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March 16, 1990

HEALTH POLICY BULLETIN

FOCUS: ACCESS TASK FORCE REPORT

The Governor's Task Force on Access to Health Care met Monday, March 5, and approved a three-volume report. The cover letter sent with the draft report states: "*The drafting group* would like Task Force members to know that it *unanimously supports the revised report.*" The thirty-three page report noted that high health care costs are inextricably linked to diminished access to care. The "undesirable social consequences" of inaccessibility are: the effects on equality of opportunity for our citizens, the failure to invest in future generations of workers, and the inability of growing numbers of employers to offer and maintain coverage for their workers.

The meat of the report is contained in chapter 4 (policy options) and chapter 5 (recommendations) and reflects the policy analysis and decision-making work of the task force. Four guiding principles framed the discussion: (1) private and public involvement are necessary to provide increased access, (2) freedom of choice in selecting providers is necessary in at least one of the health plans, (3) coverage for the uninsured should provide reimbursement at a level that would ensure access to a defined basic level of services, and (4) increasing the number of persons who would receive basic services should be the goal.

Although the task force was careful to say that it was not endorsing specific cost containment strategies, the group agreed that such strategies were necessary. Cited in the report are professional liability reform, adoption of a resource-based relative value scale for physician payment, development and adoption of a statewide pharmaceutical formulary that would be compulsory for all payers, establishment of physician practice standards, adoption of a hospital all-payer reimbursement system, and use of statewide health expenditure targets.

In the end the task force did not endorse any plan but rather made seven recommendations: (1) There is a need for a universal health care plan ensuring access to care for all that includes the required cost containment objectives and is fiscally possible; (2) the Michigan congressional delegation should initiate action on a federal or federal/state plan to achieve the objectives noted above; (3) the state should pursue development of a plan that is technically and financially possible and features a partnership between public and private sectors and the state and federal governments; (4) work done by the Governor's Health Care Cost Management Team and the Special Factfinder on Medical Liability should be integrated into any plan; (5) a strategy for phasing in a universal health care plan should be developed; (6) education and consensus building activities should be carried out by the task force; and (7) the task force should be extended with state funding and staffing for another 18 months.

As it will be some time before a universal state or federal plan is likely to be implemented, the task force prioritized its initiatives around increasing access for children, persons with disabilities, and employees of small businesses. For children, four options were laid out: creating opportunities for families with incomes up to 200 percent of poverty level ($24,000 for a family of four) to obtain coverage by some combination of buying in to Medicaid and premium sharing, having the state take full advantage of federal funding by expanding Medicaid coverage to the greatest extent possible under current federal policy, encouraging insurers to develop dependent-only policies, and creating new policies that recognize single parent/child families with premiums below those of full family plans. Disabled persons who are poor could be helped by expanding the definition of disability that is used in the Medicaid disability program; this would meet the needs of some of the poor uninsured who have serious medical conditions. Finally, the creation of small employer pools to help employers obtain health insurance at reasonable costs would meet the needs of many of the uninsured; another possibility was the expansion of the Health Care Access Project being piloted in Genesee and Marquette counties.

Although the task force did not endorse a specific plan, it did look at four options that were designed to improve access. The criteria for judging the plans reflect an awareness of reality—besides access, public and private partnership, cost effectiveness, and ease of implementation, financial and political feasibility were criteria for evaluation. The task force concentrated on the two options it felt would embody the necessary cost containment measures. The first, the Michigan Health Plan, written by University of Michigan School of Public Health Professor Sylvester Berki, is a Michigan version of the Canadian health plan. All state residents would be covered; the only exception is veterans with service-connected disabilities (who, at least theoretically, are covered by the Veterans Administration). Medicare and Medicaid would no longer exist. Small copayments for routine services and larger copayments for other services where discouraging utilization is important are features of the plan, but all medically necessary services would be covered. Berki assumed

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enough money would be saved through administrative efficiency and cost containment measures that the rate of growth in future health expenditures could be held to 2 percent, an assumption that some participants in the debate regard with suspicion. The plan would leave the present health care delivery system intact and would not change fundamentally the way services are delivered. The other plan represents an incremental approach to broadening access and would target specific vulnerable groups through voluntary plans, a statewide program for children, Medicaid buy-ins for some groups, and insurance pools for small businesses.

What are some of the advantages and difficulties of the Michigan Health Plan? Opinion among task force members was divided about its effects: Some felt that it would be a plus for businesses, and others felt it would be a negative. Conclusion? Further study and exploration of its effect on the state's business climate are needed. Federal cooperation would be needed to avoid the loss of funding for Medicaid and Medicare programs so that they could be folded into the system; severing the relationship between employment and coverage could result in higher income taxes for working individuals who no longer would receive health care coverage as a tax-free benefit, and lastly, some form of federal promise would be needed so that whatever Michigan did could be integrated with federal initiatives as they were adopted. On the state level there was concern that the constitution would have to be amended to avoid the Headlee amendment, that the financing mechanism and single payer approach was too simple, and that the feasibility of using cost reductions to produce savings that would help finance the system was questionable.

Senator William Sederburg, chair, Senate Committee on Health Policy, said, "The sixty-four dollar question is money. It is not a matter of state policy to want to deny services to people; it is a matter of whether or not as a society we want to put up the money. My instinctive feeling is that one cannot save enough money through centralized administration and cost containment to fund a Michigan plan. I also am not convinced that the Canadian model is the way to go."

Charles Ellstein, group vice-president, health delivery and finance, Michigan Hospital Association, observed, "I think it is a useful report. It focuses attention on the problem, but it is not clear that this administration [Blanchard's] is committed to focusing on the issue of impaired access to care and the crumbling of the delivery system. How can you focus on improving access for the uninsured when you continually underfund Medicaid?"

Beverley McDonald, executive director, Michigan League for Human Services, said that the league supports the report: "In the current climate we are delighted with the recommendations to expand access for children. Overall, we [the task force] informed at least one hundred more people about the problem—that is a necessary first step to change, and the issue is on the front burner." She also noted that "a Michigan Health Plan would be hard on business, particularly small businesses, since many would have to do more than they do now."

Two major reports on health care have been delivered in the past four months. As one might expect, there are more areas of agreement than disagreement between them. Both endorse the concept of universal access to care principally through managed care plans, the establishment of all-payer rates (DRGS) for hospitals, reform of the current hospital capital payments system, the development of a statewide pharmaceutical formulary, changes in the medical liability system (specific recommendations await the report of the Governor's Special Factfinder on Medical Liability), and bringing the supply of medical professionals more into line with estimated needs. Both reports fudge on financing: The cost containment report is more concerned with lowering costs, while the access report rests on some questionable assumptions. When it comes to cracking the nut of rationing care, both reports agree that the present system of implicit rationing is immoral; both reports, however, sidestep the issue of explicit rationing.

To a great extent the reports dovetail: If many of the access to care recommendations are to be carried out, then many of the cost containment team's initiatives will have to be implemented. For example, a statewide health care plan without utilization review and case management controls would founder very quickly through overutilization and the provision of unnecessary services.

OF INTEREST

The House Committee on Public Health plans to report out HB 5426, the adult day care licensing bill, in March.

The Senate Committee on Health Policy has no definite schedule for reporting out the following bills: SBs 469–471 (genetic profiling), SBs 796–798 (preadmission screening for nursing home admissions), SB 584 (resident hours), SB 769 (asbestos standards), and HB 4952 (emergency medical services).

—Frances L. Faverman, Editor