# Legislative Analysis

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**HMO CONTRACT: OUT-OF-POCKET EXPENSES**

**Senate Bill 88 as passed by the Senate**
**Sponsor: Sen. Bill Hardiman**
**House Committee: Health Policy**
**Senate Committee: Health Policy**

**First Analysis (12-5-05)**

***BRIEF SUMMARY:*** The bill would remove the restriction on HMOs to keep copayments "nominal," allow contracts to include coinsurance, allow HMOs to offer healthy lifestyle program incentives, and require the OFIS commissioner to issue an annual report on the impact of the changes on the number of employers offering HMO plans to employees and the number of employees enrolling in HMO plans.

***FISCAL IMPACT:*** This bill will have no fiscal impact on the State of Michigan government, including its Medicaid program, nor on local units of government.

***THE APPARENT PROBLEM:***

Nationally, enrollment in managed care plans offered by employers has increased dramatically over the past 17 years, from 27 percent of workers covered by employer plans in 1988 to 95 percent in 2004. Yet, enrollment in employer-sponsored HMO plans has been decreasing in recent years – from a high of 31 percent in 1996 to just 25 percent in 2004. (Kaiser Family Foundation, "Trends and Indicators in the Changing Health Care Marketplace, Section 2: Trends in Health Insurance Enrollment", Health Care Marketplace Project, Pub. No. 7031, found at www.kff.org.)

There may be multiple factors influencing an employer's or employee's choice of health coverage, but some feel that, in Michigan, a significant factor is the inability of HMOs to offer competitively priced benefit plans to employers. Under provisions of the Insurance Code, any copayments (fixed dollar amounts per service) or coinsurance (percentage of the cost of the service) required under an HMO benefit plan must be "nominal" and are capped at no more than 50 percent of the plan's reimbursement rate to the provider for that service. As a result, an HMO, unlike other types of managed care plans, cannot structure a plan for an employer that would shift more of the cost of the plan to the employee, which in turn would lower the cost of the premium to the employer. Since many employers cite the high cost of premiums as a major factor in determining whether or not to offer their workers health insurance benefits, some in the health insurance industry feel that the Insurance Code should be amended to give HMOs the same flexibility in structuring benefit plans that other types of insurers enjoy.

***THE CONTENT OF THE BILL:***

The bill would amend the Insurance Code to allow a health maintenance organization (HMO) contract to include coinsurance and to offer healthy lifestyle programs. It would remove the restriction requiring copayments to be "nominal" and would also require the commissioner of the Office of Financial Services (OFIS) to determine annually the bill's impact on the number of employers providing HMO services to their employees and the number of employees receiving those services.

Out-of-pocket expenses. Currently, an HMO may offer contracts with deductibles and copayments. A copayment for basic health services required under Section 3501(b) of the code must be nominal and cannot exceed 50 percent of the HMO's reimbursement to an affiliated provider, nor can it be based on the provider's standard charge for the service.

Instead, the bill would allow HMO contracts to include deductibles, copayments stated as dollar amounts for the cost of covered services, and coinsurance stated as percentages for the cost of covered services. The requirement that copayments for basic health services be nominal would be deleted. The existing language regarding a copayment not exceeding 50 percent of the HMO's reimbursement rate would apply to coinsurance instead.

The authority of the commissioner of OFIS to regulate and establish fair, sound, and reasonable copayment and coinsurance limits, including out of pocket maximums, would not be limited by the new provisions.

Commissioner's report. By May 15, 2008, and each May 15 thereafter, the commissioner would have to make a determination whether the greater copayment and coinsurance amounts allowed under the bill increased the number of employers who contracted for HMO services and whether those levels increased the number of enrollees receiving HMO services. The bill would specify the types of information and data to be considered in making the determination and would allow changes to be made in the report if the findings were disputed or if the circumstances changed on which the report had been based. A public hearing to seek advice and input from independent sources would have to be held by February 1, 2008 and additional public hearings could be held after that time. The reports and certifications required under the bill would have to be forwarded to the Governor, the Clerk of the House of Representatives, the Secretary of the Senate, and all members of the Senate and House standing committees on insurance and health issues.

Healthy lifestyle programs. An HMO could offer to all currently enrolled or covered subscribers one or more health lifestyle programs – a program recognized by an HMO to enhance health or reduce risk of disease. Such programs could include promoting nutrition and physical exercise and compliance with disease management programs and preventive service guidelines supported by evidence-based medical practice.

The code currently prohibits an HMO contract from providing cash payments or other material benefits to an enrollee. Under the bill, goods, vouchers, or equipment that supported achieving optimal health goals would not be considered valuable consideration, a material benefit, a gift, a rebate, or an inducement and so would not be prohibited.

A provision allowing the commissioner to approve rate differentials based on certain criteria (i.e., based on sex, age, or residence) would not apply to a healthy lifestyle program. An HMO would not be required to continue a healthy lifestyle program or to continue any incentive associated with a program.

State and federal health programs. Currently, the code allows HMOs to participate in state and federal health programs (i.e., Medicaid or Medicare). Under the bill, unless it was in receivership or under supervision, an HMO that participates in a state or federal health program would have to meet the insurance code's solvency and financial requirements but would not be required to offer benefits or services exceeding the requirements of the governmental health program. Furthermore, the bill would exempt state or federal employee health programs from this provision.

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***ARGUMENTS:***

***For:***

As the cost of providing health insurance to workers continues to skyrocket, many employers are opting out of providing health insurance coverage at all. According to a survey conducted by the Kaiser Family Foundation and the Health Research and Educational Trust, 5 million fewer jobs provided health insurance to workers in 2004 than in 2001. Hardest hit are workers in small companies (3-199 workers), with the smallest firms (3-9) being the most likely not to offer health insurance. By comparison, 99 percent of large firms (200 or more workers) offered health insurance in 2004, but only 63 percent of small firms did so. Moreover, when health insurance is offered, a large firm is more likely than smaller firms to offer employees a choice of health plans (88 percent of jumbo firms, 76 percent of large firms, and 14 percent of small firms offered workers a choice of health plans in 2004).

The single most cited factor affecting an employer's decision to offer health insurance and to offer a choice in plans is price. According to the president of the Kaiser Family Foundation, "Health insurance is becoming unaffordable, especially for small employers. We should expect the ranks of uninsured to grow as small employers can't afford health insurance." ("Health Care Premiums Jump 11.2 percent", *Detroit Free Press*, Sep. 9, 2004.)

Increasingly, employers are looking to shift some of the cost of health insurance to their workers in an attempt to lower their premium costs. One way to do this is to offer employees a plan with higher out-of-pocket expenses. For smaller firms, a plan with

higher out-of-pocket expenses for workers may be the only option between providing some insurance coverage and no insurance coverage.

However, Michigan law currently disadvantages HMOs. By law, the out-of-pocket copayments and coinsurance for covered services must remain "nominal." The result is that though HMO plans are generally less expensive than other types of managed care plans, they still cannot compete with plans that offer employers lower premium plans with a higher worker out-of-pocket share.

Senate Bill 88 would remove the restriction that copayments and coinsurance rates be nominal, but would still cap coinsurance charges at no more than half of the plan's reimbursement rate for the service rendered. In addition, the commissioner of the Office of Financial Services (OFIS) would still retain authority to regulate and establish fair, sound, and reasonable copayment and coinsurance limits for HMO plans. Therefore, the primary change in the bill would be merely to allow HMOs to compete on a level playing field with other managed care plans regarding creating plans with lower premium costs to employers.

The bill would also require OFIS to collect data and report to the governor and lawmakers regarding the impact of the bill on HMO enrollment. The report should reveal if the legislation is enabling more employers to offer health insurance coverage through HMOs and the impact on a workers' ability or inclination to enroll in HMO plans.

***Response:***

As currently written, the study called for in the bill would only reveal if the HMO market share of employer-sponsored plans has increased as a result of the legislation, not if the legislation is having a positive or negative impact on the number of employers offering health insurance coverage to workers or the number of covered workers. Whether a large or small firm opts for an inexpensive HMO plan, the out-of-pocket costs charged to employees could make signing up for it impossible for those whose wages are at or near minimum wage. After all, annual increases in premium costs are outpacing both inflation and wages. The result could be that more workers are priced out of health care coverage altogether. And, if people delay medical treatment because they can't afford office visits to the doctor or prescription drugs, health care costs would increase even more due to emergency room visits, more and longer hospitalizations, more surgeries, and worse outcomes.

In addition, the Kaiser Family Foundation survey reported that only 1 percent of employers were planning to drop health insurance coverage altogether in the near future. Therefore, the bill is more likely to increase the HMOs' market share of employer contracts by shifting employer choice from a low premium PPO plan to an even lower HMO plan (which could have higher employee costs) than to increase the number of employer-sponsored plans in the state or increase the overall number of insured workers.

***Against:***

A recent Kaiser Foundation survey on employer health benefits finds that even though the premiums for HMOs are generally below those charged by PPOs, employers are

moving away from offering HMO plans to their employees. According to the "2005 Summary of the Findings," enrollment in employer-sponsored HMO plans "fell to 21 percent of covered workers from 25 percent in 2004," where enrollment increased in PPO plans from 55 percent in 2004 to 61 percent this year. It would seem, therefore, that the price of plans alone may not be as much of a determining factor as supporters of the bill would like the public to believe; perhaps employers are looking at benefits available in PPO plans but not in HMO plans, such as having a greater choice in choosing doctors from network and non-network providers and, for employees who like to travel, the ease in receiving out-of-area care.

***Response:***

Though the cost of an HMO plan may be less than that of a PPO, under Michigan law, more of the cost of a PPO plan can be shifted to the employee than that of an HMO. Therefore, the bill is needed so that HMOs can design plans that will lower the actual cost to the employer and enable HMOs to compete more fairly with PPOs and other types of employer-sponsored insurance plans.

***For:***

The bill would encourage HMOs to offer healthy lifestyle programs as an incentive to enrollees to engage in lifestyle changes known to improve health, such as smoking cessation classes. It would clarify that rebates, vouchers, discounts, etc. offered by these programs would be exempt from the Insurance Code's prohibition on offering bribes. Also, the design of a healthy lifestyle program would not have to be based on actuarial principles or the same kind of statistical analysis required for OFIS-approved rate differentials.

***Against:***

The bill really is not needed. HMOs already offer plans with premiums cheaper than the average PPO plan, and yet employers are choosing PPO products over HMOs. The market is sending a message as to the type of plans it wants. Also, if the bill is targeting small firms with the promise of giving employers cheaper plans (for the employer, more expensive for the employee), only 15 percent of firms reported in the Kaiser Family Foundation survey that they plan on increasing the employee share of costs in the near future and only 1 percent planned to drop health insurance coverage altogether. Therefore, there may be little market for the types of plans allowed under the bill.

Also, the bill encourages a potentially dangerous trend – for employers to continue to shift more and more of the cost of health insurance to workers. Employee spending for health insurance coverage increased 126 percent between 2000 and 2004, and employees' share of costs increased 63 percent for single coverage and 58 percent for family coverage during the same time period. Yet, employee wages, especially in small firms or in the service industry, have remained fairly stagnant. Add to that the fact that 50 percent of all bankruptcy filings in recent years were partly the result of medical expenses, and that 50 percent of workers in the lowest-compensation jobs and mid-range compensation jobs either had problems with medical bills in a 12 month period or were paying off accrued debt from medical bills, and it is easy to see that the trend in shifting premium

costs to workers via higher copayments and coinsurance rates and deductibles is not the answer to the health care insurance crisis.

***POSITIONS:***

The Michigan Association of Health Plans supports the bill. (11-29-05)

A representative of Spectrum Health indicated support for the bill. (11-29-05)

A representative of Priority Health indicated support for the bill. (11-29-05)

A representative of the Grand Rapids Chamber of Commerce indicated support for the bill. (11-29-05)

A representative of the National Federation of Independent Business indicated support for the bill. (11-29-05)

The Office of Financial and Insurance Service (OFIS) is neutral on the bill. (10-26-05)

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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.