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BILL ANALYSIS

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Senate Bill 88 (as introduced 1-26-05)
Sponsor: Senator Bill Hardiman
Committee: Health Policy

Date Completed: 10-25-05

CONTENT

The bill would amend the Insurance Code to do the following:

-- Delete a requirement that copayments for basic health services provided under a health maintenance organization (HMO) contract be nominal.
-- Limit an HMO enrollee's out-of-pocket costs to $5,000 per year for an individual and $10,000 per year for a family; and allow those amounts to be adjusted by the Commissioner of the Office of Financial and Insurance Services (OFIS) upon petition by an HMO.
-- Limit the out-of-pocket costs for services provided by a nonaffiliated provider under a prudent purchaser contract to two times the out-of-pocket costs for those services provided by an affiliated provider.
-- Require an HMO that participated in a State or Federal health program, excluding a State or Federal employee health program, to meet the Code's solvency and financial requirements.

Under the Code, an HMO may have contracts that require copayments for specific health maintenance services. Copayments for services required under Section 3501(b), excluding deductibles, must be nominal, 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.

(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.)

The bill would delete these provisions. Instead, an HMO could have contracts that required copayments for specific health maintenance services. The copayments would have to be stated as dollar amounts for the cost of covered services, and coinsurance would have to be stated as percentages for the cost of covered services. Coinsurance for basic health services and copayments for inpatient hospital and facility-based outpatient surgical services, excluding deductibles, could not exceed 50% of the HMO's reimbursement to an affiliated provider and could not be based on the provider's standard charge for the service.

Under the bill, an enrollee's aggregate out-of-pocket costs for coinsurance for basic health services and an enrollee's aggregate out-of-pocket costs for copayments for inpatient

hospital services and facility-based outpatient surgical services could not exceed $5,000 per year for an individual and $10,000 per year for a family. The maximum coinsurance and the copyament out-of-pocket costs would have to be adjusted annually to the greater of the following:

-- By March 31 of each year in accordance with the annual average percentage change in the consumer price index for all urban consumers in the United States city average for medical care for the 12-month period ending the preceding December 31, as reported by the U.S. Department of Labor, Bureau of Labor Statistics, and as certified by the OFIS Commissioner.
-- The maximum annual out-of-pocket expenses for a high-deductible health plan under Section 223 of the Internal Revenue Code, as certified by the OFIS Commissioner.

(Under Section 223 of the Internal Revenue Code, "high-deductible health plan" means a health plan that has an annual deductible of at least $1,000 for self-only coverage or at least $2,000 for family coverage, and, for 2005, a cap on the sum of the annual deductible and other annual out-of-pocket expenses (excluding premiums) for covered benefits of $5,100 for self-only coverage and $10,200 for a family.)

Upon petition by an HMO to the OFIS Commissioner, the maximum coinsurance and copayment costs would have to be adjusted to an amount warranted by current market conditions. Within 90 days after the date of the petition, the Commissioner would have to make the adjustment or reject the adjustment as not being warranted by current market conditions. ("Current market conditions" would include higher coinsurances and copayments being used in the same or similar products marketed by other health insurers. "Health insurer" would mean an HMO, nonprofit health care corporation, or commercial insurer regulated by the State's insurance laws and providing any form of health insurance or coverage.)

The bill would allow an HMO to have health maintenance contracts under Section 3353 with separate out-of-pocket costs for services performed by nonaffiliated providers that did not exceed two times the out-of-pocket costs prescribed by the bill for services performed by affiliated providers. An HMO could not have separate out-of-pocket costs for emergency services or for services performed by nonaffiliated providers that were authorized by the HMO.

(Section 3533 allows an HMO to offer prudent purchaser contracts to groups or individuals. In conjunction with those contracts, an HMO may pay or reimburse enrollees, or may contract with another entity to pay or reimburse enrollees, for unauthorized services or for services by nonaffiliated providers in accordance with the terms of the contract and subject to copayments, deductibles, or other financial penalties designed to encourage enrollees to obtain services from the organization's providers.)

Under the bill, an HMO that participated in a State or Federal health program would have to meet the solvency and financial requirements of the Code, but would not be required to offer benefits or services that exceeded the program's requirements. The bill specifies that this provision would not apply to State employee or Federal employee health programs.

MCL 500.3515 et al. Legislative Analyst: Julie Koval

FISCAL IMPACT

This bill would have no fiscal impact on the State's Medicaid program and an indeterminate fiscal impact on expenditures for State employees' health insurance coverage.

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 would allow HMOs to offer contracts that contained a more restricted package of benefits than is required under current law, the bill would 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 would lower the "floor" for the scope of services that must be provided by HMO contracts, there is a potential that the State could experience a reduction in expenditures for health insurance coverage if a less costly, reduced-benefit HMO contract were provided to State employees. However, such a reduction in health benefits, and the concomitant reduction in expenditures, would be subject to the collective bargaining process.

Fiscal Analyst: Steve Angelotti

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