House Office Building, 9 South
Lansing, Michigan 48909
Phone: 517/373-6466

HMO REFORM

Senate Bill 1209 with House committee amendments
Sponsor: Sen. Bev Hammerstrom

Senate Bill 1211 as passed by the Senate
Sponsor: Sen. Shirley Johnson

House Committee: Health Policy
Senate Committee: Health Policy

First Analysis (5-30-00)

THE APPARENT PROBLEM:

Under current law, Health Maintenance Organizations (HMOs) are regulated by the Department of Community Health under the Public Health Code and by the Office of Financial and Insurance Services (OFIS). All other health care plans and health insurers are regulated by the OFIS. Though the different types of health plans and carriers offer similar services and assume the same types of risks, HMOs are not treated in the same way as the other plans. One difference is that HMOs can be licensed with little capital or net worth. This increases the risk that a plan could become insolvent if it experienced shortfalls in investments or a financial setback from paying claims. When an HMO goes out of business, its enrollees face hardships in finding another plan to cover them and having to change doctors if their current doctors are not affiliated with the new plan. Further, other than revoking an HMO's license, there is little action that the commissioner of OFIS can take against an HMO for violations of current law. Since revocation of an HMO's license may not be in the best interest of residents who are enrolled in the HMO, state regulators have little leverage to encourage health plans to better serve consumers or to encourage compliance with state regulations short of an all-out shutdown. Another weakness in the laws pertaining to HMOs regards rate changes. Currently, a requested rate change can only be approved or disapproved. If the rate change was disapproved because the increased rate would still be below expected losses, the HMO would have to operate with inadequate rates while a new proposal was drafted and submitted. This practice increases the risk that an HMO experiencing some difficulty may become insolvent. At the prompting of the OFIS, legislation is being offered to address these and other concerns.

THE CONTENT OF THE BILLS:

Senate Bill 1209 would amend the Insurance Code to repeal Part 210 of the Public Health Code and transfer the regulation of health maintenance organizations (HMOs) to the Insurance Code, and Senate Bill 1211 would amend the Public Health Code to remove references to HMOs that are no longer appropriate in light of the transfer. (Currently, regulation of HMOs is overseen by the Department of Community Health and regulated under Part 210 of the Public Health Code.) Specifically, the bills would do the following:

Senate Bill 1209 would amend the Insurance Code (MCL 500.102 et al.) to, among many things, add Chapter 35, entitled "Health Maintenance Organizations". Part 210 of the Public Health Code (MCL 333.21001 to 333.21098), which currently regulates HMOs, would be repealed. Under the bill, all of the provisions of the Insurance Code that apply to a domestic insurer authorized to issue an expense-incurred hospital, medical, or surgical policy or certificate, including, but not limited to, Section 223 (application for initial or renewal certificate of authority, fee, and deposit), Chapter 34 (disability insurance policies) and Chapter 36 (group and blanket disability) would apply to an HMO unless specifically excluded or otherwise provided for in the bill. However, Chapter 77 (Michigan Life and Health Insurance Guaranty Association Act) and Chapter 79 (Property and Casualty Guaranty Association Act) would not apply to HMOs, nor would several sections pertaining to capital, surplus, or assets; loans and investments; corporate powers; and authority for domestic, alien, and foreign insurers to transact insurance in the state. Oversight would be provided by the commissioner of the Office of Financial and Insurance Services (OFIS). Some of the more significant changes are as follows:

• An HMO would be required to receive a certificate of authority (instead of a license) before issuing health maintenance contracts. A license issued under Part 210 of the Public Health Code would automatically become a certificate of authority on the bill's effective date.

• The bill would change the process by which an HMO's net worth is determined, and would increase the net worth and working capitol requirements. HMOs licensed on the bill's effective date, and which have unimpaired net worth as currently required, would have to come into compliance with the new levels no later than December 31, 2003. For HMOs that contract or employ providers in numbers sufficient to provide 90 percent of the HMO's benefit payout, the minimum net worth would be the greater of $1.5 million, four percent of the HMO's subscription revenue, or three months' uncovered expenditures. For an HMO that does not contract or employ in numbers sufficient to provide 90 percent of the HMO's benefit payout, the minimum net worth would be the greater of $3 million, ten percent of the HMO's subscription revenue, or three months' uncovered expenditures.

• HMOs applying for a certificate of authority or wishing to maintain a certificate on or after the bill's effective date would have to maintain a deposit in an amount determined adequate by the commissioner, but not less than $100,000 plus five percent of the annual subscription revenue up to a $1 million maximum deposit.

• An HMO would have to hold assets in its own name and not commingle funds and assets with affiliates or other entities.

• An HMO could not use financial incentives, or make any payment to a health professional, that acted as an inducement to deny, reduce, limit, or delay a specific medically necessary and appropriate service. Payment arrangements would be allowed that were not tied to specific medical decisions or that prohibited the use of risk sharing that is otherwise permitted under the bill's provisions.

• The bill would incorporate National Association of Insurance Commissioners model legislation pertaining to insolvency. HMOs would have to have a plan in place to handle insolvency that would allow for the continuation of benefits for the duration of the contract period, including a contract between the HMO and its affiliated providers to provide for the continuation of provider services in the event of the HMO's insolvency. Such a contract would have to provide a commissioner-approved mechanism for appropriate sharing by the HMO of the continuation of provider services; but, the contract could not provide that continuation of provider services was solely the responsibility of the affiliated providers. The bill would prescribe criteria for satisfying solvency requirements. If an HMO that contracted with a state funded health care program (e.g., Medicaid) became insolvent, the commissioner would have to inform the state agency responsible for the program of the insolvency. Enrollees of an insolvent HMO covered by a state funded health care program could be reassigned in accordance with state and federal statutes governing the particular program.

• The bill would incorporate numerous provisions currently contained in departmental rules and would also incorporate provisions contained in model legislation proposed by the National Association of Insurance Commissioners (NAIC). For example, the bill would incorporate credentialing criteria that are part of the NAIC credentialing model act for health professionals who contract with HMOs.

• The bill would make changes to the grievance procedure for insurers and HMOs. The time frame in which a determination for an internal review is to be issued would be reduced from 90 days after the insured or enrollee submitted a formal grievance to 25 days. Under current law, this time period may be tolled for any period of time that the insured or enrollee is permitted to take under the grievance procedure. The bill would add that the time period could also be tolled for a period of time that could not exceed five days if the insurer or HMO had not received the requested information from a health care facility or health professional. Beginning October 1, 2000, a notification of an adverse determination would have to include a written notice in plain English that the insured or enrollee could request a review by an independent review organization under the Patient's Right to Independent Review Act (House Bill 5576). An insured or enrollee could authorize, in writing, any person (including a physician) to act on his or her behalf during the grievance proceeding. Currently, summary data on the number and types of complaints and grievances filed is collected. Beginning April 15, 2001, the data for the previous year would have to be filed annually with the commissioner of the Office of Financial and Insurance Services on forms provided by the commissioner.

• The regulatory fee for HMOs would be calculated using the same formula as for other insurers. Other fees paid by insurers that would be applicable to HMOs

include a $25 filing fee and a $5 agent's appointment fee.

• Each HMO would have to develop and maintain a quality assessment program to assess the quality of health care provided to enrollees and a quality improvement program to design, measure, assess, and improve the processes and outcomes of health care as identified in the program. The quality improvement program would be under the direction of the HMO's medical director.

Senate Bill 1211 would amend the Public Health Code (MCL 333.20106 et al.) to make technical changes regarding HMOs in light of the transfer of the regulatory framework pertaining to HMOs from the Public Health Code to the Insurance Code.

HOUSE COMMITTEE ACTION:

Several committee amendments were adopted to Senate Bill 1209 to bring the bill into conformity with its House counterpart, House Bill 5575. The committee-passed versions of Senate Bills 1209 and 1211 are identical to House Bills 5575 and 5574, respectively, as passed by the House.

FISCAL IMPLICATIONS:

Fiscal information on the Senate bills is not available. However, according to a departmental analysis by the Division of Insurance dated 4-27-99, House Bill 5575 (the counterpart to Senate Bill 1209) will result in a need for additional staff to perform duties required under the bill. The revised assessment amounts and the licensure fees under the bill should help mitigate costs for additional staff required to implement the provisions under the bill.

ARGUMENTS:

For:

The package of legislation as a whole, including House Bill 5572 ,which would create an HMO report card, House Bill 5573, which deals with internal reviews of disputed claims, and House Bill 5576, which would create a "Patient's Right to Independent Review Act", would help to make HMOs more user friendly. The regulation of all insurance carriers and health plans would be under one roof, rather than being divided between two state agencies. Further, Senate Bill 1209 would restructure the regulations of HMOs, making them consistent with regulations that apply to the rest of the state's regulated health plans. In addition, Senate Bill 1209 would address weaknesses in the HMO laws that put HMOs at greater risk for insolvency. For instance, under the bill, the net worth, statutory deposit, and working capital requirements for HMOs would be increased, thus providing greater financial stability. Placing the regulation of HMOs under the Insurance Code would allow the commissioner of OFIS to approve a rate change with modifications, instead of denying a requested rate increase because the increase wasn't great enough to cover expected losses, as is currently required under the Public Health Code. This would allow HMOs to continue to operate using rates that were deemed appropriate by the commissioner for the HMO's risk assumption.

Senate Bill 1209 also would allow more options for the commissioner when enforcing compliance with state laws. Currently, the commissioner has little choice other than to take license sanctions against an HMO, even though such a severe action may not be in the best interest of consumers. Under the bill, the commissioner could levy civil fines in addition to obtaining a cease and desist order to stop the HMO from engaging in undesirable actions. Further, if an HMO should become insolvent and close down, the commissioner could order other carriers who may be covering an affected group to offer a 30-day open enrollment period to the subscribers of the insolvent HMO. The commissioner could also assign enrollees to other HMOs in a service area if there were no available carriers involved with the affected group. In short, the consolidation of regulatory functions under one administrative roof, consistency and continuity of regulations across all health carriers and health plans, and setting solvency standards will increase protection to consumers and create a more level field for health carriers competing to offer quality health care plans.

For:

Senate Bill 1209 would shorten the time frame for internal grievance processes from 90 days to 25 days. Even though internal grievance procedures contain an expedited process for those who are critically ill, many who would not fit the strict criteria for an expedited review may nevertheless be in urgent need of treatment. The 25-day period should be sufficient to gather all relevant information, as the time period can still be tolled, or frozen, upon the request of the person disputing the claim. For example, if after the process is started, the person discovers that his or her physician is away and unable to provide the medical information in a timely fashion, the 25-day count can be frozen under provisions in the plan's internal review procedure.

Some health carriers have been concerned about reducing the time period for internal grievance procedures because they do not always receive requested medical information from a person's health professional in a timely fashion. The bill would address this concern by allowing a health plan to also toll the 25-day period if unable to access the needed information. This would give a plan an additional five days to obtain and review the medical information pertaining to a disputed claim.

Response:

The Senate-passed version would have reduced the time frame by half, from 90 days to 45 days. This further reduction may be too drastic to allow for a careful review of a disputed claim. Before judging a 45-day time line to be an inadequate reduction, some time should be given to allow the legislation to take effect and to see how the process functions. As information is disseminated to educate consumers of their right to appeal adverse determinations, it is not known at this time what impact the legislation will have on the number of requests for external reviews. A 25-day time line may prove to be too short for an individual, health professionals, and health plans to function within. Once the process is up and running, it should become clearer if the time lines set in statute need to be adjusted further. It should also be remembered that the time lines specified in the legislation are maximums, not minimums. Hopefully, both internal and external appeals will be handled as quickly as possible and well under a 45-day maximums.

POSITIONS:

There are no positions on the bills.

Analyst: S. Stutzky

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.