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# Complexities of health care for the very poor

## *Eliminating GAMC isn't a solution*

**By Lynn A. Blewett, PhD**

The General Assistance Medical Care (GAMC) program was established by the Minnesota Legislature in 1975 to provide health care assistance to low-income individuals not eligible for other public programs such as Medical Assistance (Medicaid) or MinnesotaCare. GAMC is one of the few state health coverage programs that is financed entirely by state tax dollars, with no support from the federal government. GAMC was designed to provide care for the very poor and to make sure providers, typically hospitals, were compensated for caring for this unique and often difficult-to-treat population. It now covers approximately 35,000 Minnesotans.

The dangers of eliminating GAMC are complex, but it is important to understand that eliminating the program will not eliminate the need for GAMC, nor will it lessen the cost of needed health care. Minnesota taxpayers will still pay for the care of this population, through care provided in emergency rooms, through increased enrollment in MinnesotaCare, and through more expensive care due to delays in treatment. The cost of care for the GAMC population will not disappear by removing GAMC from the state's budget; instead, the cost of care for this population will be shifted to providers, other state coverage programs, and taxpayers.

### GAMC and MinnesotaCare

The GAMC program is currently financed by the Minnesota general tax fund. Eliminating the program will save the general fund approximately $381 million. However, the state estimates that about half of the costs saved will simply be shifted to the state's Health Care Access Fund, which funds MinnesotaCare. In the end, $190 million of the state's previous "savings" will be transferred to the Health Care Access Fund when many in the ex-GAMC population enroll in MinnesotaCare. The state estimates that not all GAMC enrollees will sign up for MinnesotaCare, and that those who do not enroll in MinnesotaCare will simply go without needed care, visiting the emergency room when illness reaches a crisis level.

There are three key concerns about shifting the GAMC population to MinnesotaCare. First, it is estimated that up to half of the GAMC population would not enroll in MinnesotaCare. MinnesotaCare enrollment procedures are much more complex than those of GAMC. For example, there is a four-month waiting period to enroll in MinnesotaCare, and there are premiums and copayments similar to private health insurance. Many in the GAMC population will not fill out the lengthy application form and cannot afford the associated costs of MinnesotaCare, and will choose to go without coverage.

Second, the MinnesotaCare population is relatively healthy compared with the GAMC population. The more expensive GAMC population will drain the current source of MinnesotaCare funding, contributing to projected Health Care Access Fund estimated shortfalls of $300 million by the 2012 fiscal year and over $660 million in 2013. The GAMC population will eventually "crowd out" more than 114,000 MinnesotaCare enrollees, two-thirds of which are families with children, leading to more uninsured Minnesotans. This will also intensify pressure to increase the provider tax, in order to pay for a GAMC-burdened MinnesotaCare population needing more services.

Finally, GAMC expenses belong in the general fund. The general fund provides coverage for welfare-related services, and GAMC has historically provided care for the very poor in the context of welfare. MinnesotaCare, on the other hand, is modeled on commercial insurance, and provides an affordable option to low-wage workers and their families. These programs have two very different histories of financing: GAMC is welfare-based, bearing primary responsibility for the very poor and vulnerable; MinnesotaCare is based on affordable coverage for working families, uses cost sharing, and is financed by a tax on the health care sector. Shifting costs from the general fund to the Health Care Access Fund not only under-

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mines the framework of the Health Care Access Fund, but also will overwhelm MinnesotaCare with enrollees for whom it has limited resources to aid.

### Who is the typical General Assistance patient?

Researchers at the University of Minnesota School of Public Health have conducted several studies on Minnesota public programs. GAMC enrollees are generally not a healthy population—two-thirds report below-average health and one-third poor health; 43 percent report poor emotional health and one in four screens positive for depression. Nearly two-thirds are limited in activities of daily living due to poor health; and, even with GAMC coverage, one in three enrollees report unmet health needs and over half report delaying care due to cost concerns.

GAMC enrollees tend to be single male adults, averaging 45 years of age. They are likely to be white, unemployed, and have at least a high school degree; they often have no immediate family, and report being "down on their luck." They have limited income and virtually no assets.

### Minnesotans will still pay for care of the GAMC population

Hospitals that provide care to Medicare populations are required to assess and provide emergency medical care to all patients. Currently, hospitals are retroactively reimbursed by the state for care provided to the GAMC population. Without reimbursement from GAMC, care provided to these patients goes uncompensated, and the cost of their care will eventually be passed on to "paying customers" (i.e., those with health insurance coverage, as well as insurance companies) in the form of higher charges for both routine and emergency care, and higher premiums and deductibles. The expense of caring for the GAMC population does not go away—it is simply passed on.

### Resources

For additional information about GAMC and MinnesotaCare programs and enrollees:

- Heather Sacks and Stan Dorn. Economic and Social Research Institute. Minnesota: A Case Study in Childless Adult Coverage State Report August 2004. www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46183

### What about federal health care reform?

If federal health care reform legislation passes in 2009, there may be an opportunity to connect the existing GAMC program to federal program expansions. A provision in health reform legislation moving in both houses of Congress would expand Medicaid coverage to all U.S. citizens with incomes under approximately 100–133 percent of the federal poverty level (equal to $10,803–$14,403 for an individual, in 2009). This would guarantee federal financial support in expanding state coverage for poor single adults with no children who are not currently eligible for Medicaid (currently, the GAMC population). Based on the current Federal Medical Assistance Percentage of 50 percent, Minnesota would receive assistance subsidizing half of every Medicaid dollar spent. It is also possible that the federal government would provide additional matching payments, subsidizing the first few years of mandated Medicaid expansions covering populations like the GAMC enrollees.

It is imperative that the Minnesota congressional delegation pay careful attention to the final reform language so that states that have already covered newly eligible Medicaid-eligible populations through programs like GAMC are not penalized for providing a state-only program, thereby missing out on federal funding. This has happened in the past. When the initial State Children's Health Insurance Program (SCHIP) was passed in 1997, the funding to states was based on the number of low-income uninsured children. Since Minnesota had already provided health insurance coverage to a majority of low-income children through the initial MinnesotaCare program, few eligible children existed for additional SCHIP coverage, so the state received limited federal funding for children. Minnesota was essentially punished for proactively covering a population under a state-only public insurance program. We need to be careful that this doesn't happen again.

The Minnesota Legislature will need to restore GAMC, even if on an intermittent basis, to provide "bridge" funding for the GAMC population in anticipation of federal reform. This will not be easy, given the current projected Minnesota budget deficit of $2.6 billion for the upcoming legislative session. Yet, care for the very poor and most vulnerable must be a top priority.

### A proposed solution

The health care needs of the most vulnerable should not be overlooked. The Legislature will need to act and act quickly in order to restore GAMC coverage. I propose they pursue a strategy that reinstates GAMC, but also reforms the program to provide increased care management for the GAMC population. Under this model, an accountable care organization would be provided with a monthly capitated payment, in return for using existing safety net providers to provide targeted mental health, case management, and coordinated medical care. If incentives are provided for better managed care, GAMC enrollees would likely avoid preventable and expensive hospitalizations, and use GAMC funds more efficiently.

The bottom line: Minnesotans will pay for the care of the GAMC population either directly, through public coverage under MinnesotaCare, or indirectly, through the inefficient use of emergency rooms and urgent treatment centers. Reinstating GAMC is not only a matter of compassion, but also makes fiscal sense when examining the plight of safety net providers who bear the cost burden of treatment for the poor and uninsured. Providing and paying for care for the poor is complex, but that complexity should not prevent us from doing the right thing and providing needed care to the most vulnerable in a better and more coordinated way.

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