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HEALTH POLICY BULLETIN

FOCUS: A STATE HEALTH CARE PLAN?

Governor Engler's budget recommendations for the Michigan Department of Public Health contain a paragraph instructing Vernice Davis Anthony, director of the department, "to develop an alternative approach to the provision of state funded health care. Such an approach will address issues of liability reform, community practice standards, use of managed care, administrative efficiencies, personal responsibility, and others." What does this mean?

In a speech delivered April 30 to the Coalition for Access to Health Care, Ms. Davis Anthony indicated that she and the directors of the departments of Social Services and Management and Budget, the Office of the State Employer, and the governor's advisor on health policy would be working to develop a plan. Her speech stressed the goals that a comprehensive approach would ensure: short-term savings for FY 1992, more control over the long-term growth in medical care expenditures, investment in health promotion and prevention, better access to care for Medicaid recipients, and private sector employer participation to provide coverage to uninsured employees and/or to benefit from the plan's savings. The key comment in her speech: "The preferred delivery system should be managed care entities: HMOs, prepaid PPOs, or some variation thereof with a quality assurance program and a utilization control component."

The plan would depend upon "develop[ing] statewide community standards of practice that appropriately limit the application of extraordinary medical procedures . . . [M]anaged care plans are the only organized systems that can and do establish standards of practice." Turning to liability reform, she referred to a five-year demonstration project in Maine that will allow participating physicians "to use the practice parameters and risk management protocols as an affirmative defense in malpractice cases."

Perhaps, in developing a comprehensive plan, Michigan should consider a managed health plan that would cover all state employees, Medicaid recipients, crippled children, state retirees, public school retirees, prisoners, judges, state police, elected officials, and anybody else whose health care costs are funded by the state.

Active state employees (62,100) currently are covered by a self-insured state plan administered by Blue Cross and Blue Shield of Michigan and by 19 health maintenance organizations; about 60 percent of the state's employees are enrolled in the self-insured plan and pay 5 percent of the premium, while the remaining 40 percent enrolled in HMOs have the entire premium paid by the state (the HMO premium is less than the self-insured plan premium). Employees electing vision and dental coverage pay 10 percent of that premium, too. The total cost to the state in the fiscal year ending September 30, 1990 (FY 1990), was $160 million.

Retired state employees are covered by the same system; this category includes public school retirees, state police, some judges, and members of the legislature. All except legislators pay 5 percent of the premium and 10 percent of the premium for elected dental and vision coverage; legislators are exempted from the premium copayment because their system is funded in part by a one percent levy on their salaries as well as an annual appropriation. All but state police retirees are shifted to Medicare upon reaching the age of eligibility; current state police retirees are ineligible for Medicare because of the uniformed services exclusion. Medicare supplemental coverage is provided by the state through its self-insurance plan at no cost to the retiree.

How much do these systems cost the state? For FY 1990 the cost for the 24,194 state retirees and their survivors was $69.4 million. Public school retirees (69,818) cost the state $155.8 million, state police retirees and their dependents (1,203) cost $5.3 million, and judges (about 120) cost a minuscule $72,600. The total cost for health benefits for 94,012 retirees was $230.4 million general fund/general purpose (GF/GP) monies, almost one and a half times as much as the cost for active state employees and their dependents. Adding together the costs for state employees and retirees yields a total of $390 million GF/GP in FY 1990; or put another way, $41.93 per citizen went to pay state employee and retiree health benefits. The average annual cost per active employee was $2,576 and per retiree was $2,451.

What is worrisome is that in 1983, the per-person annual cost for 16,284 retirees in the state system was $1,130; in seven years costs across the system grew by 117 percent, while the number of persons being covered increased by

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48.6 percent. The average annual cost for public school retirees was $2,231 in FY 1990 versus $526 in 1981, an increase of 324 percent in the decade, while the number of persons covered grew by 81.7 percent.

How does this compare with state spending on Medicaid? Statistics contained in the report submitted by the Medical Services Administration (MSA) in late April to the House Appropriations Subcommittee on Social Services indicate that in FY 1989, the latest year for which these numbers are available, the state spent $1.95 billion on medical services for 1,117,196 people, an average payment per person of $1,749. Of that amount, the state's GF/GP share was $805 per recipient. The same report shows total Medicaid costs increasing by 90 percent from FY 1980 to FY 1990.

The wide discrepancy between the GF/GP dollars spent on state employees and retirees versus Medicaid recipients has led to concerns about an explicit two-tier system funded by the state. One way to address these concerns is to create a plan that puts all state-funded health care in the same plan with the same benefits. A single state-funded health care plan for employees, retirees, prisoners, and Medicaid recipients would have as advantages administrative efficiencies, the ability to enforce standards of practice, and better access for Medicaid recipients.

A state-run or organized HMO or PPA with approximately 1.21 million members would have great clout in negotiating fees and setting standards of practice. The mechanism to administer such a plan exists in the Medical Services Administration. Some estimates suggest that such a managed health care plan probably could save as much as 20 percent of the current cost of health care for state employees and retirees and prisoners.

What are the stumbling blocks? State employees and retirees and their unions will be the biggest losers. Providers currently billing the state at their usual rates may be frozen out of a state-organized HMO or PPA. Who gains? Medicaid recipients and the state budget—costs for prisoners would decrease, access for Medicaid recipients would improve, and the state's costs for health care would decline.

Denise Holmes, Chief, Bureau of Community Health Services, MDPH, notes that the governor's directive is giving the state an opportunity to "begin a public dialogue" on the issues that surround health care benefits for public employees and public insurance benefits for the poor and uninsured.

FOCUS: GROWTH IN MEDICAID EXPENDITURES

According to information supplied by the National Association of State Budget Officers, federal payments for Medicaid have grown from $21.5 billion in 1985 to $39.2 billion in 1990. During that same time administrative expenditures for the program have declined from 5.6 percent of the dollars spent for medical assistance payments (MAP) to 5.1 percent.

What is most interesting about the growth is how it has shifted within categories. Before 1985 growth in Medicaid expenditures was driven by long-term care; since 1985 and the expansion of coverage to pregnant women and children, the growth in expenditures has been driven by inpatient hospital services.

Looking at Medicaid growth regionally, only regions IV (Atlanta, 20.2 percent) and II (New York, 16.1 percent) had higher growth rates than Region V (Chicago—the region that includes Michigan—13.6 percent). According to the Health Care Financing Administration, the federal share of Medicaid payments is expected to rise approximately 4.5 percent in the current fiscal year.

OF INTEREST

In the next thirty days, look for

- the House Committee on Public Health to report out HB 4699 (dental hygienists limited independent practice), HB 4407 (optometric scope of practice), and HBs 4555–4556 (Sudden Infant Death Syndrome);
- the House Committee on Public Health to work on SB 243 (distribution of abortion information by schools); and
- the Senate Committee on Health Policy to take up SB 268 (immunity from suit for emergency room physicians).

A draft version of the first conference report on SB 154 is available. The bill, a vehicle for considering auto insurance issues, is in conference committee. Major provisions affecting health care providers caring for persons with auto-related injuries are (1) the use of case management and utilization review to determine appropriateness of care, (2) the ability of auto insurers acting collectively to create managed care organizations to provide care, and (3) use of the workers' compensation fee schedule to reimburse providers until managed care systems are available to 80 percent of the auto insurance policyholders in the state. These will be addressed in conference committee hearings in May, June, and July. The bill's final form will be shaped after the hearings.

—Frances L. Faverman, Editor