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HEALTH POLICY BULLETIN

FOCUS: GENETIC DISCRIMINATION

The ability to map the human genome (the DNA blueprint of traits contained in every cell) has tremendous potential for diagnostic and therapeutic benefits; it also has mind-boggling implications for health care policymakers and others. More than 3,000 diseases with distinct genetic components are known; over 400 genetic "markers" or signposts for these diseases—including muscular dystrophy, Huntington's disease, a variety of cancers, alcoholism, and some psychiatric disorders—have been located on all 46 human chromosomes. Access to a person's molecular secrets raises questions about privacy, confidentiality, employability, and insurability—all opportunities for new forms of discrimination in American society. Should an insurer or employer be able to test for a certain disease and decide not to insure or employ a person based on that information? Each person by virtue of his/her genetic profile has the potential to become a member of a new minority created by the probability of suffering a particular illness.

Insurers are frightened by adverse selection and the resulting fiscal liability. Individuals are frightened by the problems of confidentiality and discrimination. The problems are more significant for life insurance than for health insurance, because health insurance is written largely for groups, while life insurance, especially large policies, is almost always written for individuals. Nevertheless, the ability of health insurers to exclude pre-existing conditions may mean that large numbers of people could become uninsurable on the basis of their genomes, especially if genetic markers are recognized as reliable predictors of the likelihood of disease. The specter of significant numbers of people being unable to have access to health insurance because of their genetic histories may give new meaning to the current debate about access to health care for the uninsured.

Sickle cell anemia testing in the early 1970s first made people aware of the critical implications of genetic testing when the widespread confusion about the distinction between carriers and persons who actually had the disease led to employers refusing to hire carriers. While genetic markers have not been addressed specifically in state or federal laws, many authorities feel that laws banning discrimination against handicappers may be applicable. Michigan courts have defined a handicap as a "determinable physical or mental condition which is **unrelated** to an individual's ability to perform his or her assigned job." This does not necessarily prohibit employers from testing; it only prohibits decisions not to hire or to fire based on positive tests.

Insurers face fewer potential restrictions than do employers in excluding persons from coverage. Jean Carlson, Deputy Commissioner, Office of Policy, Michigan Insurance Bureau, is not so certain that laws preventing discrimination will apply to persons with genetic markers: "How important genetic testing will become depends on what the state and federal governments do about health insurance. If coverage by employers is mandated, insurance companies won't be able to exclude people. If we continue with the present system, they would be able to. It certainly is something we ought to start thinking about." Currently, testing in Michigan is nondiscriminatory: insurers cannot discriminate on the basis of race, age, sex, geographical location, or lifestyle. For example, if a company wants to test for AIDS an applicant who seeks $50,000 worth of life insurance, it must test all persons applying for that much coverage for AIDS. In the end, the issue may not be whether testing should be allowed, but rather how it should be controlled so that individuals can be protected from the consequences of their genetic histories.

A 1982 survey by the Office of Technology Assessment (OTA) revealed that 6 of the 366 responding companies nationwide used genetic tests on applicants or on employees. The same survey indicated that 55 companies had plans to start using such tests within the next five years. A 1988 report from the same agency noted that the extensive use of such tests was unlikely in the near future; however, the report pointed out that as the tests become more widely available and enter clinical practice, they also will enter individual medical histories and become available to insurers when people apply for insurance.

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FOCUS: SPECIALTY NURSE REIMBURSEMENT

An attorney general's opinion issued February 1 would seem to clear the way for direct reimbursement by Blue Cross and Blue Shield of Michigan (BCBSM) to the 327 certified specialty nurse practitioners in Michigan. Carol Franck, Executive Director, Michigan Nurses Association, said "the issue is important to us because BCBSM either supplies or administers about 70 percent of the health insurance in the state. Nurse practitioners cannot survive without direct reimbursement." Several private insurers, including Aetna and Travelers, will reimburse nurse practitioners and nurse midwives directly if the service provided is covered in the contract. The state Medicaid program also reimburses nurse midwives directly, and the Medicare program does so for nurse anesthetists.

Others are not so sure. The optometrists received a similar opinion in 1986, and according to Dr. Robert Klein, Chairman, Prepaid Vision Care Committee, Michigan Optometric Association, they still are negotiating with the Blues about what they will and will not cover. Again, many insurers are paying optometrists for services that the Blues deny.

Kevin Kelly, Assistant Executive Director, Michigan State Medical Society (MSMS), is watching the situation with great interest. In his view, the attorney general's opinion "really asks the question, does the nurse practitioner perform the same or equivalent clinical service and assessment as the physician? That hasn't been clarified yet by the Blues. The real question is how will Blue Cross determine what procedures are reimbursable?" He noted that MSMS has historically opposed direct reimbursement for specialty nurse practitioners and will continue "to monitor this issue closely as it impacts health care costs and issues of physician delegation."

Mary Faroni, Director, Government Policy, BCBSM, states: "We are reviewing that attorney general's opinion for applicability, and we are pulling together a group to review its implications. That group will consist of BCBSM representatives as well as the nursing association and the Department of Licensing and Regulation." Originally, the opposition to direct reimbursement had been based on cost considerations; she noted that may no longer be a concern with nurse midwifery (one kind of specialty nursing practice) since it represents little possibility of the duplication of services. "However," she continued, "we may have a concern with other nursing specialties. Any profession representing an add-on to the cost of the delivery system troubles us."

To Franck such an argument misses the point. She says that about 90 percent of all pediatric care and 75 percent of all adult care can be provided by nurse practitioners at significant cost savings. "If a nurse delivers the same service as a physician, shouldn't she get paid?" Despite the experience of the optometrists, Franck is optimistic about achieving direct reimbursement from the Blues: "I believe there have been significant changes at Blue Cross and Blue Shield of Michigan in the last year, and they may begin to respond better to our concerns."

OF INTEREST

At the time we went to press last month, we did not have State of Michigan employee health costs. We do now. Michigan's costs for health care benefits in FY 1987-88 of $3,043 per employee in the self-insured program and $2,740 per employee for those in health maintenance organizations exceeded the national average of $2,300 for state employees. Total costs of health related benefits (health, dental, vision, and long-term disability, but excluding administrative costs) was $218.8 million for active employees and $47.6 million for retirees, whose average cost was $1,951 per person. Projections by the department show that costs for October through January in FY 1988-89 are running 10.6 percent ahead of the same period in FY 1987-88.

In the next thirty days, look for the

- Senate committees on Government Operations and Health Policy to recommend confirmation of the Certificate of Need Commission appointees at a joint hearing to be held on May 10 at 8:00 a.m.;
- House Committee on Public Health to report out the House medical waste package (HBs 4135-4142) and SBs 69 and 72 from the Senate package, the dental specialty licensing bill (HB 4176), and the associate psychologist licensing measure (HB 4638); and
- Senate Committee on Health Policy to report out SB 393, the essential provider bill offering financial aid to physicians and nurse practitioners willing to practice in underserved areas.

The first meeting of the CON Commission is scheduled for June 5 in the MSU Student Union, Parlor C, 1-5 p.m.

— Frances L. Faverman, Editor