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Community-Based Financing for Health Care Access

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Issue Statement

Health insurance is particularly important to the employment status of persons with disabilities because they may have higher health-care needs (Livermore, Nowak, & Stapleton, 2001). Rising health-care costs and the high cost of providing health insurance for people with disabilities are believed to be major contributors to the low rate of employment among this population in the United States (Burkhauser, Butler, & Gumus, 2003; U.S. Bureau of Labor Statistics [BLS], 2009; U.S. Census Bureau, 2009). Although programs such as Medicaid and Medicare offer a health-care option for people with disabilities, these programs come with strict eligibility requirements that often push people out of the workforce who would otherwise need only temporary or partial benefits (Urban Institute, 2009). Furthermore, with 24.7 percent of persons with disabilities reported to be living in poverty (Cornell University, 2008), many who are offered employer-sponsored insurance may not be able to afford the premiums. How can access to health care be expanded to working people with disabilities who may otherwise become unemployed in order to obtain coverage through public insurance? This issue paper examines community-based financing health-care (CBF-HC) initiatives in a variety of settings to identify alternative means for providing health-care coverage to persons with disabilities. It studies the potential impact of CBF-HCs on persons with disabilities, presenting an analysis of current practices as well as recommendations for structuring and designing programs to best meet the needs of this population.

1.0 Introduction

The U.S. Department of Labor's Office of Disability Employment Policy (ODEP) provides national leadership on disability and employment policy by developing and encouraging the use of evidence-based disability employment policies and practices, building collaborative partnerships, and delivering authoritative and credible data regarding the employment of people with disabilities. This issue paper—which covers current practices and potential impacts of community-based financing health-care (CBF-HC) initiatives, the employment of persons with disabilities, and access to health coverage—aims to identify promising practices, policy implications, potential outcomes, and implications through a combination of quantitative and qualitative analyses of existing research and statistical data.

In order to evaluate CBF-HCs for their potential impacts on the employment prospects for persons with disabilities, the use of qualitative interview guided approach and quantitative econometric microsimulation combines scientific research with professional wisdom. This is the definition of evidence-based research as put forth by the Department of Education (Whitehurst, 2002). The qualitative interview guided approach allows for a semi-structured interview with key stakeholders of CBF-HC initiatives. This often produces quotations, which are the main source of raw data (Patton, 1987, as cited in Sewell, n.d.). The qualitative interview provides optimum information when evaluating programs, about their processes, individual differences between experiences and outcomes, and variations in programs operating in different sites (Sewell, n.d.). This process when applied to existing CBF-HC programs, presents insights into the development, implementations, and best practices to understand potential impact on persons with disabilities. An econometric microsimulation, which, chosen for its ability to answer the evaluation problem (Heckman & Smith, 1995, as cited in Mitton, Sutherland, & Weeks, 2000) through calculating outcomes for persons with disabilities not in a CBF-HC program and outcomes for persons with disabilities after the implementation of a CBF-HC program. A microsimulation provides a structured framework that one can explore a range of inquiries centered on 'what if?' about the outcomes of potential policy reform, or program change (Mitton, Sutherland, & Weeks, 2002).

Section 1.1 describes the intent and purpose of studying CBF-HCs as a viable alternative to withdrawal from the labor force in order to obtain coverage through public insurance. Section 1.2 looks at the relationship among and interactions between health-care access, employment, and disability. Section 1.3 briefly discusses existing CBF-HC programs found in the United States. Section 2 introduces the variability of program characteristics and the reasoning behind them. Within Section 2, Section 2.1 discusses regulations and CBF-HCs; Section 2.2 addresses existing model characteristics with program examples; Section 2.3 considers other characteristics as they apply to CBF-HCs; and Section 2.4 explores program structure components such as cost containment processes, funding, community, task forces, outreach and recruitment. Section 3 synthesizes of the interviews, literature review and a microsimulation econometric analysis as they apply to persons with disabilities. Finally, Section 4 revisits the issue paper's purpose, highlighting key points and conclusions.

1.1 The Intent and Purpose

Government-sponsored health coverage, such as Medicaid and Medicare, can provide a valuable source of health insurance coverage for persons with disabilities. This is especially true for those who may be limited in their employment options or not able to work at all. However, the strict eligibility requirements for these programs can present an all-or-nothing choice for many individuals who find themselves in need of supplemental income and health insurance coverage: a choice between work and benefits (Urban Institute, 2009). In fact, many who become beneficiaries of government programs do not need lifetime benefits; rather, they would work again if offered training, accommodations, or health insurance coverage (Urban Institute, 2009).

To understand why a CBF-HC access program would be beneficial to an individual with a disability, one must first understand the current infrastructure for assisting people with disabilities, including recently acquired disabilities. Medicaid, Medicare, Social Security Insurance (SSI), and Social Security Disability Insurance (SSDI) are the most common government programs, with SSI being the largest cash transfer program in the United States (Wittenburg & Favreault, 2003). Persons with disabilities are more likely to live in poverty and have lower rates of economic mobility than other demographic groups (Schartz, Hendricks, & Blanck, 2006). Thus, they may need supplemental income in the form of government programs, especially when work hours must be reduced. Statistics show an average 61 percent earnings drop in the fourth month of disability onset (Perry, Kenney, & Tereshchenko, 2009). Medicaid also requires a waiting period before an individual can receive any health-care benefits, necessitating some to put much-needed medical care on hold. In addition, health costs can be considerably higher for a person with a disability, especially if that disability is linked to a chronic condition (Urban Institute, 2009). All of this means that health insurance, along with access to health care, is an extremely important part of an individual's decisions regarding work.

To qualify for public programs, an individual must meet certain income requirements. In many cases, this leads to the individual's departure from the workforce in order to meet those requirements. In most states, the eligibility for Medicaid is the same as that of someone receiving SSI. In fact, an individual often becomes eligible for Medicaid as soon as he or she is deemed eligible for SSI. Some states have tests that are even stricter in their eligibility requirements, further perpetuating an individual's need to reduce or eliminate income in order to receive health-care benefits (Wittenburg & Favreault, 2003). This presents a paradox for individuals with disabilities: access to health care likely improves their ability to reenter the workforce, but if they reenter the workforce, they lose their access to health care.

For those with employer-sponsored insurance (ESI), it can contribute to a job lock or prevent them from taking the time off to fully recuperate or manage their disability. Job lock is the lack of choice or the inability to choose to leave a job, reduce work hours, or change jobs because of the need to maintain health insurance coverage, even at the expense of better pay or improved working conditions (Perry, Kenney, & Tereshchenko, 2009). This phenomenon has especially pointed implications for persons who may be struggling with higher health-care costs due to their disability. Finally, another group of low-wage workers, those who either work part time or are unemployed, do not have access to health insurance benefits. This uninsured group is growing in size due to the increase in the cost of health care. For many of these individuals, the onset of a disability heightens the need for health insurance coverage.

CBF-HC initiatives offer another option for individuals caught within this cycle. These programs are generally structured around ensuring that uninsured or underinsured populations have access to health care. Because the programs target individuals who do not meet the eligibility requirements for government programs and who lack the ability to afford insurance in the private market, CBF-HC programs provide a choice for individuals who may be trying to figure out how to remain in the workforce after receiving disability benefits. In addition, these programs enable employed people with disabilities to remain employed and to retain their ability to advance, while still retaining health-care benefits for themselves and their families.

1.2 The Relationship among Disability, Health Insurance, and Employment

As of May 2009, the Bureau of Labor Statistics (BLS) reported that 38.8 percent of non-institutionalized persons ages 16 and up with disabilities were currently in the workforce. This is a stark contrast from the 87.6 percent of individuals without any reported disabilities in the workforce. Recent increases in the cost of health care and the high cost of providing health insurance to employees with disabilities are believed to be two factors in the low rate of employed persons with disabilities (Burkhauser, Butler, & Gumus, 2003; BLS, 2009; U.S. Census Bureau, 2009). The majority of persons with disabilities are under the age of 65 and in their working years (Adler, 1990). Of this group, 13.3 million reported difficulties finding or retaining jobs due to health-related conditions (Brault, 2008). Given this information, it is not surprising to find that 24.7 percent of people with disabilities live in poverty (Cornell University, 2008).

According to LaPlante (1993), "Poverty has substantial negative associations with employment and with private insurance and positive associations with public insurance and disability" (p. 45). The amount of people covered by private insurance decreases as the severity of the disability increases. In the lower income brackets, ESI is less likely to be offered, with 45.9 percent of the working poor uninsured, as opposed to 12.1 percent of the working non-poor (LaPlante, 1993). The uninsured population is predominantly low income with significant health-care needs. More than one in three low-income uninsured adults reported either a chronic physical or a mental health condition (Rowland, Lyons, & Rudowitz, 2009). Yet, this same population has limited access to affordable health-care coverage. Eligibility for public insurance has historically been linked to the inability to work. The requirements for Medicaid eligibility are similar to, if not identical to, those requirements for receiving SSI (Wiener, 2003). SSI uses a strict means test,¹ and both SSI and SSDI require that individuals show they are unable to work at all. This supports LaPlante's assertion that poverty is positively associated with public insurance and disability.

¹ A strict means test is the test of income or income limit due to inability to participate in the workforce.

When a person with a disability lacks insurance, he or she may not receive needed care, posing risks of worsening health and secondary conditions that might otherwise have been prevented (Marge, 1998; Pope & Tarlov, 1991, as cited in LaPlante, 1993). When this scenario occurs, many people, especially those in the lower income brackets or those working part time due to disability onset or progression, must choose either continued employment or health-care insurance through public programs. Although a study conducted by Hennesey and Muller (1994, as cited in Stapleton, Livermore, Schrivner, & Tucker, 1997) found that only 3.7 percent of those who returned to work cited Medicare eligibility and buy-in options as a reason for returning to work, numerous studies show that loss of health insurance is a strong reason for not working (Stapleton et al., 1997).² These studies highlight the fact that health insurance is irrevocably tied to the decision of a person with a disability to remain in or reenter the workforce. Health insurance, or the lack thereof, has been identified as one of the main barriers keeping people with disabilities from obtaining employment and from being self-sufficient (Wittenburg, Baird, Schwartz, & Butler, 2008).

1.3 What Is Community-Based Financing

Community-based financing (CBF) is a general term that can mean any number of funding arrangements used by a group of individuals who want to achieve a common goal, whether it is workplace improvement, housing, microenterprise development, or the acquisition of health care. This issue paper focuses on the concept as a mechanism for improving access to health coverage for people with disabilities and/or chronic conditions without insurance. CBF-HCs are largely unregulated, not-for-profit programs that evolved within different communities to meet specific needs. They improve access to health care for the uninsured and underinsured. Due to their unregulated nature and the circumstances in which they are developed, no two programs are identical; rather, they are tailored to their communities. Depending on a community's needs, a CBF-HC could have many different characteristics, including cost sharing, microinsurance, in-kind or donated care, risk pooling and management, and self-funding. Understanding how these various components work is essential to identifying best practices and replicating them to improve access to health care for people with disabilities and chronic conditions.

Many CBF-HCs utilize an a la carte structure, pulling from various principles and characteristics and adapting them to create an affordable health coverage product for their communities. Though *versatility* is the word most associated with existing CBF-HCs in the United States, all programs have certain traits in common. In order to be stable and sustainable, a CBF-HC must include the following: (1) it must operate at the community level by the community and its members; (2) it must have innovative funding based on available avenues in a specific community; (3) it must have effective cost-containment procedures; and (4) care management and education must be provided for the population being served. These core characteristics, when applied effectively within each program's structure, help ensure that CBF-HCs are able to reduce costs, increase understanding of and decrease inappropriate use of medical resources, and focus on the core principle of providing affordable health care to uninsured or underinsured individuals.

² The authors cite three studies. One study of chronic dialysis patients (N=359) found that 79 percent of non-employed and 78 percent of employed respondents viewed the loss of health insurance as a barrier to employment. The second, in Dane County Wisconsin, found that 54 percent of those with severe physical disabilities felt that the potential loss of Medicaid or Medicare was the main reason for not working. The third study, of a vocational rehabilitation service, saw that 42 percent of respondents receiving SSI and SSDI named loss of medical insurance as their reason for not taking a job.

2.0 Characteristics of Community-Based Financing Health Care Programs

2.1 Regulations and the CBF-HC

2.1.1 Government Regulation of Insurance: Background

In the United States, health insurance is regulated at both the state and the federal levels. Although the Supreme Court has long established a preeminent role for the federal government to regulate the insurance business, Congress has passed legislation to specifically grant the state regulatory powers in insurance matters (Klein, 1995). The federal government has, at times, reasserted its regulatory role in health insurance by passing legislation required of all health insurance carriers. First, federal legislation exclusively regulates self-insured health insurance plans—that is, the health insurance coverage that employers fund and maintain themselves, without a third-party insurance carrier. State laws cannot interfere or regulate the health insurance provided by these self-funded plans (Mariner, 2006). Second, by passing the Consolidated Omnibus Budget Reconciliation Act (COBRA), Congress established minimum requirements for the continuation of employer-provided health insurance coverage in case of qualifying events, such as beneficiaries being laid off or the death of a beneficiary and the continuation of family. Finally, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which mandates *guaranteed issue* in the small group market, requiring insurance carriers to issue plans to people regardless of age or health status. HIPAA also establishes protections for beneficiaries in relation to “preexisting condition” exclusions (Department of Labor, 2009).

States have passed legislation that improves access to health care for uninsured or underinsured populations, including mandated coverage of specific procedures and rules for setting premium rates, although they vary widely from state to state. For instance, New York is one of the most heavily mandated states, with more than 30 mandates in place (Novak, 2003). In contrast, Delaware, Idaho, and Wyoming have very few mandates, all related to very basic coverage items (Jensen & Morrissey, 1999). In addition, states set different rules for premium rate variation. In some states, carriers can take into account age, gender, geographic location, smoking habits, and previous claim experience to set up premiums. In others, carriers must set premiums using fewer factors (Kofman & Pollitz, 2006).

2.1.2 Regulation and CBF Initiatives

In CBF-HC programs, special attention is paid to the distinction between a health insurance plan and a health-care access program. Health insurance plans are subject to both state and federal laws. Although health-care access programs provide many of the same health-care services that health insurance plans offer, health insurance laws do not regulate the former. Of the programs reviewed for this issue paper, Ingham County (Michigan) offers small businesses one subsidized health insurance product called Third Share, which complies with all state and federal regulations. The other two products that Ingham County offers, however, are explicitly described as health-care access programs and thus are not subject to the same regulations (Health Plan Management Services, 2008).

The two health-care access programs (Plan A and Plan B) offered by Ingham County are funded in part by a Medicaid fund waiver. In practice, this means that although the programs are not subject to state and federal laws that regulate health insurance providers, they must comply with the terms of the waiver. In addition, the Michigan Department of Community Health closely monitors all three programs. The limited regulatory oversight allows the programs latitude to design their coverage around costs only (J. Welter, personal communication, June 2, 2009).

The classification of these health-care access initiatives outside the scope of federal and state regulation allows greater flexibility in program structure and in the ability to customize health-care services to a community's needs and resources. In at least two instances in the United States, legislative action has attempted to explicitly classify health-care access programs as being outside the scope of regulatory legislation. The Church Health Group of Memphis (Tennessee) offers health services to working families through a free clinic. In addition, it offers an "insurance-like" plan to small businesses. Participation in this program requires payment of a monthly fee by employers in addition to a sliding fee based on income per medical service. However, the employer-based nature of enrollment into the "insurance-like" program led to a complaint from the Tennessee Department of Insurance, which held that the program acted like an insurance carrier but did not comply with insurance regulations. As a result, the Church Health Group pushed for state legislation to declare that it could continue to operate, while making it clear that the program does not constitute health insurance (T. Bolton, personal communication, June 8, 2009). Similarly, Offering the Uninsured of Cabell County Healthcare (OUCH), a West Virginia-based program, benefited from legislation designed specifically to exclude it from laws that regulate health insurance plans (L. Masilamani, personal communication, June 26, 2009).

2.1.3 Oversight from Funding Sources

The main checks and balances on the functioning of CBF-HC programs originate in the source of their funding and the imposition of accountability requirements. Since most programs have multiple sources of funding, they are often required to report different aspects of the program to different sponsors. In some cases, funding comes from government agencies. For example, Access Health of Adams County (AHAC) of Illinois, which manages a donated care program in Adams County, was initiated with funds from a Health Resources and Services Administration (HRSA) grant. As a result, the program must report to HRSA and comply with that agency's rules. In addition, the program reports to its board of directors.

The reporting requirements of CarePartners of Maine, which counts on many benefactors, are imposed by several funding sources. In addition to HRSA grant requirements and the requirements of private foundations, CarePartners reports annually to local hospitals. A central aspect of the program's success is the collaboration of hospitals—in addition to providing hospitalizations and specialized care, the program includes a large number of physician practices in the state (C. Zechman, personal communication, June 3, 2009). Still, health-care access programs such as these have a substantial margin within which they can maneuver, because they can decide exactly what type of services to cover, which individuals or groups to target, plus a wide array of other variables.

2.2 Existing CBF-HC Model Characteristics

As discussed above, each CBF-HC is unique and designed to answer a need within a specific community. No two communities have the same funding sources available, populations to serve, or facilities and services to provide. Thus, a critical step in designing a CBF-HC is locating funding and determining how to allocate it to optimize care and minimize cost. A balance must be created between providing care and sustaining the program's operations. There is a variety of ways to structure a CBF-HC. A review of existing peer-reviewed published and unpublished research reports and documents revealed two existing structures of CBF-HCs in the United States, each centered around two predominant characteristics: cost sharing and donated care. These models also optimize different funding sources to

provide care and care management. Through qualitative³ interviewing of program directors and key stakeholders within some of these programs, we were able to determine that the characteristics of these two models have proven effective in their ability to operate at community and county levels.

Through our review of the existing literature and analysis of different programs, we were also able to identify other model characteristics as potential design structures that could be used to meet the needs of persons with disabilities. These characteristics, which include microinsurance, high-risk pooling, and self-funding, are not currently used at the community level in the United States. However, they offer the potential to extend needed care to certain populations, including persons with disabilities. This section reviews the existing structure characteristics and then discusses other potential design elements and their implications for use with CBF-HCs.

2.2.1 Cost Sharing

Cost sharing is a multiparty arrangement that spreads the cost of health care across all of the involved parties in accordance with an agreed-upon formula. In cost sharing, a consumer may be required to pay a portion of the bill for covered services in order to secure lower premiums or to increase consumer control over the health-care services (Neis & McEwen, 2001). Cost sharing removes the heavy financial burden from one person and spreads it across all parties involved, making the health coverage a more affordable option for those who are deterred from the private and group markets due to cost. Cost sharing, in one form or another, can be found in many of the existing CBF initiatives, both directly and indirectly. Although many programs operate on a donated-care basis, they may still share the cost of operations with members enrolled through sliding fee scales for co-pays and premium pays. One example of a program structured directly around the cost-sharing principle is the OUCH program, which closed in December 2008 due to the expiration of its funding grants. The decision for the program to close was not based on the lack of success; rather, it was made because the program had accomplished what it set out to do, which was to test a viable model of a low-cost health-care access initiative (L. Masilamani, personal communication, June 26, 2009). Another example is Ingham County's Third-Share Plan, which, like OUCH, operates as an insurance product for small businesses and thus is subject to federal and state regulation. Both programs split the cost of premiums among an employer, an enrolled member, and a community fund comprised of grant monies.

An Overview of OUCH

OUCH split its premiums among employers, employees, and a group health-care fund. Each employer paid \$36 monthly per member enrolled in the plan, each member contributed \$36 a month, and community fund contributed a final \$178 per member per month. The community fund contained \$285,447 from a federal HRSA grant, a grant from the Robert Wood Johnson Foundation, \$5,000 from the Bingham program, and community donations (Masilamani, 2004). Eligibility for the program was determined differently for members and employers. Each member was required to be between 134 percent and 200 percent of the federal poverty line (FPL), between the ages of 19 and 64, working, and willing to participate in a payroll deduction plan (Masilamani, 2004). An employer wishing to participate must not have offered health insurance to its employees in the past twelve months, be willing to make payroll deductions, and never have previously participated in OUCH and terminated that membership (Masilamani, 2004). Each individual member had an annual \$3,000 cap on health-care expenditures after a 30-day waiting period. After a member reached \$3,000, he or she became fully responsible for medical costs.

The benefits package was discretionary, or established on a case-by-case basis. OUCH was the only program analyzed that targeted a specific need or gap in coverage. It identified needed coverage and ensured that those eligible through other programs obtained it through those programs before assuming responsibility. For example, a pregnant woman needing prenatal care and nutritional management in West Virginia would be eligible for the Family Care Plan, so OUCH's care managers would coordinate and negotiate her admittance into that program rather than have her use her \$3,000 of OUCH coverage for that care. They also arranged for specialists, as needed, and negotiated discounted fees for their members. Members were reimbursed for the services shown

2.2.2 Donated Care

Donated care, also known as in-kind care, may be the most versatile type of CBF-HC model. It often includes clinics or networks of doctors who donate their services to low-income people and others without access to health care. Without donated care, the participants would have traditionally relied on hospital emergency rooms for their health-care needs. Currently, the United States spends more than \$100 billion annually on providing health care to the uninsured population through emergency room services. Furthermore, hospitals pay close to \$34 billion annually for the care of often-preventable conditions that were not treated due to lack of health insurance coverage (National Coalition on Health Care, 2009).

Donated care can be considered a coverage product rather than an insurance plan⁴; it is included here because of its ability to improve access to health care for low-income, underinsured persons, including those with disabilities who are not eligible for Medicaid or Medicare. One reason a community may choose donated care over another program model, such as cost sharing, is that many of the other models often carry higher administrative costs (Healing Fields Foundation, 2008) that would need to be offset. Freed from some of the administrative costs and limitations of cost sharing, a donated-care model can use more traditional, money-based funding sources on care management and education programs that aid in the prevention of disease.

The Church Health Organization and MEMPHIS Plan

One example of a CBF-HC initiative with a donated-care component is the Church Health Organization in Memphis, Tennessee. A consortium of local churches funds the program, which includes a walk-in medical, dental, and optometry clinic, as well as a wellness center. The Church Health Center also manages the MEMPHIS plan, a donated-care program that has 200 participating doctors who have each agreed to take 10 new patients at low or no fees annually. Although the MEMPHIS plan is not legally a health insurance plan, in practice it is very similar. Its revenues come from the \$10 per member monthly premium paid by employers, the \$35 monthly premium paid by the employees, and the \$5 to \$10 per visit co-pay for some services. This income generates sufficient revenue to cover administrative costs and contribute to program operations, while health-care providers donate the actual services themselves. To be eligible for the MEMPHIS plan, employers and self-employed individuals must have no more than 200 eligible employees, live in Tennessee, and not offer insurance (or have employees making no more than 200 percent above the Federal Poverty Level (FPL) who cannot afford the insurance offered). Employees who are eligible must have been without coverage for at least six months prior, been with their current employer at least three

2.3 Other Characteristics for Consideration

A literature review conducted for this issue paper, which included international programs and other health-care access designs, highlighted three model characteristics that carry unique considerations for anyone designing a program targeted specifically at improving access for persons with disabilities. Persons with disabilities may have unique health-care needs. In many of the plans offered in the private market, these needs may be excluded or come with high deductibles or require waiting periods. A survey conducted in 1998 of 1,000 Americans with disabilities found that among the individuals with insurance, 32 percent reported having a special need related to their disability that was not covered by their plan (Livermore, Nowak, & Stapleton, 2001). These data reaffirm that certain populations have unique needs that must be considered when designing programs. This section reviews three program design characteristics that show possibility for positive impact.

2.3.1 Microinsurance and Mutual Insurers

Microinsurance covers a targeted population of low-income individuals and offers protection against specific conditions. Premiums are calculated as a function of the likelihood and cost of a health insurance claim(s) (Consultative Group to Assist the Poor [CGAP], 2009). This form of insurance is usually aimed at keeping premiums low (CGAP, 2009), but benefits are limited. Microinsurance policies offer restricted coverage based on the most prevalent health-care needs of a population and can be tailored to those individuals with chronic conditions. Despite low premiums, mutual microinsurance programs often have a low premium collection rate, a high dropout rate, and usually fewer than 1,000 members (CGAP, 2009). Microinsurance programs are more common in developing countries, where premiums are often adjusted according to a population's cash-flow patterns (e.g., if harvest time means a group has more resources and income, that is when premium payments will be scheduled) and are sometimes paid in kind (CGAP, 2009). These characteristics help explain the observed high dropout and low collection rates, as harvest time can be fickle and in-kind payments are hard to process or track.

Microinsurance offers an interesting path to providing health-care access when assimilated into a CBF-HC design. It bears consideration for its ability to provide access for *known* health-care needs. In theory, a CBF-HC with a microinsurance component could offer care management and coverage for specific conditions related to a person's disability at a reduced premium because a person elects *not* to have coverage for conditions from which he or she does not currently experience. Ideally a microinsurance plan would cover basic and preventive care, plus specialized care attached only for the specified condition. This characteristic seems to offer one avenue for retaining the care needed in order to continue in the workforce. However, as is the case with cost-benefit balance, possible negative impacts must also be considered.

Essentially, if individuals elect to carry a microinsurance plan, they are weighing their risk of needing procedures or other services that are not covered against keeping their premiums low and affordable. This poses a potential crisis situation if, for example, a person opts for diabetes coverage only and then faces a diagnosis of cancer. Microinsurance offers, at most, a stopgap for an individual looking to retain coverage for specific conditions in order to remain employed. If a CBF-HC were to incorporate microinsurance into its design, these aspects must be considered in light of their ability to provide care for the population they are targeted to help.

2.3.2 High Risk Pooling and Risk Management

Risk pooling is a mechanism that charges a flat rate to members, regardless of health status or age. Members make the same payments and use the same amount of services across the span of their lifetimes, and the risks and benefits of coverage are spread throughout the risk pool over that time. In the United States, risk pools are generally based on age, employment, and/or income (Smith & Witter, 2004). Currently, 34 states have created state-run high-risk pools to address the problem of people with serious medical conditions for which they cannot obtain coverage.

The risk pool at a state level can, when compared with group coverage, involve less risk sharing and more risk absorption by the individual (Hall & Moore, 2008). On smaller levels, such as within communities, it can offer individuals who are self employed or small-business owners an opportunity to purchase insurance at group rates from the private market rather than individual rates. A risk pool bears consideration for inclusion in a CBF-HC because the higher costs (actual and perceived) of care that persons with disabilities face can create unreasonably high premiums and deductibles, especially if the individual is fully underwritten⁵ by a private insurance company.

There is a downside to risk pooling, however. At the state level, these programs are subject to a phenomenon known as adverse selection, a process in which the more ill of the population flock to the plan, while the healthy drop out, causing costs to rise. Without a healthier population paying into the plan, the risk is not spread, and the plan must charge members more in order to keep going. When incorporated into the design of a CBF-HC, adverse selection must be taken into account. These programs currently work best at the state level, where they can be financed through a variety of sources at a state's disposal.

2.3.3 Self-Funded Insurance

Self-funded or self-insured initiatives include businesses or individuals that choose to put money aside for any medical costs rather than paying into a private or group plan. These initiatives are subject to federal rather than state laws, meaning that appeals and processes go through the U.S. Department

⁵ *Fully underwritten* is a term applied when an individual buys a single plan in the private market.

of Labor (DOL). According to Goodenow (2003), “More and more towns are deciding to self-insure, either by reducing coverage or dumping insurance altogether.” Although self-funded plans operate as insurance, the insured entity acts as the insurance carrier, determining which benefits are covered and how premiums are set. Towns such as Fishers (Indiana), Palm Beach (Florida), Southington (Connecticut), and Gilbert (Arizona) have all moved to fully or partially self-funded insurance plans for their employees (Goodenow, 2003).

Self-insurance warrants consideration in CBF-HC design because of its high level of control over the money and dispensing of funds within the program. A CBF-HC that self-insures would be able to structure its benefits package in accordance with the needs of its population. In addition, the regulations of insurance do not apply to self-funded initiatives; instead, such programs must abide by Employee Retirement Income Security Act (ERISA) regulations. This potentially relieves a CBF-HC of having to have a certain amount of money in savings and meet certain minimum benefits requirements outlined for private insurance carriers. In addition, if the design is specifically geared toward persons with disabilities, the allocation of funds could be better targeted. Essentially, the benefit of this design is the level of flexibility and control over the organization’s funds and how they are used.

Maximized control comes at a high price, however. In a self-funded CBF-HC, the money would come from members or employers completely, rather than from outside sources or government subsidies. Although this eliminates many regulatory aspects (i.e., keeping a large cash fund in the bank), it restricts a program to the funds that it can accumulate. With the majority of the uninsured population being predominately low income with some health conditions (Brault, 2008), it bears consideration that this population may not be able to afford to self-insure. The underlying issue with self-funding is risk, and in the case of a low-income group, the risk may be too high.

An Overview of the Self-Funding Plan of Fishers, Indiana

Fishers self-insures the health coverage of its town employees and contracts a third-party administrator to handle the claims. The town offers low-deductible health insurance to individuals or families at a monthly payroll deduction of up to \$144.42 per month for a family. All covered persons have a yearly \$150 wellness benefit. The program pays 100 percent of covered charges up to \$150 before or after the deductible is met. Charges over the \$150 maximum and after the deductible is met are covered at 80 percent. Included wellness preventive care procedures are physical examinations and related tests performed within 30 days of the exam, such as pap smears, electrocardiograms, blood work, prostate-specific antigen tests, mammograms, and chest X-rays. Immunizations (including those for foreign travel) and flu shots are also included.

2.4 Program Structure

When considering the structure of a CBF-HC initiative, community readiness and accessibility to local providers are critical (J. Welter, personal communication, June 2, 2009). With funding and cost containment being the critical components to ensure sustainability, many CBF-HC initiatives utilize innovative funding to sustain their operations. They hold the 501(c)(3) IRS tax exemption for not-for-profit entities, which enables them to receive public and private grant funding and donated monies from people requiring tax deductions for their donations (Charity Net, n.d.). Because of the complexity of establishing a viable CBF-HC effort, many entities assemble a task force to plan for outreach, recruitment, and implementation. It is essential that CBF-HC initiatives formally designate an executive director and administrative staff to monitor the program, communicate with participants, secure additional funding to expand the range of available health-care services, and reduce premiums for low-income participants. New CBF-HC initiatives that formally incorporate under the 501(c)(3) tax exemption begin with basic organizational development activities, including preparation of a mission statement that describes the purpose of the new organization, the target population, and benefits to program participants. The mission statement must also describe the organization's structure. Incorporation under 501(c)(3) ensures that organizations exist as separate legal entities, owning their assets and protecting executives from personal liability.

2.4.1 Funding

In reviewing CBF-HCs, the issue of funding arises in all areas, from start-up grants to sustainability and loss management. Government subsidies for any CBF program will reduce costs to members across the board, whether that program is a cost-sharing enterprise, a reinsurance program, or a high-risk pool. Financial sustainability, however, often depends on a subsidy of one form or another, either through grants and contributions from the local community or through state and federal agencies. CBF-HC programs can choose from a variety of funding sources to obtain start-up resources; these sources include state general revenues, tax expenditures; Medicaid/State Children's Health Insurance Program (SCHIP) funds (through a waiver); disproportionate share hospital (DSH) funds, assessments on insurers (primarily seen in reinsurance and risk pool programs), tobacco settlement funds and taxes, and provider discounts (Chollet & Taylor, 2005). Although the sources of funding are varied, they are very specific to the state or local community. Importing a CBF-HC approach should leave room for local solutions regarding funding, as alternatives available in one community may not be available in others.

Indigent care and disproportionate share agreements are resources given to hospitals that see large numbers of indigent people and Medicaid/Medicare populations. Through collaborative partnerships and contracts with hospitals, many CBF-HC programs draw from this funding source. Ingham County, Michigan, for example, has a CBF-HC program that offers three health-care access plans: two noninsurance products (Plan A and Plan B) and one insurance plan for small businesses (the Third-Share Plan). Each plan targets a different population and has different funding sources. Plan A is the adult benefits waiver plan, which is subsidized by unused SCHIP funds under a waiver.⁶ Plan B is funded through hospital contracts—hospitals receive disproportionate share funding from the federal government for the care provided to uninsured and indigent people. In Ingham County, hospitals

⁶Michigan was able to obtain this waiver for these monies because it already had a program in place to provide insurance for children when the federal government came out with SCHIP. Because SCHIP was less coverage than Michigan's state coverage, they were not utilizing the SCHIP funds. Through a waiver granted to them, they were able to take those unused funds and apply them to Plan A.

transfer these funds to the county health plan to support the program, care coordination, and management (J. Welter, personal communication June 2, 2009).

Another example of creative local funding sources is Maine's CarePartners program. This program started in 2001 with a grant from the Robert Wood Johnson Foundation and a federal HRSA grant for \$1 million (C. Zechman, personal communication, June 3, 2009). CarePartners is maintained by a large donated care network and is anchored on the free care provided by three large area hospitals.⁷ CarePartners' administrative fees are subsidized through a combination of resources from Maine Health, the Maine Medicaid program, and donated management by the third-party administrator (C. Zechman, personal communication, June 3, 2009). Both Michigan's Ingham County and Maine's CarePartners plans are examples of communities taking an in-depth look at their existing programs and their components and then expanding and working with them to improve or build their CBF-HC partnerships.

2.4.2 Cost Containment

Cost containment is a key component of all CBF-HC programs. There are endless ways to contain costs while still offering a reasonable product, though lower-cost health-care products undoubtedly come without "bells and whistles." Restricting benefit packages, education, negotiations, and discretionary tactics are effective cost-cutting measures.

Although a CBF-HC product is not insurance by traditional measures, it must balance cost with quality and comprehensive coverage. In Ingham County, the budget is set, and the benefits are thought through and determined based on what the budget can cover (J. Welter, personal communication, June 2, 2009). In Maine, on the other hand, the CarePartners benefits package changes as new services become available. For example, if a urologist signs on, then urology may become a covered benefit (C. Zechman, personal communication, June 3, 2009). The cost-containment process is even more unusual in Cabell County's OUCH program. OUCH set a \$3,000 coverage limit per individual. Individual members then have discretionary use of that allotment, though they are guided and helped by people who understand the system and all available programs and can help keep individuals' costs down to maximize their coverage (L. Masilamani, personal communication, June 26, 2009).

A CBF-HC's cost-containment measures must fit the community. CarePartners in Maine can offer a more comprehensive benefits package not just because of its program structure but also because of its partners; Maine has a small population with a close-knit community willing to participate (C. Zechman, Personal communication, June 3, 2009). This level of familiarity opens lines of communication among community residents, health-care providers, and the program itself. The experiences of various programs show that what works in one area may not work in another; thus, understanding how costs will be managed is an important step in ensuring sustainability.

2.4.3 Community

For new CBF-HC initiatives to be successful *and* sustainable, the community in which they reside and their catchment areas must be in a state of readiness. A community-readiness study should assess the needs, motivations, and unique characteristics of the community. Sprechman and Pelton (2001) suggest considering target audience, community interest in the issues, objections of the community, personal interests, and/or preferences about health care. Answers to these considerations will inform

⁷Hospitals have an interest in participating in the program, because they are already providing free care to the uninsured. CarePartners offers care management and the reduction of uncompensated emergency room use, which represents a lesser liability to hospitals.

the program's structure, objectives, and goals. For example, CarePartners presented a list of factors that could impact 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 (Ormond & Gerrish, 2006). Likewise, OUCH started with a 17,000-person survey in order to identify community factors and perceptions of need (L. Masilamani, personal communication, June 26, 2009). Both projects started with community-readiness assessments that identified unique needs and infrastructures in their communities; only then did they move forward to determine feasibility through logistical assessments. To design a feasible CBF-HC, First Nations Development Institute (2004), a national group that works on the research and development of community programs within various Native American communities, suggested several design considerations, such as where the working capital would come from, the form that the access being offered would take, how the program would assess the services, and any issues related to setting costs, distributing them, and ensuring they can cover operations and be affordable.

2.4.4 Task Force

The process of defining a community's needs must be followed by the identification of a task force. Board members should be community leaders from the political, business, government, health-care, and independent sectors with an interest in health care for the uninsured. Having the right people involved will provide the requisite knowledge and social capital through which to build and sustain a CBF-HC (J. Welter, personal communication, June 2, 2009) and thus is an important first step in getting a new community-financing initiative off the ground.

The task force must have clearly defined goals and objectives that are consistent with the overall work of the organization (Anonymous, 2009). The ideal size of the task force depends on the amount and type of work required. Smaller groups are efficient for making key decisions that may affect the entity and its target population. On the other hand, larger groups have better outreach capabilities, which may assist in fundraising and social marketing (Anonymous, 2009). Finally, task force members should enhance the group's credibility and ensure that at least some members have a vested interest in the initiative, such as lawyers, doctors, and community members, as well as persons with disabilities and chronic conditions who can speak to the needs of the targeted population.

2.4.5 Outreach

Community outreach and recruitment is also critical to a CBF-HC program. Because most CBF-HC initiatives have limited resources, they require both the promotion of the program to its target audience and the education of individuals in the community about preventive care and its benefits.

One promising example of effective low-cost recruitment and outreach is the Church Health Organization program in Memphis. Using the church consortium network, the program identified "lay advisers" who participated in an eight-week training course on community health care to educate them on common uncorrected or treated community diseases or conditions (Garr, n.d.). These lay advisers then went out into the community to identify people who seemed to need preventive or corrective care, using their "natural busy body approaches to encourage them to get it" (Garr, n.d.). The visibility of these advisers is part of the effort to make the community aware of the program's features and benefits.

In Maine, CarePartners has also found an economical and highly effective way to spread the word about its program. Individual discharge papers from emergency rooms in three counties display the CarePartners name and contact information, as do state denial letters from Medicaid or Medicare.

CarePartners also distributes posters and flyers in and around participating counties. Finally, participating providers often refer uninsured patients. All of these efforts ensure that those who need care hear about the program at a time when the information is pertinent and helpful.

If a program does not have effective outreach and communication in its community, enrollment is hard to maintain. Relying only on word of mouth does not reach as many people as proactively marketing a program with seminars, pamphlets, and other documents with targeted dissemination. Outreach also works toward effective recruitment strategies and processes, as larger numbers served can produce higher levels of interest in the community and those surrounding it.

2.4.6 Recruitment

CBF-HC program managers interviewed for this issue paper unanimously indicated that recruiting the right players from the start is integral to the success of an initiative (J. Welter, personal communication, June 2, 2009; C. Zechman, personal communication, June 3, 2009; L. Masilamani, personal communication, June 26, 2009). Hospitals, especially those that are federally qualified or have indigent care agreements, are critical to a CBF-HC's success. Lawyers, public figures, and legislators who could help in getting applicable legislation passed or in ensuring compliance also play an important role. Finally, the community itself must be represented in order to ensure that the focus remains on its needs.

Recruitment extends beyond board members and key players, however. If a community is savvy and innovative in obtaining services beyond health care, it can reduce operational costs even more. For instance, CarePartners has a third-party administrator process its claims and make membership cards on a pro bono basis (C. Zechman, personal communication, June 3, 2009). The Church Health Organization's MEMPHIS network began with one man, Dr. Scott Morris, who recruited each doctor and each employer for this program at the outset, requesting only small amounts of donated time and care from each until a network was established.

The versatility of each program and the avenues they each pursue in order to bring about sustained success produces an enormous amount of information. For comparison, Table 1 outlines each program's status, eligibility, type, and makeup.

Table 1. Program Characteristics of Selected Community Financed Health Care Programs

Name of Program	Type of Program	Eligibility Requirements	Benefit Type	Funding Sources	Number of Members Served	Still Operating	Cost to member	Cost to Employer	Benefit Cap
OUCH! Offering the Uninsured of Cabell County, West Virginia Health Care	Cost Sharing (3 Party)	<ul style="list-style-type: none"> • 134%-200% FPL • Working • Ages 19-64 • Not eligible for any other health insurance programs¹ • Agree to payroll deduction • Agree to \$36 /Mo. 	Basic	<ul style="list-style-type: none"> • Federal and local grants • Donated care • Premium payments 	150 (2004)	No	\$36/ Mo.	\$36/Mo.	\$3,000
AHAC Access Health Care Adams County	Donated Care	<ul style="list-style-type: none"> • Household income at or below 200% FPL • Under the age of 65 • No work requirement 	Basic	<ul style="list-style-type: none"> • Federal and local grants • Donated care 	Unknown-(target population: 17,000)	Yes	N/A	N/A	None
Church Health Organization/ MEMPHIS	Donated Care/ Cost Sharing	<ul style="list-style-type: none"> • Work at least 20 hours per week • Not eligible for other insurance¹ • Complete 3 consecutive months of employment • Earn no more than \$416.00/ week • Family income 200% FPL 	Comprehensive	<ul style="list-style-type: none"> • No government funding • Donated care • Sliding scale fees and premium payments 	50,000 combined Church Health Center and MEMPHIS Plan served	Yes	<ul style="list-style-type: none"> • \$35/Mo. (member) • \$25/Mo. (dependent) • \$120/Mo. (family) 	\$10/ Mo.	None
CarePartners	Donated Care	<ul style="list-style-type: none"> • Ages 19-64 • Resident of specified locale • Not eligible for other insurance programs¹ • Countable assets less than \$10,000 for individual (less than \$12,000 for family) • 175% FPL 	Comprehensive	<ul style="list-style-type: none"> • DSH funds² • Robert Wood Johnson Foundation grant • Donations from community 	<ul style="list-style-type: none"> • 1,054 currently enrolled • Over 6,000 served total 	Yes	<ul style="list-style-type: none"> • \$10 per member per visit copay • \$5, \$15, \$25 co-pay for pharmaceuticals as needed 	N/A	None
IHP PLAN A Ingham Health Plan	Donated Care	<ul style="list-style-type: none"> • 35% FPL • Resident of specified locale • Determined eligible by Family Independence Agency (enrollment currently closed) 	Basic	<ul style="list-style-type: none"> • Waivered SCHIP funds³ • Donated Care 	15,323 in all 3 plans total	Yes	Nominal sliding scale co-pay (\$2-\$12)	N/A	None
IHP Plan B Ingham Health Plan	Donated Care	<ul style="list-style-type: none"> • Ages 19-64 • Low-income (150% FPL) • Resident of specified locale • Not eligible for other health insurance programs¹ 	Basic	<ul style="list-style-type: none"> • DSH funds² • Donated Care 	15,323 total in all 3 plans	yes	Nominal Sliding Scale Co-pay (\$2-\$12)	N/A	None
Ingham Health Plan 3 rd Share Plan "The Ingham County Advantage"	Cost Sharing	<ul style="list-style-type: none"> • Small Employers located in Ingham County • Been in business 2 years • Not offered health insurance in 2 years • Between 2-20 employees • Not less than 50% of all employees make \$10 or less 	Basic	<ul style="list-style-type: none"> • Donated Care • IHP County health Plan Subsidy 	15,323 total in all 3 plans	yes	Variable at Employers discretion up to \$135	Variable up to \$135	Annual Cap-35,000 Life Cap-200,000

¹ Medicare, Medicaid, or private market insurance² Medicaid Disproportionate Share Hospital (DSH) funds obtained through contracts with hospitals³ State Children's Health Insurance Program

3.0 Research Analysis and Implications

This section addresses the question at the center of this issue—how can CBF-HCs impact access to health care for persons with disabilities? It utilizes a combination of qualitative and quantitative measures to study the potential impact of a CBF-HC's low- or no-cost health-care access on the targeted population of uninsured individuals with disabilities in and out of the workforce. Qualitative analysis of literature and research, combined with stakeholder interviews, offers insight into operational processes that benefit persons with disabilities. Using data from the Medical Expenditure Panel Survey (MEPS) and the Current Population Survey (CPS), the microsimulation estimates the share of the targeted population that would potentially benefit from coverage of a CBF-HC, while also considering the restrictive aspects of many programs with limited resources. It also estimates the percentage of the target population that would benefit overall from the implementation of a CBF-HC. Recommendations for policy and further research are drawn from existing literature and research, as the potential for CBF-HCs to improve employment through health-care access is explored.

3.1 Implications for Persons with Disabilities and Labor Force Participation

Current literature on CBF-HCs does not focus specifically on the interaction of these programs with persons who have disabilities. This is not to say that persons with disabilities are not served by or do not have the chance to benefit from these programs in their communities. Medicaid and Medicare offer one option for health-care coverage if a person qualifies; however, the restrictive eligibility requirements (e.g., having to prove one is unable to work at all) and the limited income eligibility requirements of these programs can force individuals who would otherwise work to not do so in order to obtain the health care they need. This is especially true for low-income or part-time workers with disabilities who do not have access to employer-sponsored insurance (ESI) or who cannot afford the premiums to obtain it.

Poverty is positively associated with public insurance programs and disability. This indicates that a large part of the population that reports one or more disabling conditions is forced to choose between obtaining the needed health care and continuing employment. Studies show that health insurance is considered a large disincentive for returning to work (Stapleton et al., 1997). Thus existing programs have produced a situation in which an individual who may have only needed temporary assistance is now set up for a lifetime of benefits. CBF-HCs can fill the gap between public benefits and the less-affordable private market insurance plans. Access to a CBF-HC provides relief to persons with disabilities in a variety of capacities. For example, a CBF-HC can provide temporary medical care while a person with a disability is in the waiting period required to obtain Medicaid benefits or assist low-income workers who cannot afford or obtain ESI or private insurance. CBF-HCs also have the potential to provide immediate care for an individual directly following disability onset, potentially preventing worsening health or secondary conditions.

The structure of a CBF-HC can influence its range of impact for persons with disabilities. One structural component in CBF-HCs is the practice of care management and case managers, who are trained in all of the available public programs and help individuals gain access to those for which they qualify. These same care managers provide guidance on proper care, as well as on proper use and navigation of the health-care system. This practice especially benefits persons dealing with disability onset or related chronic conditions that have high health-care needs. Care management blends program needs with member needs in one setting to achieve optimum outcomes for all involved.

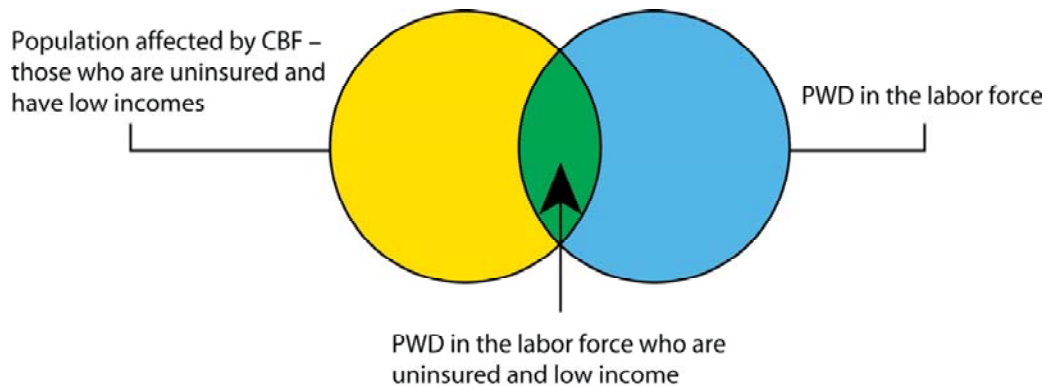
3.2 Impact of CBF-HC Microsimulation Model

Persons with disabilities in the labor force cannot benefit from CBF-HC programs unless they meet eligibility requirements. Therefore, in order to assess the potential impact of CBF-HC programs on persons with disabilities in the labor force, it is critical to first determine the proportion that would be eligible.

Eligibility requirements for seven selected CBF-HC programs are summarized in Table 1 above. Every program contains an income threshold and most also restrict eligibility to those who are working and uninsured. This sub-section analyzes Census data and Medical Expenditure Panel Survey (MEPS) information to quantitatively estimate the impact of CBF-HC programs relative to individual variables, such as employment status, insured status, income and medical expenditures.

The population of interest is persons with disabilities in the labor force (PWD-LF). This issue paper is interested in the proportion of this population that meets typical CBF-HC eligibility requirements (Figure 1).

Figure1. Schematic of CBF Study Population



For PWD-LF who are eligible, CBF-HC programs could lead to low-cost coverage unless there are restrictions on pre-existing conditions. Most of the programs modeled as insurance products identified in this issue paper involve very affordable monthly premiums. This issue paper is interested in the impact these programs would have on the availability and affordability of insurance for PWD-LF. Toward that end, a profile was developed that will help identify those who are in the overlap and, among those, how many would find insurance affordable due to CBF-HC programs.

This issue paper analyzes the micro-data from the Annual Social and Economic Supplement to the 2009 Current Population Survey (CPS), released September 10, 2009.⁸ For March 2009, the data show 6.1 million PWD-LF, of which 5.3 million were employed and 803,000 were unemployed (Department of Health and Human Services, September 2009). The profile contained in Table 2 and Table 3 shows the estimated numbers broken down by family income and insurance categories for both employed and unemployed PWD. Table 4 focuses on the uninsured as these are the most likely to be eligible for CBF-HC programs.

⁸ See Appendix A for additional information on this and the MEPS.

Table 2. *March 2009 Profile of Employed Persons with Disabilities-LF*

Poverty Level (%)	Source of Insurance				Total
	Employer	Individual	Public	Uninsured	
<100	74,981	35,626	156,305	159,981	426,892
100 - 150	142,002	33,954	144,183	142,261	462,400
150 - 200	220,601	42,008	87,598	116,481	466,686
200 - 250	231,785	57,008	65,940	83,577	438,310
250 - 300	262,823	51,831	78,367	68,235	461,256
300 - 350	312,252	31,686	53,392	52,292	449,622
350 - 400	263,620	30,128	42,946	53,558	390,251
400+	1,760,806	181,448	146,177	103,298	2,191,728
Total	3,268,868	463,688	774,907	779,682	5,287,145

Source: 2009 Bureau of the Census (Department of Commerce)

Table 3. *March 2009 Profile of Unemployed Persons with Disabilities-LF*

Poverty Level (%)	Source of Insurance				Total
	Employer	Individual	Public	Uninsured	
<100	13,734	8,822	97,552	96,821	216,929
100 - 150	33,548	7,945	56,194	33,272	130,959
150 - 200	25,518	4,541	10,442	29,952	70,453
200 - 250	42,782	4,212	15,529	37,630	100,153
250 - 300	31,961	2,927	4,938	16,712	56,537
300 - 350	25,191	0	9,514	11,000	45,705
350 - 400	26,952	630	9,339	17,010	53,931
400+	99,546	4,198	9,931	14,357	128,032
Total	299,232	33,274	213,438	256,755	802,699

Source: 2009 Bureau of the Census (Department of Commerce)

The eligibility requirements of the plans reviewed in Table 1 differ in the details but predominately include being employed, uninsured, and of low income. As of March 2009 it is estimated there were about 780,000 employed PWDs with no health insurance (Table 4, column 1). The subset that would be eligible for a CBF-HC program depends upon the low income threshold. In the programs reviewed, the most common threshold is 200 percent Federal Poverty Level (FPL). This translates into 418,000 eligible PWDs, representing 54 percent of those who are employed and uninsured. If CBF-HC programs were to include the unemployed (Table 4, column 2), the 200 percent FPL threshold would result in 580,000 eligible PWDs, or about 56 percent of the PWD-LF without insurance.

Table 4. *March 2009 Profile of Uninsured Persons with Disabilities*

Poverty Level (%)	Uninsured PWD-LF		
	Employed	Unemployed	Total
<100	159,981	96,821	256,802
100 - 150	142,261	33,272	175,533
150 - 200	116,481	29,952	146,433
200 - 250	83,577	37,630	121,207
250 - 300	68,235	16,712	84,947
300 - 350	52,292	11,000	63,292
350 - 400	53,558	17,010	70,568
400+	103,298	14,357	117,655
Total	779,682	256,755	1,036,437

Source: 2009 Bureau of the Census (Department of Commerce)

Unfortunately, CBF-HC programs, with their limited resources, are not well suited to covering higher risk individuals. The MEMPHIS plan does not enroll individuals with high immediate health care requirements, while the OUCH plan caps health care payments at \$3,000. Thus, while significant numbers of the uninsured PWD-LF population may meet income and employment eligibility requirements for CBF-HC plans, those with poor health status may be excluded or find that the coverage is inadequate.

Table 5 provides information to help assess the extent to which the health status of PWD-LF might reduce their eligibility for CBF-HC programs or render the programs inadequate in terms of coverage. It compares the per capita healthcare expenditures of PWD-LF with their non-disabled counterparts according to employment status. For the employed group, both the mean and median expenditures per capita are over three times higher for PWD compared to those without disabilities. Patterns are roughly similar for the unemployed group.

This shows that PWD are generally at higher risk for health care spending and could, therefore, be denied access to CBF programs that exclude certain pre-existing conditions. It also shows that CBF-HC program benefit caps would leave many PWDs with inadequate coverage. The \$3,000 cap for OUCH, for example, is less than half of the average health care spending for employed PWD-LFs. For unemployed PWD-LFs, the cap is less than one-fourth of average spending.

Table 5. 2006 Per Capita Health Expenditures⁹

	Mean	Median
Employed		
PWD	\$7,770	\$2,519
Other	\$2,492	\$717
Unemployed		
PWD	\$12,511	\$6,452
Other	\$3,914	\$1,083

Source: 2008 Department of Health and Human Services

⁹ All methods for estimating data from the Annual Social and Economic Supplement (ASEC), the Current Population Survey (CPS), and the Medical Expenditure Panel Study (MEPS) are documented in the Technical Appendix.

CBF-HC programs are admirable in their creative approaches to funding health insurance for persons who would otherwise not be able to obtain coverage; however they cannot always provide coverage to individuals with relatively high health care needs. While some PWD-LFs may not fall into this category, the findings suggest that many do. Therefore, CBF-HC programs are likely to fill only a small part of the gap in the availability of health insurance to PWD-LFs.

3.2 Limitations and Lessons Learned

Although microsimulation shows that potential impact can be limited due to CBF-HC's limited resources and their inability to meet high health-care needs, many of the interviewed program directors indicated that in some cases they can arrange for the care to be donated. For example, CarePartners in Maine maintained that their benefit package was only limited when they could not recruit a doctor to offer the care (C. Zechman, personal communication June 3, 2009). It is also important to consider that access to the preventive and basic care these individuals need might prevent some of the disabling and chronic conditions that the programs may not be set up to treat. With limited resources but aggressive care management and affordable services, these programs can provide a stopgap for an uninsured individual who is suddenly faced with the onset of disability or has a disability-related condition. These programs can also provide for the individual's continued participation in the workforce, thus preventing the progression to disability benefits.

3.1.1 Limitations

Funding is a complex issue that can derail CBF-HC programs. Many programs are constrained by the number of people they can serve due to the costs. However, the programs can get around these constraints by limiting the benefits they offer. The Ingham County Third-Share Plan is a cost-sharing insurance program wherein the insurance costs are covered by premium payments from members and employers; a third share of the costs is subsidized by the county health plan program (i.e., the same organization that manages the county's Plan A and Plan B). Although the subsidized insurance program looks attractive and the share of the subsidy has increased above the one-third original estimates, this program is not performing according to expectations. Each share of the premium was set at \$50, which plan organizers considered affordable, especially when compared with market prices. Unfortunately, enrollment has been very low. The employers' lack of participation has been attributed to their inability to afford their share of the premiums or unwillingness to assume the responsibility for the health care of their employees (J. Welter, personal communication, June 2, 2009).

3.1.2 Lessons Learned

Another issue is ensuring that the right people participate, from start-up and planning through implementation and follow-up. Without key members from the community, the CBF-HC misses pieces of the mosaic. Ensuring that the right people take part in the CBF-HC's development and operations can help overcome serious hurdles related to community understanding and willingness. Maine's CarePartners, for example, reaches out to individuals with disabilities who may not be eligible for government programs by listing the program's contact information on Medicaid denial letters (C. Zechman, personal communication, June 3, 2009).

Because program reports and outcome studies are targeted at the overall population served, disability-specific information is not currently available. However, qualitative data gained from review and interviews is indicative of CBF-HC's support for individuals with disabilities, though no studies have been done that show an explicit link between the two. The development of a microsimulation model has

aided in addressing potential impact and highlights the limitations that minimal resources have on the ability of such a program to offer the level of care that may be needed for persons with disabilities, especially those with high-cost, specialized needs.

3.3 Recommendations for Future Practices, Policy, and Research

Extensive review of literature, combined with interviewing major stakeholders, has produced some universal themes and highly successful practices to consider for anyone designing a CBF-HC program of their own. However, synthesizing these themes with population-specific needs produces further considerations as one endeavors to meet the needs of persons with disabilities who are either in the workforce or looking for avenues to return to the workforce. Although the concepts of collaboration, education, and creativity have already been discussed in regard to one aspect or another, these concepts need to be taken a step further when addressing the needs of persons with disabilities, whether or not they are currently utilizing Medicare, Medicaid, SSI, or SSDI.

Collaboration between key personnel and stakeholders within the community is key to starting up and sustaining a program. When a program is targeting persons with disabilities, the organization must include members of the disability community; as one program director said, “You don’t ask insurance companies about the uninsured; they specialize in the insured” (Anonymous, personal communication, June 24, 2009). The same concept applies here. Key members of the disability community can answer to and identify the unique needs of the population; therefore, their inclusion is critical to the successful implementation of any CBF-HC. In addition, their presence will ensure that care managers, facilitators, and educators are more informed.

Care management and education are two components that must go hand in hand. According to Spikoff, (2003), “Educating and managing patients with chronic conditions is an effective way to stabilize overall health care costs” (para. 1). With 78 percent of people who are on Medicare reporting at least one chronic condition (Partnership for Solutions, 2002), and an understanding that some of the most prevalent causes of mobility issues are arthritis, joint problems, back problems, heart disease, and chronic lung disease (Iezzoni, 2003), these components are critical to the efficacy of any CBF-HC. CarePartners, Ingham Health Plan, the Church Health Organization (MEMPHIS plan), and numerous other CBF-HCs share a common thread in regard to their clients, goods, and services: management and education. All programs have aggressive case managers for program members. Care is coordinated by these managers to ensure timely receipt of services; appropriate use of primary care, specialist, and emergency services; and ongoing education of the community about proper use of these services, as well as proper care of their conditions. Ensuring that program members are educated lowers the cost of care, optimizes preventive care, and mitigates risks.

Care management can be extensive and time consuming. Therefore, trying to nationalize what is essentially structured around and dependent upon a community setting can be ineffective. Current research shows that the most efficient and sustainable programs are based around a high level of community participation and communication (Silow-Carroll, Anthony, Seltman, & Meyer, 2001). Collaboration is not about large groups of people; it is about small groups of unique ideas coming together (Denise, n.d.). The CBF-HC programs are structured around this collaboration and would lose much of this process if translated to a national level:

One reason for the small size of most effective collaborations is that they are highly vulnerable to the protocols required by larger forms of togetherness. They do not fare well under ground rules—whether of agendas, turn taking, or almost anything else. Collaborations are interpersonally rather than structurally determined. (Denise, n.d., p. 4)

Therefore, it is strongly recommended that CBF-HCs remain on a community level, though this does not exclude government support or involvement. Many grant foundations, such as the Robert Wood Johnson Foundation, The Kellogg Foundation, and the federal HRSA grant programs, set a model of information, guidance, and start-up seed money that state and federal governments can expand to aid other communities in researching, designing, and implementing their own programs, as well as for moving existing programs to more areas. These foundations have produced programs that continue to exist throughout the country.¹⁰ With support and information at a community's disposal, CBF-HCs stand a greater chance of successful start up and continuance.

4. Summary and Conclusions

Research and analysis of existing CBF-HC programs have produced a variety of strategies for design and implementation of such programs in communities across the United States. Understanding the makeup of a community and incorporating the ideas and participation of community members is critical. With program characteristics such as cost sharing, the program design must have specific supports in place, such as legislation to exempt it from a state's insurance regulations. If a program is built around donated care, identifying physicians and specialists who are willing to participate is obviously crucial to success. Creative funding for any style of program is also imperative. In addition, locating hospitals willing to contract with the program may provide funding through the DSH process.

Design and implementation integrate the information from the community with the available resources and funding components that exist for that community to create a program that is tailored to the needs of the targeted population. Ensuring that the right people are present during this process produces a more wholly integrated program that is informed by key individuals who will participate as members, administrators, proprietors, and workers within the program. Outreach and recruitment are also two crucial components of a program's design, both for targeting participating medical field personnel and for enrolling potential members.

Finally, CBF-HCs programs have the potential to affect various segments of a population. This type of program will best serve persons with disabilities if it considers their needs and situations. Keeping a program at the community level increases its ability to meet those needs and to coordinate the services associated with care, such as transportation, home care, and specialized services. Education and management contribute to this coordination through seminars, individual consultation, and knowledge transfer. The affect of CBF-HC programs can be wide reaching if the right circumstances and parameters are in place to be applied where they are most needed.

¹⁰ These community programs can be reviewed at the Web sites sponsored by Communities Joined in Action, Community Voices, and Communities in Charge.

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Appendix A

Technical Appendix

**Impact of Reinsurance / Community-Based Finance on
Access to Health Insurance for Persons with Disabilities**

The analyses and estimates presented in the quantitative modeling of the effects of reinsurance and community-based financing – a quasi-microsimulation approach – were based on the construction of a profile of persons in the labor force with a disability. This profile, in turn, relied on three survey databases that individually did not contain the full set of required variables. This technical appendix briefly describes how the datasets were analyzed and synthetically merged to create the profile.

The Annual Social and Economic Supplement to the 2009 Current Population Survey

The Annual Social and Economic Supplement (ASEC) is the featured dataset upon which we built the profile required to conduct the simulation estimates. Adding to the monthly Current Population Survey (CPS) questions that largely address employment, each spring additional topics are addressed by the ASEC.¹¹ These data are cleaned; they and a report were released on September 10, 2009.¹² The value of the ASEC comes from the inclusion of questions covering topics such as: household and family characteristics; marital status; income; poverty; work status/occupation; and health insurance coverage. Its value is also a function of the sample size, i.e., about 77,000 interviews. Most important for our profile is ASEC's data on income, poverty, and health insurance status (yes/no) and type (employer-based, individual coverage, Medicare, Medicaid, etc.)¹³

Before this 2009 release there was no standardized method to identify persons with disabilities. The six questions that are currently used in the CPS to identify PWDs were, for the first time, incorporated into the 2009 ASEC. Accordingly, programming that Altarum (and others) have done to remedy this deficiency for earlier years is no longer required (the Altarum program language is available for those who wish to conduct analysis using previous ASEC data releases). Thus, we believe the work shown in the modeling section above represents the first time when the six questions to identify PWDs have been combined with the rich data contained in the ASEC, particularly regarding employment, income levels (poverty), and insurance status.

The 2006 Medical Expenditure Panel Survey

To further delve into variations on definitions for persons with disabilities, and to complete our profile by obtaining a snapshot of healthcare expenditure information, we programmed the 2006 Medical Expenditure Panel Survey (MEPS) – Household Component (HC). The 2008 MEPS Codebook states:

¹¹ Formerly these added questions were fielded in March which explains why this became known as the “March Supplement.” This process now unfolds over the February, March, and April timeframe (personal communication with Steve Hipple, Bureau of Labor Statistics, April 14, 2009).

¹² DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-236, *Income, Poverty, and Health Insurance Coverage in the United States: 2008*, U.S. Government Printing Office, Washington, DC, 2009.

¹³ As a technical matter, the CPS employment data for March 2009, first released in April 2009, differs slightly from that shown in this report which is based on the 2009 ASEC. The latter data incorporate updated weighting factors to adjust the survey to be nationally representative.

This survey provides nationally representative estimates of health care use, expenditures, sources of payment, and health insurance coverage for the U.S. civilian non-institutionalized population. The MEPS Household Component (HC) collects data in each round on use and expenditures for office- and hospital-based care, home health care, dental services, vision aids, and prescribed medicines. Data were collected for each sample person at the event level (e.g., doctor visit, hospital stay).

The complete data file was released on November 17, 2008 and included 34,145 respondents. The central programming challenge was to identify individuals in MEPS who would roughly match those now being identified in the CPS via a “yes” response to at least one of the six disability questions (Exhibit 1).

Exhibit: The CPS Six Questions (beginning June 2008)

1. Is anyone deaf or does anyone have serious difficulty hearing?
2. Is anyone blind or does anyone have serious difficulty seeing even when wearing glasses?
3. Because of a physical, mental, or emotional condition, does anyone have serious difficulty concentrating, remembering, or making decisions?
4. Does anyone have serious difficulty walking or climbing stairs?
5. Does anyone have difficulty dressing or bathing?
6. Because of a physical, mental, or emotional condition, does anyone have difficulty doing errands alone such as visiting a doctor’s office or shopping?

Fortunately, MEPS contains variables that closely align with these six questions. Exhibit 3 displays the MEPS variables we used, which values we selected, and how many persons with disabilities (aged 16 and over) were identified.

Table A1: MEPS Variables to Match Six CPS Questions & Number Identified (16 years of age and older)

Variable	Description	Values	# Identified
HEARNG42	HEARING IMPAIRMENT	Major (4) or Deaf (5)	958,219
VISION42	VISION IMPAIRMENT	Blind (5)	712,057
COGLIM53	COGNITIVE LIMITATIONS	Yes	10,352,151
STPDIF53	DIFFICULTY WALKING UP 10 STEPS	Some Difficulty (2) A Lot of Difficulty (3) Unable to Do (4) Completely Unable to Walk (5)	17,360,717
ADL3M053	ADL HELP 3+ MONTHS	Yes	3,806,976
IADL3M53	IADL HELP 3+ MONTHS	Yes	7,598,799

Note: ADL is Activities of Daily Life (e.g., eating, getting out of bed, dressing, bathing); IADL is Instrumental Activities of Daily Life (e.g., using the telephone, paying bills, taking medications, preparing light meals, doing laundry, or going shopping).

Overall, this mapping identified 23.938 million persons with disabilities (at least one limit from these six variables), 4.845 million of whom were employed (MEPS does not allow one to determine who is in the labor force and unemployed as is the case with the Bureau of Labor Statistics protocol). Exhibits 3 and 4 show the relevant counts, and the healthcare expenditures, respectively from MEPS using the above algorithm. Once PWDs are estimated, we take total annual health care expenditures directly from MEPS calculations. For simplicity, we show the mean and median total annual expenditures in Exhibit 5. As an

example, MEPS shows that employed PWDs had average annual health care expenditures of \$7,770 in 2006. This compares with an average of \$2,492 for people without disabilities who are employed.

Table A2: Employed Status and Disabled Status Counts Using Six MEPS Variables

	Cohort	Weighted Cohort
DERIVED EMPLOYED FLAG		
Employed	14,703	148,350,923
Unemployed	10,207	83,321,328
	24,910	231,672,250
DERIVED DISABLED FLAG		
Disabled	2,931	23,938,317
Not Disabled	21,979	207,733,933
	24,910	231,672,250

Table A3: MEPS Healthcare Expenditure Data for Employed/Unemployed, Disabled/Not Disabled

		Cohort	Weighted Cohort	Mean Expense	Median Expense	Total Expense
DERIVED DISABLED FLAG	DERIVED EMPLOYED FLAG					
Disabled	Employed	504	4,844,918	7,770	2,519	37,645,189,245
Disabled	Unemployed	2,427	19,093,399	12,511	6,452	238,876,883,211
Not Disabled	Employed	14,199	143,506,005	2,492	717	357,669,538,605
Not Disabled	Unemployed	7,780	64,227,928	4,244	1,442	272,571,166,144
		24,910	231,672,250	3,914	1,083	906,762,777,205

Appendix B

Qualitative Methodology

The qualitative research presented in this issue paper is based on two data-gathering methodologies: (1) a comprehensive review of the literature on community-based financing initiatives in the United States, and (2) a series of interviews with stakeholders in these programs. For the literature review, the authors identified published, peer-reviewed research and unpublished studies or documents, program evaluations, and policy analysis reports that provided information on the design, implementation, and efficacy of existing CBF-HCs. The authors also identified reports developed by the programs themselves. Using an approved protocol, the authors contacted nine individuals at the administrative departments of several CBF-HCs and requested a one-hour telephone interview on the workings and the performance of their programs. In total, five interviews were conducted regarding programs in five counties. The list of key stakeholders was proposed by the researchers and pre-approved by the Office of Disability Employment Policy (ODEP). The protocol included detailed questions about the origins of the initiatives and the regulatory and legislative framework in place; the organization's management, impact, and performance; obstacles the programs encountered; potential expansion in the future; and a confidentiality agreement and consent form that all interviewed stakeholders were required to fill out prior to the interview.

The following approved script was used for the interview regarding Ingham County Health Plan. Similar questions were adapted for other county programs.

Interview Questions

- 1) We have reviewed the literature on community-based financing for health care and understand that there is considerable variability from one program to another. Although we have reviewed your Web site/brochures/materials, we would like to obtain a better understanding of your program through this interview. Our goal is to get an overall understanding of the program as a whole, but also to get some detail on the services offered, costs, funding sources, and target population. Would you please take a moment to describe your community-based financing program?

[Interviewer should skip any question below that has been clearly addressed in response to question 1.]

- 2) What was the impetus for this program? How did it come to be developed?
- 3) What services does the program provide?
- 4) What is the cap on benefits?
- 5) What is the cost to participants?
- 6) Do you expect this program to continue (barring huge changes in the health-care system currently in place in the United States)?

[If ongoing]

- a. What funding sources do you expect for the ongoing program?
 - b. Do you expect any changes in the size of the program over time, in terms of either the population it serves or the services it provides?
- 7) What are the goals of this program?
 - a. Reduce premiums? Improve access to health care?
 - 8) To what extent do you feel those goals have been achieved?

- a. **[If little or not at all]:** Can they be attained?
 - b. **[If greatly]:** What's next? What are your plans for the future of the program?
- 9) What population do you target with this program?
- a. To what extent do you think you've reached this population?
 - b. **[If individuals with disabilities are not included in the response]:** Has the program focused in any specific way on people with disabilities?
 - c. **[If persons with disabilities targeted]:** To what extent do you think people with disabilities have achieved more access to health care because of the program?
- 10) Are there state laws that impact or regulate your program?
- a. **[If yes]:** Can you tell us a little more about that?
 - i. What laws are they?
 - ii. What impact do they have?
- 11) Are there federal laws that impact or regulate your program?
- a. **[If yes]:** Can you tell us a little more about that?
 - i. What laws are they?
 - ii. What impact do they have?
- 12) Has any research or evaluation been conducted on your program?
- a. What were the findings?
 - b. Are there reports or data we can access that would provide us with more detail?
- 13) What is the impact of the economic crisis on enrollment? Is there a spike in demand for participation? How does your program deal with demand fluctuations?
- 14) Do you abide by efficiency/quality measures? What are they?
- 15) If you had it to do over, what would you do differently? What advice would you give someone trying to design and implement a community-based financing program?
- 16) How do you think President Obama's universal health-care plan, if enacted, will impact your community program?
- 17) If you had it to do over, what would you do differently? What advice would you give someone trying to design and implement a community-based financing program?
- 18) We've talked with you at some length now about your program. In addition to all you've shared, there appears to us to be a less tangible networking/political context impacting the development of these types of programs. Is there anything you would like to add that you think would enhance our understanding of community-based financing for health care in general or your program in particular?

Appendix C

Benefit Tables

Table of Benefits: OUCH

TableA1. Reimbursable Products or Services from OUCH

Product or Service	Co-pay
<ul style="list-style-type: none"> • Primary care services • Generic prescriptions • Over-the-counter medications prescribed by a physician 	\$5
<ul style="list-style-type: none"> • Labs • Basic dental services • Outpatient mental health services 	\$10
<ul style="list-style-type: none"> • Vision services 	\$15
<ul style="list-style-type: none"> • Specialty care radiology • Chiropractic services • Dental periodontal services and surgeries • Rehabilitation services 	\$20
<ul style="list-style-type: none"> • Urgent care center services • Ambulance services 	\$25
<ul style="list-style-type: none"> • Outpatient specialty services • Surgery • Emergency services 	\$50
<ul style="list-style-type: none"> • Inpatient hospital and mental health stays 	\$100
<ul style="list-style-type: none"> • Labor and delivery • Elective surgery 	Variable

Source: Church Health Center, 2009

Appendix C continued

Table of Benefits: Church Health Organization

Table A2 . Reimbursable Products or Services from Church Health Organization/MEMPHIS

Product or Service	Co-pay
<ul style="list-style-type: none"> ● Preventive care <ul style="list-style-type: none"> ○ Routine examination¹⁴ ○ Vision screening² ○ Hearing screening² ○ Immunizations 	No co-pay
<ul style="list-style-type: none"> ● Outpatient sick care <ul style="list-style-type: none"> ○ Primary care physician office visit ○ Diagnostic testing ○ Laboratory services ○ X-rays ○ Subspecialty services¹⁵ 	\$5
<ul style="list-style-type: none"> ● Inpatient sick care (hospital services) <ul style="list-style-type: none"> ○ ER due to accident or sudden onset of medical condition ○ Surgical care ○ Semiprivate room ○ Hospital ancillaries ○ Physician visits during inpatient care as needed ○ Concurrent care for unrelated conditions ○ Consulting physician care 	No co-pay
<ul style="list-style-type: none"> ● Dental services 	\$10

Source: Masilamani, 2004

¹⁴ Visits limited, based on age

¹⁵ Referral from primary care physician required