully operational,” she says. “We have more than enough physician and hospital capacity, and we have the unmet need. We could easily expand our administrative infrastructure to serve a much larger number of people.”

Austin, Texas

The population of Travis County, Texas, which includes Austin and surrounding towns, rose from more than 576,000 people in 1990 to nearly 870,000 in 2004—a 51 percent increase. About 200,000 people, or nearly 23 percent of county residents, do not have health insurance.

In 1997, before Communities In Charge began, executives of twelve Travis County safety net health care providers, including several hospitals, clinics and the medical society, formed the Indigent Care Collaboration, or ICC, to improve the financing and delivery of health care to all residents of the central Texas region. They established the ICC with the explicit expectation that it would design and oversee strategies to improve their ability to serve patients or reduce their costs. Diana Resnik, a senior vice president at Seton Healthcare Network, known as the “whirling dervish” of health care in Austin, spearheaded the creation of the ICC. Staffed by Resnik and other volunteers, the ICC was incorporated as a not-for-profit 501(c)(3) organization in 1998.

Safety net providers, worried about the growing number of uninsured people in the county, looked to the ICC for help. “I had been meeting with colleagues for years and we talked about the situation, but we couldn’t do anything about it except cry and make each other feel better,” said Resnik. “So my boss asked if the ICC could do something. I agreed to try, but I said to him, ‘You have to be there. The big guys won’t come for me.’ So with my chief executive at the table, the other CEOs came as well. In addition, the reason the ICC members stayed engaged was our commitment to action. We were not willing to meet and just talk. We knew we wanted to work on a uniform health care screening tool, and we wanted to find a way to share information with one another. When we heard about the Robert Wood Johnson Foundation program, we knew what we wanted to do.”

According to Paul Gionfriddo, project director of the Travis County Communities In Charge project from April 2001 until May 2005, “We didn’t do a new product like some of the others because we couldn’t afford to. Estimates showed it could cost as much as \$350 million to cover everyone. Our

thinking was that if we couldn't afford the product, we would have to work with what we already had." Patricia Young Brown, president and CEO of the Travis County Hospital District and chair of the ICC board of directors, adds, "We started with projects that were important to people who were paying the bills and providing the care. We also knew from the start that we needed to raise public money and get an ongoing funding stream. So we started exploring the possibility of creating a hospital taxing district in which a portion of property taxes would be dedicated to health care."

Although the opportunity to participate in Communities In Charge was attractive, leaders of Austin's health care community were initially reluctant to apply. Mildred Vuris, director of governmental and community relations at the Austin Travis County Mental Health Mental Retardation Center and one of the original members of the ICC, recalls, "Some people said, 'This is too hard, too much work. Do we want anyone from the outside controlling what we do?' I said, 'Yes we do!' And so we agreed to apply." Concerned that an application featuring only one county would not be well-received by the Robert Wood Johnson Foundation and because many people who work in Austin live in adjacent Williamson and Hays Counties, the ICC opened its membership to those counties as well.

When the ICC received the implementation grant, it hired a full-time project director, Paul Gionfriddo—a former state legislator, mayor, and executive director of a non-profit organization. With the Foundation's and the federal Healthy Community Access Program's funds in hand and an experienced leader on board, the ICC got to work. It used the Communities In Charge funds to create a range of technology-based tools that would give its members comprehensive online information about their patients and help low-income people obtain coverage through existing programs such as Medicaid and SCHIP. As people moved from uninsured to covered status, providers would be reimbursed for services, thereby increasing their revenue and reducing the burden of providing uncompensated care. In quick succession, the ICC:

- Launched "Medicaider," an online tool for staff members in health care settings in the three counties to screen patients for eligibility for federal, state, and local health coverage. Medicaider takes about three minutes to complete, and people who appear eligible for coverage receive assistance in completing their applications and obtaining benefits. As of November 2005, of the more than 215,000 people screened using Medicaider, 42,000 had been found eligible for an existing public program. Providers who use Medicaider agree to pay for it because it saves them money when their patients have coverage.
- Created I-Care, a Web-based database to store patient-specific health information contributed by each ICC member. I-Care captures data such as zip code, age, gender, and ethnic background of patients served by clinical programs. It also gives participating providers online information about diagnosis and procedure codes for patients' prior medical visits. I-Care complies with the strict federal and state privacy rules required by the Health Insurance Portability and Accountability Act (HIPAA). As of November 2005, I-Care contained information on more than 1.8 million patient encounters and 440,000 individual patients.
- Initiated Project Access, patterned after a project in Asheville, North Carolina, in which physicians volunteer their time to provide free care to needy patients. As of September 2005, the more than 850 physicians participating in Project Access had served 1,165 patients.
- Expanded annual Dental Sealant Days, during which more than 450 children receive free dental screenings and dental sealants.

- Created a pharmacy assistance program that enabled uninsured and indigent patients to gain access to free and subsidized drug programs offered by pharmaceutical companies. From its inception in June 2004 through November 2005, nearly 2,400 people received a total of 15,400 free prescription drugs that, if purchased, would have cost \$4.3 million.

In total, Travis County leveraged \$5.3 million in federal, state, local, and private funds to support these efforts.

When Hurricane Katrina stormed through Louisiana and Mississippi, many residents fled or were evacuated to Texas. About 7,000 were temporarily housed at Austin’s convention center. The ICC quickly discovered that many evacuees had serious medical needs and had left their homes without essential prescriptions or medical equipment. While some evacuees had private or public health insurance, virtually no one could document that they had coverage. According to Kit Abney, director of “insure a kid,” a community collaborative that screens people for government-funded health care coverage and assists them in enrolling, “As a result of the relationships and protocols established by our Communities In Charge project, Ann Kitchen, the executive director of the ICC, pulled together the safety net providers on a conference call, and right away we came up with a system for helping evacuees living in Austin find a doctor and get care. All the providers said they would waive eligibility; my office became the hotline and referred people to the provider closest to them and the one best positioned to meet their health care needs. The medical society developed a specialty care line to get people to specialists, and we worked with the people to make sure they could get to their appointments.”

In May 2004, Travis County voters authorized a “countywide hospital district to furnish medical aid and hospital care to indigent and needy persons residing in the district.” The new hospital district is financed by a levy added to property taxes paid by people who live in Travis County and provides some funds to the ICC.

Ann Kitchen, a social worker, attorney, former state legislator, and health policy expert, who took over the ICC in May 2005, says, “We have a lot of challenges ahead, including sustaining funding and improving the user-friendliness of the I-Care technology. We are also beginning new projects that will take our collaboration to the next step. For example, we are creating a disease-based management program for patients with chronic conditions such as diabetes or mental illness. These patients tend to require care from multiple providers, and often no one sees the whole picture. With our Web-based registry, providers will be able to get that picture. We have also started a project to determine the real gaps in physician services in our region. We know we do not have enough primary and specialty care physicians, but we also know we can do better with what we have by being more efficient.”

Travis County’s approach has generated interest elsewhere in Texas and across the country. In 2004, after consulting with ICC staff, health care providers in San Antonio created the “Access to Care for the Uninsured” collaborative to address the needs of San Antonio’s uninsured residents. With assistance from Kitchen and others at the ICC, this group applied for and secured a \$950,000 federal Healthy Community Access Program grant to create a tool like Medicaid and a program for sharing patient information, much like I-Care. In Florida, Paul Gionfriddo, now the head of the Palm

Beach County Community Health Alliance, is replicating many of the strategies developed in Travis County: a Medicaid eligibility screening tool, a system of shared information based on I-Care, and a Project Access network where volunteer physicians provide care to needy patients. “The truly remarkable thing about what happened in Austin is that it does appear to be a transportable model,” says Gionfriddo. “And the people who sustain it are the people who will benefit from it.”

Communities In Charge in Retrospect

With nearly \$17 million of Foundation funds and \$81 million of leveraged funds, the 12 Communities In Charge sites enrolled only 30,000 people in new health care coverage programs. If the measure of success is coverage of new people, the program clearly did not succeed.

The picture improves somewhat, however, if the measure of success is expanded to consider whether people who enrolled in existing or new coverage programs as a result of Communities In Charge received preventive and primary care. The Communities In Charge evaluation, led by the University of Michigan economist Catherine McLaughlin, found that in the three communities it surveyed—Austin, Texas, Alameda County, California, and southeastern Maine—there was a noticeable increase in physician visits, and an even larger increase in the number receiving physical exams, Pap smears, and breast exams.⁸ In Austin, for example, the percentage of women having had a breast exam rose from 22 percent in the year before enrolling in the program to 51 percent within a year after enrolling; 30 percent reported having had a Pap smear within a year prior to enrolling and 62 percent said they had a Pap smear within a year after enrolling. Only 28 percent of enrollees said they had a physical exam in the year prior to enrolling, while 59 percent had an exam within a year after enrolling. These findings raise the possibility that because people were receiving preventive care, health problems might have been detected earlier and treated more inexpensively than would have otherwise been the case.

If the measure of success is further expanded to include whether grantees produced useful products and strategies, certainly some did. National program director Stoller said, “If you look at Travis County, they created a relatively inexpensive, successful, and replicable set of strategies. Things like that are real accomplishments.” Similarly, the policy forums in Jacksonville offer an innovative method of changing the way safety net providers make decisions. While created specifically to plan for Jacksonville’s Communities In Charge project, the forums continue to bring together a group of powerful health care and political leaders who talk with knowledge and broad understanding about health policy.

Robert Wood Johnson Foundation senior program officer Anne Weiss says, “Certainly, Communities In Charge didn’t yield the vast new numbers of covered people that we hoped for. But just because those things weren’t what we were looking for at the outset, we should not miss the many good things that did happen. For example, that Travis County voters authorized basically a new taxing mechanism to pay for indigent care is not a small thing.”

By 2002, the Foundation’s priorities had shifted from supporting community-based efforts to expand coverage to encouraging expansion of health insurance at the national level. “We concluded that we

did not lack for solutions,” says Weiss. “What is lacking is the national will to make the kinds of changes that would be necessary. The Foundation made a decision to invest future funds and efforts into creating that will.”

Evaluator Catherine McLaughlin offered a similar observation on the lack of potential of community programs to expand coverage. “What I saw 20 years ago when we were evaluating a program in Rochester, New York, what I saw 10 years ago in Hillsborough County, and what I see now is that a lot of this is luck,” she said. “In Rochester and Hillsborough, the stars were all in alignment—the right people were in place, the need was urgent, and funds became available. These community innovations are anomalies and it is not reasonable to expect that what they did can be done anywhere else or at any other point in time. To the extent that financing and regulation are not local, it is naïve for community leaders to think that they can do this.”

Mark Kessler, of Brooklyn HealthWorks, has a different perspective. “I understand that we need a national will. Certainly Brooklyn HealthWorks is not going to solve the entire problem,” he said. “At the same time, I don’t think it’s wise to focus so much on creating the will. That could take a long time and while it might benefit future generations, our business owners, their employees and their children all lack insurance now. And we can’t ignore them while we wait for the will. We have to do both.”

Notes

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