

# The Costs and Adequacy of Safety Net Access for the Uninsured Bexar County (San Antonio), Texas

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## I. Introduction

This report examines San Antonio, Texas, as part of a series of case studies whose purpose is to explore whether well-structured safety net systems are able to provide low-income uninsured people adequate access to care at reasonable cost. Safety net providers include a variety of public and private hospitals, clinics and physicians who serve disadvantaged patients, with or without health insurance (Snow Jones and Sajid 2009). While the newly enacted Patient Protection and Affordable Care Act of 2010 will cover an additional 30 million people and offer other protections to many more, at least 20 million people will likely remain uninsured, leaving many to rely on safety net care for most of their health needs (Holahan and Garrett 2010). At the same time, increased Medicaid enrollment could strain the existing capacity of safety net providers. As a result, the costs and adequacy of safety net care remain vitally important issues for health care public policy (Hall 2009).

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These sites were selected after a thorough national review to reflect a variety of program structures and demographic and delivery-system settings. Each case study examines a safety net system that arranges for low-income uninsured people to have access to a fairly complete range of medical services (hospital, specialist physicians, prescription drugs) in at least a somewhat coordinated fashion based in a primary care medical home.

Each case study collects, analyzes and evaluates available data regarding the structure, adequacy and costs of the safety net system. Necessarily, these measures and indicators vary from one case study to the other, but common elements include:

1. the system's history, purpose, setting and funding;
2. the system's size, scope and structure;
3. how various access measures for the covered population compare with local and national norms; and
4. how the system's costs compare with the costs for covering a comparable population with either private insurance or Medicaid.

This study was approved by the institutional review board at Wake Forest University Health Sciences and a draft of this report was reviewed by project advisors and other informed sources. However, these analyses and conclusions are solely the author's.



## II. Texas and San Antonio Demographics

Texas has the highest percentage of uninsured residents in the country (Task Force for Access to Health Care 2008): 25 percent in 2008. This is due in part to having had one of the leanest Medicaid programs for adults,<sup>1</sup> plus a large number of undocumented immigrants (estimated at 1.5 million in 2005, Strayhorn 2006). To address urgent medical needs for the uninsured, Texas law requires each county or public hospital district to provide basic medical care to those who are “indigent,”<sup>2</sup> currently defined as below 22 percent of the federal poverty level. Most counties comply only with the legal minimum, but there are a few notable exceptions. This report focuses on San Antonio, located in Bexar County (pronounced “bare”), population 1.6 million. Similar to the state as a whole, 25 percent of the county’s non-elderly adults were uninsured in 2008 and 17 percent of the population was below poverty (substantially above the national averages of 17 percent uninsured and 10 percent poor). Almost 60 percent of the population is Hispanic, one of the largest concentrations among U.S. metropolitan areas.

**Table 1: San Antonio Safety Net, Key Facts, 2008**

Bexar County			
	Population	1.6 million	
	Hispanic	60%	
	Poor	17%	
	Uninsured	1 in 4 adults	
CareLink Enrollment and Costs		CareLink Benefits	
		Covered	Not Covered
Average enrollment	51,504	Hospital inpatient and outpatient	Cosmetic treatment
Members with full benefits (below 200% of poverty)	44,948	Primary care, specialists, mental health, home health	Routine dental and vision care
Members below 75 percent of poverty	12,728	Rx, lab tests, diagnostic radiology	Surgical treatment of obesity
Total costs	\$95.8 million	DME, prosthetics, therapies	Hearing aids

<sup>1</sup> In 2009, eligibility for non-disabled and non-elderly adults was only up to 26 percent of the federal poverty level and only for parents with minor children. Only Arkansas was substantially leaner (17% of poverty). Five other states clustered around 24-27 percent (Kaiser Foundation 2010).

<sup>2</sup> Indigent Health Care and Treatment Act of 1985. The state subsidizes counties that spend more than 8 percent of their general tax funds on this obligation. For more information, see Fenz 2000, Hermer and Winslade 2004, and Texas Department of State Health Services 2010.

*The CareLink program provides comprehensive medical services to approximately 50,000 low-income uninsured residents.*

Bexar County is one of several urban counties in Texas with large public or nonprofit hospitals that have developed programs for serving a wider range of medical needs for a greater proportion of low-income uninsured (Kronkosky Foundation 2009, Felt-Lisk et al. 2001).<sup>3</sup> Bexar County's hospital and clinics are now operated as University Health System (UHS), which is affiliated with the University of Texas Health Science Center at San Antonio. Since 1997, UHS has operated the CareLink program, which provides comprehensive medical services to approximately 50,000 low-income uninsured residents. CareLink covers the full range of services

typically found in commercial and Medicaid insurance, including many that are often omitted from other safety net programs, such as ambulance, contraception and sterilization, dialysis, durable medical equipment (DME) and home health (including breathing assistance), mental health, solid organ transplants, prosthetics, and sleep studies and therapies (UHS 2006, 2010). The only significant exclusions are routine dental and vision care, surgical treatment of obesity, cosmetic treatment and hearing aids. Virtually all CareLink members have a primary care medical home, provided by 16 clinics or offices. Specialist and hospital services are provided primarily by the county's University Hospital and its affiliated medical faculty and residents, but CareLink also contracts with community providers for a portion of these services.

### III. CareLink Program

CareLink was an outgrowth of national health care reform efforts during the Clinton administration and the state's reform of Medicaid. The county hospital's leaders were concerned that newly-insured people would change providers and that Medicaid enrollment shifting to managed care organizations would shrink their historical patient base. Therefore, in the mid-1990s they initiated an HMO (described more below) and crafted CareLink to create a more integrated delivery system with a primary care base. The aim was to build a more enduring treatment relationship with the hospital's patient base so that patients would remain with the county and medical school system once they obtained insurance or enrolled in a Medicaid HMO (Coughlin et al. 2001, Andrulis and Gusmano 2000, Hernandez et al. 2009). In order to manage their health and medical costs better, the system's leaders sought to enroll uninsured patients in a primary care medical home before they needed expensive hospital and specialist services.

Full CareLink coverage is available to uninsured county residents below 200 percent of poverty.<sup>4</sup> Notably, proof of citizenship or legal immigration status is not required. Similar to the area's demographics, 66 percent of CareLink members are Hispanic. Initially, CareLink advertised extensively, seeking to enroll eligible people into primary care before they developed serious

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<sup>3</sup> Others include Parkland Hospital in Dallas and the Travis County Healthcare District covering Austin (Task Force for Access 2008, Moylan 2005, and Hermer and Winslade 2004).

<sup>4</sup> Above that level, more limited benefits are available to people up to 300 percent of poverty, in what is called the "Plus Plan." Their maximum liability is not capped, and coverage is more limited. The Plus Plan covers only the core set of county and medical school providers and a more limited formulary, and it excludes a variety of benefits such as home health, prosthetics and DME. Because only about 5 percent of CareLink's membership is enrolled in this Plus Plan, this report does not address it further, and most numbers are limited to those with full membership benefits. Roughly another 5 percent are enrolled in a pharmacy-only program called MedLink, which is mainly for low-income Medicare patients.

health problems. At the beginning, enrollment shot up quickly to almost 80,000 people in 1998 (after less than two years), but the system reached capacity and so ceased aggressive outreach (Andrulis and Gusmano 2000). Now, new members are referred by public service agencies, and most enrollment occurs at the point of service when uninsured patients seek care. Service centers are distributed in different parts of the county, but most are in the southern half.

*CareLink stresses patients' responsibility to pay a portion of the costs for most services.*

Once members are screened for eligibility, they receive an identification card good for a year (two years for those on fixed income), and are assigned a primary care physician. Those with high-cost chronic illness receive care management. Prior authorization is required for specialty services and is adjudicated using fairly rigorous criteria. The program is funded mainly by a county property tax levy, supplemented with some state funds (Medicaid "disproportionate share hospital" payments), and collections from members. Although CareLink's adult enrollment is only 20 percent of the county's low-income uninsured, enrollment has not been capped, despite the recent economic downturn.

CareLink differs from other safety net systems in two significant ways. First, its providers render little or no care for free. CareLink reimburses all providers, even those owned or employed by University Health System. It pays the hospital at Medicaid rates and its physicians and clinics at Medicare rates. It also contracts with some community providers, usually at Medicare rates, but some specialists receive 115 percent to 140 percent of Medicare, depending on negotiations. Second, CareLink stresses patients' responsibility to pay a portion of the costs for most services, at a level that varies by income. CareLink is not a free care program. Instead, it bills itself as a "financial assistance program." This feature is seen as critical to continuing support of the program by both ends of the political spectrum (Coughlin et al. 2001).

**Table 2: CareLink Payment Schedule, 2007**

Poverty Level	Monthly Payment	Average Payment
<75%	2.5% of income	\$ 15.52
<100%	3.37% of income	\$43.30
<150%	5% of income	
<200%	6.7% of income	\$103.89
<300%	10% of income	\$192.19

CareLink has a unique and complex payment structure that evolved from the county hospital's longstanding sliding-scale financial assistance rules (Coughlin et al. 2001, Andrulis and Gusmano 2000 and Hernandez et al. 2009). Depending on how one views it, this payment structure can be seen in various ways – as resembling a premium, or a deductible, or a monthly payment plan for accrued debt – rather than the normal fixed

copayments made at the time of service.<sup>5</sup> Unlike insurance, members have no financial obligation until they first use services. Then, they are billed actual charges (at the negotiated discounted

<sup>5</sup> The exception is for pharmacy and emergency services, which have copays of \$5-\$15 and \$15-\$65, respectively, depending on income (75% - 200% poverty). These copays function normally (they must be paid when the service is received), but pharmacy copays are capped at \$50 per visit, so patients with several more expensive prescriptions can batch when they are filled in order to better manage costs. Also, these copays are waived for members unable to pay who are below 75 percent of poverty or in emergencies.

*CareLink provides access and coverage broadly comparable to Medicaid.*

rates),<sup>6</sup> but they are given a payment plan at a monthly amount that is based on income, following a progressive stepladder (Table 2). For instance, in 2009 a single person earning \$8,000 a year would pay \$16.39 a month once she started to use services, and a family of four earning \$40,000 would pay \$196.06.

Monthly payments are owed until the full account is satisfied, except that the account is always capped at 48 times the member's monthly amount.<sup>7</sup> For instance, in the example just mentioned, the single person's account would never exceed \$786.72 (48 x \$16.39), but the family's could reach \$9,410.88 (48 x \$196.06), because of their different poverty levels.<sup>8</sup> When an account reaches this maximum, additional charges are waived regardless of how many services are used.<sup>9</sup> To summarize, at any point, patients owe the lesser of two amounts: either actual charges for services used or 48 times their current monthly payment (which is based on income level).

Members who are above 75 percent of poverty (about two-thirds of enrollees) are disenrolled if they fail to keep up with their required payments, and those over 150 percent of poverty (only about 15 percent of enrollees) must provide a direct-debit arrangement for making scheduled payments automatically. CareLink continues to treat members below 75 percent of poverty (accounting for one-third of enrollees) regardless of whether their payments are in arrears. Overall, CareLink adults pay out of pocket for about 15 percent of their total costs of care and the rest is absorbed by University Health System.

#### IV. Adequacy of Access

Safety nets often are regarded as places of "last resort" for indigent, uninsured people with no other options. We explore here whether CareLink provides a level of access to care that is similar to access by insured populations. There is no established yardstick for adequate access (Ricketts and Goldsmith 2005, Davidson et al. 2004), but several indicators will be considered.

According to focus groups and key informant interviews, CareLink provides access and coverage

*CareLink members had office visits at a rate 50 percent greater than commercial plan members, but used the emergency room only 10 percent more.*

<sup>6</sup> The full billing rules are somewhat more complex than this. Services provided under contract with community providers are billed to patients at essentially the same rates as for services provided by the UHS network, even though some community providers negotiate higher rates.

<sup>7</sup> Thus, members are expected to continue making their monthly payments for up to four years past the receipt of their last service, although it is likely that many fail to do so. Patients who fall behind can be disenrolled, and their account sent to collection, unless they are below 75 percent of poverty. Such a patient who wants to re-enroll must first agree to a payment plan for the old debt, as well as restart the normal monthly payments for current service.

<sup>8</sup> For additional explanation and illustrations, see Coughlin et al. 2001, Andrulis and Gusmano 2000, and Hernandez et al. 2009.

<sup>9</sup> In this respect the novel arrangement also functions as a type of catastrophic coverage. However, new charges can be incurred each month at the amount of the monthly payment owed, so that the account can remain at its maximum rather than wiping the slate clean each year as insurance deductibles usually work.

**Table 3: Health Screening, Bexar County, 2004-2005**

	North County	South County
Uninsured	17%	35%
Population	871,034	605,262
% of all physicians	72	28
<i>Population receiving</i>		
Annual checkup	67%	63%
Pap test	81%	80%
Mammogram	69%	56%

Source: Health Collaborative 2006

for those enrolled that is broadly comparable to Medicaid, and patients consider the quality of care to be excellent (Wilson et al. 2004). The program actively monitors wait times for scheduling appointments, in order to strive for National Committee for Quality Assurance standards of no more than two weeks for appointments to receive routine (non-urgent) care. On average, new members in 2007 were seen by their primary care physician within one week (Hernandez et al. 2009).

Specialist access is more constrained, however. The average wait in 2007 was six weeks, and an internal report from July 2009 showed a wide range of delays over various services and months.<sup>10</sup>

Standard population measures do not indicate substantial access advantages countywide for the uninsured, compared to other similar Texas cities (such as Houston) or statewide. This is likely because the extent of uninsured need in San Antonio is several times greater than what even this large program and several smaller ones currently provide (Felt-Lisk et al. 2001, Kronkosky Foundation 2009, and Wilson et al. 2004). Looking within the county, however, is more revealing. The socioeconomics of the southern half of Bexar County are much less favorable than the north. On average, incomes for families living in the north are 70 percent higher than for families living in the south and the rate of uninsurance in the south is twice that in the north (Health Care Collaborative 2006). Also, the south has about half the number of physicians per person. Nevertheless, both parts of the county reported very similar rates of receiving a routine checkup in 2004: 67 percent in the north compared to 63 percent in the south. Both parts also reported similar rates for various health screenings (Table 3).

**Table 4: Service Use Per Adult Member, 2005**

	CareLink	Commercial Health Plan	Ratio of CareLink to Commercial
Office visits	7.4	4.9	1.5
ER visits	0.36	0.32	1.1

Source: Claims data from University Health System

Within CareLink, 70 percent of members had at least one primary care visit in 2007 (Hernandez et al. 2009), a rate in between national norms for people with and without insurance (National Center for Health Statistics 2009). A comparison using 2005 claims data from CareLink and the commercial health plan owned by University Health System (described above) showed that adult

<sup>10</sup> Over the course of 12 months, wait times for CT, MRI, ultrasound and cardiac evaluation were from zero to three weeks, but for mammography and colonoscopy, zero to four months, and up to three months for sleep studies and pain clinic. For specialist visits, wait times were mostly less than a month over the course of a year, except for dermatology, endocrinology, nephrology and neurology, which were up to two or three months.

members of CareLink had office visits at a rate 50 percent greater than commercial plan members, but used the emergency room only 10 percent more (Table 4). Also, the proportion of emergency visits at University Hospital in 2002 that were avoidable (non-emergent, or primary care treatable) were essentially the same for CareLink members as for those covered by Medicaid or commercial insurance, although more than the uninsured without CareLink (Table 5). And, CareLink’s rate of emergency room visits was substantially lower than people on Medicaid nationally (0.36 visits per CareLink adult compared with the 0.8 visits per Medicaid adult, reported by Pitts et al. 2008).<sup>11</sup>

**Table 5: Rates of Unnecessary ER Visits, University Hospital, 2002**

Insurance Status	Ratio of Non-Emergent or Primary-Care-Treatable to Necessary Emergency Visits
Commercial	2.72
Medicaid	2.50
CareLink	2.60
Uninsured	1.60
Overall	2.77

*Source: George Washington University (Wilson et al. 2004)*

## V. Cost Comparison

To evaluate CareLink’s costs, they are compared with the premium rates for private or public insurance coverage of an equivalent population. It is not conventional to measure uncompensated care on a “per member per month” (pmpm) basis since, by definition, the uninsured are not enrolled in an insurance plan. However, an adequate safety net can be thought of as providing a form of coverage for a defined population when the safety net system is structured like CareLink, in a manner that enrolls eligible patients and provides them a primary care medical home (Hall 2009).

CareLink’s per member costs will be compared with premiums charged by Community First Health Plan (CFHP), the nonprofit insurer owned by University Health System that contracts with its providers as well as others in the community. CFHP’s commercial insurance covers mainly state government employees in the San Antonio metro area, and is more generous than most in charging no deductibles (only copayments). CFHP also offers a Medicaid managed care plan serving the same region. Two approaches were used to compare CareLink’s costs with CFHP’s rates (Tables 6 & 7). First, CFHP’s actuarial consultant analyzed 2005 medical data from CareLink, CFHP commercial insurance, and CFHP Medicaid. Second, this analysis was updated for 2008, using claims cost information obtained from CareLink administrators, and publicly reported CFHP Premium rates.

<sup>11</sup> Emergency room rates depend on source and structure of survey, and so are not directly comparable (Owens et al. 2010).

**Table 6: Comparison of CareLink to CFHP Commercial Insurance**

	2005			2008		
	CareLink	CFHP Commercial	Ratio CFHP/CL	CareLink	CFHP Commercial	Ratio CFHP/CL
Member months	517,890	49,232		495,024		
Average members per month	43,158	4,102		41,252		
Male	41.4%	41.2%		43.0%		
Average age	42	41		approx. 40		
Average months of enrollment	7.10	9.40				
Total members	72,927	5,238				
Claims paid pmpm	\$175.13	\$214.52	1.22	\$174.51		
Collections pmpm	\$28.72	\$14.13		\$34.44		
Net medical pmpm	\$146.41	\$200.39	1.37	\$140.07		
Rx pmpm net	\$3.04	\$24.65	8.11	\$1.30		
Net pmpm	\$149.45	\$225.04	1.51	\$141.37	\$210.05	1.49
Risk score	1.33	1.01	0.76	1.33	1.01	0.76
Adjusted pmpm	\$149.45	\$298.85	2.00	\$141.37	\$276.46	1.96
Administrative overhead	\$5.53	\$47.82	8.65	\$5.23	\$44.23	8.46
<b>Total</b>	<b>\$154.98</b>	<b>\$346.66</b>	<b>2.24</b>	<b>\$146.60</b>	<b>\$320.69</b>	<b>2.19</b>

Source: Claims data and administrative reports from University Health System, analyzed by its actuarial consultant and the author.  
Note: CareLink data is limited to members with full benefits below 200 percent of poverty.

The actuarial analysis of 2005 CareLink data focused on non-elderly adults (age 20-64) below 200 percent of poverty. Based on enrollment data, there were 72,927 such members, accounting for 517,890 member months, or 43,158 per month.<sup>12</sup> Based on claims data, CareLink paid its providers \$90,844,340 for their medical care, amounting to \$175 per member per month (pmpm). As shown

<sup>12</sup> This excludes people in the “Plus” program, which has more limited benefits, and people who received only prescription drug assistance. In 2008, these ancillary programs accounted for only 6 percent of total CareLink claims costs, and 11 percent of its total membership. The larger member count is included when calculating some per person elements from administrative reports rather than from claims data. But, because the members with more limited benefits consumed fewer resources, some program-wide averages are adjusted according to the percent of expenditures, rather than the percent of people, allocable to the core membership being studied here (non-elderly adults with full CareLink benefits). See also note 16 below.

in Table 6, CareLink collected an estimated average of \$29 pmpm from adult members that year,<sup>13</sup> and it incurred an additional \$3 pmpm for prescription drugs, net of copayments. This results in total net costs to CareLink of \$149 pmpm.

In comparison, CFHP in 2005 paid \$215 pmpm for medical care of non-elderly adults (ages 20-64) under its commercial insurance, and it collected \$14 pmpm in copayments (it had no deductibles). According to its rate filings for state employees (its largest group), CFHP's prescription costs in 2005 were 12.3 percent of medical costs (both net of copayments), yielding total net costs of \$225 pmpm, or 51 percent greater than CareLink's claims costs (Table 6).

To determine how these two populations compared in terms of health status and actuarial risk, the Chronic Illness and Disability Payment System (CDPS) was used to generate a risk score for each group. CDPS is a well-validated risk-adjustment tool employing diagnosis and demographic information that is widely used for these purposes (Kronick et al. 2000). Based on this actuarial analysis, the expected costs of the adult CareLink population is 32 percent greater than CFHP's commercial population, meaning that if CFHP had covered CareLink's adult population in 2005, the estimated net medical care costs would have been 32 percent more than they were for its own commercial population. That would amount to \$299 pmpm, which is twice the actual costs incurred by CareLink. The differential appears to be due to the fact that CareLink pays providers less than CFHP, and the fact that CareLink imposes greater financial obligations on patients, which likely reduces utilization. This projected cost difference is further increased by adding administrative overhead. CareLink reported 3.7 percent overhead, while CFHP included 16 percent for overhead in its rate filings, resulting in the total net pmpm differences shown above in Table 6.<sup>14</sup>

CFHP also serves as a Medicaid managed care plan. Its Medicaid capitation rate for non-disabled adults in 2005 (\$192, after subtracting administrative overhead) was used as a basis for comparison, as shown in Table 7. Because this portion of Medicaid covers only parents with dependent children, the Medicaid rate is compared to costs for CareLink adults of a younger age range, 19-50. Unadjusted, Medicaid capitation was 55 percent higher than CareLink's pmpm costs for this age group in 2005, but risk adjustment is required since Medicaid parents consist primarily of females. Applying the same risk-adjustment methods described above (for commercial insurance) would predict CareLink's 19-50 age population to have about 26 percent greater costs than CFHP's Medicaid population of the same age. Applying that ratio and adding administrative overhead (at the 10 percent rate used in Medicaid rate setting) generates an estimated cost of \$267 a month if Medicaid were to have covered this portion of CareLink's population (adults 19-50) in 2005 – twice the actual costs to CareLink (Table 7). Because Medicaid pays lower rates to providers

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<sup>13</sup> Also included in this payment amount is \$5 pmpm collected in 2005 from third-party insurance, for treatment initially billed to CareLink but later allocated to insurance, usually through retroactive Medicaid enrollment. In 2008, retroactive insurance collections amounted to \$11 pmpm.

These calculations are made from administrative reports that use a cash-received rather than accrual basis. Thus, they disregard the fact that CareLink's accounting system actually allocates current payments to the patient's oldest outstanding bills, which could be from several years prior. According to financial officials with CareLink, this cash basis is a reasonable approximation because the program's membership and billing and collection policies were in a fairly steady state in the few years surrounding 2005. In 2008, for instance, payments by patients based on a cash basis were within \$2 pmpm of a rough estimate of patients' expected payments for care received in 2008, based on an accrual basis.

<sup>14</sup> The actual premium rates charged for CFHP coverage of state employees (far and away its largest insured group) in 2005 were about \$300 per month for adults. If this actual premium were risk-adjusted for the CareLink population, the CareLink projection would be about \$400/month. However, according to CFHP's actuarial consultant, the state chose to allocate premiums between adults and children in a manner that reduced costs for parents and children below their actuarial risk and increased costs for adults without dependents above their actual risk levels. Thus, the state's premium for adults appears to be somewhat greater than a strictly actuarial rate based on their costs.

than does CareLink, the major driver of this difference is probably CareLink’s leaner coverage, in the form of much greater cost-sharing by patients.

**Table 7: Comparison of CareLink to CFHP Medicaid, Non-Disabled Adults**

	2005, ages 19-50			2008, ages 19+		
	CareLink	CFHP Medicaid	Ratio CFHP/CL	CareLink	CFHP Medicaid	Ratio CFHP/CL
Member months	335,830	12,115				
Average members per month	27,986	1,010				
Male	42.4%	13.5%				
Average age	36.4	31.7				
Total members	52,698	2,491				
Average months of enrollment	6.37	4.86				
Claims paid pmpm	\$149.61			\$174.51		
Collections pmpm	\$28.72			\$34.44		
Net medical pmpm	\$120.89			\$140.07		
Rx pmpm net	\$3.04			\$1.30		
Net pmpm	\$123.93	\$191.78	1.55	\$141.37	\$351.12	2.48
Risk score	1.19	0.94	0.79	1.33	0.94	0.71
Adjusted pmpm	\$123.93	\$242.37	1.96	\$141.37	\$373.53	2.64
Administrative overhead	\$4.59	\$24.24		\$5.23	\$37.35	
<b>Total</b>	<b>\$128.51</b>	<b>\$266.61</b>	<b>2.07</b>	<b>\$146.60</b>	<b>\$410.88</b>	<b>2.80</b>

Source: Claims data and administrative reports from University Health System, analyzed by its actuarial consultant and the author.

Note: CareLink data is limited to members with full benefits below 200 percent of poverty.

These comparisons were updated for 2008 based on administrative reports from CareLink, and published premium rates for CFHP. For CareLink, the reported average cost for adult members less than 200 percent of poverty was \$175 pmpm. Adding administrative and net prescription costs and subtracting member payments in the same fashion described for 2005<sup>15</sup> results in net monthly

<sup>15</sup> Program reports were for total CareLink membership, including some programs with more limited benefits. See note 12 above. Also, some administrative reports were available only for all ages, not just for adults. In 2005, non-elderly adults accounted for 93 percent of total costs and 81 percent of membership within the core programs (known as Plans A, B and C). Administrative data were adjusted using these metrics (and those in notes 12 and 16) to estimate the portion allocated to its core membership of adults with full benefits.

care costs of \$147 per person (Table 6).<sup>16</sup> In comparison, the estimated premium for covering this population with CFHP's commercial insurance is \$321 per month.<sup>17</sup> The differential in costs of 2.2-to-1 (for risk-adjusted commercial compared to CareLink) is the same as in 2005. For Medicaid, the unadjusted capitation rate was \$351 (without administrative overhead). Assuming the Medicaid risk profile in 2008 remained the same as in 2005, the adjusted Medicaid cost would have been even higher, at \$411 (Table 7).

These cost comparisons are limited by several factors, and they leave some questions unresolved. First, CareLink's costs capture only treatment provided through its contracted network. Not measured are costs of care incurred by the enrolled population at other community providers. For instance, CareLink members sometimes also seek treatment from other hospitals or physicians who might be more convenient, or whose billing and collection policies might be more lenient in particular situations (such as emergencies). Second, there are undoubtedly some unobserved differences in the risk profiles of the compared populations, which might reduce or increase the magnitude of the observed differences. Third, available data does not reveal the extent to which CareLink's lower costs are due to reduced utilization by patients or to reduced payments to providers. Also unresolved is the extent to which reduced utilization is due to effective care management or to reduced patient demand resulting from significant cost sharing, and whether the latter worsens health outcomes. Answering these and other questions would require additional data and analysis.

*CareLink's costs are less than half that of comprehensive insurance.*

## VI. Implications

During the next few years, until health insurance reforms take full effect nationally, states and communities will continue to struggle with substantial numbers of uninsured people. Even after

*This unique program is adaptable to a wide range of demographic, political and delivery-system settings.*

that, federal reforms still will leave many millions uncovered by expansions in Medicaid and private insurance. These uninsured will include people for whom insurance remains unaffordable, people who are temporarily uninsured while transitioning between public and private coverage, and low-income people who do not qualify for Medicaid or public subsidies due to citizenship status.

San Antonio's CareLink is an instructive example of one way to improve access to health care for people who remain uninsured, both leading up to and

<sup>16</sup> This is 8 percent less than net costs in 2005 because CareLink increased payments from members and third-party insurance. Also, due to availability of administrative data, the CareLink figures for 2008 reflect all adults, including those over 64, who probably used fewer services, biasing the overall average slightly downward. In 2005, for instance, the elderly constituted 10 percent of CareLink adults, and their pmpm costs were 41 percent of the costs for non-elderly adults.

<sup>17</sup> This is derived from the state employee rate for CFHP adult coverage, adjusted for the risk differential measured in 2005 and the particular rating practices for state employees noted in footnote 14 above. Available data indicates that the risk profiles of CareLink's and CFHP's populations have not changed dramatically since 2005. Therefore, according to CFHP's actuarial consultant and key informants with both organizations, the risk adjustment factors measured for 2005 are still a reasonable rough estimate of the health status differences in 2008.

following national reforms. For over a decade, CareLink has succeeded in providing low-income uninsured residents good access to a full range of medical services based in primary care medical homes, regardless of citizenship. Impressively, its costs to the county and its hospital system are half that of comprehensive insurance.

Carelink, however, has several limitations. First, area needs outstrip its capacity, such that it enrolls only about 20 percent of the county's low-income uninsured adults. As a result, any major influx of new beneficiaries would most certainly stretch CareLink's existing capacity. Second, its cost-sharing requirements undoubtedly deter many people from joining or from using its services more fully. Finally, the access to care provided by Medicaid or by generous commercial insurance is superior to that provided by even a well-structured safety net program such as CareLink. Nevertheless, this unique program merits attention as a potential model for other communities. Because it pays providers throughout the community and requires substantial financial contribution from patient members, it is potentially adaptable to a wide range of demographic, political and delivery-system settings.

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