House
Legislative
Analysis
Section

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WORKERS' COMP REPORTS/HMO QUALITY ASSESSMENT FEE/HMO COPAYMENTS: REVISE

House Bill 6327 as enrolled
Public Act 621 of 2002
Sponsor: Rep. Clark Bisbee

House Committee: Insurance and Financial Services
Senate Committee: Financial Services
Second Analysis (1-22-03)

THE APPARENT PROBLEM:

Since 1984, the Insurance Code has required the commissioner of the Office of Financial and Insurance Services (OFIS), his or her predecessors, and the legislature to determine whether or not competition exists throughout the worker's compensation insurance market. If it is determined that competition does not exist, whether in the market as a whole, in a particular geographic area, or for certain kinds of insurance, then the commissioner is empowered to employ the means necessary to create competition. A similar determination exists for determining the availability of worker's compensation coverages and the state of competition in the commercial liability insurance market. Currently, the commissioner is required to hold a public hearing and then make a tentative report no later than January 15 and a final report no later than August 1 of each year detailing his or her findings. The requirements for a preliminary and a final report seem unnecessary and duplicative. In addition, the hearings generate little, if any, interest by the public. Instead, in the interest of efficiency and cost savings, the suggestion has been made to eliminate the hearing and just require the commissioner to make a determination as to whether or not competition exists in these insurance markets. Then, if competition was deemed not to exist, the commissioner could hold a public hearing and issue a single report; a supplemental report could then be issued later if the determination were disputed or if the information the report was based upon changed.

In addition, an insurer is considered as controlling the worker's compensation insurance market if it has more than 15 percent market share. Reportedly, this figure was decided upon in an arbitrary manner some years ago and so does not represent a statistically supported threshold. Some feel that the commissioner should be granted the authority to determine market share based on a number of economic factors. Therefore, it has been proposed that the percentage level for controlling the market be eliminated.

In an unrelated matter, adjustments need to be made to provisions placed in the Insurance Code by Public Act 304 of 2002, which established a Medicaid quality assurance assistance fee on HMOs that contract with the state to provide Medicaid services to low-income persons. The purpose of the fee was to increase Medicaid reimbursement rates to those HMOs. Revenue generated from the fee, when coupled with appropriations from the general fund, enables the state to qualify for more federal matching dollars than it would otherwise. The money generated from the additional federal match is then used to increase Medicaid reimbursement rates. (For more information, see the House Legislative Analysis Section's analysis of Senate Bill 748 dated 5-2-02.) At the time the bill was enacted, it was believed that the language in the bill was sufficient to meet all federal requirements. Since that time, the state budget office has been informed by federal officials that the new language is unsatisfactory and that the federal government could deny the state's plan to use these fees to acquire greater federal matching dollars. Amendments are necessary to ensure compliance with federal regulations.

Further, current law prohibits HMOs from requiring a copayment higher than 50 percent of an HMO's reimbursement to an affiliated provider for providing a service. HMOs believe that this restriction has limited their ability to compete. Legislation addressing these concerns has been offered.

THE CONTENT OF THE BILL:

The bill would amend the Insurance Code to change the reporting procedure regarding competition in the workers' compensation and commercial liability insurance markets, make changes to allowable copayments for HMOs, and make changes to the Medicaid quality assurance assessment fee for HMOs.

Competition in the workers' compensation and commercial liability insurance markets. The following changes would be made in the procedures utilized for determining the level of competition in the worker's compensation insurance market and the commercial liability insurance market:

- By May 15, 2003 and by each May 15 after that, the commissioner would have to make a determination as to whether a reasonable degree of competition in the worker's compensation insurance market and the commercial liability insurance market existed on a statewide basis. (According to OFIS staff, the determination would be accessible by the public.)

- If the commissioner determined that a reasonable degree of competition in the workers' compensation or the commercial liability insurance market did not exist on a statewide basis, he or she would have to hold a hearing and issue a report delineating specific classifications and kinds or types of insurance, if any, where competition did not exist. The report would have to be based on criteria currently specified in the code, but the report would no longer have to include a certification of whether or not competition existed.

- If the results of either report were disputed or if the commissioner determined that circumstances that either report were based on had changed, he or she would have to issue a supplemental report or reports not later than November 15 immediately following the release of the initial one. The supplemental report would have to include a certification of whether or not a reasonable degree of competition existed in the applicable market.

- Currently, if an insurer has more than a 15 percent market share, the insurer is considered to control the worker's compensation insurance market or the commercial liability insurance market. The bill would eliminate these thresholds.

HMO copayments. Currently, the Insurance Code allows an HMO to have copayments only if the copayments are nominal (no more than 50 percent of the reimbursement to the provider for providing the service). Instead, the requirement that copayments be nominal would apply only to copayments for basic health services (as defined by the code in Section 3501).

HMO verification for health professionals. The bill would make several changes considered to be technical in nature with regard to information on health professionals seeking affiliation with an HMO. Currently, an HMO must obtain primary verification (evidence obtained from the issuing source of the credential) of the person's current license status to practice in the state and past license history; current level of professional liability coverage; status of hospital privileges; specialty board certification status; current drug enforcement agency registration certificate; graduation from medical or other appropriate school; and completion of postgraduate training. Under the bill, the last four criteria would be moved from this provision to a provision requiring an HMO to obtain specified criteria by either primary or secondary verification (evidence obtained by means other than direct contact with the issuing source of the credential). Further, an HMO would no longer have to obtain every three years primary verification of a participating health professional's current DEA registration certification or specialty board certification.

HMO Medicaid quality assurance assessment fee. Public Act 304 of 2002 amended the code to require the Department of Community Health (DCH) to assess on each HMO that has a Medicaid managed care contract with the state a quality assurance assessment fee that equals a percentage established by the DCH that, when applied to each HMO's non-Medicare premiums paid to the HMO, totals an amount that would equal a five percent increase for the Medicaid managed care programs net of the value of the quality assurance assessment fee. The bill would delete this provision and instead specify that the DCH would assess, on each HMO with a contract to deliver Medicaid services in the state, an assessment fee that would equal six percent of the non-Medicare premiums collected by that HMO.

The bill would also make the following changes to provisions pertaining to the HMO Medicaid quality assurance assessment fee:

• A provision requiring the entire quality assurance assessment fee and all federal matching funds attributed to that fee be used to maintain the Medicaid reimbursement rate increase would be deleted.

• Instead of basing the quality assurance assessment fee on the non-Medicare premiums collected by each HMO in the year 2001, the fee would be based on an HMO's most recent statement filed with the commissioner under Sections 438 and 438a of the code. If an HMO did not have non-Medicare premium revenue listed in a filing in that year, the assessment fee would be based on an estimate by the DCH of the HMO's non-Medicare premiums for the quarter and be payable upon receipt.

• The sunset provision for the Medicaid quality assurance assessment fee would be extended from October 1, 2003 to October 1, 2007.

MCL 500.224b et al.

BACKGROUND INFORMATION:

In addition to the Medicaid quality assurance assessment fee assessed on HMOs, similar assessment fees are assessed on nursing homes, hospital long-term care units, and hospitals. Public Act 303 of 2002 (enrolled House Bill 4057) created the Medicaid quality assurance assessment fee for nongovernmentally-owned nursing homes and hospital long-term care units. This assessment fee, which – along with any matching federal funds - must be used to maintain increased per diem Medicaid reimbursement rate increases, is scheduled to sunset October 1, 2007.

House Bill 5103 of 2002 would have established a hospital quality assurance assessment fee, but that bill was vetoed by the governor. Similar provisions creating a quality assurance assessment fee for hospitals were later added to Senate Bill 1323, which became Public Act 562 of 2002. PA 562 allows part of the assessment fee to be used to maintain increased Medicaid reimbursement rate increases and allows a portion of the funds collected to be used to offset any reduction to existing intergovernmental transfer programs with public hospitals that may result from implementation of the enhanced Medicaid payments financed by the assessment fee. The hospital Medicaid quality assurance assessment fee will sunset September 30, 2004 or in any year in which the assessment fee is not eligible for federal matching funds. For fiscal year 2002-2003 only, the act specifies that $18.9 million of the quality assurance assessment fee be deposited in the general fund.

FISCAL IMPLICATIONS:

According to the House Fiscal Agency, the bill would reduce the costs imposed on OFIS in preparing a second, final report on competition in the worker's compensation insurance market. However, these savings are likely to be negligible. These costs are generally met from revenue generated by assessments on the insurance industry.

The bill would also allow the state to retain a portion of the estimated $88 million assessment revenue collected under the quality assurance assessment fee levied on health maintenance organizations (HMOs). Retaining a portion of this revenue could be used to reduce general fund costs for the Medicaid program. (1-13-03)

ARGUMENTS:

For:

According to an analysis on the bill by the Office of Financial and Insurance Services (OFIS), the requirement for a preliminary and a final report regarding competition in the worker's compensation and commercial liability insurance markets was based on a mistaken view that data would be available on a timely basis and that it could change from the time of the preliminary report to the time of the final report. This has not proven to be the case, especially for the commercial liability report. The data needed for this report first goes to the National Association of Insurance Commissioners (NAIC) for encoding before being disseminated to the states. According to OFIS, due to the arrival times of this data, the preliminary and final report have no new data to report on except for profitability data. Reportedly, access to this information has been delayed in recent years, thus delaying the release of the commissioner's reports. The bill offers a more practical approach by requiring only one report for each market, and then only if a determination were made by the commissioner that competition did not exist. A second, or supplemental, report would be required only if something in the report were disputed or if facts and circumstances that the report were based on changed. Though the bill would eliminate a mandatory annual hearing, under current law, any interested party can request a hearing on the matter. Reportedly, the annual hearings had few if any attendees and the markets have shown sufficient competition for many years. Therefore, the bill will

increase the efficiency of the agency by eliminating what is seen as an unnecessary duty.

For:

According to OFIS, there is no accurate measure of premiums for workers' compensation insurance for self-insurers, and therefore no available market share data. Because of this, OFIS maintains that it is difficult, if not impossible, to determine if one insurer exceeds the current 15 percent limit of the total market share for workers' compensation insurance. Furthermore, it would appear that the 15 percent amount for both workers' compensation and commercial liability insurance was arbitrarily chosen. A better approach would be, as the bill proposes, to eliminate the percent limit and allow the commissioner to determine the level of competition based on more relevant indicators. The elimination of these thresholds will also allow the commissioner greater flexibility in adapting methods of making a determination to fit the ever changing nature of insurance markets in a global economy.

For:

The amendments to the provisions pertaining to the Medicaid quality assurance assessment fee for HMOs are largely technical in nature. Apparently, though at least 26 other states have created some type of provider tax to generate more federal matching dollars to use to increase Medicaid reimbursement rates, Michigan is the first state to assess such a fee on HMOs. Therefore, in order to secure federal approval for the state's plan, it is necessary to make some changes. Further, in light of the continuing budget difficulties, it has been necessary to extend the time period that the fee can be collected and to allow greater flexibility in how revenue generated under the bill can be used. As a result, a provision that restricted the use of the revenue generated by the fee and the matching federal dollars would be deleted under the bill. According to a representative for the HMOs, even with the change to assessing an HMO six percent of its non-Medicare premiums, the bill will still be beneficial. Without something of an increase in Medicaid reimbursement rates, HMOs would have found it increasingly difficult to continue contracting with the state to provide these services.

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. Until the recent enactment of Public Act 304 of 2002, HMOs were not allowed to charge a deductible. Some saw deductibles as an erosion of the philosophy and principle on which HMOs were founded, as deductibles could dissuade some from seeking early treatment of a medical condition. Now, the foundation is being eroded even further.

Under the bill, the requirement that copayments must be only nominal will be removed for all but those services considered to be basic services (for example, office visits and lab tests). One result is that significant copayments could be required for prescription drugs and those services that are not included in the definition of "basic services"; an HMO could even establish a cap on the amount it would pay out annually for prescription drugs. As many prescription drugs could be considered as fitting into the category of preventive treatment (e.g., the risk for strokes, heart attacks, blindness, and kidney disease are greater in those with high blood pressure, which can be treated with medication), anything which would impede access to medications must be seen as a further departure from the foundation principles of HMOs.

Further, as the premiums and services offered by HMOs become more similar to commercial insurers, a disproportionate share of sicker individuals could shift their enrollment to Michigan's Blue Cross and Blue Shield plan since it is the state's insurer of last resort. Such a shift to BCBSM at a time when that carrier is already struggling with staggering deficits could put too much of a strain on it. According to an OFIS bill analysis, removing the restriction on copay amounts for some services "could have far-reaching, negative effects on health care in Michigan at a time when affordable health care is reaching a critical stage and government sponsored health services are being reduced as a result of budget cuts."

Response:

On the contrary, the removal of the restriction on copayments for non-basic services will enable HMOs to continue to offer affordable health plans. Some have read the bill's provision to mean that an HMO could now cap the amount it would pay annually for some services or charge a copay in excess of 50 percent. However, this reveals a misunderstanding of the nature of a contract between an HMO and a plan purchaser (e.g., employer). A plan purchaser typically decides what he or she can afford to spend on health insurance for his or her employees. The purchaser then looks at different products offered by different types of insurers before deciding on a particular type of plan or insurer. The specific benefits in a health plan are decided by the purchaser who then contracts with an insurer to provide those benefits. Reportedly, some purchasers send out RFPs

(request for proposals) that specify that they want a plan that has the employees sharing a greater portion of the cost of certain services such as prescription drugs. Unless HMOs are able to offer such a plan, they are automatically excluded from consideration.

According to a representative for the HMOs, many initiatives are driven by purchasers. For example, some employers may want to provide some level of pharmacy benefits, but may not be able to afford a plan that requires only a $10 or $20 per prescription copay. The result is that many choose a benefit plan without prescription drug coverage. The bill would allow, not require, an HMO to offer a benefit plan with higher copays for medications. Though a purchaser's employees would have higher out-of-pocket expenses than a plan with, say, a $10 copay, the employees would still save money overall if the alternative was for the employer to purchase a benefit plan with no prescription drug coverage. In these days of escalating medical costs, particularly for prescription drugs, more and more employers – especially small business owners - are finding it necessary to ask their employees to take on a greater share of the cost of insurance benefits. For those companies able to provide a more generous health benefit package, plans with lower prescription drug copays will still be available. Further, a benefit plan that requires high copays or that caps desired benefits at a low level, coupled with the cost to purchase such a plan, is unlikely to attract many purchasers. Fears that the bill will lead to HMOs offering only high-priced plans with few real benefits should be offset by the realization that employers are not going to spend a lot of money for something that provides little benefit to their employees. However, HMOs need to be able – like other types of insurers - to offer a competitively priced plan that fits the budget of some employers.

On a more technical level, removing the "nominal" copayment restriction for non-basic services recognizes that some health service products are harder to price than others; therefore, determining what constitutes a "nominal" copayment can also be difficult for both HMOs and insurance regulators. Under the bill, HMOs could work with purchasers to develop health plans that meet certain needs.

It is true that HMOs were built on the principle of encouraging good health by early prevention and treatment. The bill does not depart from the philosophy; it would leave intact the restriction that copays for basic services be "nominal." This protects those core services so necessary to enable easy access for annual check-ups, early detection and treatment of diseases, preventative care, and emergency care. At the same time, it is unrealistic to expect HMOs to be identical to what they were in the early 1980s. A changing economic climate, changing demographics, escalating medical services costs, and so on necessitate some changes so that HMOs can continue to exist and continue to offer health plans that focus on core issues such as wellness and prevention.

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■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.