# The Communities Building Access Act

## Common Questions

**How much will this cost?**
The bill is requesting $45 million spread out over seven years.

**How many individuals will be covered?**
Given that each community has some discretion in how their grant is used, and the Secretary has some discretion in the amount of each grant depending on the application, it is very difficult to make such estimates. An additional variable—for Title I—is the amount the employer, employee, and community contribute (must be at least 70%), and—for Title II—the amount the community matches (must be at least 33%).

More importantly, Title III of the bill requires community grantees to account for and report annually various data including how many individuals and businesses are receiving coverage or care under the grant that previously did not have regular access to care. Ultimately, because of the fact that that every federal grant dollar under these programs will be matched 2 or 3 times by the community, the federal government is virtually guaranteed a measurable return on these grants.

**Will grants for employer coverage drive employers to drop current private coverage?**
The bill includes requirements that a community plan must include mechanisms that will prevent crowd-out, or displacement of private coverage for public coverage. The default mechanism, which is commonly used in similar community programs now, requires that an eligible employer must not have offered coverage to employees in the last 12 months.

**How is this going to solve the national crisis of the uninsured?**
This legislation in not considered a silver bullet for the uninsured, but rather an interim step that will aid creative communities to develop solutions for their uninsured populations.

Local health care access programs can be laboratories for learning about national solutions for the uninsured. They have yielded important findings such as the level of subsidy necessary to get small employers to purchase coverage for their employees, how to effectively market access programs to the uninsured, and how to effectively manage chronic care among lower-income populations.

**Does the bill duplicate other federal spending or initiatives for the uninsured?**
The bill was carefully designed *not* to duplicate other federal spending or popular initiatives for the uninsured such as Association Health Plans and Health Savings Accounts. The targeted populations for these grant programs are (1) those working in businesses that have not offered coverage in the last year, and (2) those below a certain income level without access to employer coverage, spousal coverage, and those ineligible for Medicaid or Medicare.

Title II, Specialty Care Access Networks, was designed to narrowly focus on the lack of specialty health care faced by the uninsured, and is careful not to duplicate current primary care clinics that receive funding for the uninsured from the federal government.

**Why put a proven success at risk with Government intervention?**
While these models have been tested and proven successful, many are financially unstable and in need of at least a small, dependable source of funding. In addition, many communities have examined the possibility of establishing similar programs for their uninsured populations but have postponed initiatives due to lack of funding. The legislation as drafted is careful to allow flexibility for tailoring programs to local needs, and not to over-regulate or interfere with successful experience.

**Will these programs eventually become independent?** It is possible that many of the programs, once a stable, integral part of the community, could be fully funded by those in the community. Important to note is that many of the employers that have utilized the multi-share employer program have moved on to commercial coverage.

**Does the bill promote individual responsibility?**
The Multi-Share employer programs (Title I in the bill) require employees to pay a monthly share of their coverage, similar to commercial insurance. Many of these individuals have never had health insurance, and this is therefore an important first step of personal health care responsibility.

Additionally, the bill requires community plans to include chronic care management programs and other cost control mechanisms. Several community programs, such as the one in Muskegon, Michigan, motivate individuals to take responsibility for their chronic conditions by offering lower cost-sharing for those who maintain their care.

**What about chronic care management?**
As mentioned above, in order to be qualified for an employer multi-share grant (Title I), a community must have a plan for coordinating chronic conditions across provider settings. The Specialty Care Access Networks (Title II) allow grants to be used for medical training specifically for managing chronic conditions.

**Can the grants be used for health information technology?**
Yes. The development of Electronic Medical Records (EMR) for groups of uninsured individuals in a community have proven to be very beneficial for continuity of care, reducing duplicative care, and inducing providers to volunteer medical care. Therefore, the bill specifies that grants for Specialty Care Access Networks (Title II) can be used for the purchase of information technology systems used for developing electronic medical records for uninsured individuals enrolled in the network.

**How is this legislation different from other federal health programs that have recently been defunded?**
According to the President's budget for 2007, the Congress terminated or reduced spending in a number of HHS programs that were "either duplicative, inefficient, or not producing results."

These concerns were seriously considered during the drafting of this legislation. The legislation includes several accountability provisions for grantees, and is careful to target specific populations who do not qualify for other federally funded programs. In addition, to ensure the greatest return on investment, the legislation was modeled after two proven community models that have accumulated an impressive amount of expertise that can be disseminated to grantees creating similar models.