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HEALTH POLICY BULLETIN

FOCUS: AUTO INSURANCE COST CONTAINMENT

The recent introductions of HB 5317 by Rep. Wartner and SB 712 by Sen. Posthumus (SB 712 is identical to HB 5317) signal the arrival of health care cost containment measures for auto accident injuries. While the Michigan Insurance Federation does not support HB 5317, auto insurers, according to Nancy McKeague, president, are being used by health care providers to make up the losses the latter suffered through the Medicaid and Medicare programs. "We are under so much fire over auto insurance rates we can't look the other way," she said.

Although auto insurers have said HB 5317 would save money, there are no specific dollar amounts attached to the bill. Auto insurers apparently do not break out medical care expenses from personal injury protection (PIP) payments, but the average PIP claim payment has risen from $4,504 in 1984 to $6,751 in 1988, while in the same period payments for residual liability have risen from $13,633 to $16,855 per claim.

Among the remedies auto insurers have for reducing their medical care costs are adoption of the workers' compensation fee schedule for reimbursement of providers, limiting coverage amounts for PIP in place of the current unlimited medical expenses, and making health and disability coverage, not no-fault coverage, the primary source of payment for all medical care for injuries. Insurers also hope to lower their costs for residual liability, which includes protection for drivers against personal injuries, property damage, and liability if sued. In return, the insurers will give Michigan's consumers a 25-percent reduction in the price of state-mandated PIP coverage (medical expenses, work loss income benefits, and payment for services normally provided by the injured party) and residual bodily liability, not 25 percent on the entire auto premium as one press release erroneously said. McKeague noted that PIP is the only state-mandated coverage that is not subject to a fee schedule.

In a rare instance the Michigan Trial Lawyers Association and the health care providers are on the same side. Jane Bailey, legislative counsel for the trial lawyers, said, "The premise of the bill is that it offers meaningful reduction of auto insurance rates, and that is a sham. Rather than reduce current insurance rates, the bill reduces insurance benefits and takes away the rights of injured victims. The proposal is a total farce and an insult to Michigan's insurance consumers. Consumers should have the political head of every legislator who votes for that package."

What does this mean for the health care provider community? Adoption of the workers' compensation fee schedule for reimbursement means that one of the few payers actually paying their billed charges would be off the hook for a portion of the Medicaid, Medicare, and uncompensated care burdens, and providers would assume more of the burden. Charles Ellstein, group vice-president, health delivery and finance, Michigan Hospital Association, said, "The bill focuses on reducing the cost to auto insurers; it reduces payouts to providers while doing nothing about our costs of doing business. Everybody is willing to limit the cost shift, but nobody is willing to address the reasons for the cost shift, particularly the shortfall from Medicaid."

Mary Anne Ford, chief of state government affairs, Michigan State Medical Society, pointed out that the society already has several problems with the workers' compensation fee schedule that it is trying to surmount: "We have no difficulty in recognizing the unique nature of workers' compensation, but the attempt to transfer a fee schedule developed for one specific situation to another creates problems." Most likely to be affected by the adoption of the schedule are general, orthopaedic, plastic, and neurological surgeons and specialists in anesthesia, physical medicine, and emergency medicine. Since most automobile accidents are medical emergencies, the physician's lack of choice is also an impediment: "In emergency situations, the physician doesn't have a choice—by law, the patient must be cared for," she commented.

Aside from the reimbursement problems for providers there is the more nagging problem of cost shifting. The effect of various court decisions, according to Mary Faroni, director of government policy, Blue Cross and Blue Shield of Michigan, has been to make health and disability policies the primary payers in auto injuries. "My concern is that the adoption of such a policy by statute will only encourage purchasers of group plans and employers who are self-insured to exclude coverage for those injuries from their plans. I think it is bad public policy," she observed. She noted that other health insurers have tried very hard to become secondary to PIP. Most HMO plans in the state, for example, exclude coverage for auto-related injuries. Eugene Farnum, executive director and legislative consultant to the Association of Health Maintenance Organizations in Michigan, said, "We certainly are going to have problems with the auto insurers shifting the medical care costs of their policyholders to us."

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FOCUS: GOVERNOR'S HEALTH CARE COST MANAGEMENT REPORT

Entitled *Michigan's Health Care Costs: Strategies for the 1990s*, the report contains 33 recommendations aimed at making cost containment more effective within the state. The recommendations are grouped by their source, with six from the steering committee, nine from the health promotion/risk reduction work group, three from the benefit and finance alternatives work group, and twelve from the delivery effectiveness initiatives work group.

The steering committee presented its own recommendations because the issues involved (1) were related to work being done by the Governor's Task Force on Access to Care and/or the Governor's Special Factfinder on Malpractice Liability, (2) fell across work group boundaries, or (3) had not come up in the appropriate group. Their recommendations include developing Michigan-specific expenditure data to permit accurate measurement of cost containment efforts and to enable areas where costs are increasing most rapidly to be more quickly identified. This would establish what Michigan Health Care Corporation data would be available to the public and how it could be used by purchasers to make rational health care choices. The second recommendation, developing and establishing publicly stated goals for the management of health care costs, is related to the first since goals without measurement tools tend not to be useful. The third recommendation, that "Michigan should endorse the concept of universal access to health care," dovetails with the report of the task force on access to care. The fourth recommendation urges a comparison of Michigan medical liability costs with those of other states and a determination of how these costs contribute to the state's cost of health care, a task being undertaken by the Governor's Special Factfinder. The fifth recommendation regarding inappropriate referrals (defined as referrals by physicians to facilities or entities in which the physician has a financial interest) urges annual disclosure of such interests to the Michigan Department of Licensure and Regulation and increased efforts to discourage such practices by prohibiting the Medicaid program from paying for services under those circumstances and making the avoidance of referrals from financially interested professionals a condition of granting a certificate of need. The last recommendation suggests that a state agency investigate the implicit or explicit rationing of health care and the assessment of medical technology.

Major recommendations of the health promotion/risk reduction work group focused on increasing taxes to make the use of alcohol and tobacco less attractive, establishing smoke-free workplaces, and encouraging the development of employee assistance programs and employer-sponsored substance abuse services. The group also advocated that the legislature declare family planning a basic health service. The report noted that all the recommended activities are demonstrably cost-effective measures to promote health.

The benefit and finance alternatives work group came out against mandated health insurance benefits but recommended that insurers be required to offer riders for certain coverage. Some public financial support for the Michigan Health Data Corporation's efforts was recommended along with the states' assumption of the responsibility, using available data, to produce reports with provider-specific information on cost, quality, access, and utilization. Data based on their own claims experience should be made available to employers, health and welfare trust funds, and other purchasers. The group's final recommendation urged the state to develop criteria for the evaluation of managed care programs, to target appropriate groups for receiving the information, and to find ways to eliminate barriers to access to high quality, managed care programs.

The most elaborate and extensive recommendations originated in the delivery effectiveness initiatives work group; its recommendations were subdivided into payer, provider supply, and hospital reimbursement and system capacity initiatives. Among the payer initiatives were the establishment of a state utilization review (UR) authority to regulate UR companies, state coordination of technical innovation and assistance to refine cost management strategies, development of a statewide pharmaceutical formulary, and development of a health care reform strategy to assure high quality and cost containment in the provision of care. Provider supply initiatives included endorsing a two-year moratorium on the licensing of additional health professions as well as establishing a strategic manpower planning process to bring the supply of professionals into line with demonstrated needs and to deal with problems of maldistribution. Of the six recommendations of the hospital reimbursement and system capacity work group, the two most important favor the development of regional health care systems and specify which services should be included and provide the basis for the development of an all-payer system based on DRGs for hospitals.

OF INTEREST Both House and Senate plan to adjourn for the holidays on Wednesday, December 13. When they return in January, work on the medical waste and records bills will be on the agendas of the House and Senate committees on public health issues.

—Frances L. Faverman, Editor

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