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HEALTH POLICY BULLETIN

FOCUS: THE HOLLISTER PLAN

One of the state's foremost advocates of improving services for the poor and holding health care providers' feet to the flames to contain costs has devised a new and creative approach to financing care for some persons with AIDS. Representative David Hollister (D-Lansing) put boilerplate in the FY 1990 Social Services (DSS) budget bill requiring the department to come up with a proposal to identify potential Medicaid recipients testing positive for the human immunodeficiency virus (HIV-1) and to pay their private insurance premiums so that they can stay off the Medicaid rolls. Under the federal Combined Omnibus Budget Reconciliation Act of 1987, employers who provide health insurance to their employees are required to allow employees who are terminated for any reason except gross misconduct to continue to purchase their health insurance at 102 percent of the group insurance premium for 18 months.

Hollister says the idea came to him last year while attending a conference as a member of a panel convened by the National Academy of Science to study the problem of equitable financing for AIDS: "I was the only state legislator there. All the rest of the participants were providers or insurers. I was struck by how nonchalant the industry was about the epidemic. They figured their exposure was minimal because IV [intravenous] drug abusers generally had no health insurance, and employed persons who got AIDS eventually get too sick to work and didn't represent any exposure since they no longer had insurance." He added that the idea surfaced during a lunch with a gay attorney from Denver, after William Roper, M.D., then the director of the Health Care Financing Administration, had shot down Hollister's suggestion for national health insurance.

A two-year pilot project in Wayne, Oakland, and Macomb counties, designed by Scott Merwin, senior policy analyst for Medicaid policy in the DSS, was approved by the full appropriations committees of both legislative houses this spring. Beginning October 1, 1989, the state Medicaid program will pay the group health insurance premiums for people with AIDS who become unemployable because of their illness. Merwin's analysis—relying on case projections from the Michigan Department of Public Health and adjusting for IV drug abusers (36 percent of AIDS cases) and the 10 percent of the state's population that is uninsured and factoring out the 50 percent of the group with AIDS that would not be Medicaid eligible—estimates about 261 people would be eligible this year, 531 in 1990, and 830 in 1991. He estimates the benefit/cost ratio at 5 to 1; if federal matching dollars were available to help pay premiums, the ratio would be 12 to 1.

Using the average monthly cost per employee ($135) of the state's self-insured plan and the $1,600 a month the Medicaid program pays for an AIDS case as reference points, the savings to the state were estimated at $1,465 per person per month. Hollister commented, "The feds are in a win-win situation. They don't have to match the dollars, but they get half the savings." When asked how the lengthening survival times for AIDS patients (currently 18 months) would affect the program, he explained that the longer people lived, the greater the savings to the state.

Dennis Paradis, group vice-president for governmental relations, Michigan Hospital Association, said, "I think it is probably a good idea. We are not sure how this will reduce the indigent and uncompensated care burdens for us, but it sure makes sense for Social Services." Arlene Mikel, vice president for operations, Mercy Hospitals and Health Services of Detroit, and administrator of the Marshall Park Health Services facility (an organization that has a certificate of need pending for the creation of a 20-bed AIDS care center and is a member of the AIDS Consortium of Southeastern Michigan) observed: "Any provision for payment at acute care levels would be critical to us. Maintaining appropriate levels of reimbursement for AIDS patients is critical to our ability to provide the care these people need."

Mary Faroni, director, government policy, Blue Cross and Blue Shield of Michigan, commented that "group customers, especially smaller employers, would be affected. Their claims experience could change and affect the overall group rate because of the continuation of the group insurance. We have no way to measure that effect yet." Linda Becker, public affairs representative, Ford Motor Company, a self-insuring employer, explained that it was unlikely that Ford employees would be eligible for the program: "Most of our employees would go on medical leave, disability, or retirement, and

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their coverage would continue. However, we have no problem with Medicaid paying insurance premiums for people who are eligible."

Hollister's plan has attracted considerable interest nationwide. "I've been getting calls from all over, especially Governor Cuomo's office in New York," said Hollister.

FOCUS: MEDICAL MALPRACTICE REPORT

The long-awaited report, "Claims Experience and Market Conditions for Medical Malpractice Insurance," has been released by the Michigan Insurance Bureau. Tort reform legislation (P.A. 173 of 1986) requires the insurance commissioner to report to the legislature every two years on the state of the malpractice market in Michigan and to make recommendations concerning the market. Most of the data regarding claims experience comes from the Form A (report of initial court action) and Form B (report of closed claims) reports that insurers, attorneys, self-insured hospitals, and anyone else who has assumed liability for payment of a claim must file with the bureau.

The bureau has concluded that no recommendations for changes in the marketplace are necessary right now because "not enough time has passed for the effect of the 1986 tort reforms to be measured . . . the availability of medical malpractice insurance is better than it has been in years. . . . The claim information reported to the bureau does not point to any specific problem or problems as the cause of the so-called malpractice 'crisis' . . . ." Among the report's conclusions are the following: (1) Physicians have more options for coverage than ever before (risk retention groups and other alternatives to traditional insurance), (2) rate increases are flattening out, (3) Michigan is not suffering a decline in the number of physicians practicing, (4) filings for malpractice actions peaked in 1986 and have declined since then, (5) obstetricians have the highest number of claims filed against any specialty; however, they amount to less than 5 percent of all closed claims, and the total indemnity paid for obstetrical claims amounts to less than 10 percent of the dollars paid for all claims closed each year, (6) hospitals have experienced rate decreases so that it is unlikely that such costs will be a factor in hospital closings, and (7) the general trend shows claims incidence declining across all specialties including obstetrics.

Reactions to the report are varied. Nancy Fiedler, vice-president, public affairs and communications, Michigan Hospital Association, said, "We are very disappointed and concerned that the report implies there is no further cause for concern. Although the number of claims has moderated, it is small comfort because the settlements grew 40 percent from 1987 to 1988." Brian Hodges, communications director, Michigan Physicians Mutual Liability Company, one of the state's two major malpractice insurers commented: "The report obscures the problem by talking about the number of claims filed going down. Eliminating the filing of nonmeritorious claims doesn't solve the problem. Availability may not be an obstacle, but the premium imposes a financial hardship on physicians."

Kevin Kelly, assistant executive director, Michigan State Medical Society, expressed the group's feelings: "Physicians are very disappointed and frustrated by the lack of recognition of the cost crisis. The bottom line is that the flattening of claims has had no impact on liability. The unpredictability of cases is still there and will be until we make further changes in the system for dispute resolution."

Michael Franck, executive director, State Bar of Michigan, said, "It seems to express what we have felt all along—this report and Mann's report ["Product Liability Law in Michigan: Searching for a Fair Balance," Lawrence C. Mann, special counselor for products liability, June 1989] suggest one should look elsewhere for the source of the problems, like the insurance industry. The medical society and the provider community are in the peculiar position of saying that when claims are going up, there is a crisis, and when claims are going down, there is a crisis. I suspect that what they are really after is immunity from suit. Look at Senator Schwarz's bill [SB 323 would grant emergency room physicians and hospitals immunity from suit under some circumstances]."

OF INTEREST

The House, according to Speaker Lew Dodak, will meet all summer to resolve the budget, while the Senate still plans to meet every two weeks.

The first meeting for the work group on HB 4736, the proposed Uniform Health Care Information Act, is scheduled for July 13th at 2 pm in Room 424 of the State Capitol Building.

The Certificate of Need Commission will hold two days of meetings on August 1 and 2 at the Lansing Sheraton Hotel, Creyts Road and I-496. The meetings will begin at 10:00 a.m. both days and will be devoted to examining the ten review standards proposed by the Office of Health and Medical Affairs and the Michigan Department of Public Health at the June meeting of the commission.

— Frances L. Faverman, Editor