

The Costs and Adequacy of Safety Net Access for the Uninsured in Genesee County, Michigan

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Abstract: This commentary examines Genesee County (Flint) Michigan to explore whether a well-structured safety net system is able to provide low-income uninsured people adequate access to care at a reasonable cost. Genesee County is one of the more economically challenged communities in the country. This commentary explores the cost and adequacy of safety net care in Genesee County under the Genesee Health Plan (GHP). The analysis compares the cost of services under GHP to the cost of the same services offered by local private insurers and Medicaid. An analysis found that GHP, Flint-area physicians, hospitals, and foundations have succeeded in providing basic medical care access to a substantial majority of their low-income uninsured citizens. The costs of care, both paid by GHP and donated by local providers, are substantially less than the estimated costs if this population were covered by full Medicaid or private insurance.

Key words: Safety net, access, cost, uninsured, community, Genesee County.

This commentary explores whether the safety-net program in Genesee County (Flint), Michigan provides low-income uninsured people adequate access to care at reasonable cost. While the Patient Protection and Affordable Care Act of 2010 will cover an additional 30 or more million people and offer other protections to many more, at least 20 million people will likely remain uninsured, leaving them to rely on safety-net care for most of their health needs.¹ As a result, the cost and adequacy of safety-net care remain vitally important issues for health care public policy.²

Genesee County, Michigan was selected for study after a thorough national review of safety net systems that arrange for low-income uninsured people to have access to a wide range of medical services (hospital, specialist physicians, prescription drugs) in a partially coordinated fashion based in a primary care medical home. This case study collects, analyzes, and evaluates available data regarding the structure, adequacy, and costs of the Genesee County safety net system.

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Program Structure and Demographics

Michigan has one of the hardest-hit economies in the country. In 2009, it had the nation's highest unemployment rate (exceeding 15%, three points higher than the next highest state). At the same time, its rate of uninsured nonelderly adults shot up three points in one year, to 18.7%, the second biggest increase in the country.³ These conditions put enormous strain on the state's safety-net programs.⁴ For Medicaid, Michigan limits enrollment of non-disabled childless adults to those whose income is no more than 35% of the federal poverty level. Moreover, Michigan periodically freezes enrollment in this optional tier due to caps in funding.

In 73 of Michigan's 83 counties, "county health plans" are the vehicle for covering non-disabled childless adults enrolled in Medicaid.⁵ According to key informants, many communities see the county health plans as good places to invest money in primary and preventive health care that can keep uninsured county residents healthier, thus reducing unnecessary or preventable use of emergency departments and preventable hospitalizations. County health plans are usually run by private, non-profit corporations with community boards. Approaches vary, but each county health plan has two distinct populations: Plan A is the county's childless adult Medicaid program. Enrollees must have incomes at or below 35% of the federal poverty level and assets of \$3,000 or less.⁶ Plan B can cover uninsured county residents with income as high as 250% of the poverty level, but most counties go up to only 150% of poverty. Neither plan covers inpatient hospitalization, and many counties set caps on enrollment or spending, so that most have Plan B enrollment well below 1,000 people.

Ingham County (encompassing Lansing, the state capital) and Genesee County (which includes Flint) are notable exceptions to the limited size of most Michigan county health plans. Because Ingham County's plan was started several years earlier, it has received the most attention to date.⁷⁻¹⁰ The Genesee Health Plan (GHP) is our main focus because it has the largest enrollment in the state and it receives strong community support.¹¹ In both counties, local funding for Plan B is much more substantial than elsewhere in the state. Active outreach efforts have produced enrollments of 15,000 in Ingham County and 25,000 in Genesee County. Both counties actively manage care by giving each person a membership card and assigning a primary care medical home that provides access to a well-organized system of specialist referrals, diagnostic testing, pharmacy benefits, and care management for chronic illnesses. There is no enrollment fee, and copayments are minimal (\$1-\$3 for covered prescriptions and \$3-\$5 for doctor visits and other services).

The Genesee Health Plan was incorporated in 2001 with funding from the Charles Stewart Mott Foundation, the state of Michigan, and the Greater Flint Health Coalition. Through a series of broad partnerships at the state and county level, GHP was conceived and designed to provide low-income, uninsured residents of Genesee County with access to a coordinated, patient-centered system of medical care.¹² By covering preventive care, office visits, laboratory and radiology services, and a limited prescription formulary, plan supporters believed the health of the community would improve. Pharmacy benefits consist mostly of generic, lower-cost prescription drugs. However, GHP assists patients with enrolling in the low-income free-access programs offered by

major pharmaceutical companies for their major products that are patented. While the adequacy of such programs may be debated, program data indicates that medication assistance helped 777 low-income patients receive \$1.3 million in free medication in 2007. Also limited are mental health and physical therapy benefits, constraining enrollees to a fixed number of visits. Not covered at all are nursing homes, home health, hospice, dental care, prosthetics, most durable medical equipment, IV therapy, and dialysis.

Also notably limited is coverage for hospital services (Table 1). Emergency services are covered only for Plan A members, but inpatient services are excluded from both Plans A and B, statewide.¹³ (Coverage of outpatient services is limited and varies between counties and plan types.) Hospital services not covered are available only on an uncompensated, charity-care basis. In Genesee County, the three local hospitals mutually support the program by considering enrollment in the county health plan as indicating eligibility for charity care, usually without the patient's having to file a full application; however, only one of Ingham County's two hospitals reportedly offers this accommodation. Patients in GHP use primary care physicians affiliated with each of the area's three hospital systems and tend to use the main hospital where their physician has privileges.

Funding for county health plans comes from two sources: the state makes capitation payments for enrollees in Plan A, but Plan B services are funded or donated locally. Many counties rely almost entirely on organized volunteer physicians for their Plan B services, but some counties contract with local providers for negotiated payment rates, while others operate their own primary care clinics.⁷ In Genesee County, care is provided by a large network of independent physicians and clinics. For several years, Genesee Health Plan (GHP) paid providers 14% above Medicaid rates for primary care and 4% above Medicaid for specialist and diagnostic services.⁸ When Medicaid rates were cut in 2009, GHP did not follow suit, so (as of October 1, 2009) GHP's provider rates were 24.5% above Medicaid rates for primary care and 13.2% for specialist and diagnostic services. Genesee Health Plan also makes lump-sum payments to hospitals

Table 1.

GENESEEE HEALTH PLAN STRUCTURE AND COVERAGE, 2008

	Plan A	Plan B
Funded by	Medicaid	County
Eligibility	<35% Poverty	35%–175% Poverty
Average Adults Membership	3,811	21,669
Hospital Inpatient	Not Covered	Not Covered
Emergency Room	Covered	Not Covered
Hospital Outpatient	Covered	Partial
Physicians	Covered	Covered
Pharmacy	Covered	Partial

to defray a portion of the facilities' costs for outpatient services for Plan B members and inpatient care for Plan A members.

Genesee Health Plan patients choose a primary care medical home from a network of 192 physicians, who in turn coordinate referrals to a network of 289 specialists. Of GHP's 14 employees, eight are trained as Health Navigators, who provide support to physicians and their GHP patients in improving healthy behaviors, managing chronic diseases, and accessing medical and community resources through the Health Navigator Self Management Support model.^{12,13}

In its early years, GHP was supported by \$1.7 million in grants from local foundations (the Charles Stewart Mott Foundation, the Ruth Mott Foundation, and the Community Foundation of Greater Flint). In November 2006, local citizens voted to increase property taxes by about \$11.3 million a year (through 2013) in order to increase substantially the program's size and capacity, which was opened to any uninsured adult county resident with a household income up to 175% of poverty. As a result, enrollment grew rapidly, to over 25,000 (Figure 1). According to the health plan's latest figures, 59% of new GHP members are unemployed, 27% say their employer does not offer health care coverage, and 11% say they cannot afford employer-offered coverage.

This willingness to fund low-income access comes from a community that is known for its history of serious economic problems. Flint is the birthplace of General Motors and the home of Buick's main plant. Its population was once one-third larger and had nearly 80,000 auto workers with full benefits coverage. However, by 2006, only about 8,000 auto workers remained. Median household income in Genesee County was about \$44,827 in 2008, compared with the national average of \$50,000, and over a third of Flint residents live below poverty. Unemployment rates at the end of 2009 were 27%

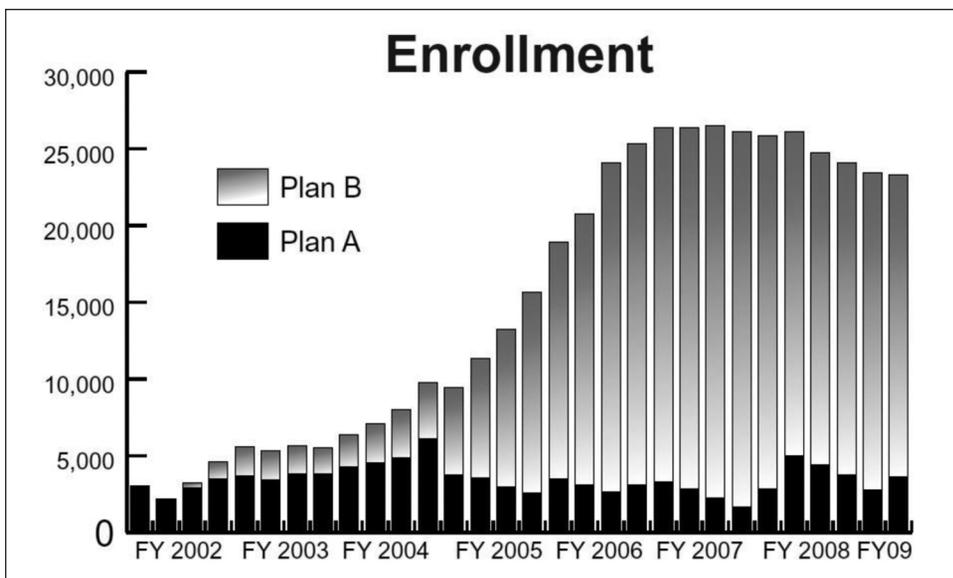


Figure 1. Genesee Health Plan quarterly enrollment, 2002–2009.

in Flint and 17% countywide. The greater Flint area (pop. 350,558) had the highest rate of uninsured adults (22.9%) among metropolitan areas in the state in 2005–2007.¹⁴

Adequacy of Access

Safety-net institutions often are regarded as places of last resort for indigent, uninsured people who lack other options. We explore here whether GHP provides access to care that is similar to access by insured populations. Several access indicators will be considered.^{15,16} One potential indication is that many people appear to consider GHP membership as equivalent to some form of insurance coverage, even though it is not considered insurance under Michigan law. A local survey conducted biennially by the University of Michigan Prevention Research Center specifically asks about GHP membership as one form of insurance coverage (even though it is not). The survey reports that over 90% of adults are covered (91% in 2009, 95% in 2007), which is substantially higher than the 82%–86% reported statewide from other surveys.^{4,17}

Another survey suggesting that GHP members consider GHP equivalent to at least a limited form of insurance is the U.S. Census Bureau's Current Population Survey. It reports that 20% of adults below 250% of poverty were uninsured in Genesee County in 2006, compared with 28% statewide—a statistic that contradicts others indicating that the area's economic indicators are worse than the state's overall. This 20% figure represents about 19,000 low-income uninsured adults in Genesee County compared to about 25,000 actually enrolled in GHP. This is also much lower than the 35,000–40,000 low-income uninsured estimated from other sources.¹² A plausible explanation for these discrepancies is that many people in GHP did not report being uninsured. The same point has been noted for Ingham County's health plan. When its members were surveyed, many reported having insurance, as one researcher recounts:

Even though [Ingham Health Plan (IHP)] is not an insurance product . . . , it is often perceived as such. To patients, providers and the community, IHP looks like a managed care plan and enrollees with membership cards and a primary care provider “feel” like they have health insurance. . . . [Thus] the IHP program appears to reduce the number of people who identify themselves as uninsured. The people covered by the IHP carry a membership card, are assigned to a medical home, have benefits that are set forth in a membership booklet, obtain medicine from virtually any pharmacy in the community, and are referred for specialty care and diagnostic services. In a recent Health Assessment Survey performed by the Health Department, some IHP-covered respondents did not identify themselves as being uninsured, mentioning they had coverage through the IHP.^{11(p.5)}

This survey anomaly is one potential indicator of the level of access to basic outpatient medical care. However, the anomaly also makes it difficult to identify precisely the population covered by county health plans in standard surveys, which confounds the comparison of Genesee County to elsewhere in meeting the needs of low-income uninsured citizens. For instance, a representative sample from Genesee County in 2006–2008 was not statistically different overall from the rest of Michigan in lacking a usual source of care or failing to get needed care due to costs.¹⁸ Furthermore, annual

surveys in Genesee County show no consistent improvement overall between 2003 (prior to GHP's rapid enrollment increase) and 2009 in the percentage of adults who reported being unable to see a doctor or fill a prescription due to cost.¹⁶ While just holding steady against the area's worsening economic tide might itself be considered a partial victory, firm conclusions cannot be drawn on the basis of this evidence.

Descriptive information is perhaps more revealing. Equivalency of access to out-patient care is confirmed by a study performed by Health Management Associates (HMA) comparing non-risk-adjusted utilization rates of GHP members in 2008 to adult members of a local, commercially-insured HMO and to national rates.¹² This study found that GHP members used primary care and wellness visits at rates comparable to the county's commercially insured (Figure 2). Specialty visits by GHP members are at only half the rate as those with commercial coverage, but this may be due in part to successful care management since these rates are close to general levels nationally. Additionally, newly enrolled Plan B members visited specialists at almost 10 times the rate (5.1 visits per person) in their first year as did GHP members overall, indicating good specialist access for patients who enroll with immediate needs. The HMA study

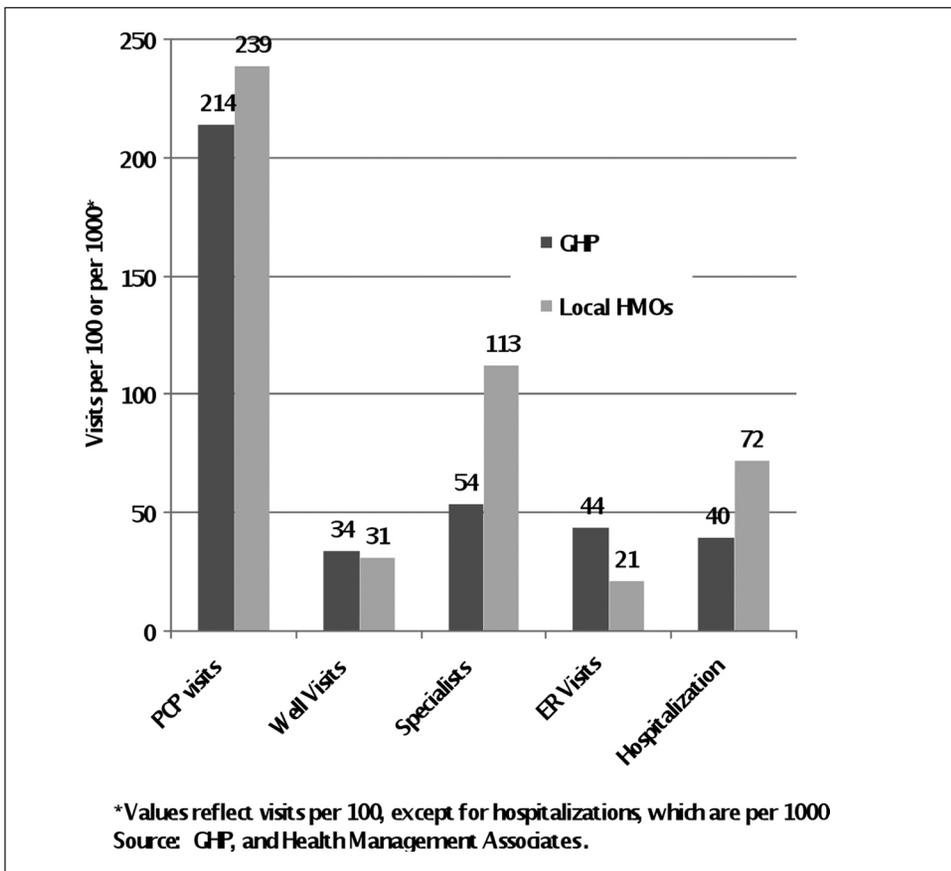


Figure 2. Genesee Health Plan (GHP) service use compared to local HMOs, 2007–2008.

also found that GHP members used the emergency room at about twice the rate (0.4 visits per person) at which the commercially insured used it, but at only about half the national rate for people on Medicaid, which is a more similar population.

Rigorous evaluation of health outcomes from enrollment is lacking, but Genesee Health Plan surveys its members annually to determine access to covered services.¹⁹ The 2008–2009 survey indicated that 94.8% of members received the services they expected from their doctor, 93.3% said they can get in to see their doctor within seven days when they are sick, 69.6% see their doctor more now than before they signed up for GHP, and 89.7% said they see the doctor within one hour of appointment time.

A cause for concern is that, because GHP does not cover inpatient hospital services, its members were hospitalized at only about half the rate (four admissions per 100 people) as people enrolled in local commercial HMOs. Even though local hospitals accept GHP members as qualified under their charity care policies, they do not have uniform policies and procedures regarding what proportion of charges they will waive. Additionally, some GHP members have reported they are concerned that they will be billed for at least some portion of the costs, or that they are reluctant to seek care on a charity basis. Therefore, it is likely their hospitalization usage is not at the level that would be expected with more adequate coverage.

Cost Comparisons

To evaluate GHP's costs, we compare them with the per member per month (pmpm) premium rates for private and public insurance coverage of an equivalent population. Table 2 shows enrollment and costs of services for GHP Plans A and B during calendar year 2008. Enrollment demographic characteristics and paid services were reported by GHP based mostly on data collected by its claims administrator. Administrative costs include both a pmpm fee paid to the claims administrator and an allocation of overhead costs that is based on program financial reports. Paid hospital services differ substantially because Plan B does not cover emergency services and covers only a limited range of hospital-based outpatient services. Neither plan covers inpatient hospitalization.

Next, uncompensated service (for non-covered care) was valued at the reported institutional costs, which were estimated as follows. For Plan A (which is funded by Medicaid), the best source of information comes from reports to the state by the three Flint hospitals of their Plan A discharges April 2008–March 2009. These reports value the care provided according to Medicaid rates, even though the care in fact is uncompensated. To convert the Medicaid values to costs, an average Medicaid-to-cost ratio of 0.77 was derived from 2009 reports by the three Flint hospitals. This produced an estimate of \$110 pmpm. Separating out the \$26 pmpm portion already counted above as compensated service (through the previously-noted lump-sum payment) results in an estimate of the uncompensated portion of inpatient costs of \$84 pmpm. Combining both compensated services and uncompensated costs yields a total of \$304 pmpm.

For Plan B, hospital costs were based on the following calculation, using data obtained from Health Management Associates (a research firm based in Lansing, Michigan). Flint hospitals reported total hospital costs for GHP patients in 2008, excluding any psychiatric and labor/delivery admissions (in order to better compare with Medicaid

Table 2.**GENESEE HEALTH PLAN COSTS, 2008**

Members	Plan A (<35% Poverty)	Plan B (>35% Poverty)	Total
Average Number	3,811	21,669	25,480
Member Months	45,731	260,032	305,763
Average Age	41	39	39
% Female	36	53.4	50.8
Average months enrolled	8.8	7.5	7.6
Paid Services PMPM			
Physicians	\$49	\$32	\$35
Hospital Outpatient ^a	\$19	\$6 ^a	\$8
Emergency Room	\$17	n/a	—
Hospital Inpatient ^a	\$26 ^b	n/a	—
Drugs	\$19	\$12	\$13
Administration	\$13	\$10	\$11
Subtotal PMPM	\$143	\$61	\$73
Uncompensated Services			
Hospital Inpatient	\$84	\$23	—
Hospital Outpatient	n/a	\$24	—
Emergency Room	n/a	\$17	—
Physician In-patient services	\$77	\$16	—
Total PMPM	\$304	\$141	\$165

^aFor Plan B, Genesee Health Plan reimburses only a limited set of outpatient ancillary services, and it pays hospitals a lump sum of \$1.2 million to defray unreimbursed outpatient expenses (such as surgeries).

^bBased on an additional lump sum of \$1.2 million to defray unreimbursed Plan A inpatient expenses. PMPM = Per Member Per Month

capitation). The portion attributable to Plan B patients was estimated based on the assumption that Plan A members would use the hospital at a rate 75% greater than Plan B members (based on the average of two risk-adjusted estimates derived from an actuarial analysis of GHP's outpatient claims). Applying this 1.75:1 ratio to each component of reported hospital costs produced pmpm estimates for Plan B uncompensated services of \$23 inpatient, \$24 outpatient, and \$17 emergency. The resulting total is \$141 pmpm for Plan B members, or an average of \$165 pmpm for all of GHP combined.

These estimates of Plan B's hospital costs appear reasonable, and they are broadly consistent with actuarial estimates provided by a local HMO (described below) of the likely hospital costs it would have incurred if it had covered a population with the demographic and diagnostic characteristics of GHP's Plan B members (Table 3). Nevertheless, inpatient costs might be higher if this population were to have full cover-

Table 3.**ESTIMATED MEDICAL EXPENSES, GENESEE COUNTY, MI,
UNINSURED ADULTS, 2008**

	Estimated GHP Plan B Costs	Projected HMO Costs ^a	Ratio: HMO/GHP
Physician Outpatient	\$32	\$42	1.30
Physician Inpatient	\$16	\$22	1.38
Hospital Inpatient	\$23	\$31	1.33
Hospital Outpatient	\$30	\$33	1.12
Emergency Room	\$17	\$15	0.88
Drugs	\$12	\$32	2.61
Overhead	\$10	\$41	4.05
Total PMPM	\$141	\$217	1.54

^aAdjusted to match GHP Plan B member's demographic and diagnostic characteristics, using the Diagnostic Cost Grouper (DCG) system.

GHP = Genesee Health Plan

PMPM = Per Member Per Month

age. Experts at HMA estimated that, if Plan A members were enrolled in full-coverage Medicaid, they would generate Medicaid payments for inpatient care that amount to roughly \$25–\$50 more than the costs estimated for their actual utilization (shown in Table 1). However, analysts with a local HMO (discussed below) predicted, based on risk characteristics, that the Plan A population, if covered by private insurance, would incur substantially fewer hospital expenses than estimated here and that Plan B members would incur only \$8 pmpm more than the hospital costs estimated here (see Table 2).

Comparisons with private and public insurance. To compare these costs with private insurance, analysts with a local HMO identified several thousand adults residing enrolled during 2008 who were also affiliated with a primary care provider in the county. Their costs of care were measured according to the HMO's payments for each of several major categories of service (inpatient, outpatient, ER, physician, pharmacy). Subtracted were \$27 pmpm of costs for elements of service not covered by GHP, such as behavioral health inpatient and specialists, maternity care, durable medical equipment and prosthetics, and dialysis. Maternity care is excluded because Medicaid covers low-income pregnant women. Some services not covered by GHP were not excluded from the HMO's costs because GHP covers reasonable substitutes for them. These include home health, short-term nursing facilities, hospice, and hospital-based outpatient IV therapy.

The resulting HMO costs in Genesee County of \$198 pmpm were then adjusted to match the demographic and health status characteristics of GHP's Plan B members, using the RiskSmart (version 3.0) Diagnostic Cost Grouper (DCG) system. This is a well-validated program that is widely used for such purposes, based on diagnostic and demographic risk factors derived from claims data.^{20,21} This risk adjustment predicted

that the costs of GHP's Plan B population would be 11% less than the HMO population. Based on this analysis, the HMO predicted that, if it had covered Plan B members for an equivalent set of services it would have generated claims costs (net of copayments) amounting to \$176 pmpm. Added to this is the HMO's average overhead of 23.4%, which produces a projected monthly premium of \$217 to cover Plan B's members for a similar range of medical services but with full hospital coverage (Table 3). This projection is about 50% greater than Plan B's estimated actual costs. If administrative and overhead costs are disregarded in both programs, the projected medical costs under private insurance would be about one-third greater.

Examining components of these costs as shown in Table 3, the predicted HMO costs for outpatient hospital services (combining outpatient and ER) are nearly identical—\$47 vs. \$48 pmpm—but physician costs and inpatient hospital costs are predicted to be roughly a third higher under the local HMO. This is likely due to a combination of both GHP's lower reimbursement rates and lower utilization by its members, relative to need. The largest predicted cost differences are for overhead and pharmacy. These are due to basic differences in how the two programs are administered, and to the fact that GHP directly provides only lower-cost and generic drugs, while arranging for patients to receive high-cost drugs through pharmaceutical companies' charity programs.

Full-coverage Medicaid is another point of comparison (Table 4), albeit only a rough, unadjusted comparison based on general capitation rates rather than projected costs from claims data. Many of Plan A's members have serious chronic illnesses, including mental illness; therefore, experts at HMA advised that a relevant comparison group is older Medicaid parents (TANF adults 45 years and older). Their Medicaid capitation rates in Genesee County averaged \$553 in 2008, which is 82% higher than the estimated \$304 pmpm costs for the GHP Plan A members, who have more limited coverage (Tables 2 and 4). According to HMA, Plan B GHP costs can be compared with Medicaid/TANF parents aged 26–44, for whom the capitation rates in Genesee County averaged \$316 in 2008. This is two-and-a-quarter times GHP's actual costs of \$141 pmpm for Plan B members.

This does not mean that more comprehensive coverage is wasteful or inefficient. The access to care provided by comprehensive insurance is superior to that provided

Table 4.

MONTHLY COST, GENESEE COUNTY ADULTS, 2008

	Plan A	Plan B
Genesee Health Plan (GHP)	\$304	\$141
Medicaid Parents (TANF) ^a	\$553	\$316
Ratio Medicaid/GHP	1.82	2.24

^aGHP Plan A is compared to the full-Medicaid capitation rate for over age 44, and Plan B is compared to the Medicaid rate for ages 26–44.

by a safety-net program such as GHP, especially for inpatient hospital services. Additionally, these cost comparisons are limited by several imperfections in data sources and analyses. First, measures of hospital costs and utilization for GHP are imprecise. Second, enrollment information used to calculate member-months for GHP may not accurately reflect the population covered by this safety-net system. Because enrollment does not require payment and can occur at any time services are needed, some members remain enrolled for a time even after moving away from the area or ceasing to use GHP's providers, while others continuously rely on GHP for service but allow their enrollment to lapse in between periods of service need. Finally, the Medicaid comparison is coarse since it contains no explicit risk adjustment.

Implications

Genesee Health Plan and Flint-area physicians, hospitals and foundations have succeeded in providing basic medical care access to a substantial majority of their low-income uninsured citizens. This achievement is especially notable coming from one of the more economically challenged communities in the country. The costs of care, both paid by GHP and donated by local providers, are substantially less than the estimated costs if this population were covered by full Medicaid or private insurance. Local hospitals bear a significant portion of these costs for inpatient hospitalization, which GHP does not reimburse. Additionally, the level of available services is less than offered by full-coverage plans. Nevertheless, Genesee Health Plan is an instructive example that is adaptable to a wide variety of safety net structures and approaches. Because it uses community providers rather than public or academic hospitals, any community might be able to follow a similar approach to improving uninsured access to care through local initiative.

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