Gerald Faverman, Ph.D. • *Chairman of the Board*
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HEALTH POLICY BULLETIN

FOCUS: CHILD CARING PROGRAM

The 1989 Omnibus Budget Reconciliation Act (OBRA) contains $10 million for demonstration projects to improve access to health care for uninsured persons whose incomes range from below the poverty line to 185 percent of the poverty level. In a solicitation issued this spring, the Health Care Financing Administration (HCFA) requested proposals for "innovative programs to extend health insurance coverage to pregnant women and children under age 20 . . . and to encourage workers to obtain health insurance for themselves and their children." The Medical Services Administration (MSA) and Blue Cross and Blue Shield of Michigan (BCBSM) drafted a creative proposal called the Michigan Basic Health Plan; in late August the MSA was notified that the HCFA had reinterpreted the OBRA language, and the Michigan proposal would have to be revised to exclude adults and resubmitted within one week.

The revised proposal, known as the Child Caring Program, provides and finances benefits through a partnership among the state, BCBSM, private foundations, and federal matching dollars. The program (unlike Medicaid, which has to provide services to all eligible persons regardless of budgetary constraints) is limited by its budget. The proposal calls for the program to serve approximately 12,422 children in year 1, 13,502 in year 2 and 14,582 in year 3. The department estimates that two-thirds of the participants will come from families with incomes below 100 percent of the federal poverty level, while the remaining participants will have family incomes ranging from 101 to 185 percent of the poverty level. (Michigan Medicaid eligibility is about 60 percent of the poverty level; a family of four would not be eligible for Medicaid unless its income was below $7,500. Michigan Medicaid now covers pregnant women and infants up to age one with incomes at 185 percent of poverty and, under OBRA, is required to cover all children under age six whose family incomes are less than 133 percent of poverty). The $29-a-month premium per child would be paid by federal, state, and private foundation funds; the child's family would not be required to pay any part of the premium. The department has applied for $6.6 million in federal funds and assumes that $2 million in state general funds will be needed in each of the three years and that $1.5 million will be available over the three-year period from private foundations. BCBSM contributions will be in-kind.

The benefit package is modeled after the program run by Blue Cross and Blue Shield of Western Pennsylvania (see the February 1990 *Health Policy Bulletin*) and provides coverage for office visits, emergency care, laboratory tests, immunizations, routine physical examinations, outpatient surgery, prescription drugs, and outpatient substance abuse services. While inpatient hospital services will not be covered, the MSA assumes that for most children in families with incomes between 101 and 185 percent of the poverty level, a short hospital stay will generate enough medical expenses to result in a "spend down" to eligibility for Medicaid; eligibility determination would be simplified and expedited for those children, and some coverage for hospital expenses would be available. The simplified Medicaid eligibility process for families in the program that meet spend-down requirements due to a child's hospitalization could relieve hospitals of some of their uncompensated care costs.

How do people get into the program? They apply to BCBSM. Who has priority? Former welfare recipients who have come to the end of their Medicaid extension. Vernon Smith, Ph.D., director, Bureau of Program Policy, MSA, noted that "the queuing process has not yet been determined." A first-come, first-served policy such as that in western Pennsylvania could wreck the department's assumption that two-thirds of the participants would come from families with incomes at less than 100 percent of poverty and would change the relationship among federal, state, and private foundation funds. Smith also noted that decisions have not been made about what counties or other geographic areas would be selected for the program; those decisions also could have a significant effect on the enrollment process and on fund-raising from private sources.

BCBSM will deliver services for the program through its managed care network. According to Vern Smith, with the exception of pharmacy services, which will be provided through the Blues pharmacy PPO, no decisions have yet been made about whether services will be delivered through a PPO or an HMO in the Blues network. Providers would be paid the standard Blues rates for services.

Although the proposed program represents a start in providing access to health care for Michigan's 254,000 uninsured children, a number of problems remain. Assuming that HCFA decides to fund the Child Caring Program—a decision that must be made by September 28—federal and state funds would have to be appropriated each year for the project. It is possible but unlikely that state and federal budgetary constraints could affect funding. In addition, waivers of several requirements, including statewide scope, freedom of choice, coverage of alternative assistance programs

Public Sector Consultants, Inc.
Knapp's Centre • 300 S. Washington Square
Suite 401 • Lansing, MI 48933 • (517) 484-4954

(alternatives to mainstream Medicaid), and comparability of services (services offered have to be comparable to those of mainstream Medicaid programs), would be needed for the program to take effect.

The introduction of HB 6025 by Rep. Teola Hunter would give the Blues a firm statutory footing for the program by including the elements of the program as activities BCBSM is allowed to engage in under P.A. 350, although some observers think that the existing act allows the Blues to engage in experimental programs.

FOCUS: BLANCHARD'S PROPOSAL FOR AUTO INSURANCE RATES

Legislation (HB 5998) introduced by Rep. Mary Brown puts the governor's proposal for reducing auto insurance rates by 20 percent before the state legislature. HB 5998 is much narrower than SB 712 and HB 5317 (identical to SB 712) introduced earlier in the session, which sought to impose the workers' compensation fee schedule on providers, make all forms of health coverage the primary payers for auto-related injuries, and limit personal injury protection benefits by giving the policyholder the option of selecting a benefit level. The bills were touted as offering the possibility of a 25-percent reduction in the premiums for required coverages.

The governor's plan does impose the workers' compensation fee schedule on providers for the treatment of injuries suffered in or related to auto accidents; that is its only similarity to SB 712 and HB 5317. Blanchard's proposal requires insurers to take account of their investment income derived from auto insurance when setting rates for personal injury protection, residual liability, and property damages—the state's three mandated coverages. In theory, this should enable them to lower rates. Joseph Olson, vice-president and general counsel, Citizens Insurance Company of America, notes that actuaries for Citizens question how much of a reduction in the premiums for those coverages is feasible. He thinks a reduction of 5 to 7 percent is more likely, and that competitive factors force insurance companies to file rates below what they actually need. According to him, companies already tacitly factor in investment income in calculating rates.

HB 5998 is an attempt to prevent cost shifting by health care providers to one of the two payers left who cannot negotiate rates for medical treatment but instead pay billed charges, a situation that is likely to leave providers feeling more beleaguered than ever. The bill would require auto insurers to reduce the rates on the state-mandated coverages by 20 percent from the rates in effect on February 1, 1990, for those coverages and prohibits them from raising the base rates on other coverages (collision, comprehensive, uninsured motorist, minitort, and so forth) to make up the difference. Base rates for the mandated coverages could not be raised before 1992.

Jean Carlson, deputy director for legislative affairs, Michigan Insurance Bureau, notes that the bureau had a considerable role in drafting the legislation. Carlson says the bill represents "an attempt to save no-fault auto insurance in Michigan. Estimates of a 20-percent savings are not unreasonable. The medical component of auto insurance costs has been growing as a portion of payments. We need cost containment to preserve unlimited medical benefits in no-fault insurance in Michigan." Carlson noted that in testimony in hearings this summer, providers admitted billing auto insurers more for the same services than other payers. Her view is that the legislation "restores equity" to the auto insurers. She observed that in other states, notably New York, adoption of the fee schedule resulted in savings of 20 to 40 percent on medical costs.

For providers it is clear that adoption of any of these proposals will result in curtailing their income and, in some cases, probably lead to less access to care for injured persons. The existence of a bipartisan consensus that medical costs are responsible for driving up auto insurance premium rates means the era of cost containment is coming to reimbursement for care for auto-related injuries.

It should be noted that the proposed premium reduction does not apply to assessments for the Michigan Catastrophic Claims Association ($66 per car), the Michigan Auto Insurance Placement Facility ($0 per car this year), and the Michigan Auto Theft Prevention Authority ($1 per car).

OF INTEREST

The legislature is scheduled to adjourn on September 28 and reconvene the week following the November election. Both the House Committee on Public Health and the Senate Committee on Health Policy have reported out all the legislation they are going to for this brief session. According to House legislative staff, passage of the rural health bills (SBs 889–892) and the physician licensure and discipline bills (HBs 5903–5913) are priorities. SB 892 (Medicaid reimbursement for swing beds) has an uncertain future because of the difficulties in funding the Medicaid program for FY 1991. SB 890 may be derailed due to the urban bed banking provisions. HB 4712 (impaired provider program) is now tie-barred to HB 5712, one of the fee bills in the physician licensure package.

—Frances L. Faverman, Editor

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