



# Providing Health Care Access to Workers with Disabilities through Community-Based Financing

Community-based financing for health care access (CBF-HC) is any funding arrangement used by a group of individuals to collectively improve their access to health care. This toolkit focuses on CBF-HC as a mechanism for **providing access to health care for workers with disabilities and chronic conditions** through a variety of innovative financing arrangements that are specifically tailored to a community’s needs and resources.<sup>i</sup>

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# Community-Based Financing as an Option for Employers and Employees with Disabilities

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## **Community-Based Financing Programs**

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***Help insure individuals who can't afford private health insurance and are ineligible for government benefits***

***Provide alternatives to small businesses that wish to offer health care access to employees***

***Allow workers with and without disabilities remain in the workforce by securing needed health care coverage***

Many people with disabilities are either in low-wage or part-time jobs without access to health insurance, or are unemployed in order to be covered by public health insurance programs such as Medicare and Medicaid.<sup>ii</sup> Workers who do have employer-based coverage may have difficulty reducing hours when necessary, or taking leave for recovery or rehabilitation, for fear of losing their health benefits.<sup>iii</sup> They too may face the choice between employment with little flexibility in health care coverage or eligibility for government benefits.

The CBF model presents a real alternative for individuals with disabilities who want to remain in or re-enter the workforce, and employees who want to minimize possible employee turnover caused by employees with disabilities leaving to secure health care coverage.

# Successful Models of Community-Based Financing

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## Cost-sharing

**is a multiparty arrangement that spreads the cost of health care across all involved parties, in accordance with an agreed-upon formula.** In a cost-sharing model, consumers may be required to pay part of the bill for covered services in order to secure lower premiums, or increase consumer control over health care services.<sup>iv</sup> Cost-sharing as a component of a CBF-HC program can help employers who struggle with the high cost of health insurance afford coverage for their employees with disabilities.

Cost-sharing programs may include:

- Employer participation
- Prescription drug coverage
- Co-insurance
- Restricted benefits
- Community subsidies
- Donated care
- Specialized care
- In-kind payments



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### Offering the Uninsured of Cabell County Health Care (OUCH!)

OUCH! offered a plan that split premium costs among employer, employee, and a community fund. With a \$3,000 cap and aggressive care management that worked with other public programs, members received a wide variety of discretionary services.

[http://www.capcommunity.hrsa.gov/cap/Events/Files/Jan\\_2004/Lanie](http://www.capcommunity.hrsa.gov/cap/Events/Files/Jan_2004/Lanie)



## Donated care

**also known as in-kind care, may be the most versatile CBF-HC model.** This model includes clinics or networks of health care providers who donate their services to the uninsured who might otherwise rely on hospital emergency rooms for care. While getting specialized services donated to a program can be a hurdle in some areas, appropriate outreach, marketing, and networking has been shown to bring in more comprehensive donated care. CarePartners of Maine is a good example of networking that has brought in specialized services to meet the needs of members people with disabilities, improving their ability to receive care without sacrificing employment for benefits.



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### *CarePartners*

Operating in Maine, CarePartners contracts with various local hospitals to provide donated services to people enrolled in the program. The benefits package for the program is completely based on donated services and can shift and accommodate as the program locates doctors willing to participate.

[http://www.mainehealth.org/mh\\_body.cfm?id=3441](http://www.mainehealth.org/mh_body.cfm?id=3441)



# Assessing Your Readiness for Community-Based Financing

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In order for new CBF-HC initiatives to be successful *and* sustainable, the community in question and the population within the service catchment area must be ready. A community readiness study should assess the needs, motivations, and unique characteristics of the community to understand if community-based financing is an appropriate option. Answers to the following questions will inform the structure, objectives, and goals of your potential program.



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## Questions to Assess Community Readiness<sup>v</sup>

### *Who is your target audience?*

What are their basic demographics and health care needs?

### *What is the community's interest in relation to the issue?*

How does the community stand to benefit from covering more people through community-based financing?

### *What objections might stakeholders have to community-based financing?*

Are there costs, challenges, and/or expectations that might derail plans for community-based financing?

### *What do stakeholders stand to gain from CBF-HC?*

How can local leaders and community members benefit from the new financial entity?

### *Does the community have a preference or position on the issue of health care?*

What has been done in the community around health care in the past, and are there other health care campaigns going on now?



CarePartners of Maine created a list of factors that can affect the development and design of a community program, such as the supply of primary care providers, the supply of specialists, the presence of other free care programs, the demands of the population, organizational capacities, and hospital-based programs already in place.<sup>1</sup>

[http://www.mainehealth.org/mh\\_body.cfm?id=3441](http://www.mainehealth.org/mh_body.cfm?id=3441)

# Designing a CBF-HC Program: Key Components

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## **Definition of Need**

In order to design and implement a successful CBF-HC the community must assess the specific and unique needs it is trying to address. *Identifying the needs of your target population will inform the decisions about design and implementation of your program.*

Needs in your community may include:

- Access to stopgap insurance
- Preventive care options
- Education
- Care Management
- Specialized Services

## **Partnerships**

A CBF-HC program relies on partnerships with different community stakeholders. Many directors of existing programs stress the importance of having the right players at the table from the start.<sup>vi,vii</sup> Partnerships ensure that the programs' many needs are achieved in efficient and effective manners. This reduces costs, increases the benefits a program can offer, provides community support, and educates members and the community.

Potential partners include:

- Local hospitals
- Government entities
- Educators
- Social workers
- The general public
- Members of the target population.

## **Organizational Status**

Identifying the CBF-HC framework, mission, goals, and framework is an important step in the program design process. Perhaps most important from a legislative perspective is establishing a non-profit or for-profit program. All existing CBF-HC programs referred to here are non-profits, enabling them to receive donations from the community and public. For more information on establishing a non-profit organization and related tax information, see the Internal Revenue Service Web site (<http://www.irs.gov>).

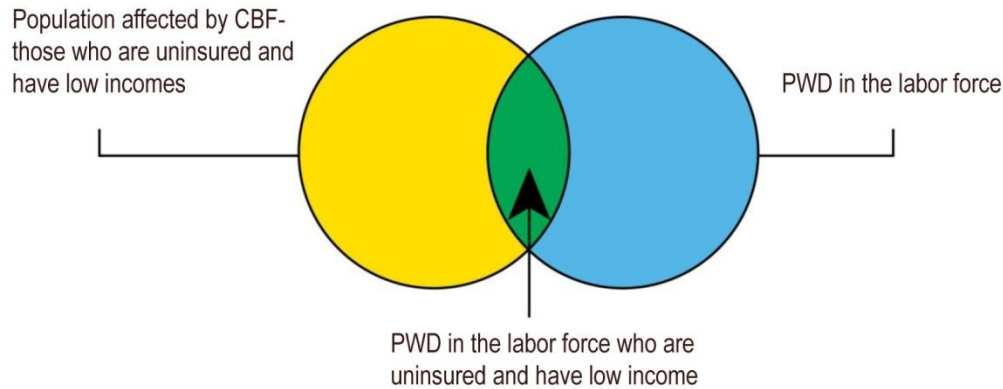
## **Governance**

A board of directors that is made up of key contributors and stakeholders will ensure sustained productivity and continued growth of the program. Including workers with disabilities adds voices representing some of the unique issues faced and care needs of this population.

### **Defined Target Population**

CBF-HC initiatives often serve people who do not qualify for government subsidy programs, including those with disabilities, but cannot afford private market insurance coverage. In order to determine the target population a CBF program can cover, stakeholders must understand a community's size, geographic location, existing resources, and any special needs that might affect the final program model.

**Figure 1. Schematic of CBF Study Population**



### ***In April 2009, Bureau of Labor Statistics reported***

- 6.11 million people with disabilities in the labor force (PWD-LF),***
- 5.31 million were employed***
- 802 thousand were unemployed.<sup>viii</sup>***

### **Eligibility Criteria**

Eligibility parameters vary. They may include:

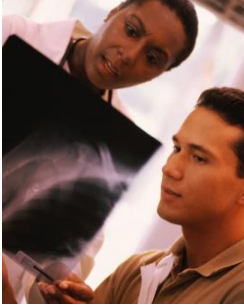
- Income
- Geographic location
- Minimum work requirement (i.e., 20 hours per week minimum for eligibility)

#### **Sample Eligibility Criteria**

Church Health Center Eligibility <http://www.churchhealthcenter.org/whoiseligible>

CarePartners Eligibility  
[http://www.mainehealth.org/mh\\_body.cfm?id=3441#How\\_do\\_I\\_know\\_if\\_I\\_am\\_eligible?](http://www.mainehealth.org/mh_body.cfm?id=3441#How_do_I_know_if_I_am_eligible?)

Ingham Health Plan Eligibility  
[http://www.communityhealthplans.org/ihp/hpqa/InghamCA/IC\\_Advantage\\_Brochure.pdf](http://www.communityhealthplans.org/ihp/hpqa/InghamCA/IC_Advantage_Brochure.pdf)



### **Services**

Services must balance the needs of the population, what the program can afford<sup>ix</sup>, and what other existing public programs might cover.

Services can be limited in what they offer to people with disabilities. However access to preventive care and care management can ensure that all covered individuals are healthier, and more likely to stay in the labor force because they have their basic care needs met.

### **Funding**

With some innovation and creativity, many funding sources can be tapped, including:

- Health Resources and Services Administration (HRSA) grants (<http://www.hrsa.gov/grants/>)
- Robert Wood Johnson Foundation grants (<http://www.rwjf.org/grants/>)
- Waivers for Medicaid, Medicare; State Children's Health Insurance Program (SCHIP) funds ([http://www.cms.hhs.gov/MedicaidStW\\_aivProgDemoPGI/MWDL/List.asp](http://www.cms.hhs.gov/MedicaidStW_aivProgDemoPGI/MWDL/List.asp))
- Disproportionate Share Hospital (DSH) adjustment payments (<http://www.hhs.gov/recovery/cms/dsh.html>)
  - Ingham Health Plan utilizes a waived SCHIP fund to pay for their health plans.
  - CarePartners utilizes a contract with participating hospitals that target the DSH funds the hospital receives into sustaining their program.
  - OUCH! relied on grants and community donations.
  - The Church Health Organization has a consortium of churches behind it if it needs more funding.

All of the programs highlighted in this toolkit use innovative funding mechanisms to provide preventive and specialized care to working people who don't have access to health care; these programs benefit individual workers, families, employers, and communities at large.

### **Cost containment**

The cost containment measures of a CBF-HC program must fit the community. CarePartners of Maine can offer a more comprehensive benefits package not just because of their program structure, but also because of the state's characteristics. What works in one area may not work in another, so understanding how costs will be managed is an important step in ensuring sustainability. The National Conference of State Legislatures (NCSL) provides examples of cost containment ideas as examples

(<http://www.ncsl.org/IssuesResearch/Health/StateHealthCareCostContainmentIdeas2003/tabid/14465/Default.aspx>).

## **Community Outreach and Recruitment**

Recruiting and retaining board members and volunteers can be a daunting task for any new community initiative. Wayne R. Pinnell<sup>x</sup>, who is responsible for the recruitment and retention of the Laura's House<sup>1</sup> board, offered the following insights:

***Remember the recruiting process is an opportunity to get to know people and for them to get to know you***

***Make sure they understand the mission of your program and that it aligns with their own views and beliefs***

***Find out how they want to serve the organization***

***Evaluate them for personal motivation***

***Place a new member in a position to thrive, not fail***

***Encourage feedback and self-reflection***

Additionally, A CBF-HC initiative must promote the program to its target audience, while at the same time educating community members about preventive care and its benefits.



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### **The Church Health Organization**

One promising example of low-cost recruitment and outreach is the Church Health Center program in Memphis, Tennessee. Using the church consortium network, the program identifies “lay advisors” who participate in an 8-week training course on community health care. These lay advisors identify people who need preventive or corrective care and encourage them to get that care, guiding them to the program. The visibility of these advisors is part of the effort to make the community aware of the program’s features and benefits.



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<sup>1</sup> Laura's House is a non-profit organization that addresses issues related to domestic violence and abuse.

# Measuring Success in Community-Based Financing

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## Defining Outcomes

The designers of CBF-HC programs expect that their programs will produce positive results, whether by insuring a larger part of the population, managing chronic care, or reducing the costs of hospital emergency room use.

To evaluate a program's outcomes requires clearly defining the expected outcomes, collecting and reporting valid and reliable baseline data, gathering information on program implementation, and collecting and reporting outcome data. CarePartners of Maine's final report provides one example of CBF-HC program evaluation. (This 91 page final report is available at <http://muskie.usm.maine.edu/Publications/ihp/CarePartners.pdf>)

## Research Methods and Data Collection

Understanding all the research methods and data collection strategies available to you and your program can be difficult. Below are some Web sites that provide basic evaluation guidance to program planners:

**Research Methods Examples: How Data can be Collected and Sampled**

[http://www.bized.co.uk/timeweb/digging/dig\\_source\\_expl.htm#2](http://www.bized.co.uk/timeweb/digging/dig_source_expl.htm#2)

**Research Methods Workshops**

[http://www.wadsworth.com/psychology\\_d/templates/student\\_resources/workshops/resch\\_wrk.html](http://www.wadsworth.com/psychology_d/templates/student_resources/workshops/resch_wrk.html)

## Data reporting

It is important to report data in a way that can be understood by all of your program partners, especially community members. For example, CarePartners' report to the community offers a simple and easy to follow guide to their programs, current status, and participating partners.

## Program Snapshots

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### **Shelby County, Tennessee**

**Church Health Center/MEMPHIS** • <http://www.churchhealthcenter.org/>

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**Program Type:** Donated Care/Cost Sharing

- Eligibility Requirements:**
- Work at least 20 hours/week
  - Not eligible for other insurance (including Medicare, Medicaid, or private market insurance)
  - Complete 3 consecutive months of employment
  - Earn no more than \$416/week
  - Family income 200% of Federal Poverty Level (FPL)

**Benefit Type:** Comprehensive

**Funding Sources:** Donated care, sliding scale fees and premium payments; no government funding

**Members Served:** 50,000

**Cost to Member:** \$35/month for member; \$25/month for dependent; \$120/month for family

**Cost to Employer:** \$10/month

**Benefit Cap:** None

### **Ingham County, Michigan**

**Ingham Health Plan IHP Plan A** <http://www.communityhealthplans.org/ihp/healthplans.asp?plan=ingham>

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**Program Type:** Donated Care

- Eligibility Requirements:**
- 35% FPL
  - Resident of specified locale
  - Determined eligible by Family Independence Agency

**Benefit Type:** Basic

**Funding Sources:** Waivered State Children's Health Insurance Program (SCHIP) funds and donated care

**Members Served:** 15,323 total in all 3 Ingham Health Plans

**Cost to Member:** Nominal sliding scale co-pay (\$2 - \$12)

**Cost to Employer:** N/A

**Benefit Cap:** None

### ***Ingham Health Plan IHP Plan B***

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***Program Type:*** Donated Care

***Eligibility Requirements:***

- Ages 19-64
- 150% FPL
- Resident of specified locale
- Not eligible for other health insurance programs (including Medicare, Medicaid, or private market insurance)

***Benefit Type:*** Basic

***Funding Sources:*** Medicaid Disproportionate Share Hospital (DSH) funds from hospital contracts and donated care

***Members Served:*** 15,323 total in all 3 Ingham Health Plans

***Cost to Member:*** Nominal sliding scale co-pay (\$2-\$12)

***Cost to Employer:*** N/A

***Benefit Cap:*** None

### ***Ingham Health Plan Third Share Plan***

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***Program Type:*** Cost Sharing

***Eligibility Requirements:***

- Small employers located in Ingham County
- Been in business 2 years
- Not offered health insurance in 2 years
- Between 2-20 employees
- At least 50% of all employees make \$10 or less/hour

***Benefit Type:*** Basic

***Funding Sources:*** Donated care and IHP county health plan subsidy

***Members Served:*** 15,323 in all 3 Ingham Health Plans

***Cost to Member:*** Variable at employer's discretion up to \$135/month

***Cost to Employer:*** Variable up to \$135/month

***Benefit Cap:*** Annual cap of \$35,000, life cap of \$200,000

## **Cabell County, West Virginia**

### **Offering the Uninsured of Cabell County West Virginia**

**Health Care (OUCH!) • [http://www.cjaonline.net/Communities/WV\\_Cabell.htm](http://www.cjaonline.net/Communities/WV_Cabell.htm)**

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**Program Type:** Cost Sharing

**Eligibility Requirements:**

- 134%- 200% of FPL
- Working
- Ages 19-64
- Not eligible for any other health insurance programs (including Medicaid, Medicare, and Private Market)

**Benefit Type:** Basic

**Funding Sources:**

- Federal and Local Grants
- Donated Care
- Premium Payments

**Members Served:** 150 (2004)

**Cost to Member:** \$36/month

**Cost to Employer:** \$36/month

**Benefit Cap:** Annual Cap \$3,000

## **Adams County, Illinois**

**Access Health Care Adams County Illinois (AHAC) • <http://accesshealthac.org/page5.php>**

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**Program Type:** Donated Care

**Eligibility Requirements:**

- Household income at or below 200% of FPL
- Under age 65

**Benefit Type:** Basic

**Funding Sources:**

- Federal and Local Grants
- Donated Care

**Members Served:** Unknown (Target 17,000)

**Cost to Member:** None

**Cost to Employer:** N/A

**Benefit Cap:** None

## **Cumberland, Kenebec, and Lincoln Counties, Maine**

**CarePartners** • [http://www.mainehealth.org/mh\\_body.cfm?id=3441](http://www.mainehealth.org/mh_body.cfm?id=3441)

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**Program Type:** Donated Care

- Eligibility Requirements:**
- Household income at or below 175% of FPL
  - Ages 19-64
  - Not eligible for any other health insurance programs (Medicaid, Medicare, or private market)
  - Resident of Specified Locale
  - Countable Assets less than \$10,000 for individual (less than \$12,000 for family)

**Benefit Type:** Comprehensive

- Funding Sources:**
- DSH Funds
  - Donated Care
  - Donations from the community
  - Robert Wood Johnson Foundation Grant

**Members Served:** 1,054 currently enrolled (6,000 served total since inception)

**Cost to Member:** \$10 per member per visit copay, \$5, \$10, \$15 copay for pharmaceuticals as needed

**Cost to Employer:** N/A

**Benefit Cap:** None



***Health care access is a key consideration for those faced with a choice to reduce hours or exit the workforce due to a disability.*** While loss of insurance is a serious concern for any individual, it is an especially serious consideration for those with ongoing health care needs related to a chronic condition, disability, or the onset of disability. When people with disabilities are uninsured, they lack access to preventive and ongoing medical care, a situation that can lead to secondary health conditions that might otherwise be prevented. The high costs of health care coverage and the perceptions of cost by employers may make people with disabilities especially vulnerable, and lack of health insurance and access to health care can be one of the largest barriers preventing people with disabilities from seeking and obtaining steady employment. Policy initiatives that increase access to health care are important points for research, as they may directly influence a person's ability and motivation to stay in the workforce, or to re-enter the workforce after a period of receiving public insurance coverage. Community-based financing offers a viable alternative that meets individual basic and preventive care needs. By creatively coordinating and providing for the health care needs of the uninsured, CBF initiatives offer individuals with disabilities the opportunity re-enter or remain in the labor force.

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## Endnotes

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