Access

Access to Care

There have been immense changes in our health system over the past two decades. In the 1980s, an economic recession focused payers' attention on cost control, spurring the growth of managed care, a model that integrated the financing and delivery of health care services. In the early 1990s, the managed care industry experimented with integrated delivery systems and new payment arrangements that would give providers tools and incentives to control the costs and improve quality. By 1996, more than three-fourths of all U.S. residents with employer coverage were covered by managed care plans (Ginsburg and Lesser 2006; Rovner 2000).

There have been immense changes in our health system over the past two decades.

In the late 1990s, however, as more Americans enrolled in managed care—many because this was the only type of coverage offered by their employers—the industry experienced a backlash. Consumers became anxious about what seemed to be needless limits on their care. Physicians opposed limits on care and payment rate restrictions. The media began to cover stories about care being postponed or refused by some managed care companies. Confronted with public outrage about practices such as so-called drive-through deliveries, state and federal legislators responded by passing laws that guaranteed minimum levels of care. With the economy booming and employers competing for workers and aware of the plummeting popularity of managed care, employers largely abandoned the managed care model, choosing instead to pass the responsibility for containing costs to their employees through higher patient cost sharing (Ginsburg and Lesser 2006; Rovner 2000).

Most recently, an emphasis on market solutions has dominated the thinking about health care. Hospitals and physicians have moved to raise revenues, focusing their investments on more profitable services. The vision of integrated delivery has been replaced with the consumer-driven health care model, which proposes giving consumers a sizeable financial stake in the cost of care and detailed cost and quality information, in the hopes that they will help to control costs and compel quality improvement. This broader economic and political climate has major implications for discussions of access to health care, with growing attention being given to controversial proposals such as limited benefit plans and consumer-directed health plans, which pair high-deductible health plans with health savings accounts. Skeptics warn that this reliance on market solutions may lead to a segmentation of the market and result in higher cost-sharing requirements, placing low-income populations at risk (Ginsburg and Lesser 2006; Ginsburg 2005).

Access to Health Care

In an influential 1974 article, Lu Ann Aday and Ron Andersen developed a framework for studying access to care in which the potential for access is measured by characteristics of the health care delivery system and the population at risk, and the realization of access is measured by

COMPONENTS OF HEALTH CARE ACCESS

Attaining good access to care requires three discrete steps:

- Gaining entry into the health care system.
- Getting access to sites of care where patients can recieve needed services.
- Finding providers who meet the needs of indiviual patients and with whom patients can develop a relationship based on mutual communication and trust.

Health care access is measured in several ways including:

- Structural measures of the presence or absence of specific resources that facilitate health care, such as having health insurance or a usual source of care.
- Assessments by patients of how easily they are able to gain access to health care.
- Utilization measures of the ultimate outcome of good access to care—that is, the successful receipt of needed services.

Source: Agency for Healthcare Research and Quality, *2005 National Health Care Disparities Report* (Rockville, MD: 2005).

utilization of and consumer satisfaction with health care services. The Aday-Andersen framework has been the basis of much of the research, policy, and practice related to access to care since then. Access is still defined by the presence (or absence) of resources that facilitate health care, such as having health insurance or a usual source of care, patient assessments of how easily they are able to secure health care, and measures that indicate whether needed health services are used (Berk and Schur 1997; AHRQ 2005).

Today, most of us receive the health care we need. Access to a broad array of primary and specialty care services has improved for sizeable numbers of Americans. But these successes mask certain realities. Research has consistently shown that particular groups of people fare far worse than others when attempting to gain access to the health care system, and that there are particular health care services, such as oral and mental health, for which problematic barriers still exist (Berk and Schur 1997).

Against this backdrop, two main approaches to improving access to health care have emerged: removing financial barriers to care by broadening insurance coverage, and removing nonfinancial barriers to care by redesigning the delivery system (Meyer and Silow-Carroll 2000).

Broadening Health Insurance Coverage

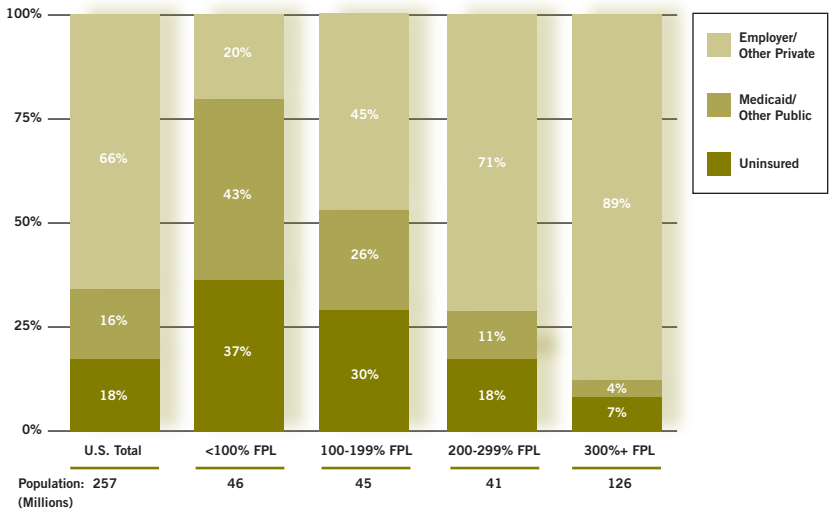
Health insurance coverage is one of the strongest predictors of access to care. Insurance coverage reduces the out-of-pocket costs of health care, providing entrée into the health care system and shielding people from the economic hardships that an unexpected injury or illness can create (Lewit et al. 2003). With the steady erosion of employer coverage, the number of people without health insurance has grown, up to 46 million in 2005 (U.S. Census Bureau 2006; Kaiser Commission on Medicaid and the Uninsured 2006).

Low-income Americans are in the greatest danger of being uninsured, despite the fact that most are in working families, because they are less likely to be offered employer coverage or able to afford individual coverage (Figure 1) (Kaiser Commission on Medicaid and the Uninsured 2005).

There are costs and consequences—to individuals and to society—of uninsurance. People without health insurance have poorer health and earlier deaths than those with insurance, often because they postpone care and have later diagnoses of serious illnesses. People without health insurance pay more than a third of their medical bills themselves, often going into debt to do so (Figure 2). The other costs of uncompensated care are covered by taxpayers, through financial support for hospitals and clinics. The economic performance of individual communities and the nation as a whole is diminished by the worse health, earlier death, and more likely disability of the uninsured (IOM 2004).

The federal response to this problem has been to make incremental expansions to one population group at a time. In 1965, Medicaid and Medicare considerably expanded coverage to the poor and the elderly. These programs have evolved over time, adding coverage for specific services or populations. Most recently, Medicaid expansions and the enactment of the State Children's Health Insurance Program (SCHIP) have improved coverage rates among lower-income children (IOM 2004). In fact, as private coverage has eroded, the number of uninsured has held steady only because public coverage has grown (Ginsburg and Lesser 2006).

Figure 1. Health Insurance Coverage of the Nonelderly by Federal Poverty Level, 2005 (percentage covered and number in millions)



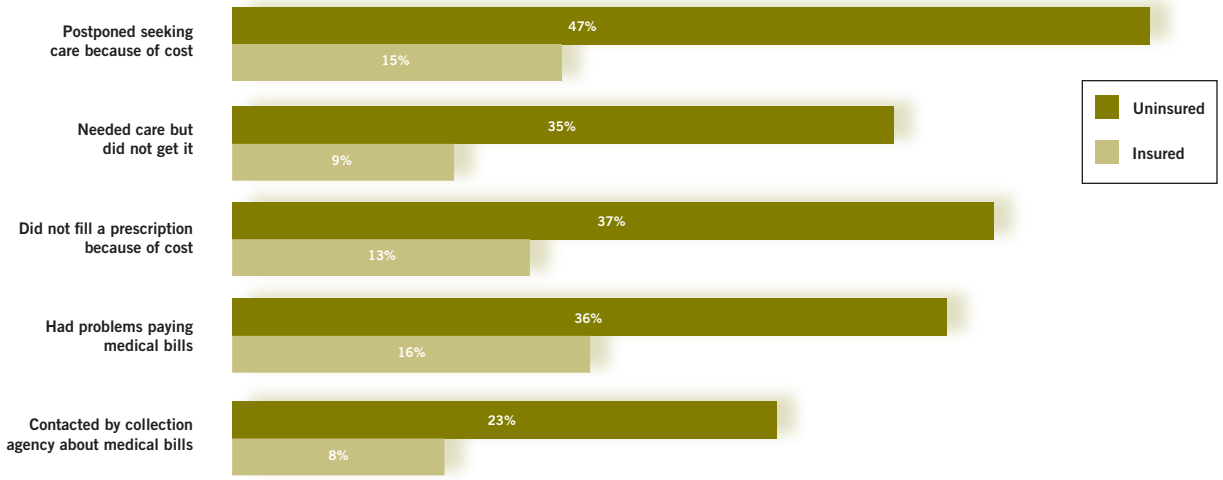
Source: Kaiser Commission on Medicaid and the Uninsured, *The Uninsured and Their Access to Health Care* (Washington, DC: The Henry J. Kaiser Family Foundation, 2005).

These government expansions have been accompanied by attempts by funders, health care experts, and community leaders to increase the enrollment of eligible populations into government-funded programs, expand employer coverage (especially among small businesses), and make individual coverage more affordable. The inroads made, however, have not succeeded in eliminating uninsurance for several reasons. Strained state and federal budgets threaten Medicaid and SCHIP expansions (GIH 2006). A large number of children eligible for Medicaid and SCHIP remain unenrolled. It has proven difficult to design plans to increase coverage in small firms (Rosenblatt 2006). And it has proven increasingly difficult to design an affordable individual benefit plan.

Redesigning the Health Care Delivery System

The existence of insurance alone does not eradicate all of the barriers to access, of course (IOM 1998). Many people with insurance are considered underinsured, because they forgo services due to deductibles and copayments that are unaffordable. And not all insurance plans are created equal, with many not providing adequate coverage for prescription drugs, dental care, or preventive or emergency care services (Chung and Schuster 2004). Even among those with insurance (and especially for those without it), an array of delivery system barriers prevent timely access to health care, including the availability and capacity of providers, their cultural and linguistic competence, and the existence of referral services.

Figure 2. People Experiencing Barriers to Health Care in the Past Year, by Type of Insurance Coverage (percentage)



Source: Kaiser Commission on Medicaid and the Uninsured, *The Uninsured and Their Access to Health Care* (Washington, DC: The Henry J. Kaiser Family Foundation, 2005).

Low-income people tend to rely on an extended but stressed network of safety net providers: those community health centers, public hospitals, individual practitioners, public health departments, and others that provide health care for the uninsured and underinsured, regardless of their insurance coverage, ability to pay, or immigration status (IOM 1998). Safety net providers are often applauded for their essential efforts to ensure access to the underserved, their leadership in developing and delivering culturally and linguistically competent health care, and the prevention-oriented primary care services that they provide (The California Endowment 2004). But there are problems with relying on the safety net to provide care to the 16 percent of Americans without health insurance coverage. Communities vary in their concentration and capacity of safety net providers (Cunningham and Hadley 2004). Primary care providers often find it difficult to locate specialists willing to provide uncompensated care to low-income people. And when they do, it is difficult to coordinate care between several different safety net providers, even in one community, which can lead to duplicated tests, treatment errors, frustrated families, and discouraged providers. Perhaps most importantly, there is no sole or sure source of financial support for safety net providers. Though this is true for all providers, safety net providers have fewer sources they can rely on to raise the revenue needed to provide a growing number of services to uninsured patients who are unable to pay for them (Regenstein and Huang 2005).

There have been valiant attempts by states, counties, and cities to reorganize safety net care in order to provide health care services to more of their uninsured and underinsured residents, reimburse providers who have been offering uncompensated care, and integrate care across fragmented health care settings and systems at the local level (Silow-Carroll et al. 2004; Taylor et al. 2006; Harvard Interfaculty Program for Health Systems Improvement 2006). These community access programs, though undeniably valuable, struggle with sustainability and expansion because of inherent financing challenges. Without federal help, few states and local communities have the wherewithal to provide health care to all who need it (Taylor et al. 2006). And even if they did, depending on scattered, diverse, small-scale efforts to cover the nation's uninsured would result in uneven access and a system of care highly susceptible to cutbacks during tough economic times (Meyer et al. 2004).

So what are we to do? There are huge differences of opinion about how to solve access problems, many of them ideologically based. The

debate about how to pay for access to care for more people is made more difficult by the relentless rise in health care costs. And there is a disheartening lack of public, and therefore political, will to make any fundamental change to our health care system. Universal coverage has been the subject of national debate at least six times in this country—during the First World War, during the Depression, during the Truman and Johnson Administrations, in the U.S. Senate in the 1970s, and during the Clinton Administration—and each time the proposals have been defeated. Every effort to enact broad reform has ended in a political skirmish over who should be covered and who should pay for it (Gladwell 2005).

And yet the status quo is unacceptable. The number of uninsured continues to grow, with another 16 million estimated to be underinsured. Hurricanes Katrina and Rita drew attention to holes in the nation's safety net. Rising health care costs are putting increased pressure on low- and middle- income consumers, particularly the growing number citing trouble paying off medical debt, and on employers and public payers. Growing Medicaid costs have become a focal point for state and federal officials looking to close their budget gaps (The Commonwealth Fund 2006).

Grantmaker Activity

As these issues have evolved over the past two decades, the ways health philanthropy has chosen to intervene have changed. Funders have supported a number of access-related successes over the years: increasing enrollment in Medicaid and SCHIP, building networks of community clinics, investing in school health centers, stimulating state experimentation, producing replicable models, supporting key research studies, and keeping attention focused on access issues. But there have also been major disappointments. Steven Schroeder, former president of Robert Wood Johnson Foundation, has called the inability to achieve stable, affordable health coverage for all Americans a heartbreaking failure (Rosenblatt 2006). As the field moves forward, its main challenges will be determining how to do thoughtful state and local work on a national problem, how the myriad incremental solutions that funders have supported over the years can be knitted together, and how to build the political will necessary to address these issues on a broader scale (GIH 2006).

Steven Schroeder, former president of Robert Wood Johnson Foundation, has called the inability to achieve stable, affordable health coverage for all Americans a heartbreaking failure.

With an eye on lessons learned, many funders are focusing their attention on encouraging and evaluating state attempts at health reform, building public support for change, and promoting delivery system innovation. A few illustrative examples of this work follow.

Encouraging and Evaluating State Attempts at Health Reform

States have come to doubt that the federal government will address the rising number of uninsured in the near future, and are preparing to take the lead (Avalere Health LLC 2006).

Dirigo Health Reform: Maine led the recent charge with the enactment of the Dirigo Health Reform Act in 2003. The purpose of the act is to make quality, affordable health care available to every Maine citizen by 2009. The plan's centerpiece is an insurance subsidy program, DirigoChoice, which offers affordable health insurance to small businesses and to families with low to moderate income (The Commonwealth Fund 2006).

States have come to doubt that the federal government will address the rising number of uninsured in the near future, and are preparing to take the lead.

The Maine Health Access Foundation encouraged state reform as early as 2002, meeting with the governor's staff to determine the resources that would be needed to move comprehensive health care reform forward; providing a grant to the nonpartisan National Academy for State Health Policy for research and technical support; and supporting consultants, staff, and technical assistance for the state's health action team, which was made up of key stakeholders and health care policy experts and was charged with helping the governor's Office of Health Policy and Finance develop the comprehensive reform plan. After the act was approved by the state legislature, the foundation awarded several targeted strategic advocacy grants to insure that it would be implemented as intended (GIH 2006).

The Commonwealth Fund has provided support for Dirigo's evaluation, to measure the effects of the insurance subsidy on three groups: low- to moderate-income individuals, small employers, and public and private payers. The evaluation, which will cover the program's first two years, will provide state and federal policymakers with information on the impact and replicability of Maine's unique approach to broadening insurance coverage (The Commonwealth Fund 2006).

The Massachusetts Health Care Reform Plan: In April 2006, Massachusetts enacted a law that could provide nearly universal health care coverage to state residents. The bipartisan legislation requires the participation of both individuals and employers. It mandates everyone in the state to purchase health insurance by July 1, 2007 (with government subsidies to ensure affordability) and will impose financial penalties of up to 50 percent of the cost of a health insurance plan on those who do not via income tax filings. It also includes a requirement that employers with more than 10 employees provide health insurance coverage or pay a so-called fair share contribution of up $295 annually per employee (Kaiser Commission on Medicaid and the Uninsured 2006).

Blue Cross Blue Shield of Massachusetts Foundation played an important role in efforts that led to passage of the state's sweeping health reform law. In 2003, the foundation convened a summit on the uninsured that drew 350 leaders from politics, health care, business, labor, and consumer advocacy. That meeting is credited with changing

the debate on the uninsured, creating the momentum that prodded state leaders to take action, and building public support for reform. After the meeting, the foundation funded a series of policy studies on specific aspects of reform, under its Roadmap to Coverage initiative. The studies, which were carried out by researchers at the Urban Institute, analyzed what it cost to care for the uninsured in Massachusetts, who paid for it, and what full coverage would add to the state's spending. The study also presented options for expansion. Foundation staff met with stakeholders in a series of meetings to help them understand the options, the costs of the current system, and the implications of reform. Finally, the foundation provided grant support to most of the advocacy organizations working for health reform in Massachusetts. These combined efforts prevented the intense political maneuvering that has blocked past health reform efforts in the state (GIH 2006).

Other states are watching the Massachusetts reform carefully for three key reasons. First, the Massachusetts reform relies very heavily on federal Medicaid funds to finance the plan, and many states intend to use Medicaid as a central component of their strategies to increase access. Second, it has so far been difficult to construct affordable health plans offering comprehensive coverage, so many are interested in how Massachusetts will address that challenge. Third, the plan combines different strategies from across the political spectrum, making elements of the plan—as well as the strategy for reaching political agreement—of interest to a wide range of observers (Kaiser Commission on Medicaid and the Uninsured 2006; Avalere Health LLC 2006). Blue Cross Blue Shield Foundation of Massachusetts is committed to playing a role in assessing and communicating what unfolds.

Health Reform in California:

Blue Shield of California Foundation, The California Endowment, California HealthCare Foundation (CHCF), The David and Lucile Packard Foundation, and other California funders have been working in concert for years on an ambitious effort to enable health coverage for all of the state's children (GIH 2006). Many of these funders have long believed that this work could help build the public's interest in the larger goal of providing access to quality, affordable health care for everyone, and would help identify coverage expansions and system fixes that could later benefit adults. That time may be near. There is currently a great deal of energy and enthusiasm on the topic of health reform in the state capitol. In January 2007, Governor Schwarzenegger announced a plan to expand coverage to Californian's 6.5 million unisured residents. In addition, state senator Don Perata has released a coverage expansion proposal in the legislature, and a number of other proposals are expected from other members of the state assembly and senate.

CHCF is currently working to support development and analysis of several coverage expansion scenarios. Led by the Institute for Health Policy Solutions (IHPS), results from that work were released in October 2006 and presented in Sacramento in late November 2006. In December 2006, the CHCF board approved $2.5 million over two years to support continued work in the coverage expansion arena, including ongoing work by IHPS. This work builds on CHCF's efforts to expand health insurance to uninsured Californians; foster informed public and private sector decisionmaking toward expanding and improving coverage; and focusing stakeholder attention on tradeoffs among cost, benefits, and coverage (Yegian 2006).

At the same time that this state-level work is taking place, reform efforts are also underway in San Francisco. In February 2006, San Francisco mayor Gavin Newsom created a Universal Healthcare Council (UHC) to develop a plan to provide access to health care for San Francisco's 82,000 uninsured adults. The council included representatives from the health care, business, labor, philanthropy, and research communities, including Crystal Hayling of Blue Shield of California Foundation, Mark Smith of California HealthCare Foundation, and co-chair Sandra Hernández of The San Francisco Foundation. In June 2006, the council recommended the development of a San Francisco Health Access Program (SF HAP). Shortly thereafter, San Francisco passed the Worker Health Care Security Ordinance, which calls for implementation of SF HAP in tandem with an employer spending requirement. SF HAP is not health insurance; it will instead provide a primary medical home to participants, allowing a greater focus on preventive care, as well as a specialty care, urgent and emergency care, mental health care, substance abuse services, laboratory,

inpatient hospitalization, radiology, andpharmaceuticals. SF HAP will be administered by San Francisco Health Plan (SFHP) in partnership with the San Francisco Department of Public Health (DPH). To be eligible for SF HAP, an individual must be uninsured, live in San Francisco, and be ineligible for other government-subsidized health benefits programs such as Medi-Cal, the Healthy Families Program, or Healthy Kids & Young Adults. SF HAP has a first phase implementation goal of July 2007.

Public perception and opinion can drive change or block it.

Building Public Support for Change

Public perception and opinion can drive change, or block it. One need only think back to the "Harry and Louise" advertising campaign of the 1990s (in which a middle-class couple lamented the complexity of Clinton's plan and the menace of a new bureaucracy) to realize that policymakers will need to advance proposals that can gain the support of the American public if they want them to succeed (Ginsburg and Lesser 2006; Sourcewatch 2006).

Cover the Uninsured Week: Robert Wood Johnson Foundation has used three strategies for addressing access issues. It has supported efforts at major reform, worked to expand insurance coverage incrementally, and funded research to inform policy decisions (Rosenblatt 2006). In the mid-1990s, when the Clinton Administration's national health reform effort failed, foundation staff took away the message that neither the public nor policymakers had an appetite for pursuing universal coverage in the near term and shifted their strategy from building infrastructure to expanding access for specific population groups. The foundation refocused its strategy toward the actions of states, which were beginning to expand Medicaid coverage through federal waivers and other means, as the best opportunity to increase access (GIH 2006).

Although states have been the locus of most recent coverage innovations, foundation staff members recognize the problems in sustaining state and local initiatives. They therefore are again setting their sights on a national solution. Since 2000, Robert Wood Johnson Foundation has invested heavily in a national awareness campaign to inform the public and national leaders about the need to expand health care coverage. The multimillion dollar Cover the Uninsured Week campaign—which is also supported by The California Endowment, California HealthCare Foundation, The Colorado Health Foundation, W.K. Kellogg Foundation, Missouri Foundation for Health, and Rose Community Foundation—is an attempt to instigate a national debate on the access issue and encourage business, labor, health, and consumer representatives to join together to find a consensus solution. Through various national and local campaigns that occur at the same time each year, the Cover the Uninsured campaign has used survey data and other research to raise public awareness about gaps in coverage and help people understand that most of the nation's

uninsured are working Americans who cannot afford coverage. With the campaign in its fifth year, Robert Wood Johnson Foundation staff acknowledge that advocates are growing impatient for the campaign to focus less on the problem and more on solutions. The foundation is unlikely to back a specific solution, but can use the foundation's convening power to push stakeholders to consider viable options (GIH 2006).

The Herndon Alliance: In May 2005, 56 people from 48 organizations interested in comprehensive health care reform met for 3 days in Herndon, VA to explore more creative ways of achieving their goal of quality affordable health care for all. The initial participants were composed of leaders of national and state organizations, faith based groups, minority groups and organized labor. At their first meeting, the participants concluded that the six attempts since 1917 to achieve universal access to health care in the U.S. had all been characterized by being underfunded, uncoordinated, and ultimately unsuccessful. The group concluded at its initial meeting that what was needed was a shared entity to develop broadscale grassroots support and coordinate efforts for an extended period of time. It also concluded that whatwas needed was not another health care plan on which organizations might differ, but instead for groups to work together to create demand for universal access (Herndon Alliance 2006).

With the support of The California Endowment, The Nathan Cummings Foundation, Missouri Foundation for Health, and Public Welfare Foundation, the alliance is using values research, marketing data, and polling to develop messaging, narratives, and initiatives that resonate with a majority of Americans and promote support for affordable health care for all. Through communications and coordination resources and policy development, the alliance engages with partners to customize and refine the messaging and initiatives for public discussion at the local and national levels. Their goal is to have these issues in public discussion in twenty states and nationally over the next year and a half, with the goal of broadening the base of American voters who support health care reform (Herndon Alliance 2006).

> It is difficult for many low-income people to find a provider who accepts their coverage or will treat uninsured patients.

Interestingly, it may be the cost question that leads to public support for health care reform. One can imagine that if patient cost-sharing continues to rise, the public (and employers who know they cannot continue indefinitely to shift costs to employees) might be more open to a national conversation on the tough choices necessary to provide quality, affordable health care for all Americans (Ginsburg 2006).

Promoting Delivery System innovation

It is difficult for many low-income people—whether privately insured, publicly insured, or uninsured—to find a provider who is conveniently located, with hours that accommodate a family's work schedule, who has the linguistic skills and cultural sensitivity necessary to provide quality care, and who accepts their coverage or will treat uninsured patients (Lewit et al. 2003). Many of these issues would remain even if universal coverage were to be achieved.

CarePartners: In 1999, a group of health care stakeholders in Maine set out to redesign uncompensated care to be delivered in a more logical and efficient manner for both patients and providers. With initial support from the Bingham Program and Robert Wood Johnson Foundation, the group developed CarePartners, in which physician visits, hospital services, pharmacy benefits and case management are provided through the donated in-kind services of physicians and hospitals. The program differs from many other donated care programs in that a local health system also provides substantial funding for administrative and support services. CarePartners has grown in to a nationally-recognized, award-winning program. The program has served approximately 1,000 low-income adults per year in three counties in southern Maine since 2001 and has been shown to reduce emergency department use and medical and pharmacy costs of enrollees over time.

A recent evaluation of the program, funded by Maine Health Access Foundation, offers valuable lessons for other communities considering

developing a managed uncompensated care program. Engaging primary and specialty providers to donate their services relies heavily on their good will and proves challenging at a time when providers feel squeezed by low reimbursements from public programs. Costs and service utilization rapidly decrease for those who remain in the program more than one year and continue to decline. Pharmacy benefits require considerable resources, and aggressively pursuing free pharmacy programs offered by pharmaceutical companies is time-consuming work. Tracking the value of donated care by multiple organizations and providers is vital to measuring program performance and providing information to make timely programmatic decisions. And finally, small safety net programs, sandwiched between large public and private programs, require a flexible program design that can be adjusted quickly to be responsive to external changes (Ormond and Gerrish 2006).

CarePartners was initially conceived of as a temporary safety net program, to serve as a stop gap until either the state's Medicaid eligibility levels were expanded or a national or state universal coverage program was established. Even after the introduction of DirigoChoice, however, the demand for CarePartners has been high, because many of those eligible for DirigoChoice cannot afford the premium, copays, and deductibles. As a result, CarePartners currently exceeds the capacity of the donated services network, and the sites have reluctantly implemented enrollment caps and waiting lists (Healthcare Financial Management Association 2006; Ormond and Gerrish 2006; Taylor et al. 2006). Like other programs of its kind, CarePartners is of enormous value to enrollees but can provide coverage or care to no more than a small percentage of the community's uninsured residents, and is therefore no substitute for broad national reform.

Palm Beach County Community Health Alliance: Communities have a choice: to meet all of the needs of some uninsured people, or to meet some of the needs of all of them. In a Palm Beach County, Florida replication of an Austin, Texas program, the Quantum Foundation is attempting the latter approach. With the foundation's support, the Palm Beach County Community Health Alliance (PBCCHA) is working directly with safety net providers to build a coordinated system of care for uninsured and other low-income people. This new system of care links providers through collaborative initiatives, with the aim of either reducing their cost of serving historically uninsured patients, or increasing the service revenue they receive through medical assistance and other third-party funded programs.

The alliance's package of collaborative initiatives includes the creation of a communitywide shared electronic health record, the implementation of a common eligibility program, a network of health care and mental health care providers, a donated care program, expansion of the delivery of free health care throughout the area, reduction of primary care burden on free clinics and hospital emergency depart-

ments, an increase in the number and capacity of federally qualified health centers, and efforts to improve language access. All of the county's safety net providers, including public and private hospitals, the county health department and health care district, multiple free clinics, the local medical society, and mental health centers, actively participate in PBCCHA. Two key attributes have helped to garner support for the alliance's efforts: they do not require large, complicated administrative structures or new coverage programs, and they do not require new behavior by patients or providers at the outset. Foundation leaders hope that if their replication succeeds, the same model will be adopted in similar areas across the country. Their recommendations to others who consider replicating their effort are to get the right people in the room when creating the common vision, choose strategies that two or more of the collaborating partners will embrace, only ask partners to do what they have the time and resource to do, and stay true to the mission (Quantum Foundation 2006).

Regional Primary Care Access Initiative: The Health Foundation of Greater Cincinnati has shifted course from trying to help individual organizations develop primary care resources to leading a regional initiative to revamp the region's health care system (GIH 2006). The foundation launched the 20-county Regional Primary Care Access Initiative (RPCAI) in September 2005. Over 50 executive leaders from the business, non-profit, insurer, primary care, and hospital sectors committed to developing a three-year workplan to achieve full access to primary care for the uninsured, low-income, and underinsured residents of the region.

The RPCAI steering committee determined that there are critical connections and infrastructure improvements that must be in place as part of restructuring the delivery of primary care. The committee prioritized five areas of fast-track projects for its first round of invited proposal funding in order to build these connections and improvements. The five areas are:

- developing pathways to quality primary care (with a focus on reducing inappropriate emergency department visits),
- building access to health care coverage for small businesses and low-wage uninsured employees,
- creating community health outreach connections for high-risk populations,
- integrating private practice physicians into primary care networks for the uninsured, and
- building the information system support.

Foundation staff hope that this multipronged approach will help jumpstart activities and realign services on multiple fronts as opposed to focusing on one area at a time. The foundation invited a limited number of organizations to submit proposals who were deemed to be capable of responding to this fast-track project funding opportunity. These grants are not for single-entity projects; they are for systemic change in the region. A key criterion for submission was an organization's ability to show involvement from multiple providers and organizations in planning or implementing a truly collaborative project. The foundation will be announcing the fast-track grants in early 2007.

The launch of the RPCAI has generated considerable interest and support from the business community, hospitals, and public officials who are either grappling with the rising costs of their health insurance plans or seeking to maintain an adequate safety net for the uninsured. For example, RPCAI is a key component of the Cincinnati Chamber of Commerce's Vision 2015 effort, a long-term plan for the community (Warren 2006).

Sources

Aday, Lu Ann and Ron Andersen, "A Framework for the Study of Access to Medical Care," *Health Services Research* 9:208-220, 1974.

Agency for Healthcare Research and Quality, *2005 National Health Care Disparities Report* (Rockville, MD: 2005).

Avalere Health LLC, *The National Medicaid Congress Conference Summary* (Washington, DC: 2006).

Berk, Mark L., and Claudia L. Schur, "A Review of the National Access-to-Care Surveys," in Stephen L. Isaacs and James R. Knickman eds., *The Robert Wood Johnson Anthology: To Improve Health and Health Care, Volume I* (San Francisco, CA: Jossey-Bass, 1997).

Bornemeier, James, "The Robert Wood Johnson Foundation's Safety Net Programs," in Stephen L. Isaacs and James R. Knickman eds., *The Robert Wood Johnson Anthology: To Improve Health and Health Care, Volume IX* (San Francisco, CA: Jossey-Bass, 2006).

The California Endowment, "The Health Care Safety Net: Challenged Like Never Before, Needed More Than Ever," *Health...In Brief* 3(3), December 2004.

Chung, Paul J., and Mark A. Schuster, "Access and Quality in Child Health Services: Voltage Drops," *Health Affairs* 23(5): 77-87, September/October 2004.

The Commonwealth Fund, "Evaluation of Maine's Dirigo Health Reform Plan," <http://www.cmwf.org/grants/grants_show.htm?doc_id=366686>, accessed October 6, 2006.

The Commonwealth Fund, "Top Health Policy Stories of 2005," <http://www.cmwf.org/general/general_show.htm?doc_id=329686>, 2006.

Cunningham, Peter, and Jack Hadley, "Expanding Care Versus Expanding Coverage: How to Improve Access to Care," *Health Affairs* 23(4): 234-244, July/August 2004.

Ginsburg, Paul B., "Competition In Health Care: Its Evolution Over the Past Decade," *Health Affairs* 24(6): 1512-1522, November/December 2005.

Ginsburg, Paul B., and Cara S. Lesser, "A Decade of Tracking Health System Change," *Commentary: Insights into the Health Care Marketplace*, No. 2, March 2006.

Gladwell, Malcom, "The Moral Hazard Myth," *The New Yorker*, August 29, 2005.

Grantmakers In Health, *Improving Health Care Access: Grantmakers Share Their Experiences* (Washington, DC: 2006).

Harvard Interfaculty Program for Health Systems Improvement, *A Strategy for Health Care Reform: Catalyzing Change from the Bottom* Up (Cambridge, MA: 2006)

Herndon Alliance, "Work to Date," <http://www.herndonalliance.org/worktodate.htm>, accessed October 2, 2006.

Healthcare Financial Management Association, "Donated Care, Maine Style" *Executive Insights*, January 2006.

Institute of Medicine, A*ccess to Health Care in America* (Washington, DC: National Academy Press, 1993).

Institute of Medicine, *America's Children: Health Insurance and Access to Care* (Washington, DC: National Academy Press, 1998).

Institute of Medicine, *Insuring America's Health: Principles and Recommendations* (Washington, DC: The National Academies Press, 2004).

Kaiser Commission on Medicaid and the Uninsured, *The Uninsured and Their Access to Health Care* (Washington, DC: The Henry J. Kaiser Family Foundation, 2005).

Kaiser Commission on Medicaid and the Uninsured, *Massachusetts Health Care Reform Plan* (Washington, DC: The Henry J. Kaiser Family Foundation, 2006).

Lewit, Eugene M., Courtney Bennett, and Richard E. Behrman, "Health Insurance for Children: Analysis and Recommendations," *The Future of Children* 13(1): 5-29, Spring 2003.

Meyer, Jack, and Sharon Silow-Carroll, *Increasing Access: Building Working Solutions* (Battle Creek, MI: W.K. Kellogg Foundation, June 2000).

Meyer, Jack A., Sharon Silow-Carroll, Emily Waldman, *Community Voices: Lessons for National Health Policy* (Battle Creek, MI: W.K. Kellogg Foundation, 2004).

Ormond, Catherine, and Sarah B. Gerrish, *Opportunities and Challenges: Improving Access and Health Outcomes through the CarePartners Program* (Portland, ME: Institute for Health Policy, University of Southern Maine Edmund S. Muskie School of Public Service, February 2006).

Quantum Foundation, "Building a Community-wide System of Health Care," *Insights*, July 2006.

Randolph, Greg D., Mark Murray, Jill A. Swanson, and Peter A. Margolis, "Behind Schedule: Improving Access to Care for Children One Practice at a Time," *Pediatrics* 113(3): 230-237, March 2004.

Regenstein, Marsha and Jennifer Huang, *Stresses to the Safety Net: The Public Hospital Perspective* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2005).

Rosenblatt, Robert, "The Robert Wood Johnson Foundation's Efforts to Cover the Uninsured," in Stephen L. Isaacs and James R. Knickman eds., *The Robert Wood Johnson Anthology: To Improve Health and Health Care, Volume IX* (San Francisco, CA: Jossey-Bass, 2006).

Rovner, Julie, *Health Care Policy and Politics: A to Z* (Washington, DC: CQ Press, 2000).

Silow-Carroll, Sharon, Tanya Alteras, and Heather Sacks, *Community-Based Health Coverage Programs: Models and Lessons* (Battle Creek, MI: W.K. Kellogg Foundation, 2004).

Sourcewatch, "Coalition for Health Insurance Choices," http://www.sourcewatch.org/index.php?title=Coalition_for_Health_Insurance_Choices, accessed October 25, 2006.

Taylor, Erin Fries, Peter Cunningham, and Kelly McKenzie, "Community Approaches to Providing Care for the Uninsured," *Health Affairs* 25:173-182, April 11, 2006.

Taylor, Erin Fries, Catherine G. McLaughlin, Anne W. Warren, and Paula H. Song, "Who Enrolls in Community-Based Programs for the Uninsured, and Why do they Stay?" *Health Affairs* 25:183-191, April 11, 2006.

U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2005* (Washington, DC: U.S. Government Printing Office, 2006).

Warren, Judith, "RPCAI Update for GIH Publication," private e-mail message to Osula Evadne Rushing, December 18, 2006.

Yegian, Jill, "Work with Schwarzenegger and Newsom," private e-mail message to Osula Evadne Rushing, December 13, 2006.

Fast Facts

Definition

Access to health care is the degree to which individuals and groups are able to obtain needed services from the health care system (IOM 1993).

Health Care Utilization

Twenty-one percent of U.S. residents with family incomes below the federal poverty level had no health care visit in 2003-2004. That number rose to 47 percent for those who were uninsured (HHS 2006).

Thirty-six percent of nonelderly adults had no dental visit in 2004. That number rose to 56 percent for those with family incomes below the federal poverty level (HHS 2006).

Affordability

In 2004, 40 percent of U.S. adults reported that they went without care because of costs (Schoen et al. 2006).

Only 58 percent of the nonelderly population lives in a state where employer insurance premiums average less than 15 percent of the population's median household income (Schoen et al. 2006).

One-third of nonelderly adults report having problems with medical bills, collection agencies, or medical debt (Schoen et al. 2006).

High out-of-pocket and premium costs compared to income affect 17 percent of all nonelderly families (Schoen et al. 2006).

Health Insurance Coverage

Most Americans under the age of 65 receive health insurance coverage as an employer benefit. In 2006, 61 percent of firms offered health benefits to at least some of their employees, down from 69 percent in 2000 (Kaiser Commission on Medicaid and the Uninsured 2006b).

People without Health Insurance Coverage

In 2005, 46.6 million people were without health insurance coverage, up from 45.3 million people in 2004 (U.S. Census Bureau 2006).

The uninsured are largely low-income adults in working families, for whom coverage is either unavailable or unaffordable (Kaiser Commission on Medicaid and the Uninsured 2006b).

The percentage of people without health insurance coverage increased from 15.6 percent in 2004 to 15.9 percent in 2005 (U.S. Census Bureau 2006).

The percentage and number of children (people under 18 years old) without health insurance increased between 2004 and 2005, from 10.8 percent to 11.2 percent and from 7.9 million to 8.3 million, respectively. With an uninsured rate of 19.0 percent in 2005, children in poverty were more likely to be uninsured than all children (U.S. Census Bureau 2006).

Uninsured people are more likely to receive too little medical care and to receive it too late, to be sicker, and to die sooner (IOM 2004).

Societal Costs of Uninsurance

People who were uninsured for part or all of 2001 received health care services valued at about $99 billion. If they became insured, total health costs for those who now lack coverage would be expected to increase by an estimated $34 to $69 billion each year (IOM 2003).

The potential economic value to be gained in better health outcomes from continuous coverage for all Americans, however, is estimated to be between $65 to $130 billion each year, assuming the uninsured will use health care as do those who now have health insurance (IOM 2003).

People with Inadequate Health Insurance Coverage

Nearly 16 million people ages 19-64 are underinsured, which is defined as being insured all year but without adequate financial protection because of exposure to out-of-pocket costs that are high relative to income (Schoen et al. 2005).

Underinsured adults are more likely to forgo needed care than those with more adequate coverage and have rates of financial stress similar to those of the uninsured (Schoen et al. 2005).

The Role of Public Coverage

The Medicaid program provides health coverage and long-term care assistance to over 41 million people in low-income families and 14 million elderly people and persons with disabilities (Kaiser Commission on Medicaid and the Uninsured October 2006a).

Over the last few years, every state has implemented policies to freeze or reduce provider payments and to control prescription drug spending. Some states also implemented policies to restrict benefits or eligibility to slow Medicaid spending (Kaiser Commission on Medicaid and the Uninsured 2006a).

Despite broad Medicaid and SCHIP eligibility for low-income children, many eligible children are not enrolled in the programs. As many as 75 percent of uninsured children are eligible for Medicaid or SCHIP but are not enrolled (Kaiser Commission on Medicaid and the Uninsured 2006).

Delivery System Barriers

The proportion of U.S. physicians accepting Medicaid patients has decreased slightly over the past decade. In 2004-05, 14.6 percent of physicians reported that they received no revenue from Medicaid, an increase from 12.9 percent in 1996-97 (Cunningham and May 2006b).

The proportion of U.S. physicians providing charity care dropped more dramatically over the past decade, to 68 percent in 2004-05 from 76 percent in 1996-97 (Cunningham and May 2006a).

Sources

Cunningham, Peter J., and Jessica H. May, *A Growing Hole in the Safety Net: Physician Charity Care Declines Again* (Washington, DC: Center for Studying Health System Change, 2006a).

Cunningham, Peter J., and Jessica H. May, *Medicaid Patients Increasingly Concentrated Among Physicians* (Washington, DC: Center for Studying Health System Change, 2006b).

Institute of Medicine, *Access to Health Care in America* (Washington, DC: National Academy Press, 1993).

Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, DC: The National Academies Press, 2003).

Kaiser Commission on Medicaid and the Uninsured, *State Fiscal Conditions and Medicaid* (Washington, DC: 2006a).

Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer* (Washington, DC: 2006b).

Schoen, Cathy, Michelle M. Doty, Sara R. Collins, and Alyssa L. Holmgren, "Insured but Not Protected: How Many Adults Are Underinsured?" *Health Affairs* 25:289-302, June 14, 2005.

Schoen, Cathy, Karen Davis, Sabrina K.H. How, and Stephen C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* 25:457-475, September 20, 2006.

U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2005* (Washington, DC: U.S. Government Printing Office, 2006).

U.S. Department of Health and Human Services, *Health, United States, 2006* (Hyattsville, MD: National Center for Health Statistics, 2006).

Recommended Reading

Aday, Lu Ann and Ron Andersen, "A Framework for the Study of Access to Medical Care," *Health Services Research* 9:208-220, 1974.

This influential 1974 article developed a framework for studying access to care in which the potential for access is measured by characteristics of the health care delivery system and the population at risk, and the realization of access is measured by utilization of and consumer satisfaction with health care services.

Cunningham, Peter, and Jack Hadley, "Expanding Care Versus Expanding Coverage: How to Improve Access to Care," *Health Affairs* 23(4): 234-244, July/August 2004. Available at http://content.healthaffairs.org/cgi/content/abstract/23/4/234.

This study examines the relative effects of insurance coverage and community health center (CHC) capacity on access to care, finding that communities that have both high insurance coverage and extensive CHC capacity tend to have the best access, although the former appears more important. The authors conclude that funding of insurance coverage expansions is likely to produce greater gains in access than if an equivalent level of funding were invested in CHCs, and recommend that policymakers consider CHC expansions as complementary to insurance coverage expansions rather than as a substitute.

Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (Washington, DC: National Academy Press, 2000). Available at http://www.iom.edu/CMS/3800/5502.aspx.

This report examines the effects of Medicaid managed care and the related issue of welfare reform on the viability and future integrity of safety net providers in primary care settings. The report recommends a new government initiative, in the form of competitive grants, to bolster the diverse set of health care institutions that provides care to tens of thousands of the nation's poor and uninsured. The report also calls for the creation of a new government oversight body to monitor and assess the condition of safety net providers and thoroughly review the impact of federal and state policies on the system.

Institute of Medicine, *Insuring America's Health: Principles and Recommendations* (Washington, DC: The National Academies Press, 2004). Available at http://www.iom.edu/?id=19175.

The sixth in a series of reports that examine the consequences of uninsurance on individuals, their families, communities and society, this report outlines principles that can be used to assess policy options. The committee recommends that by 2010 everyone in the United States should have health insurance and urges the president and Congress to act immediately by establishing a firm and explicit plan to reach this goal. The committee also offers a set of guiding principles for analyzing the pros and cons of different approaches to providing coverage.

Grantmakers In Health, *More Coverage, Better Care: Improving Children's Access to Health Services* (Washington, DC: 2005). Available at http://www.gih.org/usr_doc/More_CovBetter_Care_no25.pdf.

This report reviews how the current health care system succeeds and fails for children, emerging policy developments, what grantmakers are currently doing to promote children's access to health services, and lessons learned to help guide future work.

Grantmakers In Health, "Supporting Local Efforts to Improve Health Care Access," Issue Focus, *GIH Bulletin*, June 5, 2006. Available at http://www.gih.org/usr_doc/Issue_Focus_6_5_2006.pdf.

This article discusses foundations' support of local initiatives to provide coverage and care for the uninsured, summarizing these program's strengths and limitations. The article concludes that though these initiatives are no substitute for a national solution, in the absence of broader reform they will probably continue to be a major strategy in covering the uninsured.

Grantmakers In Health, *Improving Health Care Access: Grantmakers Share Their Experiences* (Washington, DC: 2006). Available at http://www.gih.org/usr_doc/Access_2006_min_date.pdf.

This collection of profiles tells the stories of how health funders across the country are working to improve access to health care. It includes interviews with grantmakers from Blue Cross Blue Shield of Massachusetts Foundation, The California Endowment, The Health Foundation of Greater Cincinnati, Robert Wood Johnson Foundation, The Henry J. Kaiser Family Foundation, W. K. Kellogg Foundation, Maine Health Access Foundation, Quantum Foundation, The Rhode Island Foundation, Rose Community Foundation, and Universal Health Care Foundation of Connecticut.

Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2004 Data Update* (Washington, DC: 2005). Available at http://www.kff.org/uninsured/index.cfm.

This is the latest in a series of annual chartbooks that provide data on health insurance coverage, with special attention to the uninsured. It includes trends and major shifts in coverage and a profile of the uninsured population.

Kaiser Commission on Medicaid and the Uninsured, *Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy* (Washington, DC: 2006). Available at http://www.kff.org/uninsured/7476a.cfm.

This report provides an outline of an evidence-based framework for developing public policy approaches for health coverage of the low-income population. The authors summarize the research literature on issues related to the role for publicly sponsored health insurance, eligibility, participation, use of premiums, scope of benefits, use of cost-sharing, access, and financing.

Meyer, Jack, and Sharon Silow-Carroll, *Increasing Access: Building Working Solutions* (Battle Creek, MI: W.K. Kellogg Foundation, June 2000). Available at http://www.communityvoices.org/Uploads/1qzxc5fltm3ttrqh5sqrml45_20020826091522.pdf.

This report delineates the forces driving barriers to access, and presents a comprehensive, multifaceted framework for addressing the problem. The authors lay out a series of policy recommendations, along with a list of potential funding sources, and descriptions of promising community-based efforts geared to improving access to underserved populations.

Rosenblatt, Robert, "The Robert Wood Johnson Foundation's Efforts to Cover the Uninsured," in Stephen L. Isaacs and James R. Knickman eds., *The Robert Wood Johnson Anthology: To Improve Health and Health Care, Volume IX* (San Francisco, CA: Jossey-Bass, 2006). Available at http://rwjf.org/files/publications/books/2006/chapter_03.pdf.

This article traces the foundation's 30-plus years of effort to increase Americans' access to health insurance. The author observes that the foundation has used three fundamentally distinct but not necessarily mutually exclusive strategies: supporting efforts to bring about fundamental overhaul of the system, working to expand insurance coverage incrementally, and funding research to provide a better understanding of the dynamics of the system and an empirical basis for policy decisions.

Ryan, Jennifer, *Local Coverage Initiatives: Solution or Band-Aid for the Uninsured?* (Washington, DC: National Health Policy Forum, 2005). Available at http://www.nhpf.org/pdfs_ib/IB803_LocalCoverageInitiatives_06-29-05.pdf.

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

Schoen, Cathy, Michelle M. Doty, Sara R. Collins, and Alyssa L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?," *Health Affairs* Web Exclusive, June 14, 2005 W5-289–W5-302. Available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.289.

This study estimates the number of people whose exposure to out-of-pocket costs was high relative to their incomes, placing them at financial risk and affecting their access to care. The authors estimate that nearly 16 million people ages 19-64 were underinsured in 2003. Underinsured adults were more likely to forgo needed care than those with more adequate coverage and had rates of financial stress similar to those of the uninsured. Including adults uninsured during the year, 35 percent (61 million) were under- or uninsured.

Sheils, John, and Randall Haught, *Cost and Coverage Analysis of Ten Proposals to Expand Health Insurance Coverage* (Washington, DC: Economic and Social Research Institute, 2003). Available at http://www.esresearch.org/publications/SheilsLewinall/Sheils%20Report%20Final.pdf.

This report was part of the Covering America project, which was directed by the Economic and Social Research Institute and supported by a grant from Robert Wood Johnson Foundation. The purpose of the project was to generate serious thinking and debate about comprehensive policies to extend health coverage to uninsured Americans. A major part of the effort was the publication of a series of major proposals by leading health researchers and analysts that explore a variety of options for moving toward universal coverage. This report estimates the effects that 10 of the proposed reforms would have on the number of people who would be covered by public and private health insurance and the costs of extending coverage. All of these proposals would result in an increase in national health spending; increases range from $23.0 billion to $57.2 billion for 2002.

State Coverage Initiatives, *State of the States* (Washington, DC: Academy Health, 2007). Available at http://statecoverage.net/index.htm.

This comprehensive review of coverage expansion efforts in all 50 states and Washington, D.C. is released annually.

U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2005* (Washington, DC: U.S. Government Printing Office, 2006). Available at http://www.census.gov/prod/2006pubs/p60-231.pdf.

This report presents data on income, poverty, and health insurance coverage in the United States based on information collected by the U.S. Census Bureau. Estimates are presented by characteristics such as race, Hispanic origin, nativity, and region. In 2005, 46.6 million people were without health insurance coverage, up from 45.3 million people in 2004. The percentage of people without health insurance coverage increased from 15.6 percent in 2004 to 15.9 percent in 2005. The percentage and the number of children (people under 18 years old) without health insurance increased between 2004 and 2005, from 10.8 percent to 11.2 percent and from 7.9 million to 8.3 million, respectively.