County Health Plans:
Community-Based Health Care for the Uninsured

Background

A number of communities in Michigan have undertaken the development of community-based initiatives to provide healthcare coverage for low-income uninsured persons who are not eligible for mainstream medical assistance programs. Non-profit corporations set up to serve as the vehicle to provide access to organized systems of health care operate these programs. The goal of these programs is to provide some level of basic healthcare services to low-income, uninsured individuals (generally working individuals) that do not qualify for publicly funded health care.

For the 2004-2005 fiscal year the Michigan Department of Community Health and the State Budget Office have authorized funding for 24 county health plans serving 67 Michigan counties. As of May 2005 there are 22 plans in Michigan, covering 62 counties and by June there will be 23 plans covering 66 counties. One additional plan for a single county is working towards implementation in the last quarter of the current fiscal year. (A map and list of county health plans are included later in this document.)

Community leaders have already indicated an interest to establish two additional county health plans that would provide services in four additional counties if there is an opportunity in the 2006 fiscal year. One of these plans in Monroe County is especially interested in beginning a Third Share program.

The administrative structure of the community health plans varies. Some plans contract with third party administrators, pharmacy benefit managers, local health departments or other local agencies for these services. Other plans contract with their local health maintenance organization (HMO) for services including claims processing, member and provider services, and utilization management.

Through improved access to primary care, case management, formulary management and ongoing utilization reviews, community health plans are creating access to basic ambulatory care for persons who otherwise have no reliable source for services.

Description of Programs and Persons Served

The community health plans in Michigan operate Plan A and Plan B and/or Plan C as described below.

Plan A – Adult Benefits Waiver Program (formerly State Medical Program)

Eligibility for receipt of funding for local programs is contingent on each community health plan taking over responsibility for services under the Adult Benefits Waiver (ABW) program within the county. The ABW program covers individuals with incomes less than 35% of the Federal Poverty Level. Because this is a state program, the State provides the funding and defines the eligibility requirements and benefit structure. The state (Department of Human Services) also determines eligibility.

Plan B - Low-Income Uninsured Program

The low-income uninsured program is generally targeted at non-elderly adults with incomes less than 150% of the Federal Poverty Level. Persons eligible for this program have no other health coverage and are not eligible for Medicaid or other public programs. This group is comprised of the “working poor”: low-wage individuals who don’t qualify for, can’t afford or aren’t offered employer-sponsored health care benefits.

The benefits associated with these programs are defined locally, but typically include an array of limited ambulatory benefits including primary care and specialty physician visits, outpatient laboratory and radiology services and prescription drug coverage (based on a very limited, generic formulary). While there are no premiums or enrollment fees, copayments are required for some services, i.e., physician visits and prescriptions. Medical expenses for this group typically run between $40-$60 per member per month.

Funding for this program comes from donations from local hospitals derived from Special Medicaid DSH payments that are comprised of state, local and federal dollars. The potential number of enrollees in these programs is based on the level of available funds.

Third Share or Three Share Program

These programs are aimed at employers with low-wage work forces that do not currently provide health benefits to employees. Under this program, the community health plan provides premium subsidies to reduce the cost of health coverage for participating employers and their employees. The scope of benefits under this program is more comprehensive than the Plan B programs described above, and includes an inpatient benefit as well as coverage for ambulatory services and prescription drugs.

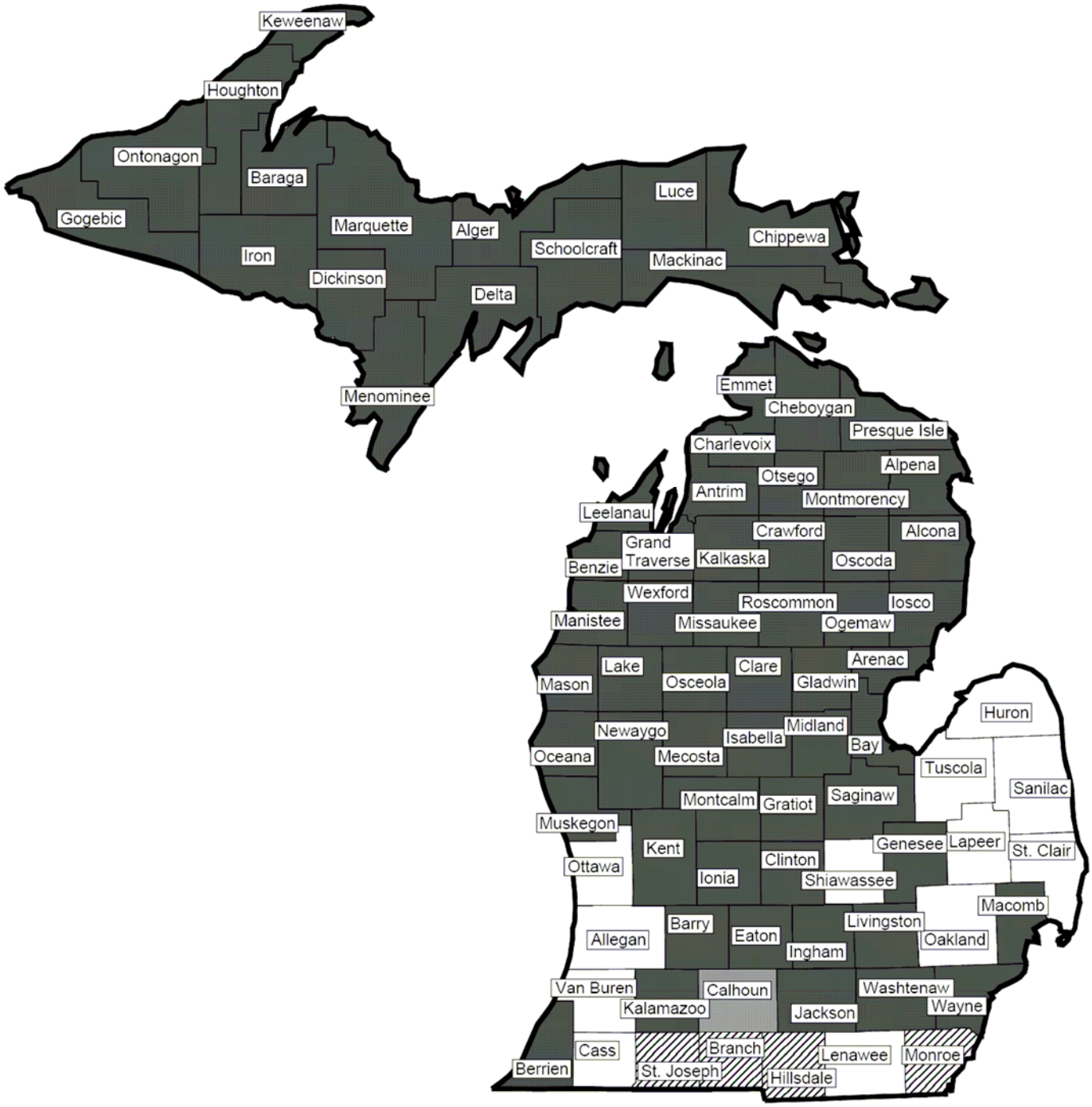
A key to success for these programs is an affordable product with an attractive benefit package. The intent of the Third Share program is to offer an insurance product with a monthly premium of no greater than $160-$180 per member per month, with affordable copayments and/or deductibles. Premium costs are split between the employer, employee and the community health plan. Typically, each party contributes one-third of the premium. By dividing the financial responsibility, this program offers affordable premiums for all parties involved. Another key is that there are no deductibles.

Employer and employee eligibility for the program is determined locally. Key decision points on employer eligibility include employer size, employee wage levels, and history of employee insurance coverage. Employee eligibility criteria include length of employment, part time/full time status, pre-existing conditions, wage and dependent coverage. Benefit design is also decided locally.

Under the current scenarios, in the most common model, the community health plan contracts with an insurance company to offer the specified policy at the specified rate. The insurer also handles eligibility determination, provider network development and contracting, member and provider services, and claims adjudication activities.

Subsidized employer programs are currently operational in four communities in Michigan, with interest from several additional communities.

County-Based Health Coverage Programs for Low Income Persons



Current Coverage Programs

Coverage Programs- Targeted Late FY 05 Implementation

Coverage Programs- In Development

Michigan County Health Plans for the Uninsured

Established County Health Plans: Enrollment as of December 2004

County Plan & Enrollment	*Plan A*	*Plan B*	*Third Share*	*Total*
Barry-Eaton (Barry, Eaton)	428	803	0	1,231
Bay	534	924	0	1,458
Genesee	3,441	8,425	0	11,866
Ingham	1,611	12,289	20	13,920
Jackson	605	354	0	959
Kalamazoo	1,287	1,348	0	2,635
Kent	3,012	2,213	50	5,275
UP Medical Care Access Coalition	1,558	584	0	2,142
Midland*	244	1,267		1,511
Mid Michigan (Clinton, Gratiot, Montcalm)	510	588		1,098
Muskegon	870	0	1,152	2,022
Saginaw Health Plan	1,451	2,065	0	3,516
Washtenaw	805	4,270	0	5,075
Wayne	22,651	0	4,310	26,961
Total	39,007	35,130	5,532	79,669

New or Under Development
Northern (Antrim, Charlevoix, Emmet, Otsego) adding Alpena, Cheboygan, Montmorency, Presque Isle
Grand Traverse (Grand Traverse, Benzie, Leelanau)
Macomb
Berrien
Central (Arenac, Clare, Gladwin, Isabella, Osceola, Roscommon)
Tencon (Crawford, Kalkaska, Lake, Manistee, Mason, Mecosta, Missaukee, Newaygo, Oceana, Wexford)
Livingston
Northeast (Alcona, Iosco, Ogemaw, Oscoda)
Calhoun
Monroe (Under development – no State agreement for funding)
Branch, Hillsdale, St. Joseph (Under development – no State agreement for funding)

Impact of County Health Plans

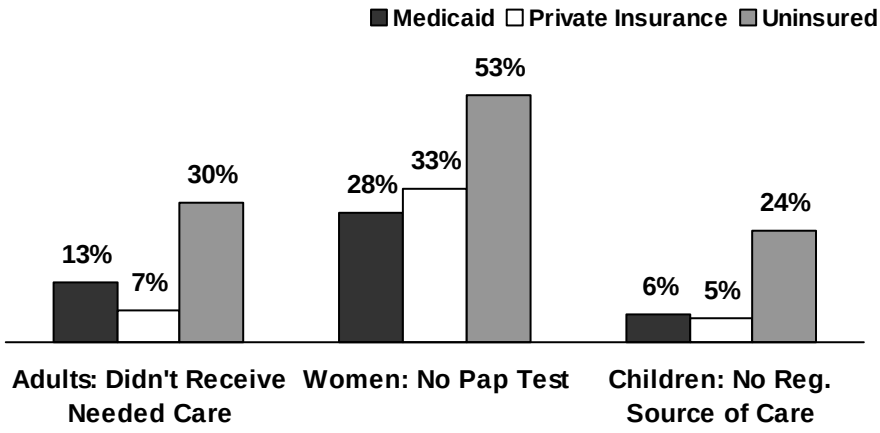
Access to Coverage

The primary goal of the county health plans is to increase access to coverage. By the end of FY 2006, based on current funding levels, between 60,000 and 75,000 low-income Michiganians without health insurance will have access to at least primary and preventive health care. Those enrolled in Third-Share programs will have access to relatively comprehensive health care services.

While none of the county plans have yet researched the impact that they are having on the health status of their members, research demonstrates that the uninsured:

- use fewer preventive and screening services;
- are sicker when diagnosed;
- receive fewer therapeutic services;
- have poorer health outcomes (higher mortality and disability rates); and
- have lower annual earnings because of poorer health.[1]

The impact of the lack of preventive care is further illustrated by the following chart, which is based on self-reported data from a national survey:[2]



A more recent national survey found that the uninsured were nearly three times as likely as the insured to not fill a prescription due to cost. More than one third had trouble payment medical bills and nearly one-fourth had been contacted by a collection agency about medical bills.[3]

While the funding of the county health plans is not sufficient to do in-depth research on these issues, at least two of the plans have evaluation grants that will seek to document changes experienced by their members.

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[1] SOURCE: Hadley, Jack. "Sicker and Poorer – The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review* (60:2), June 2003.

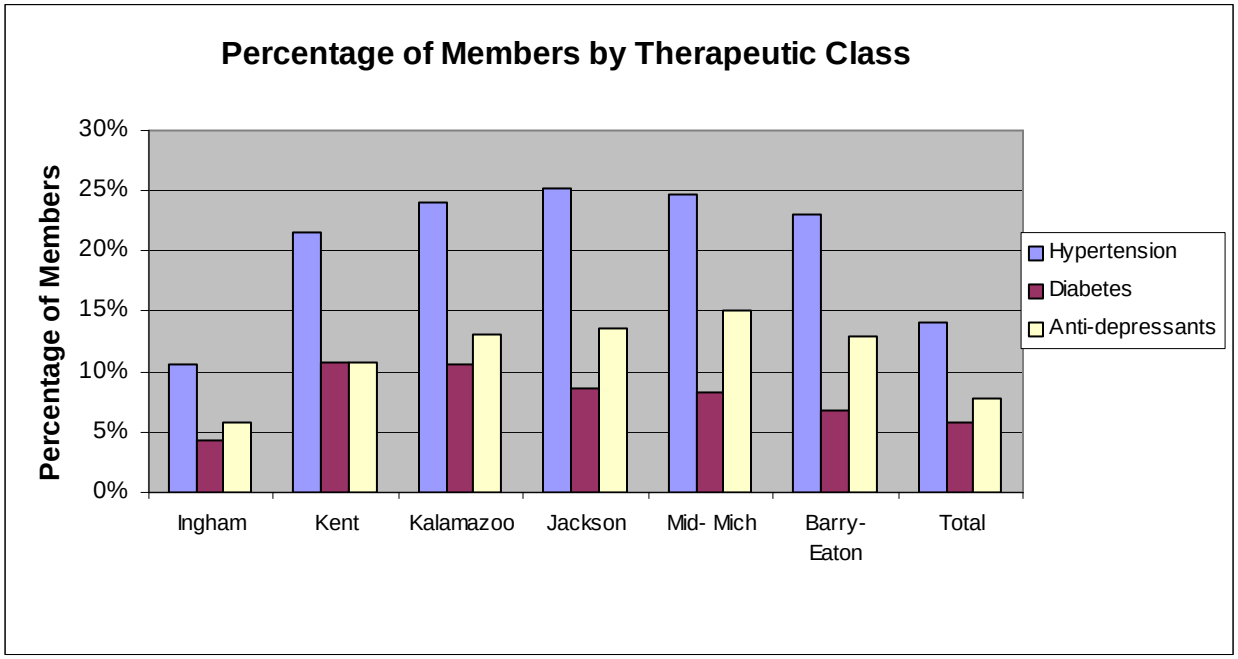
[2] SOURCES: The 1997 Kaiser/Commonwealth National Survey of Health Insurance; Women's Health, The Commonwealth Fund Survey, 1996; Dubay and Kenney, *Health Affairs*, 2001.

[3] SOURCE: Kaiser Commission on Medicaid and the Uninsured: 2003 Health Insurance Survey.

Management of Diseases

The Plan B members that would otherwise be uninsured benefit even more from access to treatment for diseases that might otherwise go untreated. In particular, those without insurance or coverage may not be under treatment for depression, diabetes or hypertension. The research literature is clear that any one of these health problems, left untreated, can result in significant medical cost, loss of productivity and other costs to society.[4,5]

Six county health plans provided data on these three diseases. For the nearly 17,000 Plan B members in these six plans, fourteen percent are being treated for hypertension, eight percent are under treatment for depression, and six percent are under treatment for diabetes.[6]



One third of all people with diabetes do not even know they have the disease. Intuitively, it would seem that the percentage of uninsured people who go undiagnosed is even higher. And it is not hard to conclude that people who now have access to care are less likely to live with undiagnosed diabetes.

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[4] For example, the literature indicates that the drug cost for treating hypertension is about $670 per year (1999). By contrast the estimated cost of treating people in the first year following a stroke was $12,634 in 1999. Estimated lifetime medical care costs for someone with heart disease ranged from $20,000 to $36,000. The estimates were made using data from the third National Health and Nutrition Examination Survey (1988-1994), the Nurses' Health Study (1995) and the Framingham Heart Study.

[5] The National Institutes of Mental Health estimates the cost of untreated mental illness, including criminal justice and social welfare costs, at about $300 billion per year. A 1999 Surgeon General's report on mental illness estimates the direct business costs of lack of parity in ability to gain treatment at $70 billion a year – mostly in reduced productivity and increased use of sick time. By comparison, when workers with depression were treated with prescription medications, medical care costs declined by $882 per employee per year, and absenteeism dropped by nine days. This is according to a study in the journal Health Economics.

[6] The Ingham Health Plan (IHP) has a large number of healthy young women that enrolled in the plan through the Health Department Family Planning clinic. These enrollees affect the data considerably. If you drop the IHP members out of the analysis, the percentages are much higher. Of the total, 23 percent are under treatment for hypertension, 10 percent for depression and 12 percent for diabetes. (Some individuals are treated for more than one of these conditions.)

The county health plans also improve the management of health care for their Plan A members who already have coverage through the State's ABW program. This occurs because these members are now linked with a primary care physician who is monitoring their health and because they have access to other care management services of the county health plans.

Disease Management – Information from Genesee Health Plan

The Genesee Health Plan (GHP) is one of the county health plans with sophisticated disease management programs. GHP has received funding from local foundations to implement enhanced disease management programs for all of its members.

Diabetes was one of the initial targets of this effort. GHP found that many diabetic patients were not aware of the resources available to them. Many were not monitoring blood sugar, and not yet aware that glucometer and strips are free through GHP. Many had no formal diabetes education, even though that service was available to them through charity care even before they joined GHP. In addition, some were not taking their medications. There was need to educate the members that there is no copayment for diabetes medications in the Genesee Health Plan. The following chart shows results in improvement in diabetes self-management for GHP diabetes management, based on 127 pre-post surveys.

Behavior or Service	Compliance at Baseline	Compliance at 3 month Follow up	P-value1
Has attended formal diabetes education	30%	54%	<.001*
Exercises regularly	35%	49%	.003*
Does not smoke	68%	76%	.003*
Checks blood sugar regularly	50%	74%	<.001*
Checks feet daily	70%	91%	<.001*
Regularly eats 3 meals a day	67%	74%	.011*
Regularly chooses low fat foods	54%	68%	.001*
Eats plenty of fruits and vegetables daily	50%	67%	<.001*
Has received eye exam within the past 1 year	47%	64%	<.001*
1= Wilcoxon Signed Rank Test		***** = Significant at p<.05*	

Emergency Department Utilization

The county health plans do not yet have any data on changes in use of hospital emergency departments (EDs). Some plans are able to document significant reductions in ED charges for their Plan A members in 2004, but this happened at a time when the member copayment was raised by the state to $25 per ED visit. (That copayment was eliminated on March 1, 2005.)

The Plan B members are not covered for ED services by the county health plans. Since they are covered with only a $5 or $10 copayment for physician office or clinic visits but must pay the full cost of any ED visits, there is a strong financial incentive to seek care from physicians offices or clinics whenever possible.

As noted above, at least two of the county health plans have recently secured funding for evaluations of their programs and will be including this issue in that analysis. This analysis will still be challenging since there is no hard data to analyze. At a minimum they will be able to survey members to learn about changes in use of hospital emergency departments.