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February 9, 1990

HEALTH POLICY BULLETIN

FOCUS: FY 1991 MEDICAID BUDGET

Yesterday, Governor Blanchard announced his FY 1990–91 budget, which calls for a 0.7 percent increase over last year in the Department of Social Services (DSS) appropriation.

Medicaid will receive an increase of $22.3 million total and $22.6 million GF/GP. This GF/GP appropriation of $836.2 million is 2.8 percent higher than in FY 1990. Once again this year, the governor has recommended significant Medicaid cost containment measures, nearly all of which fall on the hospital and pharmaceutical lines. These measures total $83.3 million, $38.2 million of which are GF/GP dollars. The cuts include decreasing the hospital indigent volume subsidy to the statutory minimum ($17 million total, $7.8 million GF/GP); instituting competitive bidding among hospitals ($10 million, $4.6 million); deferring the special FY 1990 fee increase ($10 million, $4.6 million); limiting hospital capital reimbursement ($9.2 million, $4.6 million); reducing hospital long-term care rates ($7.6 million, $3.5 million); reducing the pharmaceutical dispensing fee by 50 cents ($5.2 million, $2.4 million); limiting per diems for psychiatric hospitals ($5 million, $2.3 million); limiting the hospital graduate medical education subsidy ($4.4 million, $2.0 million); forming a pharmacy PPO ($3.9 million, $1.8 million); eliminating the dispense-as-written option for pharmacies ($3.7 million, $1.7 million); requiring prior approval for psychiatric hospital admissions ($2.2 million, $1.0 million); discontinuing reimbursement for selected high-cost drugs ($2 million, $.9 million); using a mail-order pharmacy ($2 million, $.9 million); and eliminating the special hospital indigent volume subsidy ($1.1 million, $.5 million). These measures translate into a net $65.1 million cut in the hospital line.

The Medicaid budget also includes $13.9 million ($12.2 million GF/GP) to institute the governor's Healthy Start program, which will cover children under age 10 who are not eligible for Medicaid but who have no insurance or are underinsured. The state also must devote $5.8 million more to the Medicaid program because of the repeal of the Medicare Catastrophic Coverage Act. Moreover, a shift in the federal Medicaid match will cost Michigan $6.7 million.

FOCUS: UNINSURED CHILDREN

Shortly after the governor's announcement of his program, Healthy Start, to provide health insurance coverage for children who are not eligible for Medicaid, Blue Cross and Blue Shield of Michigan (BCBSM) announced its Caring Program for Children. The proposal, which is still in the larval stage, would provide coverage for selected outpatient services at $13 per child per month, while the governor's plan would include inpatient and outpatient services at $25 per child per month. The proposed Blues' plan is modeled after the original plan in western Pennsylvania.

Charlie LaVallee, director, Caring Program, explained how the program works in western Pennsylvania. The plan's service area includes 29 counties (about half of the state) with rural and urban population centers—three large cities, Pittsburgh, Johnstown, and Erie, are included. The plan currently serves 13,500 children (the total eligible population is 42,000) from birth to age 19, and the average length of stay in the plan is 19 months. Financial eligibility requirements are a family income below the federal poverty level ($12,100 for a family of four) but above the Medicaid eligibility level ($6,500 for a family of four in Pennsylvania). Every enrolled person gets a BCBS card and is treated like any other patient when the card is presented to the provider; hospitals bill BCBS in the normal fashion for covered services and are reimbursed at a slightly lower rate, while physicians accept a reduced fee as full payment. There are no special administrative costs for the program because it is handled like the rest of the Blues' business in western Pennsylvania.

How is the plan financed? LaVallee says the individuals in a community come up with the premium money, and the Blues match it. He cited Lawrence County where a program is just starting. For 1,000 eligible children, the estimated first-year cost is $156,000, which the Blues will match. "The program challenges a community to support its kids, and the dollars stay home," he observed. "Hospitals and physicians are already providing care to some of these kids; now they have a chance to get some money for uncompensated care, and families get to retain their dignity because the program is confidential—names are not released. We are mainstreaming these kids into the health care system," he stressed. What happens when there are more children than money? "We use some of the matching funds to help kids who don't have sponsors," he replied. The program operates on a first-come, first-served basis: "There is absolutely no political interference," he noted. Is there turnover in the program? "We have had about 7,500 kids leave the program; some became eligible for Medicaid, but most left because their parents were able to get better jobs with health benefits," he said.

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Diane Valade, senior analyst, quality assurance and benefit initiatives development, BCBSM, said, "the key to keeping the plan affordable is not covering expensive inpatient hospitalization." The plan would cover outpatient services like immunizations, adolescent and well-baby care (including physical examinations), nondental outpatient surgeries, emergency medical care in emergency departments as well as "docs-in-a-box," radiology, laboratory tests, and anesthesia. However, outpatient maternity care, vision, dental, hearing, durable medical equipment, and ambulance services would be excluded. "Our intent," she noted, "is to keep the benefits as close to the western Pennsylvania plan as we can."

FOCUS: STATE HEALTH POLICY FORUM

The Michigan Health Policy Forum sponsored by the Colleges of Human Medicine, Osteopathic Medicine, and Nursing at Michigan State University and moderated by Senator William Sederburg (R-East Lansing), featured Walter McNerney, former president of the Blue Cross and Blue Shield Associations and currently Herman Smith Professor of Health Policy at Northwestern University, as its chief speaker. McNerney's address, "Health Care Issues in the 1990s," focused on costs, access, the lack of consensus, national health insurance, and the competitive market approach. Pogo's immortal line, "We have met the enemy and they are us," is a fair summation of his address. We have had "no cohesive health policy for the last eight years," he said.

McNerney said the health care industry is experiencing "its greatest frustration since the development of Medicare and Medicaid in the 1960s." He noted that in the 1960s "the battle cry was access; today it is cost." In his view, "costs are out of control in all segments" of the industry. Franchising and redundancies of service keep costs up. Insurance mechanisms are badly fragmented, and no one insurance purchaser has "the clout to leverage the market through the purchasing dollar." Our national situation is not unique, according to NcNerney. Other countries have similar problems with intensity of care and costs, and the major culprit there as here is the "halfway technology" that relieves conditions without curing them: "Ameliorative technology is a bottomless pit."

He noted that we could handle the costs if it were not for the access problem, observing that we would need an additional $50–70 billion to close the gaps in Medicaid. The system also fails the aging population because Medicare does not provide for long-term care, and only one of every five Americans on Medicare has supplemental insurance.

McNerney is not optimistic about the proffered solutions. National health insurance is too expensive and also suffers from the widespread skepticism among Americans about the ability of the government to handle a broader program when they believe that Medicare and Medicaid are run ineptly. "National health insurance, despite East Coast rumblings, is not imminent," he said. Piecemeal changes like the Bush proposals (IRAs for health, Medicaid expansion, and greater cost-sharing by states) do not provide adequate solutions.

What lies ahead, and how do we solve the problem? McNerney plumped for mandated coverage through employers, risk rating by insurers, employers' prefunding of retirement liabilities, and controlling the options an employer may offer. Expanding Medicaid and adding long-term care coverage to Medicare would improve access. A large reservoir of unsatisfied (because unaffordable) demand can be met only by a greater emphasis on preventive medicine and on increasing levels of income among low-income families. Creative solutions have to be found, and the laboratory for experimentation is the states: "The bottom line is the states have to come in out of the wings."

OF INTEREST

In February, look for

- the Senate Committee on Health Policy to report out four bills (SBs 267, 632, 633, and 754) related to tobacco use and smoking; it hopes to take up HB 4952 (emergency medical services) near the end of the month;
- the House Committee on Public Health to take up HBs 4832-4833 (acupuncturist licensure) and HB 4176 (dental specialty licensure);
- the House Public Health Subcommittee on Eye Care to take up HB 5200 (optometrists' scope of practice bill); and
- the Senate to pass HB 5103, the abortion parental consent bill.

The House and Senate committees on public health issues will hold a joint hearing in the House chambers at 2 p.m. on February 15; the committees will hear a presentation by the National Council of State Legislatures on developments in rural health care and a response from the Michigan Department of Public Health. Target dates for introduction of legislation on rural health care in the state range from February 15 to February 22.

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