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

FOCUS: STATE HEALTH PLAN

A preliminary draft of the proposed state health plan is being circulated for public review and comment. The plan, due to go to the governor and legislature in February, differs from past state health plans in that it concentrates on broad objectives and issues rather than on specific details. The plan was drawn up by the 24-member State Health Planning Council, a body composed of equal numbers of purchaser/payers, consumers, and providers.

The plan is organized around fifteen strategic objectives (each with several components) for dealing with emerging health care issues. These focus on access to care, cost containment, and quality. The strategies are grouped under the following headings: Emerging health care issues, meeting public sector responsibilities, universal access to care, paying for health care in the future, and making quality the basis for choice. The document emphasizes furthering the development of managed care and health systems.

The State Health Planning council adopted the recommendation of the access task force that a universal health plan be created and that this plan should be either a federal or a federal/state plan, but the council prefers an incremental approach because it is "politically and financially feasible." Objective 3 of the document contains three strategies to provide universal access to care that are based in part on ability to pay: phasing in coverage to defined health services, prioritizing coverage so that the most vulnerable and at-risk groups are the first served, and using public and private partnerships to expand access for underserved groups. Objective 4 specifies changing the health care system to assure expanded access and regional availability of a continuum of care. Objective 5 would use policies, regulations, and laws to maintain a sufficient supply and distribution of health care personnel. This objective contains a component that would attempt to determine the effect of consumer protection measures (right to sue) on provider availability.

Objectives 6–11 focus on paying for health care. Objectives 6 and 7 contain strategies for getting consumers to assume more responsibility for their own health to cut costs in the system and for increasing consumer participation in health care decisions. Objective 8 focuses on the use of incentives and disincentives in reimbursement and regulation policies to promote quality and cost-effective service delivery. Objectives 9 and 10 would streamline administrative costs by supporting the development of common reporting by providers of information for third-party payers and utilization review data while continuing to promote coordination among purchasers to reduce cost-shifting and enhance purchasing power among large and small purchasers of health care services. Objective 11 provides two strategies for producing a leaner system: strengthening the Certificate of Need Commission and reviewing the tax-exempt status of providers, including their use of tax-exempt financing.

The final four objectives (12–15) focus on quality as the basis for choice. Objective 12 has components for improving professional and organizational competence: curriculum revision in professional and graduate education to teach cost-effectiveness and practice guidelines. Objective 13 has four strategies for making consumers more competent to make health care decisions, including increasing public awareness of information about licensing and disciplining of health professionals and facilities, providing statewide information that would allow consumers to compare providers and facilities, and instituting in licensure, reimbursement, and malpractice insurance incentives that would support the use of best practice guidelines.

Objective 14 aims at enabling consumers to make better lifestyle decisions and increasing community support for healthy lifestyles. Objective 15 favors reimbursement policies that reward continuous improvement in the quality of care by including incentives for using practice guidelines; reward patients for choosing and providers for supplying cost-effective delivery of services resulting in optimal patient outcomes; foster development of uniform measures of quality of care so that employers, providers, and patients can assess quality and price when making decisions; and develop a uniform standard audit for facilities that would be performed by a single review entity.

The council's definition of a basic level of health care services has been the subject of much debate. Basic health care is defined as "those services... necessary and essential to promoting health, preventing illness, and treating acute medical conditions...delivered in the most appropriate and cost-effective manner." According to Carol Franck, executive director, Michigan Nurses' Association, "Universal access was very difficult. The definition [of basic health services] recognizes that the issue has to be dealt with and that there will be a public and private sector relationship but does not attempt to define that relationship." Franck also noted that there has been more concern with access than cost at the public hearings held on the plan: "The strategies contained in the plan need to balance all three [access, cost containment, and quality]; otherwise we are nowhere."

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

Beverly McDonald, executive director, Michigan League for Human Services, thinks the plan is a good one. "I was taken aback by the fact that the state spends about 25 percent of its budget on health care services. That buys a lot of health care apples and gives the state some opportunity to affect quality and efficacious delivery." McDonald also recognizes that health issues (adequate nutrition and shelter) are distinct from health care issues. In her view, the lack of specificity in the plan is a weakness. She suggests that the shift to outpatient services also needs to be considered. (The plan does mention the need to develop data on ambulatory and outpatient services.)

The major area of disagreement between the state health plan and Governor-elect Engler's action agenda for health care is regulation. For example, Engler thinks that there is too much regulation of the health care system and that competitive market forces, not the Certificate of Need Commission, ought to determine the availability of services and technologies. His ability to make appointments (one Democratic and one Republican appointment expire January 1, 1991) means control of the commission will shift to the Republicans. By appointing Republicans who share his views, a significant amount of deregulation could be achieved, because the law gives the commission the power to delete as well as to add covered services and equipment. The battleground then would shift to the legislature, which has the oversight responsibility for CON standards. The commission's ability to determine standards also could lead to deregulation because if there is no standard, there is no regulation except for that imposed in the law's capital expenditure limits.

It is doubtful that the proposed state plan will have much impact on the Engler administration. Dennis Schornack, the governor-elect's executive assistant for legislative affairs, is not optimistic about universal health care. Schornack said, "The budget crisis is so severe that, at this time, considering state expenditures to increase access to care is not practical. In the short run, what we can do is support the creation of low-cost insurance products for the two-thirds of the uninsured who are working by eliminating mandated benefits. If the Mackinac Center study is right, that would lower the cost by about 25 percent."

FOCUS: LEGISLATIVE LIKELIHOODS

All legislation not passed before adjournment on December 5th is dead. Major measures such as the physician licensure and discipline bills (HBs 5903–5913), no-fault auto insurance medical benefits (SB 712, HB 5317, HB 5998), Medicare balance billing (HB 5448), limited liability for emergency care (SB 910), nursing home waiting list (HB 4971), nursing home preadmission screening (HBs 5388–5391, SBs 796–798), and nursing home patients and Medicaid (HBs 4438–4440) will have to be reintroduced in the 86th legislative session.

The incoming Engler administration may view the concerns of providers and insurance companies more sympathetically than did the Blanchard administration. The most notable exception to this is the likely battle between auto insurers and providers over no-fault medical insurance benefits. Adoption of a fee schedule along with some choice of policy limits on medical benefits is a very real probability in the coming session. It remains to be seen who will prevail—the insurance industry or the health care industry. One possible scenario is an agreement that would make support for more tort reforms contingent upon providers accepting no-fault benefit changes.

Engler endorsed the legislative package developed by the House Republican Task Force on Affordable Insurance: HBs 6075–6076 would create tax credits for persons and businesses contributing to a Caring for Children Program; HBs 6078–6080 define dependents as direct lineal descendants and require insurers, Blue Cross and Blue Shield of Michigan (BCBSM), and health maintenance organizations (HMOs) to offer coverage for dependents; HB 6081 would allow working disabled people to buy into a special Medicaid program; HB 6090 would give BCBSM specific statutory authority to create the Michigan Caring Program for Children; HBs 6093–6095 specify that insurers, BCBSM certificates, and HMO contracts would have to cover unmarried children who were enrolled in postsecondary education programs; and HBs 6096–6098 require insurers, BCBSM, and HMOs to offer coverage to persons under 18 years of age. Only the task force recommendation that supported immunity from suit for providers treating Medicaid patients did not emerge as legislation. It is very likely that similar legislation will be reintroduced in the new session.

Limited liability for emergency care (SB 910), expert witness revisions (HB 5029), and revisions to noneconomic damages (HB 5028, SB 54), joint and several liability (SB 130), and statutes of limitations (SB 54) are still on the agenda of the Michigan State Medical Society. None of these measures would require any state dollars, thus they are apt to be very attractive to the Engler administration. According to Kevin Kelly, assistant director, Michigan State Medical Society, "The environment is extremely ripe for liability reform. We intend to develop a joint reform package with the Michigan Association of Osteopathic Physicians and Surgeons and the Michigan Hospital Association." Kelly also thinks that there is support for upper limits on payments and a schedule of benefits so that payments for injuries are consistent across Michigan.

Right to Life of Michigan supported Engler, and both that organization and others such as the Coalition for Abortion Rights have indicated that they think legislation seeking to restrict abortion rights will be introduced; others are not so sure. Abortion-related issues likely will take a back seat to the budget, at least in the opening months of this session.

—Frances L. Faverman, Editor

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