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HEALTH POLICY BULLETIN

FOCUS: WAYNE'S COUNTY CARE

CountyCare, the HMO that replaced Wayne County's Resident County Hospitalization program, has enrolled 47,000 persons in its first two months of operation. Deborah Scott, Director, Patient Care Management System (administrator of the HMO), feels the new program has gotten off to a good start: "Patients have expressed real confidence in the program. We have increased access to care for people who never before have had a doctor whom they could talk to."

Members of the Medical Care Advisory Council, which advises the Department of Social Services on Medicaid policies, are not so sure. In a November 11, 1988 letter to Wayne County Executive Edward H. McNamara, the council expressed its concerns over four major issues: enrollment of sufficient numbers of providers, especially pharmacies, by the four contractors; contractors' enrollment of recipients; coverage of dental prescriptions; and coverage of single tooth extractions. The council is also worried about the provision of adequate information to recipients about transfer (switching from the provider to whom they have been assigned) and grievance and appeal rights; a central telephone number for problem resolution and a list of all provider care sites and their addresses; assistance with access or enrollment problems; transportation to care and help with transferring medical records; the CountyCare monitoring program; and the requirement that contractors provide correct and prompt information about their responsibilities to recipients.

Ms. Scott views the council's concerns as start-up problems typical of any new program. "People did not choose the program," she explains. The number of requests for transfers in October, she says, was 112 and involved special situations, mostly chronic disease problems where the patient had seen a particular physician over a long period of time. She also noted that her office and providers have received 50 complaints, a rate that she says "compares favorably to other HMOs." Initially providers were flooded with phone calls and appointments were backed up in the first week; the addition of more operators and triaging of appointments solved both problems. Many of the phone calls were requests for information on eligibility. The brochures for recipients and materials to clarify policy issues for providers have, in her judgment, alleviated those difficulties. As for problems with dental prescriptions, she observed, "the state created the problem. Wayne County pays $1.2 million to the state to administer the dental program. What happened was that no dentists were listed as providers for the program."

What about evaluating CountyCare? "CountyCare is monitored by our department, which has that power according to the law, and by the Citizens Advisory Group for Indigent Health Care, which was created by the Wayne County commissioners and is composed of professional and lay community people. After all, it is not in our interests to have a poor program," Scott said.

Nevertheless, Kathleen Gmeiner, an attorney with Michigan Legal Services and a consumer representative on the Medical Care Advisory Council, does not share Ms. Scott's perceptions of the program. She views the county's efforts to provide program information as inadequate: "People have been advised to call—what they really need is a reliable written source." According to Gmeiner, insufficient numbers of clinic and pharmacy sites in the western part of the county (Westland and Garden City), Inkster, and Downriver (Taylor) have created difficulties for people trying to reach providers. "A list of pharmacy sites would enable people to make choices. Also the mandatory assignments to providers do not take into account people's transportation patterns," she says. Gmeiner recommends a survey of recipients and an outside monitoring program similar to that created to oversee the Primary Physician Sponsor Plan.

Unaccustomed to having a physician, many CountyCare participants are still going to hospital emergency rooms when they are ill rather than to their assigned provider. This and many of the problems that have arisen in the program's first two months, however, are likely to diminish once administrators fine-tune the ways they inform participants and participants better understand the new protocols. An ambitious overhaul of such a large program will take time.

Questions about the structure of the program remain. "Even if CountyCare were administered perfectly, there still would be problems," says Donald Potter, executive director of the Southeast Michigan Hospital Council. "Only one-

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seventh of the Wayne County indigents are covered by the program. The ball is in the court of the governor's access task force to help the other six-sevenths."

FOCUS: HEALTH INSURANCE FOR THE UNINSURED

"Americans view health care as an open-ended right, which it is—unless you have no insurance," states Senator John Kelly (D-Detroit). Kelly has drafted a proposal to combine insurance for the uninsured with the Medicaid and General Assistance (GA) programs under one umbrella, which he has entitled the "Universal Health Insurance and Safety Net Act." Senator Kelly explains: "We need $1 billion to cover the working poor and finance a primary health care delivery system. The real thrust is to expand Medicaid to cover the working poor." All employees working at least 17.5 hours per week and all GA and Medicaid recipients would be eligible for the plan. The unemployed who are ineligible for GA and Medicaid are not.

The fund would be financed by taxing currently uninsured employees 3 percent of their taxable income, to be matched by contributions from their employers and the state. (Public Sector Consultants calculates the cost to employers, employees, and the state at $3 billion.) To cover each Medicaid and GA recipient, the state alone would be required to contribute 9 percent of the average taxable income of employees participating in the program. According to Kelly, the Medicaid and GA portion would cost the state an additional $340 million, or less than half of the current Medicaid general fund budget. The total state contribution to the fund would be $1.34 billion.

Unique to the proposal is the division of the state into universal health insurance zones, composed of counties or groups of counties, each with its own universal health care insurance fund. Zones would be administered by boards of directors, made up of employers, employees, county commissioners or county executives, and Medicaid and GA recipients. Each ten-member board would be responsible for (1) selecting, monitoring, and overseeing insurers supplying services to the universal health care insurance fund; (2) designating hospitals, clinics, and other providers eligible to supply services in the insurance zone; and (3) evaluating and making recommendations regarding the coverages offered in the zone. These boards would obviously assume some of the duties of the current Medicaid administration.

Each zone's fund would be used to purchase insurance coverage for eligible persons from participating carriers; plans supplied by the carriers would have to be vetted for actuarial soundness and equivalency of benefits by the insurance commissioner. Participating insurers would be required to offer two indemnity plans or two managed care plans. One would offer only the basic benefits described in the act while the other would be typical of the comprehensive plans that the insurer offers to other purchasers in the zone.

The basic benefits plan would be required to cover inpatient and outpatient hospital and physician care, diagnostic and screening tests, and prenatal and well-baby care to children aged one year or younger. Mental health, dental, vision, and prescription drug benefits may also be elected by employers and the state. Deductibles and copayments cannot exceed $150 for nonfamily enrollees and $250 for family enrollees annually and are not permitted on prenatal and well-baby services. Coverage would be phased in gradually; by 2000 all employers of four or more persons would be required to provide health insurance.

The Universal Health Insurance and Safety Net proposal is a creative approach to access to health care for the uninsured; however, it raises several problems. The draft allows the universal health insurance fund boards great leeway—laissez-faire boards could confine their activities to making sure the supply of insurance providers was adequate while activist boards could run zonewide HMOs and PPOs. Senator Kelly's estimated $340 million general fund dollars for GA and Medicaid would be well below the $775 million spent on the programs in FY 1989. It is hard to see how the proposed program, which would expand GA benefits and cut Medicaid benefits, could be financed at less than half of their current costs. This is to say nothing of the source of the state's $1 billion share of the working poor's insurance.

OF INTEREST

In the last days of the session, the state legislature passed a comprehensive package of AIDS bills. The bills require HIV testing of incoming correctional facility prisoners, donated body parts and fluids, and persons convicted of certain crimes. Other bills encourage infected persons to notify known partners; require that, before being tested, persons receive information about anonymous and confidential testing and give written informed consent; and establish procedures for dealing with those infected with the HIV virus who willfully place others at risk of contracting the disease.

— Frances L. Faverman, Editor