House
Legislative
Analysis
Section

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MEDICARE SUPPPLEMENT POLICY AND MEDICAID ASSESSMENT FEE

Senate Bill 748 (Substitute H-3)
Sponsor: Sen. Bev Hammerstrom

Senate Bill 749 with committee amendment
Sponsor: Sen. Bill Bullard, Jr.

First Analysis (5-2-02)

House Committee: Insurance and Financial Services
Senate Committee: Health Policy

THE APPARENT PROBLEM:

Medicare is regulated by the federal government under the Social Security Act. Medicare supplement policies (also known as "Medigap" policies) also are governed by the Social Security Act. A Medicare supplement policy or certificate is insurance that supplements reimbursements under Medicare for hospital, medical, or surgical expenses of individuals eligible for Medicare or Medicare select policies or certificates. These policies allow individuals to attempt to cover their expenses for various care not paid for by Medicare.

Provisions in Michigan's Insurance Code and Nonprofit Health Care Corporation Reform Act (which regulates Blue Cross and Blue Shield of Michigan) allow the state to regulate Medicare supplement policies issued in the state; these provisions must conform to provisions in the Social Security Act that regulate Medicare supplement policies. It has been pointed out that there have been changes in the federal regulations, including the addition of provisions for optional supplement policies, since Michigan adopted its Medicare supplement policy regulations. It has been suggested that the state statutes be amended to reflect the federal changes.

In a separate matter, legislation has been requested to address two other issues pertaining to health maintenance organizations (HMOs). In an effort to maximize state and federal Medicaid dollars and continue to provide medical services to the state's poorest residents, a change was made several years ago to have managed care plans (HMOs) contract with the state to provide medical services to the state's Medicaid recipients. The health providers who participate with a health plan that contracts for Medicaid services then accept a lower reimbursement rate for the services provided. Despite attempts to keep medical costs down, costs associated with the delivery of health and mental health services have continued to climb. Unfortunately, the Medicaid reimbursements to health providers have not kept pace with the escalating costs. Some providers now find that it is too costly to continue to participate with health plans that contract with the state to provide Medicaid services, and some health plans are finding it too costly to continue to contract with the state for such services. It is not uncommon to have providers limit the number of Medicaid patients that they will see in a day, week, or month. Each time an individual provider leaves the panel of an HMO that provides Medicaid services, or each time an HMO withdraws from serving Medicaid clients, Medicaid recipients find it more difficult to access health care. Many believe that if the state were allowed to levy an assessment fee on each HMO that contracts to deliver Medicaid services, that the state could maximize allowable matching federal funds and so provide an increase in the Medicaid reimbursement rate.

Secondly, the laws regulating HMOs do not specifically allow an HMO to include deductibles in their health plan contracts. Nominal co-pays are allowed, and many HMOs do require a $5 or $10 co-pay for some services, such as office visits. Where no yearly out-of-pocket deductible would seem to be an attractive feature, in reality it means that yearly premiums are higher than other types of managed care plans, such as participating provider

organizations (PPOs), which have varying levels of yearly deductibles and co-pays. Recent industry statistics have shown a migration away from membership in HMOs and to membership in health plans with deductibles, as the yearly premium is often lower. Some industry members believe that being able to offer plans with deductibles would give consumers a greater choice of affordable health plans, and so have asked that the law be amended to do so.

THE CONTENT OF THE BILLS:

Senate Bill 748 would amend Chapter 38 of the Insurance Code (MCL 500.3515 et al.), and Senate Bill 749 would amend Part 4A of the Nonprofit Health Care Corporation Reform Act (550.1451 et al.) to revise the provisions in both the code and the act that regulate Medicare supplement policies and Medicare supplement certificates, respectively. (The provisions of Chapter 38 and Part 4A that regulate Medicare supplement policies are nearly identical in content.) Senate Bill 748 would also allow an assessment fee to be levied against health maintenance organizations (HMOs) that have contracts with the Department of Community Health to deliver services to Medicaid recipients and also to allow HMOs to add a yearly deductible for services.

The bills would amend Chapter 38 and Part 4A in the same way, to do the following:

- Provide for the sale of high deductible plans.

- Add provisions to regulate Medicare+Choice plans (which are now allowed under federal Medicare regulations).;

- Allow a policyholder to suspend a Medicare supplement policy, and have the policy reinstated, under certain circumstances.

- Specify conditions under which an applicant for a Medicare supplement policy would not be excluded from coverage because of a preexisting condition.

- Specify individuals who would be eligible for coverage, and prescribe conditions under which people could not be denied coverage.

- Establish time periods during which eligible individuals would have to be allowed to enroll.
- Require notification when a plan was terminated.

The bills also would repeal sections of the code and the act that require an insurer to report each year to the commissioner of the Office of Financial and Insurance Services, the policy and certificate number and date of issuance for every individual in the state for whom the insurer has more than one Medicare supplement policy or certificate in force.

High Deductible Plans. Chapter 38 and Part 4A allow an insurer to offer various Medicare supplement plans, known as Plans A through J, and prescribe the coverages of each plan, including the medical services and care offered, and the amounts Medicare pays, the supplemental plan pays, and the insured pays. These amounts are determined by federal regulations. The bills would change the amounts in the various plans to reflect changes that have occurred in Federal regulations.

Currently, each plan prescribes the core benefits that must be included, and limits other coverages as specified. The bills would amend Plan F and Plan J to allow for a standardized Medicare supplement high deductible plan, which would include only 100% of covered expenses following payment of the annual high deductible. The annual high deductible would be $1,580 for 2001, adjusted for inflation each year thereafter. The covered expenses would include the core benefits, plus Medicare deductibles and excess charges, and medically necessary emergency care in a foreign country. Under Plan J, covered expenses also would include an extended outpatient prescription drug benefit, a preventative medical care benefit, and an at-home recovery benefit. The annual high deductible under both Plans F and J would consist of out-of-pocket expenses (other than premiums) for services covered by the plans, and would be in addition to any other specific benefit deductibles.

Suspension of Policy. The bills would require each Medicare supplement policy to provide that benefits and premiums under the policy would have to be suspended at the request of the policyholder if he or she were entitled to benefits under the Social Security Act, and covered under a group health plan. If suspension occurred and if the policyholder lost coverage under the group health plan, the policy would have to be automatically reinstituted effective on the date of loss of coverage, if the policyholder provided notice of the loss within 90 days after the loss and paid the premium attributable to the time period.

The bills would retain current provisions that require a policy to provide that benefits and premiums must be suspended at the request of a policyholder, for a period of up to 24 months in which the policyholder

has applied for and is entitled to medical assistance under Medicaid.

Preexisting Condition Exclusion. Under Chapter 38 and Part 4A, an insurer may not deny or condition the issuance or effectiveness of a Medicare supplement policy, or discriminate in the pricing of the policy, because of the health status, claims experience, receipt of health care, or medical condition of an applicant, if an application for the policy is submitted during the six-month period beginning with the first month in which an individual who is 65 years old or older first enrolled for benefits under Medicare. The bills further provide that an insurer could not exclude benefits based on a preexisting condition if an applicant qualified under the current provisions; submitted an application within the time required under the current provisions; and as of the date of application had had a "continuous period of creditable coverage" of at least six months. If the applicant met these conditions but had had a continuous period of creditable coverage of less than six months, the insurer would have to reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary of the U.S. Department of Health and Human Services (HHS) would have to specify the manner of the reduction.

Except for the preexisting condition restrictions in the bills, and provisions in Section 3833 of Chapter 38 or Section 483 of Part 4A, the bills state that the current provisions would not prevent the exclusion of benefits under a policy during the first six months based on a preexisting condition for which the policyholder received treatment or was otherwise diagnosed during the six months before the coverage became effective. (Under Sections 3833 and 483, if a Medicare supplement policy replaces another Medicare supplement policy, certificate, or contract, the replacing insurer must waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for similar benefits, to the extent such time was spent under the original coverage.)

Under the bills, a "continuous period of creditable coverage" would mean the period during which an individual was covered by "creditable coverage", if during the period of the coverage the individual had no breaks in coverage greater than 63 days. "Creditable coverage" would mean coverage of an individual provided under a group health plan; health insurance coverage; Part A or Part B of Medicare; Medicaid other than coverage consisting solely of benefits under Section 1928 of Medicaid (which provides for a pediatric vaccine distribution program); Chapter 55 of Title 10 of the United States Code (which provides for medical and dental care for members, and certain former members, of the armed forces); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 of the United States Code (which provides for health insurance for certain Federal employees and officials); a public health plan as defined in Federal regulation; and health care provided under the Peace Corps Act.

Creditable coverage would not include any of the following:

- Coverage only for accident or disability income insurance, or any combination of accident or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; or other similar insurance coverage, specified in Federal regulations, under which benefits for medical care were secondary or incidental to other insurance benefits.

- The following benefits, if they were provided under a separate policy, certificate, or contract of insurance or were otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those types of care; or other similar, limited benefits as specified in federal regulations.

- The following benefits if offered as independent, noncoordinated benefits: coverage only for a specified disease or illness; hospital indemnity; or other fixed indemnity insurance.

- The following if it were offered as a separate policy, certificate, or contract of insurance: Medicare supplemental policy as defined under Section 1882(g)(1) of Part D of Medicare; coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the U.S. Code (which provides for medical and dental care for members, and certain former members, of the armed forces); and similar supplemental coverage provided under a group health plan.

Eligible Persons. The bills would prescribe several criteria that a person could meet to be considered eligible to obtain a Medicare supplement policy, and the "guaranteed issue time periods" during which certain individuals would be eligible. An eligible person would be an individual who met the criteria and submitted evidence of the date of termination or disenrollment with the application for a Medicare supplement policy. For an eligible person, an insurer could not deny or condition the issuance or effectiveness of a Medicare supplement policy (described in the bills) that was offered and was available for issuance to new enrollees by the insurer; could not discriminate in the pricing of the Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; and could not impose an exclusion of benefits based on a preexisting condition under the Medicare supplement policy.

One type of eligible person would be an individual who was enrolled under an employee welfare benefit plan that provided health benefits supplementing the benefits under Medicare, and that terminated or ceased to provide all those supplemental health benefits to the individual. The individual would be entitled to a policy that had a benefit package classified as Plan A, B, C, or F, offered by any insurer; and the guaranteed issue time period would begin on the date the individual received a notice of termination or cessation of all supplemental health benefits or, if a notice were not received, notice that a claim had been denied because of a termination or cessation, and would end 63 days after the date of the applicable notice.

An eligible person also would be an individual who was enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances applied; or the individual was 65 years old or older and was enrolled with a PACE provider under the Social Security Act, and there were circumstances similar to the following that would permit discontinuance of his or her enrollment with the provider if the individual were enrolled in a Medicare+Choice plan:

-The certification of the organization or plan had been terminated.

-The organization had terminated or otherwise discontinued providing the plan in the area in which the individual resided.

-The individual was no longer eligible to elect the plan because of a change in his or her place of residence or other change in circumstances specified by the secretary of HHS, but not including termination of the individual's enrollment on the basis of specific provisions in the Social Security Act; where the individual had not paid premiums on a timely basis or had engaged in disruptive behavior as specified in standards established under that act; or the plan was terminated for all individuals within a residence area.

-The individual demonstrated, in accordance with guidelines established by the Secretary, that the organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits were available or the failure to provide covered care in accordance with applicable quality standards; or the organization, or agent or other entity acting on its behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

-The individual met other exceptional conditions as the secretary provided.

Under these provisions, the individual would be entitled to a policy that had a benefit package classified as Plan A, B, C, or F, offered by any insurer. Further, for an individual eligible under these provisions whose enrollment was terminated involuntarily, the guaranteed issue time period would begin on the date that he or she received a notice of termination and would end 63 days after the date the applicable coverage was terminated.

Further, an eligible person would be an individual who was enrolled with an eligible organization under a contract under provisions of the Social Security Act; a similar organization operating under demonstration project authority, effective for periods before April 1, 1999; an organization under an agreement under a section of the Social Security Act; a health care prepayment plan; or an organization under a Medicare select policy. These provisions would apply to an enrollment that ceased under the same circumstances that would permit discontinuance of an individual's election of coverage with a Medicare+Choice organization or PACE provider, as described above. Under these provisions, the individual would be entitled to a policy that had a benefit package classified as Plan A, B, C, or F, offered by any insurer. Further, for an individual eligible under these provisions whose enrollment was

terminated involuntarily, the guaranteed issue time period would begin on the date that he or she received a notice of termination and would end 63 days after the date the applicable coverage was terminated. For an individual who disenrolled voluntarily, the guaranteed issue time period would begin on the date that was 60 days before the effective date of the disenrollment and would end 63 days after the effective date.

In addition, an eligible person would be an individual who was enrolled under a Medicare supplement policy and the enrollment ceased because of the insolvency of the insurer or bankruptcy of the noninsurer organization, or because of other involuntary termination of coverage or enrollment under the policy; the insurer substantially violated a material provision of the policy; or the insurer, or an agent or other entity acting on its behalf, materially misrepresented the policy's provisions in marketing the policy to the individual. The individual would be entitled to a policy that had a benefit package classified as Plan A, B, C, or F, offered by any insurer. If the individual's enrollment ceased because of the insolvency of the insurer, bankruptcy of a noninsurer organization, or other involuntary termination, the guaranteed issue time period would begin on the earlier of the date that the individual received a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice, if any, or the date that the applicable coverage was terminated, and would end 63 days after the date the coverage was terminated. For an individual who disenrolled voluntarily, the guaranteed issue time period would begin 60 days before the effective date of the disenrollment and would end 63 days after the effective date. (Under the bills, "bankruptcy" would mean when a Medicare+Choice organization that was not an insurer filed, or had had filed against it, a petition for declaration of bankruptcy and had ceased doing business in the State. "Insolvency" would mean when an insurer licensed to transact the business of insurance in Michigan had had a final order of liquidation entered against it, with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.)

An eligible person also would be an individual who was enrolled under a Medicare supplement policy, terminated enrollment, and subsequently enrolled, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan, any eligible organization under a contract under specified provisions of the Social Security Act, Medicare cost, any similar organization operating under demonstration project authority, any PACE provider, or a Medicare select policy. This provision would apply if the enrollee terminated the subsequent enrollment during any period within the first 12 months of the subsequent enrollment during which he or she was permitted to terminate the subsequent enrollment under a specified provision of the Social Security Act. The Medicare supplement policy to which the person was entitled would be the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same insurer, or, if not available, a policy that had a benefit package classified as Plan A, B, C, or F, offered by any insurer. For an eligible individual whose enrollment was terminated involuntarily, the guaranteed issue time period would begin on the date that he or she received a notice of termination and would end 63 days after the date the applicable coverage was terminated. For an individual who disenrolled voluntarily, the guaranteed issue time period would begin 60 days before the effective date of the disenrollment and would end 63 days after the effective date. If the individual's enrollment were involuntarily terminated within the first 12 months of enrollment, and he or she, without an intervening enrollment, enrolled with another organization or provider, plan, or program, the subsequent enrollment would be considered an initial enrollment.

Another type of eligible person would be an individual who, upon first becoming eligible for benefits under Part A of Medicare at age 65, enrolled in a Medicare+Choice plan under Part C of Medicare, or with a PACE provider under a specified provision of the Social Security Act, and disenrolled within 12 months after the effective date of enrollment. The policy to which the person was entitled would have to include any Medicare supplement policy offered by any insurer. For an individual eligible under these provisions whose enrollment was terminated involuntarily, the guaranteed issue time period would begin on the date that he or she received a notice of termination and would end 63 days after the date the applicable coverage was terminated. For an individual who disenrolled voluntarily, the guaranteed issue time period would begin 60 days before the effective date of the disenrollment and would end 63 days after the effective date. If the individual's enrollment were involuntarily terminated within the first 12 months of enrollment, and he or she, without an intervening enrollment, enrolled with another organization or provider, plan, or program, the subsequent enrollment would be considered an initial enrollment.

For the last two categories of eligible individuals, enrollment of an individual with an organization or provider or plan described in the bills could not be considered to be an initial enrollment after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, or plan.

For an eligible person whose guaranteed issue time period was not described above, the guaranteed issue time period would begin on the effective date of disenrollment and would end 63 days after the effective date.

Under the bills, "Medicare+Choice plan" would mean a plan of coverage for health benefits under Medicare Part C as defined in Federal regulations, and would include coordinated care plans that provide health care services, including, but not limited to, health maintenance organization plans with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans; medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and a Medicare+Choice medical savings account; and Medicare+Choice private fee-for-service plans. A PACE program would be a program of all-inclusive care for the elderly as described in the Social Security Act.

Notification Requirements. Under the bills, at the time of an event (described above) that caused an individual to lose coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminated the contract or agreement, the insurer terminating the policy, or the administrator of the plan being terminated, respectively, would have to notify the individual of his or her rights under the bills and of the obligations of insurers of Medicare supplement policies. The notice would have to be communicated at the same time as the notification of termination.

At the time of an event that caused an individual to cease enrollment under a contract or agreement, policy, or plan, the organization that offered the contract or agreement, regardless of the basis for the cessation of enrollment, the insurer offering the policy, or the administrator of the plan, respectively, would have to notify the individual of his or her rights under the bills and of the obligations of insurers. The notice would have to be communicated within 10 working days of the insurer's receiving notification of disenrollment.

Core Benefits. Currently, every insurer issuing a Medicare supplement insurance policy in Michigan must make available such a policy that includes a basic core package of benefits to each prospective insured. Chapter 38 and Part 4A list the core benefits that must be included. One of the benefits is coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare deductible. Under the bills, this benefit would be coverage for the coinsurance amount, or the copayment amount paid for hospital outpatient department services under a prospective payment system, of Medicare eligible expenses regardless of hospital confinement, subject to the Medicare deductible.

Outline of Coverage. Chapter 38 and Part 4A require an insurer that offers a Medicare supplement policy to provide an applicant with an outline of coverage, upon application. Senate Bill 748 provides that if an outline of coverage were provided at the time of application and the policy or certificate were issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate would have to accompany the policy or certificate when it was delivered, and would have to contain the following statement:

Notice: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

(This provision is already in Part 4A.)

HMO deductibles. Senate Bill 748 would amend the Insurance Code to allow HMO contracts to include deductibles.

Medicaid quality assurance assessment fees. Senate Bill 748 would require, beginning on the bill's effective date and continuing to October 1, 2003, the Department of Community Health (DCH) to assess on each HMO that had a Medicaid managed care contract awarded by the state and administered by DCH a quality assurance assessment fee. The fee would have to equal a percentage established by the department that, when applied to each HMO's non-Medicare premiums paid to the HMO, totaled an amount that would equal a five percent increase for the Medicaid managed care program net of the value of the quality assurance assessment fee. (According to information supplied to the House committee by the Department of Management and Budget, the fee

assessment would be 1.87 percent on non-Medicare premiums.)

The fee collected under the bill and all federal matching funds attributed to that fee would have to be used for the following purposes and only under the following specific circumstances:

- The entire fee and all matching federal funds would have to be used to maintain the Medicaid reimbursement rate increase in each fiscal year in which the fee was first assessed. Only HMOs that are assessed the quality assurance assessment fee would be eligible to receive the increased Medicaid reimbursement rates.

- The fee would be implemented on the bill's effective date and would no longer be assessed or collected beginning October 1, 2003.

-The fee would have to be assessed on the non-Medicare premiums collected by each HMO in calendar year 2001. An HMO that didn't collect non-Medicare premiums in that year would have the assessment based on the premiums collected in the preceding quarter. The fee would be paid on a quarterly basis with the first payment due 90 days after the fee was assessed. For those HMO's without the 2001 non-Medicare premiums, the first fee would have to be assessed as soon as possible and be payable upon receipt.

-The quality assurance assessment fee could only be assessed on an HMO that has in effect a Medicaid managed care contract awarded by the state and administered by the DCH at the time of the assessment.

- The DCH would have to implement these new provisions in a manner that complied with federal requirements necessary to assure that the assessment fee qualified for federal matching funds. If compliance wasn't possible, or if DCH was unable to use the fiscal year 2001-2002 level of support for federal matching dollars other than for a change in covered benefits or covered population required under the state's Medicaid contract with HMOs, the quality assurance assessment fee could no longer be assessed or collected.

- If an HMO failed to pay the quality assurance assessment fee, the DCH could assess the HMO a penalty of five percent of the assessment for each month that the assessment and penalty were not paid, up to a maximum of 50 percent of the assessment. The DCH could also refer past due amounts for collection to the Department of Treasury under provisions of Public Act 122 of 1941 (MCL 205.13).

- The Medicaid HMO quality assurance assessment fund would be established as a separate fund in the state treasury. Revenue raised through the assessment fees would have to be deposited in the fund and used as provided in the bill.

- In all fiscal years governed by the bill, Medicaid reimbursement rates could not be reduced below the Medicaid payment rates in effect on April 1, 2002 as a direct result of the assessment fee assessed under the bill. These provisions would not apply to a change in Medicaid reimbursement rates caused by a change in covered benefits or change in covered populations required under the state's Medicaid contract with HMOs.

-The amounts appropriated to the DCH, subject to the bill's conditions, would be specified in the bill for the fiscal year ending September 30, 2003.

HOUSE COMMITTEE ACTION:

The House committee adopted a substitute bill that would allow a quality assurance assessment fee to be assessed to HMOs that provide Medicaid services and to allow HMOs to add a deductible in addition to co-pays, which are currently allowed.

FISCAL IMPLICATIONS:

Fiscal information is not available.

ARGUMENTS:

For:

According to the Office of Financial and Insurance Services (OFIS), provisions in the federal Balanced Budget Act of 1997 added to the options that consumers had in choosing Medicare supplement policies. The additional options include a Medicare+Choice policy (which is a managed care program) that gives policyholders potential savings and benefits not available under other policies. Another option now allowed is a high deductible supplement policy, which gives consumers the opportunity to reduce their potential total costs by increasing their out-of-pocket expenses. Neither the Insurance Code nor the Nonprofit Health Care Corporation Reform Act has been amended to reflect these changes. According to the OFIS, insurers will not be allowed to offer these optional coverages in Michigan if the state statutes are not brought into compliance with the federal changes. The bills

would bring the state into conformity with the recent federal changes.

For:

The bills would repeal provisions in both Chapter 38 and Part 4A that require an insurer to report each year to the OFIS Commissioner the policy and certificate numbers and date of issuance for every individual in the state for whom the insurer has more than one Medicare supplement policy or certificate in force. Reportedly, this provision has never been implemented.

For:

As the costs for delivering medical services have continued to rise, Medicaid reimbursement rates have lagged behind. Now some doctors and other health providers are finding it too costly to accept Medicaid patients and have pulled out of HMO panels that contract with the state to provide services to Medicaid recipients. Others are limiting the number of Medicaid patients that their practice will accept. In some cases, it is the HMO that decides it can no longer afford to continue to contract to provide Medicaid services. Each time a health plan or a health provider stops providing Medicaid services, Medicaid recipients find it more difficult to find a doctor who will treat them, more difficult to get an appointment in a timely manner, and more difficult to find a doctor in their geographic area.

Nobody disputes the necessity to provide appropriate funding for the state's poorest citizens to receive medical care. Unfortunately, the recent economic downturn has made it impossible to raise Medicaid reimbursement rates. Compounding the problem is the fact that the economic slowdown has resulted in more people qualifying for Medicaid services because of lost employment, reduced wages, and other factors. Further compounding the problem is that federal funding for Medicaid is based on a system that changes each year based on per capita personal income data from previous years. As Michigan's economy has slumped, personal income has dropped, and this results in fewer federal dollars to the state's Medicaid program.

However, at least 26 other states have found that by levying an assessment on HMOs that provide Medicaid services, they have been able to increase the federal matching dollars that they are eligible to receive. The increased federal funding has then been used to increase Medicaid reimbursement rates. Senate Bill 748 would put a similar plan in action in Michigan. According to information supplied by the Department of Management and Budget, a 1.87 percent assessment levied on HMO non-Medicare premiums would generate enough in federal matching dollars that, when added to the state's fiscal year 2002-2003 budget, Medicaid reimbursement rates to HMOs could be increased by five percent. Though not a huge amount, it will help offset the discount given by HMOs and their providers to the Medicaid program so as to keep sufficient plans and health professionals continuing to provide health services to Medicaid recipients.

Response:

Even at just a 1.87 percent level, wouldn't this result in such a high fee that some plans would drop out of serving Medicaid patients?

Rebuttal:

Out of the state's 19 HMOs that currently contract to provide Medicaid services, 17 are expected to fully recoup their costs associated with the assessment fee through the higher reimbursement rates. One of the plans that would be negatively impacted reportedly serves a small number of Medicaid patients and is considering available options. The other HMO that would be negatively impacted is a smaller HMO that is connected to the University of Michigan, but that serves a significant number of Medicaid recipients. According to committee testimony, discussions are underway between the Department of Community Health and the HMO to explore available options. Since the bill is scheduled to sunset at the end of the 2003 fiscal year, the bill should enable the state to get through a tough economic period with minimal negative impact on HMOs or their clients.

For:

Currently, HMOs are not statutorily authorized to include deductibles in their service contracts. As a result, many HMO members pay only a nominal co-pay for services such as doctor's visits. Though it would seem that this would make HMOs very attractive to consumers, recent statistics show a migration to health plans that include deductibles along with co-pays, and away from HMOs. The problem is price. A health plan with a yearly out-of-pocket deductible often carries a lower yearly premium than the average HMO plan. As premiums increase, individual consumers and small employers find it increasingly difficult to purchase insurance. As a result, some people are choosing to forego health coverage, and many small employers are forced to drop health insurance as a benefit for their employees.

Some industry members believe that if allowed to offered plans with varying ranges of deductibles, that

consumers and employers would have more options in finding a plan that is affordable and fitting to their needs. For small employers, deductibles provide a way to share the cost of health insurance with their employees. For some small employers, it may make the difference between whether any insurance is offered or not. The days of unlimited dollars for insurance appear to be over, and though having to pay deductibles and co-pays out-of-pocket is not the ideal, for many it is the difference between having some insurance and having no insurance. Even a small yearly deductible can cut the cost of yearly premiums by as much as five percent. The bill would not mandate the inclusion of deductibles, but would allow HMOs to offer consumers a greater range of health plans to choose from.

Against:

HMOs were built, in part, on a philosophy of encouraging well-care and preventative services as a way of containing medical costs through earlier detection and treatment of diseases and medical conditions. Allowing HMOs to include deductibles in their service contracts is in direct opposition to this foundation principle. The absence of deductibles encourages people to see their physicians early on in an illness and for screening services to detect diseases or conditions in their earliest and most curable states. However, a deductible could work as a barrier in that people could delay seeking treatment until a condition worsens. This in turn could result in increased emergency room visits and longer or more costly treatments – both of which would then increase costs to provide covered benefits. Even though the bill only permits, and not requires, the inclusion of deductibles, it could erode the philosophy and principle that have enabled HMOs lead the way in containing medical costs.

POSITIONS:

The Office of Financial and Insurance Services indicated support for the bills. (5-1-02)

The Michigan Association of Health Plans indicated support for the bills. (5-1-02)

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.