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

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

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

Community-Based Financing Programs

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

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

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

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

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

Successful Models of Community-Based Financing

Cost-sharing

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

Cost-sharing programs may include:

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

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

OUCH! offered a plan that split premium costs among employer, employee, and a community fund. With a $3,000 cap and aggressive care management that worked with other public programs, members received a wide variety of discretionary services.
http://www.capcommunity.hrsa.gov/cap/Events/Files/Jan_2004/Lanie

Donated care

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

CarePartners

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

http://www.mainehealth.org/mh_body.cfm?id=3441

Assessing Your Readiness for Community-Based Financing

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

Questions to Assess Community Readiness[v]

Who is your target audience?
What are their basic demographics and health care needs?

What is the community's interest in relation to the issue?
How does the community stand to benefit from covering more people through community-based financing?

What objections might stakeholders have to community-based financing?
Are there costs, challenges, and/or expectations that might derail plans for community-based financing?

What do stakeholders stand to gain from CBF-HC?
How can local leaders and community members benefit from the new financial entity?

Does the community have a preference or position on the issue of health care?
What has been done in the community around health care in the past, and are there other health care campaigns going on now?

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

http://www.mainehealth.org/mh_body.cfm?id=3441

Designing a CBF-HC Program: Key Components

Definition of Need

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

Needs in your community may include:

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

Partnerships

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

Potential partners include:

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

Organizational Status

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

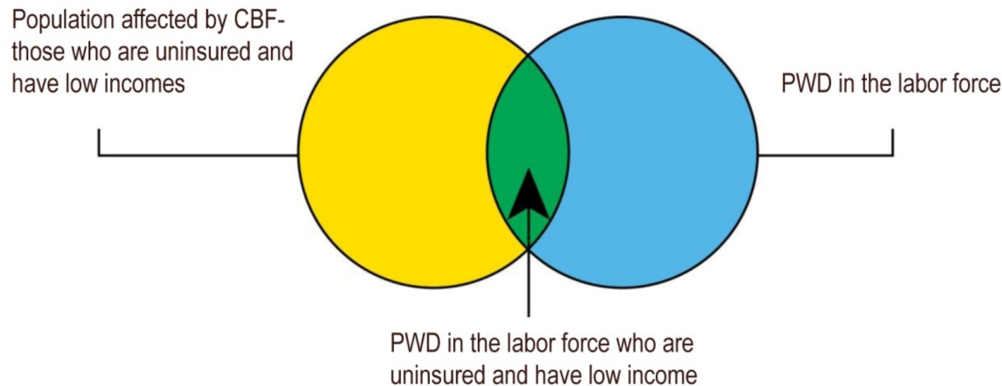
Governance

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

Defined Target Population

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

Figure 1. Schematic of CBF Study Population



In April 2009, Bureau of Labor Statistics reported

6.11 million people with disabilities in the labor force (PWD-LF),

5.31 million were employed

802 thousand were unemployed.[viii]

Eligibility Criteria

Eligibility parameters vary. They may include:

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

Sample Eligibility Criteria

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

CarePartners Eligibility
http://www.mainehealth.org/mh_body.cfm?id=3441#How_do_I_know_if_I_am_eligible?

Ingham Health Plan Eligibility
http://www.communityhealthplans.org/ihp/hpqa/InghamCA/IC_Advantage_Brochure.pdf

Services

Services must balance the needs of the population, what the program can afford[ix], and what other existing public programs might cover.

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

Funding

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

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

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

Cost containment

The cost containment measures of a CBF-HC program must fit the community. CarePartners of Maine can offer a more comprehensive benefits package not just because of their program structure, but also because of the state's characteristics. What works in one area may not work in another, so understanding how costs will be managed is an important step in ensuring sustainability. The National Conference of State Legislatures (NCSL) provides examples of cost containment ideas as examples (http://www.ncsl.org/IssuesResearch/Health/StateHealthCareCostContainmentIdeas2003/tabid/14465/Default.aspx).

Community Outreach and Recruitment

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

> *Remember the recruiting process is an opportunity to get to know people and for them to get to know you*
>
> *Make sure they understand the mission of your program and that it aligns with their own views and beliefs*
>
> *Find out how they want to serve the organization*
>
> *Evaluate them for personal motivation*
>
> *Place a new member in a position to thrive, not fail*
>
> *Encourage feedback and self-reflection*

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

The Church Health Organization

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

[1] Laura's House is a non-profit organization that addresses issues related to domestic violence and abuse.

Measuring Success in Community-Based Financing

Defining Outcomes

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

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

Research Methods and Data Collection

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

Research Methods Examples: How Data can be Collected and Sampled
http://www.bized.co.uk/timeweb/digging/dig_source_expl.htm#2

Research Methods Workshops
http://www.wadsworth.com/psychology_d/templates/student_resour ces/workshops/resch_wrk.html

Data reporting

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

Program Snapshots

Shelby County,Tennessee

Church Health Center/MEMPHIS ● http://www.churchhealthcenter.org/

Program Type: Donated Care/Cost Sharing

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

Benefit Type: Comprehensive

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

Members Served: 50,000

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

Cost to Employer: $10/month

Benefit Cap: None

Ingham County, Michigan

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

Program Type: Donated Care

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

Benefit Type: Basic

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

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

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

Cost to Employer: N/A

Benefit Cap: None

Ingham Health Plan IHP Plan B

Program Type: Donated Care

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

Benefit Type: Basic

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

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

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

Cost to Employer: N/A

Benefit Cap: None

Ingham Health Plan Third Share Plan

Program Type: Cost Sharing

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

Benefit Type: Basic

Funding Sources: Donated care and IHP county health plan subsidy

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

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

Cost to Employer: Variable up to $135/month

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

Cabell County, West Virginia

Offering the Uninsured of Cabell County West Virginia Health Care (OUCH!) ● http://www.cjaonline.net/Communities/WV_Cabell.htm

Program Type: Cost Sharing

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

Benefit Type: Basic

Funding Sources:
- Federal and Local Grants
- Donated Care
- Premium Payments

Members Served: 150 (2004)

Cost to Member: $36/month

Cost to Employer: $36/month

Benefit Cap: Annual Cap $3,000

Adams County, Illinois

Access Health Care Adams County Illinois (AHAC) ● http://accesshealthac.org/page5.php

Program Type: Donated Care

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

Benefit Type: Basic

Funding Sources:
- Federal and Local Grants
- Donated Care

Members Served: Unknown (Target 17,000)

Cost to Member: None

Cost to Employer: N/A

Benefit Cap: None

Cumberland, Kenebec, and Lincoln Counties, Maine

CarePartners ● http://www.mainehealth.org/mh_body.cfm?id=3441

Program Type: Donated Care

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

Benefit Type: Comprehensive

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

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

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

Cost to Employer: N/A

Benefit Cap: None

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

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