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October 1991

HEALTH POLICY BULLETIN

FOCUS: AUTO INSURANCE BILLS

Public pressure for lower auto premiums has led the legislature and insurers to concentrate on limiting health care costs as a way to lower premiums. Hence, the Michigan Hospital Association (MHA) and the Michigan Insurance Federation (MIF) have drafted responses to Senator Wartner's First Conference Report for SB 154. The Automobile Club of Michigan (AAA) also has thrown its proposal into the ring.

Senator Wartner's First Conference Report, Draft 1, provides for managed care, changes in personal injury protection (PIP) benefits, and coordination of health and disability policies with PIP coverage. The proposed legislation would give auto insurers the right to band together to form their own preferred provider organization for managing the care of accident victims. Wartner's draft leaves vague how insurers are to do this. Consumers would be able to choose the amount of PIP coverage to carry instead of being required to carry the current state-mandated unlimited amount.

Under Wartner's plan, health and disability insurers, health maintenance organizations, and prudent purchaser arrangements would have to pay out their benefits before PIP coverage kicked in. Under the present law, auto accident injuries are covered by the person's health insurance unless the injured person is covered by a health maintenance organization contract or an employer's self-insurance program that specifically excludes coverage for such injuries.

Wartner's plan also requires insurers to make managed care plans available to at least 80 percent of the state's auto policyholders within a year or face a 10 percent penalty in the base rates for PIP coverage beyond the 20 percent reduction already in the draft, for a total of 30 percent. Auto insurers unable to offer managed care plans would be allowed to use the Workers' Compensation Fee Schedule to pay for care.

The fee schedule would give insurers some relief from costs and some control over the volume of services provided through its utilization review process; nevertheless, since the schedule's utilization review is retroactive rather than prospective insurers would not have the degree of control provided through managed care plans. (Prospective review tells the provider before services are delivered how many physical therapy treatments for a particular condition will be paid for by the insurer, while retroactive review denies payment after the service has been delivered.) Current law requires insurers to pay billed charges for services and does not allow them to limit the utilization of services; the provider and the patient, not the insurer, decide what is reasonable and necessary.

The strongest proponent of a fee schedule is AAA. Ron Hanlon, Acting Director, Government Affairs, says, "A fee schedule represents the best way to create savings that can be passed on to our members in the form of lower premiums. We cannot identify at this time savings in the other proposals."

While health care providers are opposed to the use of a fee schedule, they are even more opposed to insurers combining to form exclusive provider organizations (EPOs), thus controlling the access of patients to care and of providers to patients. (An EPO formed by insurers would be able to direct a patient to one specific provider with whom the insurer had a contractual arrangement.) Both the MHA and MIF drafts prohibit the Michigan Catastrophic Claims Association (ACCA) from forming such an organization or contracting exclusively with any one provider for services.

The MIF draft sets out a plan for managed care in which a provider would design a detailed "clinical care management plan" for each injured person. Since the plan has to be approved by the insurer before it can be implemented, it provides for prospective review; the insurer decides what will be paid for, and patient and provider agree, in advance of the delivery of services.

The managed care plan, according to Eric Henning, general counsel, MIF, would benefit consumers "because it would provide that goal-directed benefits and measurable goals for care, which currently are not being achieved, could be achieved." In essence, the plan would relieve the consumer of the burden of being his/her own case manager. The plan for managed care also includes a detailed grievance procedure administered by a newly created medical review board within the Michigan Insurance Bureau.

The MHA draft is similar to that of the MIF; nevertheless, there are some significant differences. The grievance procedure is not spelled out in great detail. This draft would create an advisory board to the MCCA whose function would be the same as that of the medical review board described in the MIF draft.

John Vincent, Director of Legislative and Legal Affairs, MHA, notes that his association has agreed to talk about case management for cases over the threshold of $250,000 where the MCCA becomes responsible for paying for care. The MHA is opposed to fee schedules and caps on PIP benefits. He says, "The issue is access to care. Those persons most likely to take advantage of the lower PIP limits are those who are most likely to have the greatest

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need, the 16–25 age group." He rebuts the insurers' argument that they are the only group paying standard hospital rates by observing that "everybody is charged the same but the rate actually paid can be negotiated. Auto insurers are not in a good negotiating position because they cannot deliver patient volume, whereas Blue Cross and Blue Shield of Michigan [BCBSM] can."

Dan Farhat, Manager, Government Relations, Michigan State Medical Society (MSMS), says that "we are certainly willing to consider a managed care system as long as that system allows the physician to make the treatment decisions. Our concern is who makes the decision about medical appropriateness of treatment—the physician or the insurer? Everything we have seen so far puts that decision in the hands of the insurance carriers." Farhat also believes that utilization review was necessary: "It is not being done appropriately today. We definitely agree with the insurers that they are not equipped to do it," he concludes.

All three drafts preserve the present unlimited PIP coverage as an option, provide for managed care plans, and provide for payment of vocational rehabilitation expenses, durable medical equipment, home and vehicular modifications, attendant and skilled home care. The differences lie principally in details such as making managed care plans retroactive and compulsory rather than optional, in the MCCA threshold and adjustments to the threshold for catastrophic claims, and in how much, if any, reduction in the premium for PIP benefits gets passed on to consumers.

Two issues remain of interest to providers and the general public. Providers have a stake in the reinstatement of an objective rule (physical evidence of the alleged impairment) for determining damages due to pain and suffering because it is unlikely the state legislature would adopt one rule for determining pain and suffering in auto accidents and another for injuries due to medical malpractice. The second issue, the fact that the largest potion of auto insurance policy premiums is represented not by state-mandated PIP and residual liability benefits but by optional collision and comprehensive coverages, has left some observers wondering why insurers have not devoted similar efforts to reducing their costs for repairing damaged automobiles.

The health care provisions are only a part of the no-fault reform bill; passage of the health care provisions depends upon passage of the entire bill. The bill contains tort reform that promises to be difficult to resolve, given the insistence of Senate Republicans on its inclusion and the resistance of House Democrats.

FOCUS: AFFORDABLE HEALTH CARE

The hearings of the Joint Senate Committee on Affordable Health Care, co-chaired by senators Pridnia and Wartner, are almost over. Action on only one bill, SB 432, which would increase the level of government oversight for Blue Cross and Blue Shield of Michigan, remains. The committee expects to report out SB 432 when it meets on October 22 (1 p.m., first floor conference room, Farnum Building).

The committee's October 15 hearing was adjourned abruptly when an apparent agreement between Democrats and Republicans broke down and the absence of some Republican members left the committee with a quorum but not enough votes to amend and report out the bills. The difficulties were resolved when the committee reconvened on October 16 and reported out the rest of the bills except for SB 432.

As a result of amendments the affordable health care package has been tie-barred to the medical liability bills (SBs 248, 249, 265, and 268), the arbitration bills (SBs 38, 39, 40, 41, and 244), and a certificate of need bill (SB 210). Some observers believe the tie-bars reveal an all-or-nothing approach—pass the entire package or lose everything. It also has been suggested that some Senate Republicans would not be displeased if the House sent the bills back to the Senate with some of the tie-bars removed, thus enabling some bills in the package to languish while others could be passed by both houses.

OF INTEREST

House Democrats are in the process of introducing a 77-bill health package. Some already have been assigned to committees. The initiative covers seven areas: smoking, infant mortality, nursing homes, infectious diseases, patients rights, facilities reform, access, and physician licensure.

Look for

- the Senate Judiciary Committee to report out the substitutes for the bills in the medical liability package—SBs 13, 20, 248, and 249—on October 17;
- the Senate Health Policy Committee to report out SB 305, the chiropractic scope of practice bill, on October 22;
- the Senate Republican Affordable Health Care Package to be on the floor of the Senate in late October; and
- the House Public Health Committee to report out five bills on smoking: HBs 4324, 4341, 4342, 4940, and 5225.

—Frances L. Faverman, Editor