Legislative Analysis

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HMO CONTRACT: OUT-OF-POCKET COSTS

Senate Bill 88
Sponsor: Sen. Bill Hardiman
House Committee: Health Policy
Senate Committee: Health Policy

Complete to 11-28-05

A SUMMARY OF SENATE BILL 88 AS PASSED BY THE SENATE 11-3-05

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, but not be limited to, 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.

MCL 500.3515 et al

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.

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