Gerald Faverman, Ph.D., *Chairman of the Board*
Craig Ruff, *President*
William Rustem, *Senior Vice President*
Frances L. Faverman and Peter Pratt, *Editors*
December 1993

HEALTH POLICY BULLETIN

FOCUS: THE PUBLIC HEALTH ADVISORY COUNCIL

The principal subject of the Public Health Advisory Council's December 10th meeting was the future of public health in a reformed health care system. Chief Denise Holmes of the Office of Policy, Planning and Evaluation, Michigan Department of Public Health, presented two documents, *Promoting Healthy Michigan Communities: The Role of Public Health in Health Reform*, and *Healthy Michigan 2000*, the department's strategic plan.

Promoting Healthy Michigan Communities, aimed at public health professionals, is intended to enable them to make cogently the case for a revitalized public health system. Holmes observed, "Public health people believe health care is more than medical care and cutting costs. Health care reform is focused on getting everybody an insurance card and controlling costs." In a reformed health care system, whose chief goal is health insurance and access to health care for everyone, legitimate questions may be raised about the need for a direct medical care role for public health agencies.

The department argues that in a reformed health care system, a strengthened public health component is needed to continue to provide services such as health status assessment, determination of community health care needs, and care delivery to vulnerable groups of people. These activities represent an evolving public health system and are congruent with the more traditional activities focused on assuring safe water and food supplies, overseeing immunization programs, tracking infectious diseases, and providing medical care to populations that are underserved by most services.

The strategic plan, *Healthy Michigan 2000*, sets forth a series of goals and objectives that are linked to the federal publication, *Healthy People 2000*. Four priority areas are identified in the Michigan plan: Influencing health-risk behaviors, assuring the survival of the African-American male, reducing adverse environmental and occupational health effects, and leading an evolving public health system in Michigan. Within each of the priority areas, goals and objectives are listed and discussed. Finally, the document cross-references those Michigan goals for which there are also national goals. For example, reducing smoking is a national goal, and the Michigan plan calls for cutting the state's current adult smoking rate in half by the year 2000. The incredible homicide rate in the state of 206.3 per 100,000 African-American males 15–34 years old likely would be reduced to the national goal's target rate of 72.4 by the year 2000. The third state goal would protect the water supply by developing state baselines (targets) for compliance with drinking water standards and relate the standards to the national target, which is that 85 percent of the population will have access to safe drinking water by 2000.

The last state priority—leading an evolving public health system in Michigan—has no national counterpart. This state goal includes objectives for (1) establishing user-friendly mechanisms for collection and dissemination of information about health care services and (2) developing an outcome-oriented information system appropriate for Michigan.

Presentations by Kathy Holcomb, legislative aide to Representative Jamian, Republican co-chair of the House Committee on Public Health; Judy Karandjeff, House Democratic research staff; and Sen. John Pridnia, chair of the Senate Committee on Health Policy and Senior Citizens, were also a feature of the meeting. Holcomb told the group that although Representative Jamian's House Republican Task Force on Health Care was not yet ready to present a plan, Jamian is still convinced that major reform of the health care system is not necessary. She said medical IRAs were likely to be the focus of his approach. Another element Jamian is said to be considering is reducing welfare checks for families whose children are not immunized. She estimated that he will present a plan sometime near the end of January or the beginning of February next year.

Judy Karandjeff reviewed briefly the single-payer plan proposed by Representative Hollister (HB 4740) and noted that it is unlikely to emerge from committee. She said that Representative Bennane's plan (HB 4741), which is similar to the Clinton plan, is the official House Democratic caucus position. Since Bennane will be chairing the House Committee on Public Health in February, she suggested he will try to report out HB 4741 at that time. Among the likely modifications is the substitution of targets for global budgets. Further study is being done on the plan's probable costs, but it is unlikely that any actuarial information will be available before spring 1994.

Senator Pridnia commented that he and his committee have not come out with a plan because once all the alternatives are up for discussion, changes will occur. He noted that the hearings he has held around the state have focused on consumers rather than providers. In his view, the state can accomplish about 75 percent of necessary health care reform itself; the state should be able to opt out of federal plans when the state can accomplish a function better than the federal government. He is leery of both "empire builders and powerbrokers," a reference to the three or four large, integrated health care delivery systems that some theorists consider likely to dominate the provision of health care in Michigan within the next ten years. He noted that his district, located in the upper part of the lower peninsula, and inner-city Detroit have more similarities than differences. "We must," he said, "respect the right of access for everybody and recognize the limitations on the ability of employers to pay for it."

FOCUS: MEDICAID AND THE CLINTON PLAN

Earlier this month, *The New York Times* published an article that included some comments from Michigan Medicaid Program Director, Vern Smith. The *Times* story was about the objections of New York's Governor Cuomo to the current formula for funding Medicaid and the Clinton health care reform plan. Although the plan would end Medicaid as it is currently structured, states would be required to continue their present level of spending on Medicaid and would need to increase their spending to reflect increases in inflation. Public Sector Consultants went to Smith for clarification of his published comments.

According to Smith, the Medicaid matching formula, first devised in the 1960s, has historically favored southern and southwestern states, placing states in the Northeast and Midwest at a disadvantage. The formula requires the federal government to match state Medicaid spending at the level of actual spending or by a formula based on the relationship between the squares of the per capita state income and the per capita national income, whichever is greater. Differences between the states are magnified by the squaring so that states with very low per capita incomes such as Mississippi receive $5 in federal money for every $1 in state money. States like Michigan, New York, Pennsylvania, Illinois, and those of New England receive less money because their per capita incomes are higher.

State officials in the wealthier states are distressed because the Clinton plan makes no changes in the Medicaid matching formula. Sen. Patrick Moynihan (D-New York) has said that the formula will have to change if a state like New York is going to conform. Smith noted that one of the reasons the formula favored the southern states is that at the time the federal Medicaid legislation was passed, the chairman of the U.S. House Ways and Means Committee was Wilbur Mills (D-Arkansas). Again, Smith said, "There have been no fundamental changes to the formula since it was established."

All is not gloomy, however. When asked if Michigan would not benefit since the state's per capita income is under the national average, Smith indicated that, yes, it would, but the benefit would be delayed because of the time lag involved in waiting for the data to be reported to the Health Care Financing Administration (HCFA) and then waiting for HCFA to set the new matching rates.

Nevertheless, before the Clinton plan becomes effective, Smith would like to see some changes made to the Medicaid formula. He thinks two changes would help Michigan and other states with larger populations: removing the squaring component in the formula and changing the 50 percent floor to 60 percent. While these changes will be popular with congressmen from larger states, he observed that "more tax dollars will be needed to fund the Medicaid program." Given the current mood of Congress and the savings on Medicaid postulated in the Clinton plan, he did not think a change calling for the expenditure of more federal tax dollars was likely.

OF INTEREST

Neither the House Committee on Public Health nor the Senate Committee on Health Policy and Senior Citizens will meet the remainder of the month. Although Representative Jamian chaired the public health committee this month, under the terms of the shared power agreement, he also will chair the public health committee in January. Representative Bennane will not chair the committee until February 1994.

Ken Kuipers, chair of the Public Health Advisory Council, is reported to be interested in pursuing the state senate seat that will be vacated shortly by Sen. Vernon Ehlers. Kuipers is a county commissioner from Grand Rapids in Kent County. Should he decide to run and win, it seems likely that he would be interested in a committee assignment related to health care.