

The Communities Building Access Act

Summary and Facts

The **Communities Building Access Act** would provide \$45 million in federal grants over a seven-year period for two models of proven, locally designed and administered health care programs for the uninsured, and would establish a data and assistance center to evaluate and aid in the proliferation of these programs. The legislation was specifically designed to compliment, not duplicate, current federal initiatives for the uninsured, including health savings accounts, association health plans, community health centers, and Medicaid and S-CHIP programs.

Section 1. Multi-share Health Coverage Program grants:

These community grants would be leveraged with employer, employee, and other community contributions to purchase a locally-developed insurance-like product for individuals working in small businesses not already offering health benefits.

Grantee Qualifications: To qualify for a Multi-Share Health Coverage Program (MHCP) grant, a non-profit community organization must assemble a broad community consortia for the purpose of advising and planning an MHCP, and must demonstrate that it has or is capable of developing (1) a local provider delivery network; (2) an entity to manage enrollment, payment, and other administration; (3) employer and employee eligibility criteria, including protections against displacing private coverage; (4) a comprehensive health benefits package; (5) discreet programs for managing utilization, quality measurement, and chronic conditions and other high risks; and (6) a plan for evaluating the project on an interim basis.

Existing Community Models Similar to MHCPs: Access Health of Muskegon, Michigan is a community-based, multi-share health coverage initiative targeting the working uninsured in small businesses. The program, which covers a comprehensive set of preventive and acute health benefits, has enrolled 1,200 workers in 430 businesses since 1999. Enrollment in Access Health costs approximately \$160 per month per individual, with 30% of the fee being paid by the employer, 30% by the employee, and 40% by the community through various funding sources. The plan has been successful in achieving broad community acceptance with nearly 97% of physicians in Muskegon County participating. Additional “multi-share programs” in existence or under consideration include those in Jacksonville, FL; Huntington, WV; Rockford, IL; San Diego, CA; Galveston, TX; New Orleans, LA; Butler County, OH; Cincinnati, OH; Detroit, MI; Lansing, MI; Grand Rapids, MI; Marquette, MI; Charleston, SC; Brunswick, GA; Sioux City, IA; Bismarck, ND; and Franklin, Scott and Logan Counties, AR.

Section 2. Volunteer Specialty Provider Networks

These community matching grants are intended to increase access to specialty care—a known gap in health care for the uninsured—for low-income individuals who regularly access voluntary provider networks or primary care clinics for the uninsured. Examples of allowable grant expenditures include fees for recruiting specialist providers, training for treating specialty conditions, electronic medical records for uninsured individuals (known to improve providers willingness to volunteer), and administration of specialty care community clinics.

Grantee qualifications: To qualify for a Volunteer Specialty Provider Network (VSPN), a non-profit community organization must assemble a broad community consortia for the purpose of advising and planning a VSPN, and must demonstrate that it has or is capable of developing (1) an administrative entity, (2) enrollee eligibility criteria, (3) affiliations with volunteer specialist providers, (4) chronic care programs, (5) additional funding sources, and (6) a plan for evaluating the project on an interim basis.

Existing Community Models Similar to VSPNs: CareNet in Toledo (Lucas County), Ohio offers coordinated and comprehensive access to health care services for low-income, uninsured residents not qualified for Medicaid. Since CareNet was initiated in 2003 by the county and local hospitals and physicians, the program has provided ongoing care, through primary care physicians, to more than 7,600 uninsured residents. CareNet’s community partners contribute to the operating budget and local providers use their resources to provide care. While CareNet provides access to specialty providers, it has ongoing difficulty meeting specialty care needs. Safety networks of volunteer providers, similar to CareNet, exist in many communities around the country.

Section 3. Community Access Evaluation and Expertise Center:

A national center would be created to collect, evaluate and disseminate national experience and information on establishing community programs for the uninsured, and to determine the effectiveness of federal grants for such community programs.