

[CHAPTER SEVEN]

LOCAL INITIATIVES FOR
EXPANDED CARE AND COVERAGE

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Local health care safety nets help meet the health care needs of the large number of uninsured people that Medicaid, Medicare and other federal and state safety-net programs do not reach. These populations primarily include lower-income working families, adults with and without children, and undocumented immigrants. They also include large numbers of low-income children and parents, pregnant women, and disabled persons who are targeted by federal and state programs, but, for various reasons, are not covered. Local governments, private providers, and other partners have taken on the responsibility of creating local health safety nets by directly providing services or indirectly purchasing services or coverage in the private sector.

The viability of local health care safety nets is an important public policy issue in Texas, both for public health reasons, because of the consequences of untreated diseases for individuals and communities, and for fiscal reasons, since private health care providers are asked to absorb the unpaid costs of the uninsured. Public responsibility to care for the low-income uninsured is delegated to Texas counties. Minimal requirements for eligibility, service coverage and public financing were established by the Indigent Health Care and Treatment Act (IHCTA) passed in 1985 and amended in 1999 (TSHHC, 2004). Texas law mandates that counties provide care to individuals with incomes below the 21 percent federal poverty line (FPL). In addition, counties must spend 8 percent of their general revenue tax levy (GTRL) on indigent care to qualify for state assistance. To meet their obligation, counties can choose to create a

hospital district, operate a public hospital, or form a County Indigent Health Care Program (CIHCP).

The legal requirements for safety-net care are not well-monitored nor enforced, and are set well below the need (TSHHC, 2004). Many counties do more than their legal requirement and rely heavily on partnerships with hospitals to fulfill mandatory benefit obligations and more adequately address the need. Other counties provide the minimum requirements, leading to uneven access for the uninsured and unequal tax burdens on local taxpayers. Local safety-net systems differ, to the extent to which they rely on services provided by either public entities or public-funded private entities to meet their obligations to the uninsured. They also differ in the availability of reliable funding sources that support safety-net services and the strength of these sources' commitment to provide a high standard of care.

With uninsured numbers rising and no significant expansions in federal and state coverage programs in place, demand for local health care safety nets is growing, increasing the burden on local governments and communities. To cope with the increasing burden, local governments and communities are pursuing a variety of resourceful and innovative strategies. Many communities are enrolling uninsured individuals and families in organized health plans that offer coordinated services which promote preventive care and reduce inappropriate use of emergency and inpatient services. Other communities are concentrating more on extending coverage to gap populations by

working with various partners to expand product availability and/or directly provide low-cost insurance products for the uninsured.

The purpose of this chapter is to review local initiatives to determine approaches being used to effectively expand existing safety nets and/or reduce the numbers of uninsured. The goal is to identify successful models in other communities that might be replicated. This chapter summarizes the contents of the white paper “Local Initiatives to Expand Care and Coverage of the Uninsured” by Begley et. al. The full version of the white paper can be found in Appendix D of this report.

MODELS FOR EXPANDING CARE

One major strategy to expand safety-net care focuses on developing better-organized and coordinated service systems. This strategy has important features designed to:

- Provide enrollees with a medical home
- Offer some form of case management that enhances early detection of problems and promotes appropriate treatment
- Produce patient information that can be shared among public and private providers within the system
- Offer providers some incentives to serve low-income patients
- Promote the dignity of enrollees

The major features of selected models illustrating this strategy are summarized in Table I and II (White, 1999; Norton and Lipson, 1998; Nat. Assoc. of Counties, 2003; Coughlin et al., 2001; Wilson et al., 2004; Galbow et al., 2003; Andrulis and Gusmano, 2000; RWJF, 2001; Bovbjerg et al.; West, 1999; RWJF, 2004; Simmons and Gionfriddo, 2002; Simmons and Gionfriddo, 2004a; Simmons and Gionfriddo, 2004b; Morningside, 2002). More detailed information on each model can be found in Appendix D.

Table I. Local Care Initiatives, Expanding Care (Part I)

Location	El Paso, TX	San Antonio, TX	Denver, CO	Detroit, MI
Local Care Initiative	Health Care Options	CareLink	Denver Health	PlusCare
Start Date	1999	1997	1994	1992
Overview	Health Care Purchasing with Managed Care	Health Care Purchasing with Managed Care	Consolidated Safety-net Plan with Managed Care Features and Vertical Integration	Managed Care Plan
<i>Delivery System</i>				
Services Provided*	A, C	A - E	A - F	A - F
Community Partners	CHCs, FQHC, Hosp Dist, Other	Med School, Comm Medical Assoc, FQHCs	All Public Safety-net Providers	FQHCs and other Safety-net Providers
Patient Cost Share (y/n)	Yes	Yes	Yes	Yes
Provider Payment	FFS	FFS	Varies by Program	Capitation PMPM
<i>Eligibility</i>				
Income Threshold	100% FPL	200% FPL	Varies by program	\$250/month/person
Other	Residents not eligible for other programs	Residents not eligible for other programs		\$90 work expense deducted from income
Total Enrolled	7,000 (2004)	53,000 (2004)	155,000 (2002)	25,000 (2004)

*Services Provided: A. Primary and Preventative Care, B. Inpatient Care, C. Specialty Care, D. Pharmacy Access, E. Behavioral Health Care, F. Dental

Abbreviations: CHC-community health centers; FFS-fee-for-service; FPL-federal poverty line; FQHC-federally qualified health centers; PMPM-per member per month

Table II. Local Care Initiatives, Expanding Care (Part II)

Location	Indianapolis, IN	Tampa, FL	Milwaukee, WI	Austin, TX	Buncombe Cty, NC
Local Care Initiative	Health Advantage	Hillsborough County Health Care Plan	General Assistance Medical Program	ICare System	Project Access
Start Date	1997	1992	1998	1997	1999
Overview	Health Care Purchasing with Managed Care	Health Care Purchasing with Managed Care	Health Care Purchasing with Managed Care	Integrated Eligibility And Patient Records with Pub/Prio Provided Service System	Providers volunteer health care services
Delivery System					
Services Provided*	A – F	A – E	A – D	NA	A – E
Community Partners	Med School, FQHCs, Other Safety-net	Med School, FQHCs, Other Safety-net	Med School, FQHCs, Other Safety-net	All Safety-net Providers	CHCs, FQHC, Hosp Dist, Private Physicians
Patient Cost Share (y/n)	Yes if Income > 150% FPL	Yes	Yes	—	No
Provider Payment	Capitation–PMPM, FFS– Other	FFS	FFS– Physicians 80% Charges– Hospitals	—	—
Eligibility					
Income Threshold	200% FPL	100% FPL	115%–125% FPL based on family size	250% FPL depending on program	200% FPL
Other	Not eligible for other programs	Not eligible for other programs	Medical need required	—	Residents not eligible for other programs
Total Enrolled	47,000 (2004)	29,000 (2004)	25,000 (2004)	83,000 (2002)	26,000 (2005)

*Services Provided: A. Primary and Preventative Care, B. Inpatient Care, C. Specialty Care, D. Pharmacy Access, E. Behavioral Health Care, F. Dental

Abbreviations: CHC–community health centers; FFS–fee-for-service; FPL–federal poverty line; FQHC–federally qualified health centers; PMPM–per member per month

INNOVATIVE STRATEGIES FOR EXPANDING CARE

Several design features currently in use to expand systems of local safety-net care include:

- New community-wide organizations that allow for planning and coordination
- Standardized eligibility processes that identify and limit patient populations and assign them to a medical home
- Integrated data systems that make patient eligibility and medical information readily available to providers
- Provider networks that offer access to primary and specialty services
- Case management services that encourage care coordination
- Provider payment methods that create incentives to serve low-income uninsured patients

Existing governance structures often face difficulties when they attempt to operate a coordinated health care safety-net system involving multiple agencies, public and private providers, and different sources of financing. One of the ways safety-net systems have extended care is by creating organizations that work on both establishing relationships among safety-net providers and common goals, such as community-wide planning and service coordination. The form of these organizational relationships may include:

- Consolidation - Health care agencies merge for policy, administration, and delivery of services. The main intent is to centralize authority and provide a more efficient and accountable system.
- Collaboration - Health care agencies develop arrangements to take joint responsibility for policy, administration, and delivery of services.
- Coordination - Health care agencies develop arrangements for joint responsibility of the delivery of services.

Safety-net programs extend care by developing integrated eligibility systems that make it easier for clients to qualify for existing public coverage. These systems include a defined screening, eligibility and enrollment process. This process should limit eligibility, define the eligibility period and service restrictions, and encourage stable participation. Outside funding is maximized by ensuring that persons meeting eligibility criteria for local, state and federal programs become enrolled in these programs.

Innovative safety nets also use primary care assignment to expand capacity, improve continuity of care and reduce costs. Patients are assigned to a specific medical home where they have expanded access to primary care, but must be approved for referrals to specialty care. Provider reimbursement methods are developed that include risk arrangements and provide performance incentives.

Specialty care is an important component of an effective local health care initiative. Meeting the costs to maintain an adequate supply of specialty care providers can be challenging. Local health care initiatives have involved specialty care providers in the design and development of specialty provider networks and in establishing adequate reimbursement rates and performance-based payment methods for specialty care.

Another feature common to safety-net systems is the presence of structured referral procedures to coordinate care between ambulatory and hospital settings. This may involve structured protocols in clinics, hospitals and emergency rooms for patient referrals to the most appropriate and least expensive settings for care. Additional features

may include after-hours hot lines and navigators to assist patients in accessing services.

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

Innovative safety-net models have invested resources in developing quality assurance programs with patient care guidelines and case management programs. Such programs require an IPRS that allows monitoring patterns of care and outcomes. Community resources for quality assurance activities, measurement strategies, and performance targets should be determined in a new program's development phase. Periodic evaluations that permit public accountability are important to the success of a program.

Safety-net programs rely completely on local funds or on a combination of local, state and federal funds. They rarely have sufficient funds to adequately serve the target population. Those with a substantial portion of funds from a regular payer source, such as Medicaid or commercial insurance, typically have the most success. A diversified funding stream enables local safety-net programs to stabilize their budgets and protect themselves from unanticipated changes in any particular funding source.

Finally, several safety-net models are taking a broad view of health-related services necessary to meet the array of medical, social, behavioral and financial needs of the uninsured. Detailed linkages between social

services, transportation and local public health services allow coordination between treatment and prevention programs. The linkages range from consolidation to sharing facilities and referral arrangements.

MODELS FOR EXPANDING COVERAGE

A second common safety-net strategy is to develop low-cost insurance products that extend public and private coverage to larger segments of the population. This can be accomplished by developing and offering private plans to small businesses and individuals, mandating small business coverage, and/or developing cooperatives that allow small employers to join larger employers. Models of this strategy are summarized in Tables III and IV. Additional details of the programs can be found in Appendix D of this report. (Silow-Carroll et al., 2004; NIHCM, 2003; Silow-Carroll et al., 2000; Silow-Carroll et al., 2001; Fronstin and Lee, 2005; Meyer and Rybowski, 2001; Meyer et al., 2001; Rosenberg, 2003; Kronenberg, 2004; Kronenberg, 2003; Katz, 2001)

INNOVATIVE COVERAGE INITIATIVES

Issues that must be addressed by local initiatives designed to extend public and private coverage include:

- Benefit Design
- Cost
- Target Population
- Financing
- Marketing
- Provider Choice
- Program Duration
- Enrollment and Operations
- Transition

Benefit Design

The level of benefits and services offered by health plans vary significantly, reflecting different approaches to creating affordable products. Some health plans offer comprehensive services with limited cost-sharing, patterned after products available to other commercial members. In an effort to reduce the cost of coverage, a number of health plans provide more limited-benefit packages and greater cost-sharing. Several health plans conducted extensive market research to develop

an optimal benefit package. Regardless of which strategy was followed, health plans that were stable and reasonably adequate in meeting the patient population's most basic needs seemed to attract more enrollees. The reasons a particular product attracted its intended audience can be attributed to a combination of the following: a benefits package with services previously unavailable to the intended population, a competitive, low-priced product, a significant investment in marketing, and a well-defined target population.

Table III. Local Coverage Initiatives, Expanding Coverage (Part I)

Location	Kansas City, MO	Moore County, NC	Wayne County, MI	Muskegon, MI
Local Coverage Initiative	Chamber Choice	Firstplan	HealthChoice	Access Health
Start Date	1994	2002	1994	1999
Overview	Private, unsubsidized, small group coverage with choice of open or closed network	Private, partially subsidized, small group coverage with choice of open or closed network	Private, subsidized, small to medium sized group coverage with choice of open or closed network	Private, subsidized, small to medium-sized group coverage with closed network
<i>Organizational Form</i>				
Administrator	Blue Cross Blue Shield of Kansas City	FirstHealth of the Carolinas	Patient Care Management System	Access Health
<i>Delivery System</i>				
Basic Services Provided*	A–D	A–E	A–D	A–D
Provider(s)	Private physicians	FirstHealth of the Carolinas, private physicians	Private physicians	Private physicians
Patient Cost Share	Yes	Yes	Yes	Yes
<i>Financial</i>				
Funding Model	Private insurance plan	Private insurance plan	Three way shared buy-in	Three way shared buy-in
<i>Eligibility/Enrollment</i>				
Children	Yes	Yes	Yes	Yes
Adults	Yes	Yes	Yes	Yes
Income threshold	250% FPL	---	---	---
Other	Businesses with up to 50 employees	Businesses with up to 50 employees	Businesses with at least 3 employees	Business with up to 50 employees
Total enrolled	80,000 (dependants not inc, 2004)	2,000 (2005)	19,019 (dependants not inc, 2000)	1,150 (2004)
% previously uninsured	40%	19%	100%	100%

*Services Provided: A. Primary and Preventative Care, B. Inpatient Care, C. Specialty Care, D. Pharmacy Access, E. Behavioral Health Care, F. Dental

Cost and Financing

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

The health plans use numerous methods to reduce premiums, including negotiated discounts with providers, limited benefits packages, subsidized plans, enhanced cost-sharing, and lower profit and administrative fees for carriers. Despite lower premiums, some plans found their products did not attract the anticipated number of customers because the premium remained out of reach, the product's benefits were viewed as insufficient for its price, or the product seemed less desirable when compared to the company's other offerings.

Table IV. Local Coverage Initiatives, Expanding Coverage (Part II)

Location	Alameda County, CA	Alameda County, CA	New York, NY	San Francisco, CA
Local Coverage Initiative	Alliance Group Care	Alliance Family Care	Health Pass	Healthcare Accountability Ordinance
Start Date	2000	2000–2004	1999	2001
Overview	Private, subsidized, workgroup specific coverage with closed network	Private, subsidized, family coverage with closed network	Private purchasing cooperative for small businesses	Public, health insurance mandate for government contractors
<i>Organizational Form</i>				
Administrator	Alameda Alliance for Health	Alameda Alliance for Health	New York Business Group on Health	San Francisco Department of Public Health
<i>Delivery System</i>				
Basic Services Provided*	A – E	A – G	A – D	A – E
Provider(s)	Local safety-net	Local safety-net	Private physicians	Private Physicians
Patient Cost Share	Yes	Yes	Yes	No
<i>Financial</i>				
Funding Model	Heavily Subsidized	Heavily Subsidized	Cooperative	Government
<i>Eligibility/Enrollment</i>				
Children	No	Yes	Yes	Yes
Adults	Yes	Yes	Yes	Yes
Income threshold	—	300% FPL	—	—
Other	In-home supportive services workers	—	Businesses with up to 50 employees	City/County contractor
Total enrolled	4,400 (2005)	7,400 (2004)	9,111 (2004)	—
% previously uninsured	100%	100%	56%	100%

*Services Provided: A. Primary and Preventative Care, B. Inpatient Care, C. Specialty Care, D. Pharmacy Access, E. Behavioral Health Care, F. Dental

The presence or absence of plan subsidies does not appear to be a major factor in attracting the uninsured. Private health plans may find some advantages in subsidizing products, such as enhancing the provider-plan relationship through partial reimbursement for services that would otherwise be uncompensated. Also, some health plans recognize the uninsured as a potential future market. Subsidized initiatives offer exposure to the plan and may build loyalty when the individual or family is in a position to obtain commercial health insurance.

Target Population

Many initiatives restrict program eligibility due to a product's limited funding or to avoid duplication with other available coverage programs. Most of the individual products reviewed established income eligibility limits and were restricted to individuals not eligible for existing local, state, and federal programs. Some private sector products with more restrictive eligibility criteria than others experienced mixed results upon enrollment. Two health plans that did not reach desired membership levels attracted many applicants who were not eligible, despite having conducted preliminary assessments before initiating their programs. Regardless of the target population, most new health insurance products took time to attract members. Some successful initiatives did not achieve enrollment goals until one to two years after the product's launch.

Marketing

Marketing is critical to the success of coverage initiatives. The availability of a quality product at a low cost does not guarantee the target population will purchase it. Three initiatives that enrolled more than 10,000 people conducted extensive market research to determine which channels would most effectively reach their target population. For

small group products, a multi-faceted approach to marketing is generally associated with higher enrollment. Successful small-group initiatives that attracted more than 10,000 members used direct mail, brokers, the Internet, toll-free telephone numbers, and television, print and radio advertisements. Health plan representatives indicated that, of these different strategies, brokers were most essential in securing new members. Programs with enrollment difficulties either did not use brokers or worked with a limited number to recruit customers. Brokers are not only a bridge between health plans and consumers, they educate employers about the value of health insurance and the different available purchase options.

Providers

Provider choice affects program marketability and price. Nearly all health care organizations that developed insurance products employed the same network used for all other products, concluding that product success is dependent, in part, on having a network identical to that of other competing coverage. While a broad network did not guarantee consumers would purchase a product, a restricted panel did have negative consequences on enrollment.

Program Duration

Several of the initiatives were either time-limited pilot programs or intended to serve as short-term insurance. Among the shorter-term programs, enrollment has been lower than anticipated, as some pilots with limited availability experienced difficulties due to service area, income or number of potential members. Longer-established programs are better able to meet membership targets. Short-term projects provide only temporary coverage for the uninsured, since the closing of a

program usually marks the end of health benefits. Also, some employers who have made the commitment to offer a short-term product may face a predicament once the program terminates because they must decide to maintain coverage without plan subsidies, find another affordable product, or discontinue health benefits.

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

Transitions

Recognizing that many people become uninsured as a result of transition-related issues, some health plans designed products only for those individuals who: lose status as a dependent on another's policy and are unable to secure one's own coverage; change jobs or become unemployed; or lose eligibility for public programs and are unable to secure private coverage. The products addressed these age, income, and public/private transition populations by: allowing over-aged dependents to remain on

their parents' policies; guaranteeing rate stability for the near-elderly; providing subsidies to pay for a percentage of one's premiums for a fixed amount of time; and bridging the divide between the public and private sectors through cross-referrals. In general, products attempting to address transition issues have generated higher enrollment than those that have not.

Enrollment and Operations

Innovative health plans acknowledged operational and enrollment problems, such as multi-step application procedures, as major barriers to extending coverage. Failure in any step of this process can result in lack of coverage and loss of potential members. Several programs addressed enrollment issues by streamlining applications, allowing self-declaration of income, and providing multi-lingual application materials. These products attracted a greater percentage of the uninsured than others. Some people are unable to obtain care due to language or cultural barriers. Two health plans attempted to increase access by using multi-lingual case managers to help new members navigate the health care system. Members received case managers as long as the focus was on health, rather than social or career issues.

SUMMARY

Texas faces significant challenges in providing access to health care for the state's uninsured. To help develop local initiatives that address these issues a number of local programs with expanded care and coverage for the uninsured have been reviewed. The state should consider creating a program that supports local efforts for producing more coordinated and collaborative health care systems. This program should include direct financial support and/or other financial-related incentives

for innovations, such as Medicaid payment for navigator services, technology grants for electronic record systems, and/or tax credits for private insurance plans that integrate coverage with Medicaid. State support is also needed as seed money to develop community-based health insurance plans and expand existing successful plans to broader populations and geographic areas.

Some of the nation's best safety-net systems featured in this report do not have programs to assist individuals in families with incomes above 200 percent FPL. As a result, local initiatives targeting services or coverage for this fastest-growing segment of the uninsured population should be emphasized. These programs would provide more affluent people an opportunity to make a significant contribution to their own health care costs. A relatively simple step the state could take toward improving the performance of safety-net systems would be to require standardized reporting from all county safety-net programs. Using data from these reports, state and local officials could more accurately understand the features of existing programs, monitor performance, assess unmet needs and identify the potential impact of innovative strategies.

The state's limited underwriting requirements for small businesses is a major cause for the gap in small-employer coverage when compared to the rest of the country. Until these regulations are changed to include community rating and development of cooperatives, the number of commercial products available to small groups and individuals will be inadequate, even with community-based efforts to expand their availability. Current law is skewed against small employers, who comprise the majority of Texas employers and those employers who do not offer health insurance.

While local initiatives are an important part of reducing the number of uninsured residents in Texas, they do not solve all of the complex problems associated with this population. Many rural and less-populated counties do not have the infrastructure or tax base to support initiatives described in this chapter. For these areas, different approaches toward reducing the numbers of uninsured and improving their health care access need to be considered. In addition, while local counties are in a position to help reduce the numbers of uninsured, these programs are very dependent on financing and strong public health, mental health and Medicaid/SCHIP infrastructures. If these erode, none of these community-based systems will be able to make a difference.

This review shows that innovative models of community-based care and coverage have the potential to significantly expand access to care. Since Texas requires counties, through broad statutory obligation, to provide medical care to low-income, uninsured persons in the state, a comprehensive approach toward expanding these models in Texas appears warranted.

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