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HEALTH POLICY BULLETIN

FOCUS: MITCHELL'S PLAN

Using carrots and sticks is a good way to describe Senator George Mitchell's (D-ME) bill, "HealthAmerica: Affordable Health Care for All Americans Act." Employers would be required to offer health insurance plans that meet certain benefit standards or to pay into a public fund (AmeriCare) covering persons who are otherwise uninsured. Coverage would be phased in over five years, and individuals would be required to show proof of insurance for personal exemptions claimed on income tax returns.

The proposal breaks ground in three important respects. (1) The creation of uniform standards of eligibility, benefits, and reimbursement in the AmeriCare plan means that all eligible Americans would receive the same benefits. (2) The plan would create the Federal Health Expenditures Board, an eleven-member board modeled after the Federal Reserve Board, that would set national health expenditure targets (a global budget) for each sector of the health care industry. (3) Mitchell's plan would establish community-rating on a nationwide basis and bar exclusions for preexisting conditions as well as selecting risks—no one would be uninsurable.

Under the plan each state would be responsible for creating a consortium to purchase insurance, collect data, provide consumer protection, and promote managed care and competition. The state consortia also would act as payment and claims processing agencies for small insurers and negotiate prices with large insurance companies. On the industry side, the states would have the power to negotiate prices, set volume targets, and make capital allocations. The consortia could do everything except change the overall target figures for their states.

How would the plan be funded? Premiums are required to be actuarially sound. Employers would pay an average $1,680 per employee, or 80 percent of the premium. Workers covered by private insurance would pay 20 percent of the premiums, yearly deductibles of $250 for individuals and $500 for families, and copayments on services with an annual cap of $3,000 for all out-of-pocket costs. Premiums for workers whose employers chose to pay into the AmeriCare plan and whose income is below 200 percent of the federal poverty line would be subsidized on a sliding scale. The average cost for individuals would be $1,100, and for a family, $3,000. Premiums for persons currently covered by Medicaid would be paid by the federal government. Except for long-term care, Medicaid would be replaced by AmeriCare. (A proposal for long-term care is forthcoming). Dollars used to pay for Medicaid would fund premium subsidies; states would receive these dollars on a basis similar to the current method of allocating Medicaid dollars.

Senator Mitchell is convinced the plan can be funded without increasing the total bill for health care. He forecasts savings of $78 billion over the five-year phase-in period: $37.6 billion from reducing unnecessary care (reducing defensive medicine and setting practice parameters), $13.8 billion from insurance reform, $11.1 billion from competition and managed care, $8.9 billion in administrative costs, and $6.6 billion through the expenditure goals. Others, like the National Association of Manufacturers and National Small Business United, are doubtful.

Beverley McDonald, executive director, Michigan League for Human Services, has reservations about the Mitchell plan. McDonald said, "I don't see how people who are low wage earners will be able to afford it. From an access perspective, a $500 deductible is a real barrier." McDonald also noted that if the deductible were lowered, "the program would be more costly."

Chuck Ellstein, group vice-president, Health Delivery and Finance, Michigan Hospital Association (MHA), observed that Mitchell's plan "helps to shape the debate and the solution. We are still a couple of years away from a plan. The presidential election in 1992 will be a factor, and action is more likely in 1993 or 1994."

Mary Anne Ford, manager, Medical Economics, Michigan State Medical Society (MSMS), remarked that the plan is consistent with many recommendations of the American Medical Association. However, the provisions allowing small business insurers to reimburse providers at Medicare rates concerned her: "Reliance on these systems for health care financing has to be looked at."

FOCUS: AFFORDABLE CARE MICHIGAN STYLE

Michigan Senate Republicans introduced on July 11 a series of proposals for an affordable health care plan. The package consists of 28 bills, some of which already have been introduced.

Five bills (SBs 413–417) form the nucleus of affordable health insurance coverage. Two (SBs 413–414) require health and disability insurers and Blue Cross and Blue Shield of Michigan (BCBSM), respectively, to estab-

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lish basic health insurance policies at a cost of $100 per month for families and $75 for individuals; these policies would waive current mandatory benefits specified in the state's insurance code. Three bills would establish single business tax credits for employers purchasing the basic policies for their employees and eliminate premium taxes for those domestic insurers issuing the policy (SB 415), provide the same degree of tax relief to nondomestic insurers issuing the policy (SB 416), and give state income tax credits to families and individuals who buy basic policies up to a maximum of $600 for families and $450 for individuals (SB 417).

Two bills would provide access to basic health services for children. Approximately $75 million of the BCBSM capital pass-through to hospitals would be earmarked to fund expanding the BCBSM Caring Program for Children (SB 418); SB 419 would require BCBSM to enroll every eligible child in the state in the program.

Four bills dealing with medical liability reform have been introduced. SB 248 (establishing the Medical Liability Determination Board) and SB 249 (tort reforms) are the subject of hearings being held by the Senate Committee on Judiciary, while SB 265 (exempts procedures under the Medical Liability Determination Act from the Administrative Procedures Act of 1969) is in the Senate Committee on Health Policy. The last bill, SB 268, which gives some immunity to providers for care rendered in emergency rooms, is now in the House Committee on Judiciary.

Nine measures (SBs 420–428) attempt to provide a structure for a health provider disciplinary process. Seven of the bills include many of the same provisions as legislation that passed the House earlier this session.

Certificate of need reform is embodied in SB 429 and SB 210. SB 429 raises the capital expenditure threshold to $2 million, exempts CT scanners, magnetic resonance imagining equipment, and facility acquisitions from CON requirements and repeals the nonclinical services CON requirement. SB 210, which would prohibit the Michigan Department of Public Health from counting as part of the state's nursing home bed inventory beds that are being appealed under the previous CON law, is in the House Committee on Public Health.

Two bills (SBs 430–431) improve coverage for medical care to the employed. SB 430 would put into Michigan law the federal mandate preserving Medicaid coverage to families for one year after they become ineligible because of employment, and SB 431 would continue General Assistance medical coverage for 12 months after ineligibility due to employment.

Three pieces of proposed legislation (SBs 433–435) deal with physician risk management standards. SB 433 would create a medical liability demonstration project using specialty medical groups to advise on establishing practice parameters and risk management protocols for anesthesiology, obstetrics, and emergency medicine. SB 434 would allow the fact that a physician followed appropriate practice parameters and risk management standards to be used as a defense in a medical liability lawsuit. SB 435 would require the Insurance Bureau to evaluate the effect of the demonstration project on medical liability by 1997.

The last piece of legislation, SB 432, would rewrite portions of the Blue Cross and Blue Shield Reform Act of 1980 (P.A. 350 of 1980) to meet major concerns and difficulties physicians have experienced with BCBSM; two members representing small businesses would replace two existing members, and state oversight of the Blues' responsiveness to complaints would be increased.

Although plenty of support exists for a comprehensive approach to providing health insurance for Michigan's uninsured, the level of benefits likely to be provided for the premium specified in SBs 413–414 may arouse some concern. Senate Majority Leader Richard Posthumus (R-Alto) disagrees: "The policy specifications are modeled after a basic policy that Blue Cross and Blue Shield already sells. We feel that companies, relieved of mandated benefits in these policies, will come into the market with competitive products, and consumers will be able to choose the product that meets their needs." The state income tax credit provisions would lower the cost, but a family composed of two minimum wage earners ($17,000) would receive very little help (about $180 in tax credits), while the premiums would represent 7 percent of their total income.

The hospital ox would receive a major goring in the plan to use 25 percent of the BCBSM capital "pass-through" to fund the Caring Program for Children. Chuck Ellstein, MHA, notes that the capital pass-through subsidy is a matter of contract between hospitals and the Blues. "This money is used to make bond payments and to pay for projects hospitals have already committed to," he said. He also is doubtful about the legality of amending through legislation contracts between private parties.

Kevin Kelly, associate executive director, MSMS, notes: "We are pleased that the Senate package covers a number of reforms. To succeed in making real change happen [coverage for the uninsured] it is going to have to be tackled on a broad basis."

OF INTEREST

An overall budget target for FY 1992 has been agreed upon, and the budget is likely to be settled by the end of July. Social services, K-12, and higher education are apt to be sticking points.

—Frances L. Faverman, Editor

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