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May 1993

HEALTH POLICY BULLETIN

FOCUS: HOUSE DEMOCRATIC HEALTH PLANS

Health care plans have been presented by two House Democrats, Reps. David Hollister and Michael Bennane. Hollister has reintroduced a version of a plan that he and former Rep. Perry Bullard introduced 18 months ago. Hollister's universal access plan would be run by the government and financed by federal dollars and state taxes. Under the plan, which includes every state resident, insurers could no longer sell indemnity contracts.

The Hollister plan (HB 4740), called Michicare, would impose global budgets on hospitals, nursing homes, health maintenance organizations (HMOs), community health centers, and migrant health centers. All other participating providers would be reimbursed on a fee-for-service basis. The plan would be run by a board of directors that would perform several important functions, among them deciding who could be a participating provider and developing a reimbursement schedule for fee-for-service providers. The plan would be administered through the Michigan Department of Public Health.

The second plan, introduced principally by Rep. Michael Bennane, is a 14-bill package: HBs 4741–4752 and HBs 4250 and 4251. HB 4741 is the central bill in the package. The plan, known as the Michigan Health Access Program (MHAP), would exclude only Medicare beneficiaries and people covered by ERISA (self-insured) plans that provide benefits equivalent to those of the standard health care benefit package outlined in the proposed legislation.

The MHAP would create a seven-member state health commission, in the Department of Management and Budget. The governor would appoint three members of the commission, and the Speaker of the House and the Senate Majority Leader would appoint two each. Commission members would be full-time, unclassified state employees. The commission's many duties include (1) establishing a standard health care benefits package for the state, (2) establishing the premium or fees to be paid in each region of the state, (3) providing health planning for the state, and (4) developing incentives to increase the number of medical residents in primary care training.

The commission would oversee six regional health insurance purchasing cooperatives (HIPCs), which would be the central purchasing agents for all of the residents in a region. The HIPCs would also certify health plans, establish criteria for managed competition, and provide consumer education and protection.

The regions are multi-county, and every county in the state is assigned to a region. The guiding principles for determining regional divisions (some of them look a trifle peculiar) appear to be to ensure that there is (1) a population base large enough to support a certified health plan and (2) at least one major medical center within a reasonable driving distance. People would be required to enroll in a certified plan in the region where they live.

Although both plans cover a comprehensive range of services—long-term care, prescription drugs, vision/dental care, preventive health programs and health screening, home health care, and mental health and substance abuse services in addition to standard inpatient, outpatient, and physician services—Michicare is more inclusive in that it includes hospice services, personal assistance services for people with handicaps, and orthotics and prostheses.

Whereas under Michicare people could continue to use their local facilities, under the MHAP—unless a certified plan contracted with the local facilities—people could not use them. Michicare essentially retains more freedom of choice for patients at the price of state-negotiated rates. The MHAP allows freedom of choice for patients within a restricted group of providers and negotiated rates.

The MHAP requires setting a global budget for the state and for each of the six regional HIPCs; it does exclude capital expenditures and expenditures for new medical technologies and practices from the global budget. The HIPCs would be responsible for making spending recommendations in those areas. The program also would limit the rate of increase in the state's total health care spending to the rate of increase in the state's gross domestic product. Michicare, in contrast, specifically says that global budgeting will apply to facilities such as hospitals, nursing homes, HMOs, community health centers, and migrant health centers. The Michicare plan, while not specifically saying so, does include a total plan budget, according to Rep. Hollister. How the negotiated fee-for-service reimbursements would fit into the total plan budget is unclear.

The fate of ERISA plans is unclear. Under Michicare, they would be prohibited. The MHAP would allow them as long as their benefits equalled those of the standard health care benefit package, requiring a modification of the existing federal legislation, which is preemptive.

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In addition, Group Vice-President Dennis Paradis, of Legislative and Regulatory Affairs, Michigan Hospital Association, asserts that the Michicare plan does not envision as much restructuring of the health care delivery system as does the MHAP. Paradis said, "Michicare is based on the Canadian model and respects the fact that these health facilities are private property, whereas the Michigan Health Access Program is based on a managed competition model and assumes that the system will be downsized." Paradis, however, is willing to give Bennane and Hollister considerable credit for presenting alternatives. He says, "There are valid concepts that need to be discussed in each plan. We do not yet have the political consensus to make hard choices that will lead to true health care reform. We are tinkering at the edges."

Sheila Abood, director of Legislative Affairs, Michigan Nurses' Association, reports that the group has set up a task force to examine the legislation and to develop positions and strategies for approaching it. She notes that the American Nurses' Association has developed an agenda for health care reform that would (1) emphasize restructuring the system, (2) emphasize universal access to a federally defined benefit package that would offer benefits equivalent to those found in a good Medicaid program, (3) keep the Medicaid program but expand it to allow small businesses to buy in, (4) use a mixture of private and public funding, (5) emphasize a community-oriented delivery of care system such as clinics in work sites, and (6) guarantee participation by nurse practitioners.

Mary Anne Ford, manager, Medical Economics, Michigan State Medical Society, noted that her group has several concerns about how well a Canadian-style plan would work here. In her view, a plan like Michicare does not take into account the cultural differences between Canadians and Americans. She said,

> The Michigan Health Access Program relies heavily on a global budget. We feel a global budget does not allow for changing demographics or emergencies that may exceed the budget. It is an artificial number and does not provide any flexibility. We do support some of the House package, particularly uniformity of utilization review requirements and the administrative simplicity a standard claim form would provide.

Ford also observed that the Bennane bills would implement price controls, which, she said, have never worked. Both price controls and the artificiality of a global budget would create a system of explicit rationing. Ford prefers the spending targets that the American Medical Association has offered because targets provide flexibility rather than locking providers and patients into the inflexibility of a global budget.

Ford considers one of the most distressing features of the MHAP plan to be the "lack of patient responsibility; the plan has no provisions," she commented, "for patients to take responsibility for their lifestyle choices and no provisions for financial responsibility [copays and co-insurance]."

A very foggy area, we think, within both plans is financing. Michicare would take the $24 billion spent on health care in 1990 and use it to cover everybody. It is assumed that there would be significant administrative savings from a single-payer plan and that these savings would provide a margin by which the cost of care could be lowered. The MHAP starts from a figure of $20 billion (subtracting out the $4 billion spent by Medicare beneficiaries) and assumes that this amount would be available to cover those state residents who are not covered by qualified ERISA plans.

No agency has a good handle on the amount of dollars spent on health care by employers who self-insure. Some estimates say that half of the state's work force is covered by such plans. Given the comprehensive benefit packages that characterize both plans, we wonder if there is enough money to provide the coverage, and if not, where will the additional money come from?

Rep. David Hollister observed that "this [Michicare] is a publicly funded and administered plan. It is a Western European approach." He continued, "I believe both plans will fall within the parameters that the Clinton people are setting."

What advantages does the Michicare plan have over the MHAP approach? According to Hollister, "It includes workers' compensation, and does not leave out Medicaid, Medicare, or ERISA. It is a more holistic approach. People can pick and choose their providers." What does having two competing approaches to health care reform on the table mean? For Hollister, it means that there will be a public debate on the merits of both plans. "I'm willing to have the chips fall where they may," he said.

OF INTEREST

In the next 30 days, look for

- the legislature to continue to fail to give both auto insurance reform and medical liability reform immediate effect,
- the House Committee on Public Health to pass the minor portions of the Democratic Health Care package but to be stymied on the basic bill, HB 4741, and
- the Senate Committee on Health Policy to finish its hearings on health care.