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BILL ANALYSIS

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Senate Bill 88 (as enrolled) **PUBLIC ACT 306 of 2005**
Sponsor: Senator Bill Hardiman
Committee: Health Policy

Date Completed: 1-12-06

RATIONALE

Health care costs are of increasing concern to employers who wish to offer health care benefits to their employees. Often, employers pass on some of the costs to workers by increasing co-pays and deductibles, or require workers to pay for their benefits by freezing wages. In some cases, employers, particularly small businesses, feel they must drop health care coverage for their employees altogether.

One option employers (and individuals) have is to obtain coverage through health maintenance organizations (HMOs). Under State law, HMOs are required to provide "basic health services", which include physician services, ambulatory services, inpatient hospital services, emergency health services, outpatient mental health services, substance abuse care, laboratory and radiological services, home health services, and preventive health services. Previously, the Insurance Code required that copayments for these services be nominal. It was suggested that eliminating this requirement could give HMOs more flexibility in the plans they offer and result in lower premiums, which might mitigate the financial pressure on employers who are considering eliminating health care coverage for their workers. Additionally, it was suggested that encouraging enrollees to take preventive health measures through healthy lifestyle programs could lower health care costs.

CONTENT

The bill amended the Insurance Code to do the following:

-- Delete a requirement that copayments for basic health services provided under a HMO contract be nominal.
-- Allow HMO contracts to include copayments and coinsurance stated as dollar amounts and percentages, respectively, of covered services; and make coinsurance subject to limits that had applied to copayments.
-- Require the Commissioner of the Office of Financial and Insurance Services (OFIS), beginning in 2008, to make an annual determination as to whether the greater copayment and coinsurance levels allowed by the bill have increased the number of employers who have contracted for HMO services and the number of HMO enrollees.
-- Require the OFIS Commissioner to hold a public hearing by February 1, 2008, and issue a report delineating specific examples of copayment and coinsurance levels in force, and suggestions to increase the number of HMO enrollees; and require the Commissioner to issue a supplemental report if the results are disputed or circumstances have changed.
-- Specify that a prohibition against a contract's providing for payment of cash or other material benefit to an enrollee does not prohibit an HMO from promoting optimum health by offering healthy lifestyle programs to enrollees.
-- Provide that a healthy lifestyle program is not subject to the OFIS Commissioner's approval for a rate differential.

-- **Require an HMO that participates in a State or Federal health program, excluding a State or Federal employee health program, to meet the Code's solvency and financial requirements, unless it is in receivership or under supervision.**

The bill took effect on December 21, 2005. It is described below in further detail.

Copayments & Coinsurance

Previously, an HMO could have contracts that required copayments for specific health maintenance services. Copayments for services required under Section 3501(b) (that is, basic health services), excluding deductibles, had to be nominal, could not exceed 50% of an HMO's reimbursement to an affiliated provider, and could not be based on the provider's standard charge for the service.

The bill deleted these provisions. Instead, an HMO may have contracts that include copayments stated as dollar amounts, and coinsurance stated as percentages, for the cost of covered services. Coinsurance for basic health services, excluding deductibles, may not exceed 50% of an HMO's reimbursement to an affiliated provider, and may not be based on the provider's standard charge for the service. The bill specifies that this provision does not limit the OFIS Commissioner's authority to regulate and establish fair, sound, and reasonable copayment and coinsurance limits, including out-of-pocket maximums.

(Section 3501(b) defines "basic health services" as physician services, including consultant and referral services by a physician, but not including psychiatric services; ambulatory services; inpatient hospital services, other than those for the treatment of mental illness; emergency health services; at least 20 visits per year for outpatient mental health services; diagnostic laboratory and diagnostic and therapeutic radiological services; home health services; and preventive health services. The term also includes intermediate and outpatient care for substance abuse, as provided in the Code.)

Annual Determination & Reports

Under the bill, beginning in 2008, by May 15, the OFIS Commissioner must make an annual determination as to whether the greater copayment and coinsurance levels allowed by the bill have increased the number of employers who have contracted for HMO services, as well as the number of HMO enrollees. In making this determination, the Commissioner must hold a public hearing by February 1, 2008, and may hold a subsequent public hearing. The Commissioner must seek the advice and input from appropriate independent sources, including all HMOs operating in this State and with enrollees in Michigan, and must issue a report delineating specific examples of copayment and coinsurance levels in force, and suggestions to increase the number of people enrolled in HMOs.

If the results of the report are disputed, or if the Commissioner determines that the circumstances upon which the report was based have changed, he or she must issue a supplemental report that includes copies of the written objections disputing the determinations or that specifies the change of circumstances. The supplemental report must be issued by December 15 immediately following the release of the initial report and must be supported by substantial evidence.

For the purpose of issuing the reports, the OFIS Commissioner must consider all of the following:

-- Information and data gathered from HMOs regarding the effects of the greater copayment and coinsurance levels allowed by the bill.
-- Information and data provided by employers who employ Michigan residents.
-- Any other information and data the Commissioner considers relevant.

The required reports and certifications must 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

The Code prohibits a health maintenance contract from providing for payment of cash or other material benefit to an enrollee, except as otherwise allowed. The bill specifies that this does not prohibit an HMO from promoting optimum health by offering healthy lifestyle programs to enrollees. It also does not prohibit an HMO from offering enrollees goods, vouchers, or equipment that supports achieving optimal health goals. The bill specifies that the offering of goods, vouchers, or equipment does not violate the prohibition against payment to an enrollee and may not be considered valuable consideration, a material benefit, a gift, a rebate, or an inducement under the Code.

The bill defines "healthy lifestyle program" as a program recognized by an HMO that enhances health or reduces risk of disease, including promoting nutrition and physical exercise and compliance with disease management programs and preventive service guidelines that are supported by evidence-based medical practice.

The Code allows the OFIS Commissioner to approve a rate differential based on sex, age, residence, disability, marital status, or lawful occupation, if it is supported by sound actuarial principals and a reasonable classification system, and is related to the actual and credible loss statistics or reasonably anticipated experience for new coverage. The bill specifies that a healthy lifestyle program is not subject to the Commissioner's approval under this provision and does not have to be supported by sound actuarial principals or a reasonable classification system, or be related to actual and credible loss statistics or reasonably anticipated experience for new coverage.

The bill specifies that an HMO does not have to continue a healthy lifestyle program or any incentive associated with a program, including goods, vouchers, or equipment.

State & Federal Program Participation

Under the bill, an HMO that participates in a State or Federal health program must meet the Code's solvency and financial requirements, unless the HMO is in receivership or under supervision, but is not required to offer benefits or services that exceed the requirements of the State or Federal program. This provision does not apply to State employee or Federal employee health programs.

MCL 500.3515 et al.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

In a May 2004 survey of southeastern Michigan business leaders by John Bailey and Associates, 75% of the respondents said the cost of health insurance was causing them to consider cutting health benefits for their employees. When this occurs, employees who cannot afford to purchase insurance on their own must either go without coverage, or turn to the Medicaid system. Eliminating the requirement that copayments be nominal will enable HMOs to offer plans with lower premiums, which should encourage employers to continue offering coverage to their workers. In turn, more people will have health care coverage and fewer will seek expensive care in an emergency room on a crisis-by-crisis basis, which drives up costs throughout the health care system. The bill will give employers who feel overburdened by the cost of a comprehensive health plan an alternative to dropping coverage for their employees altogether. Additionally, the bill is permissive, meaning that employers who wish to purchase HMO plans with low or no copayments or coinsurance may do so. Individual purchasers of HMO plans also may find products with higher deductibles and copayments to be more affordable, and choose this type of coverage over the risk of carrying no coverage at all. The bill provides consumer protection by authorizing the OFIS Commissioner to regulate copayment and coinsurance limits, including out-of-pocket maximums.

The state of health care in Michigan places a tremendous burden on the economy. Health care costs are one of the main factors businesses consider in deciding where to locate. These costs sometimes prompt businesses to cut back on hiring and interfere with their ability to make necessary investments. By giving HMOs the flexibility to offer health benefits packages with co-pays that fit employers' budgetary

constraints, the bill will create a more competitive health care environment and help promote business and job growth.

Response: Although the bill might increase the number of insured people, some employers might pass on a larger share of health care costs to their workers, resulting in higher out-of-pocket costs for some HMO enrollees. This might discourage some people from seeking basic health services, necessitating more expensive treatment in the future if their conditions worsen.

Supporting Argument

Chronic disease drives most health care costs. Traditionally, HMOs have focused on disease prevention and management, and worked with at-risk patients to mitigate exacerbating factors such as obesity and smoking habits. The bill's focus on preventive measures through healthy lifestyles programs will help HMOs educate more people about disease prevention and management, and create awareness of the effects of personal choices, such as diet, physical activity, and treatment alternatives, on monetary and physical costs. The bill might encourage some people to adopt healthy lifestyles, rather than living irresponsibly, becoming ill, and relying on an expensive health care plan.

Legislative Analyst: Julie Koval

FISCAL IMPACT

This bill will have no fiscal impact on the State's Medicaid program and an indeterminate fiscal impact on expenditures for State employees' health insurance coverage. The determination, public hearings, report, and possible supplemental report regarding HMO contracts and enrollees will lead to a marginal increase in administrative costs for OFIS.

Medicaid Program

In order to receive Federal matching funds for the Medicaid program, states are required under Federal law to provide certain basic services to Medicaid beneficiaries. These services include inpatient and outpatient hospital services, physician services, emergency services, preventive services, laboratory and radiological services, and home health services, to name a few. While this bill allows HMOs to offer contracts that contain a more restricted package of benefits than was required under previous law, the bill will have no impact on the scope of services that must be provided to Medicaid beneficiaries who receive services through HMOs.

State Employees' Health Insurance Coverage

Because this bill lowers the "floor" for the scope of services that must be provided by HMO contracts, there is a potential that the State will experience a reduction in expenditures for health insurance coverage if a less costly, reduced-benefit HMO contract is provided to State employees. However, such a reduction in health benefits, and the concomitant reduction in expenditures, will be subject to the collective bargaining process.

Fiscal Analyst: Steve Angelotti

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.