I. Introduction

This report examines Genesee County (Flint) Michigan, 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, without 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 cost and adequacy of safety net care remain vitally important issues for health care public policy (Hall 2009).

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 of covering a comparable population with either private insurance or Medicaid.

Research for this report was done in collaboration with Linda D. Hamacher, senior consultant with Health Management Associates and President and CEO of Genesee Health Plan. The 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. Michigan Demographics and County Health Plans

Michigan has a strong history of broad insurance coverage owing to the historical strength of labor unions. With 87 percent of its non-elderly population insured in 2008, it ranked in the top third of states nationally. However, Michigan also 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 non-elderly adults shot up 3 points in one year, to 18.7 percent, the second biggest increase in the country (Families USA 2009). These troubles are not new to Michigan. The automobile industry’s misfortunes have hit its economy hard for over a decade.

These downturns put enormous strain on the state’s safety net programs (Sack 2010). For non-disabled childless adults, Michigan’s income limit for Medicaid eligibility is only 35 percent of the federal poverty level, and this expansion enrollment is periodically frozen due to caps in federal and state funding. Moreover, the meager coverage for childless adults excludes hospital inpatient services (as permitted by a federal waiver).

In 73 of Michigan’s 83 counties, county health plans are the vehicle for covering non-disabled childless adults enrolled in Medicaid (the component known as the Adult Medical Program or the Adult Benefits Waiver (ABW)) (HMA 2005). 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 (Dalton et al. 2009):1 Plan A is the county’s childless adult Medicaid program. Enrollees must have income at or below 35 percent of the federal poverty level and assets of $3,000 or less. Plan B can cover uninsured county residents as high as 250 percent of the poverty level, but most counties only go up to 150 percent 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.

III. Genesee County Health Plan

Ingham County (home of the state capital of Lansing) and Genesee County (home of Flint) are notable exceptions to the limited size of most county health plans.2 The Genesee Health Plan (GHP) is our main focus because it has the largest enrollment in the state and it receives strong community support (GHP 2009). 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

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1 A few county health plans also sell or subsidize a coverage plan for employees of low-income employers.

2 Because Ingham County’s plan was started several years earlier, it has received the most attention to date (RWJF 2005, Quincy et al. 2008, Ingham Community Voices 2010, and Silow-Carroll 2001).
access to a well-organized system of specialist referrals, diagnostic testing, pharmacy benefits and
care management for chronic illnesses.3 There is no enrollment fee and copayments are minimal
($1-$3 for covered prescriptions and $3-$5 for doctor visits and other services).

Table 1: Genesee Health Plan
Structure and Coverage, 2008

<table>
<thead>
<tr>
<th></th>
<th>Plan A</th>
<th>Plan B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funded by</td>
<td>Medicaid</td>
<td>County</td>
</tr>
<tr>
<td>Eligibility, Adults</td>
<td>&lt;35% povt</td>
<td>35%-175% povt</td>
</tr>
<tr>
<td>Average members</td>
<td>3,811</td>
<td>21,669</td>
</tr>
<tr>
<td>Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital inpatient</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>ER</td>
<td>Covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>Covered</td>
<td>Partial</td>
</tr>
<tr>
<td>Physicians</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Covered</td>
<td>Partial</td>
</tr>
</tbody>
</table>

Notably limited, however, 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. (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 consider enrollment in the county
health plan as indicating eligibility for charity
care, usually without having to file a full
application,4 but only one of Ingham County’s
two hospitals reportedly offers this
accommodation.

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 (Dalton et al. 2009). In Genesee County, the main focus of this
report, care is provided by a large network of independent physicians and clinics. For several
years, Genesee Health Plan (GHP) paid providers 14 percent above Medicaid rates for primary
care and 4 percent above Medicaid for specialist and diagnostic services. 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 percent above Medicaid rates for primary care and 13.2 percent for specialist and
diagnostic services. GHP also makes lump-sum payments to hospitals to defray a portion of the
facilities’ costs for outpatient services for Plan B members and inpatient care for Plan A members.

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. By covering preventive care, office visits, laboratory and
radiology services and a limited prescription formulary, plan supporters believed the health of

3 Pharmacy benefits are somewhat limited. They consist mostly of generic, lower-cost prescription drugs provided for copayments of $1-$3.
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. In 2007, 777 such patients received $1.3 million in free medication. Mental health and physical therapy benefits are
also limited, 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.

4 The actual level of charity discount offered by each hospital varies somewhat based on exact income levels, but generally speaking patients
qualify for free care if they are below 100 percent of poverty.
the community would improve.

GHP patients choose a primary care medical home from a network of 192 physicians, who in turn coordinate referrals to a network of 289 specialists. Eight of GHP’s 14 employees provide support to physicians and their GHP patients in improving health habits, managing chronic diseases, and accessing medical and community resources.\(^5\)

In its early years, GHP was supported by $1.7 million in grants from local foundations (the C.S. 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 substantially increase the program’s size and capacity, which now is open to any uninsured adult county resident with a household income up to 175 percent of poverty. As a result, enrollment grew rapidly, to over 25,000 (Figure 1). According to the health plan’s latest figures, 59 percent of new GHP members are unemployed, 27 percent say their employer does not offer health care coverage, and 11 percent 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.

Figure 1: GHP Quarterly Enrollment, 2002-2009

![GHP Quarterly Enrollment, 2002-2009](image)

This willingness to fund low-income access comes from a community that is known for its history of serious economic problems. Flint, population 125,000, is widely identified with the decline of the U.S. auto industry. The birthplace of General Motors and the home for Buick’s main plant, Flint’s 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 to 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 percent in Flint and 17 percent 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 (Michigan Department Community Health, June 2009). However, the county overall (pop. 430,000) has economic statistics closer to statewide averages, according to U.S. Census Data. For instance, in 2006, 14.1 percent of non-elderly

\(^5\) GHP reports that because of this program, healthy behaviors, including exercise and healthy eating, have increased by 57 percent among members who have received this support and that about 89 percent of diabetes patients enrolled in the health plan have improved their self-management.
residents were uninsured in Genesee County, compared with 12.3 percent statewide and 17.8 percent nationally.  

**IV. Adequacy of Access**

Safety nets often are regarded as places of “last resort” for indigent, uninsured people who have no other options. We explore here whether GHP 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. 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 insurance. 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 percent of adults are covered (95% in 2007, 91% in 2009), substantially higher than the 82 percent – 86 percent reported statewide from other surveys (Families USA 2009).

Another survey suggesting that GHP’s 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 percent of adults below 250 percent of poverty were uninsured in Genesee County in 2006, compared with 28 percent statewide – a statistic that is out of line with others indicating that the area’s economic indicators are worse than the state’s overall. This 20 percent 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 (GHP 2009). A logical 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 (Silow-Carroll 2001):

> 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.

This survey anomaly is one potential indicator that access to basic outpatient medical care may be adequate. However, the anomaly also makes it difficult to precisely identify the population covered by county health plans in standard surveys, which makes it difficult to estimate how well Genesee County compares 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 (Michigan Department of Community Health, Aug. 2009). Furthermore, annual surveys in Genesee County show no consistent improvement overall.

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6 Note, though, that having membership in GHP may cause people to under-report being uninsured, for reasons explained in the next section.
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 (Prevention Research Center 2009). 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 outpatient 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. 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 the study speculates that this may be due in part to successful care management since these rates are close to general levels nationally. Also, 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 also found that GHP members used the emergency room at about twice the rate (0.4 visits per person) as the commercially insured, but at only about half the national rate for people on Medicaid, which is a more comparable population.

GHP surveys its members annually to determine access to covered services. In the 2008-2009 survey, 95 percent of members reported receiving the services they expected from their doctor, 93 percent said they could get in to see their doctor within seven days when they are sick, 70 percent saw their doctor more than before they signed up for GHP and 90 percent saw 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 (4 admissions per 100 people) as under local commercial HMOs. Even though local hospitals accept GHP members as qualified for substantial discounts or a waiver of all charges under their charity care policies, 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 under more adequate coverage.

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7 There were reported improvements of 7 to 8 percentage points in adults who had a routine checkup or saw a health professional last year, but it is undetermined whether these changes are statistically significant.

8 One qualitative case study of four anonymous counties reported, based on interviews with managers of safety net organizations, that some county health plans have considerably more success in improving access than others (Dalton et al. 2009).
V. Cost Comparisons

To evaluate GHP’s costs, they are compared with the premium rates for private and 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 GHP, in a manner that enrolls eligible patients and provides them a primary care medical home (Hall 2009).

A. GHP Cost Estimates

Table 2 shows enrollment and costs of services for GHP Plans A and B during calendar year 2008. Enrollment demographics 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 DRG rates, even though the care is in fact uncompensated. To convert the Medicaid values to costs, an average DRG-to-cost ratio of 0.77 was derived from reports by the three Flint hospitals for services to Medicaid patients that were compensated, in the fiscal year ending in 2009. 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.

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9 These reports are required as a legacy of the state’s “resident county hospital” program, which previously paid hospitals partial reimbursement for their Plan A members. The reporting requirement remains even though this program is now largely defunct.

10 Due to the fact that Medicaid DRG payments are considerably below costs, Michigan hospitals receive supplemental lump-sum payments funded by hospital provider taxes, but these are not included in the fee-for-service DRG rates. Therefore, these calculations produce only a rough estimate of inpatient costs, since the populations and reporting periods are not identical for the various elements and applications of this ratio.

11 The goal here is not to capture total uncompensated costs for services to GHP members. Instead, it is to estimate uncompensated costs only for services that GHP does not cover. GHP payments, like Medicaid payments, do not fully compensate for the costs of many services GHP does cover, but those are valued simply at the actual reimbursement costs.
For Plan B, hospital costs were based on the following analysis, using data obtained from Health Management Associates, a research firm based in Lansing that specializes in Medicaid and other data analyses relevant to safety net care. 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 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 percent greater than Plan B members. This estimate is 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 coverage.

B. Comparisons to Private and Public Insurance

The primary point of comparison is private insurance. Analysts with a local HMO identified several thousand adults residing in Genesee County and enrolled with its primary insurance products 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, durable medical equipment and prosthetics and dialysis.

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12 One estimate, done by the local health plan that serves as GHP’s claims administrator, predicts that Plan A members would use 2.1 times more care than Plan B. The other estimate, by analysts at another local health plan (discussed more below), calculated a predicted cost index overall for the Plan A group that was only 1.4 times the Plan B group. Although there is a sizeable difference between these two projections, this does not matter a great deal for estimating Plan B’s hospital costs. The issue here is how much of total GHP hospital costs to allocate to Plan A versus Plan B, but because Plan A accounts for only about 15 percent of total GHP membership, the per person costs in Plan B would be only modestly higher even if all GHP hospital costs were allocated to Plan B and none to Plan A.

13 This is after subtracting what GHP actually paid for Plan B outpatient services.

14 Note that the ER costs were virtually the same for the two populations, even though, anecdotally, Plan A members used the ER much more, and Plan B’s outpatient costs were greater than Plan A, again contrary to actual risk levels. However, the comparison uses different valuation methods for these components of Plan A and Plan B services. Consistent with other case studies in this series, reimbursed services are valued at their actual rates of reimbursement, whereas uncompensated services are valued at their reported costs. For Plan A, hospitals were paid for emergency care at Medicaid rates, which cover substantially less than average costs, whereas Plan B members’ emergency services were uncompensated and therefore valued at full average costs.

15 Experts at HMA estimated that, if Plan A members were enrolled in full-coverage Medicaid, they would generate DRG payments for inpatient care that amount to roughly $25-50 higher than the costs estimated for their actual utilization (shown in Table 1). This is based on comparing the costs and utilization of the segments of the regular Medicaid population (discussed below) that HMA experts believe most closely resemble Plan A and Plan B members. 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).

16 This reflects only what the HMO was obligated to pay and excludes amounts paid by patients.

17 Maternity 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,\textsuperscript{18} 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 (Meenan et al. 2003, Peterson et al. 2005). This risk adjustment predicted that the costs of GHP’s Plan B population would be 11 percent 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, this would have generated claims costs (net of copayments) amounting to $176 pmpm. Added to this is overhead of 23.4 percent that the HMO averaged for its Genesee County premiums, which would produce 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 percent greater than Plan B’s estimated actual costs.

Examining components of these costs as shown in Table 3, the predicted HMO costs for outpatient hospital services are nearly identical ($47 vs. $48 pmpm, combining outpatient and ER), 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. Plan A’s income eligibility limits are extremely low (35% of poverty) and many of its members have serious chronic illnesses, including mental illness. Therefore, experts at HMA advised that a relevant comparison group for GHP Plan A, based on the range and intensity of conditions, is older Medicaid parents (“TANF” adults 45 years and older) with full coverage. The Medicaid

\begin{table}[h]
\centering
\caption{Estimated Medical Expenses, Genesee County Uninsured Adults, 2008}
\begin{tabular}{|l|c|c|c|}
\hline
 & Estimated & Projected & Ratio: \\
 & GHP Plan & HMO Costs* & HMO/GHP \\
 & B Costs & & \\
\hline
Physician & $32 & $42 & 1.30 \\
Outpatient & & & \\
\hline
Physician & $16 & $22 & 1.38 \\
Inpatient & & & \\
\hline
Hospital & $23 & $31 & 1.33 \\
Inpatient & & & \\
\hline
Hospital & $30 & $33 & 1.12 \\
Outpatient & & & \\
\hline
ER & $17 & $15 & 0.88 \\
\hline
Drugs & $12 & $32 & 2.61 \\
\hline
Overhead & $10 & $41 & 4.05 \\
\hline
Total & $141 & $217 & 1.54 \\
pmpm & & & \\
\hline
\end{tabular}
\end{table}

* Adjusted to match GHP Plan B member’s demographic and diagnostic characteristics, using the DCG system.
Sources: Genesee Health Plan; Center for Healthcare Research and Transformation

\textsuperscript{18} Only Plan B is compared to the HMO because Plan A’s population, many of whom are destitute and have serious mental and other chronic conditions, is too different from the commercial HMO’s population for the HMO to be a useful comparison to Plan A.
capitation payments for older Medicaid parents in Genesee County averaged $553 in 2008, which is 82 percent higher than the estimated $304 pmpm costs for the GHP Plan A members, who have more limited coverage (Tables 2 and 4). HMA advised that 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 by a safety net program such as GHP’s, especially for inpatient hospital services. Also, 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 actually 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, methods used to measure and adjust for health status are imprecise and so may either fail to account for some unobserved risk, or may overstate the degree of actual difference in risk. The Medicaid comparison is particularly coarse since it contains no explicit risk adjustment.

### 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 implementing federal reforms, many millions will remain 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.

Genesee Health Plan is an instructive example of one way to improve access to health care for people who remain uninsured, both leading up to and following national reforms. Working with

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19 These Medicaid capitation rates do not include behavioral health services, which are covered by a separate capitation “carve-out.” Also, the TANF program for parents does not include maternity-related costs for pregnant women, which are covered by a special maternity capitation payment paid at the time of delivery. These carve-outs do not bias the comparison of Medicaid with GHP since GHP members switch to Medicaid if they become pregnant.

20 Although the DCG risk adjustor is well validated and widely used for these purposes, initially it was developed for use with Medicare populations and some dimensions of risk among the uninsured may differ from the populations from which DCG’s adjustment methods were developed. Also, because DCG relies on diagnostic information obtained from claims or clinical encounter data, it may be somewhat less reliable for populations that have shorter periods of enrollment from which to draw such data. Here, two years of claims data were available for GHP members, whose average enrollment in 2008 was 7.6 months, compared with average enrollment in the local HMO of 9.8 months.
Flint-area physicians, hospitals and foundations, GHP has succeeded in providing basic medical care access to a substantial majority of 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 comprehensive insurance.

GHP has several limitations, however. First, local hospitals bear a significant portion of the costs for inpatient hospitalization which GHP does not reimburse, and the hospitals’ ability to continue offering charity care at this level is strained. Second, GHP is operating at full capacity so it would need to secure additional funding to accommodate any major influx of new members. 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 GHP.

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, potentially any community could follow a similar approach to improving uninsured access to care through local initiative.
Acknowledgements

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