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# HEALTH POLICY BULLETIN

## FOCUS: HEALTH CARE REFORM AND MICHIGAN

In a recent session of Michigan State University's Michigan Health Policy Forum, Carl Volpe, senior policy analyst with the National Governor's Association, discussed Clinton's plan for health care reform and its potential implications for the states. Following Volpe's speech, representatives of the Michigan departments of Social Services (Medicaid), Public Health, Mental Health, and the Insurance Bureau explained the plan's potential effect on the departments. This piece includes some highlights from Volpe's keynote speech and covers the panel discussion that followed.

State responsibilities, Volpe explained, include setting the number, kind, and boundaries of health alliances within the state. The alliances would be regulated by a board appointed by the governor. The federal government, however, would be responsible for setting and enforcing the alliance budgets. According to Volpe, the Clinton plan does not recognize the difficulty of predicting costs and cost savings; however, a cost-sharing approach could do so. Volpe suggested that states should be able to permit an alliance that comes in under budget to keep a portion of the excess, with the remainder to go to state and federal government. In addition, state and federal governments also would share a portion of the excess costs if the alliance is over budget.

Volpe stated that the plan does offers the states some potential benefits, such as incorporating Medicaid into the mainstream health care system. The plan also provides some protection to states from Employment Retirement Insurance Security Act (ERISA) preemption for corporate alliances. Volpe noted that to develop a health care system, states need data that are not yet available. He also indicated that each state needs about $500 million for administration and data collection instead of the $100 million allocated by the federal government to the states for all transition activities.

In the panel discussion that followed Volpe's talk, Vern Smith, director of the Medical Services Administration of the Department of Social Services, stated that the plan appears to meet Medicaid's goal of ensuring that the poor have access to mainstream health care. He added that incorporating Aid to Dependent Children recipients and Supplemental Security Income recipients in the mainstream health care system would increase the quality and availability of care for the needy. Smith, however, expressed concern that the plan may not meet the needs of certain individuals using Medicaid services that are not usually covered under a traditional insurance plan. Since Clinton's plan does not outline specific covered services, it is not clear what services the plan will and will not cover. For example, the plan does not discuss such details as whether individuals with physical disabilities will be eligible for personal care assistance or home modifications.

Denise Holmes, chief of the Office of Policy, Planning, and Evaluation for the Michigan Department of Public Health (MDPH), made several observations. Holmes stated that the plan's portability, emphasis on disease prevention, and universal coverage should make delivery of care via local public health departments less necessary in the long term. The core functions of a public health department—such as ensuring a safe water supply, maintaining vital records, monitoring infectious disease outbreaks, and offering community education—would continue to be supported by federal government through formula grants. Holmes expressed concern about whether the plan would cover rural and urban areas and care for the chronically ill. She noted that traditionally Medicaid funds have supported some MDPH programs. Once Clinton's plan is implemented such Medicaid funds may not be available, she said.

Marilyn Hill, director of the Office of Federal Liaison Entitlements for the Department of Mental Health, expressed some reservations about the plan. She suggested that the plan indirectly encourages institutionalization and that the bloc grants will create competition among departments in Michigan that deal with health care. Hill also believes that the plan does not recognize the needs of people who have serious disabilities but who do not fit into the plan's categories—the developmentally disabled, for example. Hill, however, stated that the plan's basic principles do outline an acceptable mental health package.

David Dykhouse, Commissioner of Insurance, suggested that the Insurance Bureau will have to be restructured since insurers will no longer have real financial responsibility under the Clinton plan. Dykhouse opined that the plan creates a single payer system disguised as managed competition. Because the bureau's current tools for regulating financial stability assume a different type of market, they are no longer usable. In fact, Dykhouse suggested that the strong dose of regulation in the proposal does not leave much of a market at all.

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All of the session's speakers expressed concern about the two-year implementation period. Marilyn Hill's comment seems to zero in on the issues at hand: "It takes one year just to get a waiver up and running. How are we going to change the entire system in two years?"

—Corina Andorfer, Writer

## FOCUS: THE HEALTH EQUITY AND ACCESS REFORM TODAY ACT

The Senate Republican Task Force Proposal on Health Care, known as the Chafee Plan (after Sen. John Chafee, R-RI, task force chair), released in mid-September shares many similarities with the Clinton Plan. Although some significant differences exist, both plans rely fairly heavily on government regulation—health care could become a semi-regulated public utility under Chafee's plan.

Similarities include the following: a standard benefit package created by a national commission, insurance market reform, the establishment of health insurance purchasing cooperatives (HIPCs), mandated insurance coverage, mandated use of an alternative dispute resolution process in medical liability actions, greater emphasis on preventive care, administrative streamlining, data collection according to federal standards, antitrust reform, and federal subsidies for the purchase of insurance financed by reducing the rate of growth in Medicaid and Medicare expenditures and by savings achieved through reforms in the plan.

The Chafee plan differs from the Clinton plan in a number of ways. Under the Chafee plan the individual pays for health insurance, not the employer. In addition, medical liability reforms are more traditional—including a cap on noneconomic damages, periodic payments, and a federal statute of limitations. HIPCs are voluntary for individuals and small businesses, and HIPCs or health alliances may cross state lines. The Chafee plan allows tax deductibility of insurance premiums for everyone up to the tax-cap limit. The plan would include integration of individual medical expense accounts with a catastrophic benefit plan, no ceilings on the growth in overall health care costs or insurance premiums, and no global budget.

With the Chafee plan, individuals could choose between a standard benefit package and a catastrophic benefit plan, but all must be insured. Those who do not buy insurance would be penalized an amount equal to 120 percent of the average of the three lowest premiums in their region, payable to the Internal Revenue Service. Employers who currently do not offer health insurance would be required to offer a certified insurance plan to their employees but would not have to pay for it.

The standard benefit package would require coverage for medical and surgical services and equipment, prescription drugs and biologicals, preventive health services, rehabilitation and home health services related to an episode of acute care, severe mental health services (narrowly defined), and copayments and deductibles for all services except some preventive health services.

The alternative catastrophic benefit plan is integrated with a medical savings account and would provide the same benefits as the standard package but with higher levels of cost sharing and deductibles. Any amount not spent could be rolled over from year to year. Individuals whose incomes qualified them for federal help with the cost of insurance (i.e., 90 percent of the poverty level in 1995 and increasing to 240 percent of the poverty level in 2000) would receive a federal voucher that would aid them in purchasing insurance.

Tax deductibility is limited to the average cost of the lowest priced one-third of the certified health plans offered in the HIPC area where a person lives or works. In other words, if five plans are offered in an area, the average of the premiums of the two cheapest plans would be the amount used to establish the maximum tax deduction that may be taken by an individual or by the employer who pays for health insurance. This approach is likely to result in the clustering of plan prices, since wide disparities in plan prices would hurt higher priced plans. The tax deductibility provision in the Chafee plan is far more generous than that of the Clinton plan, which permits employers to deduct their 80 percent of costs and self-employed individuals to deduct 100 percent of their costs, although employees cannot deduct their 20 percent share.

HIPCs would have a far different configuration under the Chafee plan than under Clinton's. Under the Chafee plan, several employers and employees in businesses of fewer than 100 employees and individuals who are not enrolled in an employer health benefit plan could combine to form a cooperative. Hence, the cooperatives could be much smaller than those envisioned in the Clinton plan, in which the cutoff for a business is 5,000 employees. With the Chafee plan, it also will be possible for more than one HIPC to exist in a geographic area. Furthermore, HIPCs would be able to charge their members fees for belonging to the cooperative, and in an area with more than one cooperative, an employer would choose which cooperative to join. This provision could force employees to buy their insurance from a source chosen by an employer who is not paying for it or for the membership fees.

The Chafee plan does not appear to address any of the issues raised in recent years by ERISA plans. Large employers will be able to form cooperatives or other entities for buying insurance. Employers with facilities in more than one state may choose to treat each facility as a separate entity for the purposes of insurance coverage; that is, an employer with facilities in several states could offer insurance plans through cooperatives in each state or it could form its own cooperative for insurance purposes.

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