Legislative Analysis

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HMO OUT-OF-POCKET COSTS

Senate Bill 1150 as passed by the Senate
Sponsor: Sen. Bill Hardiman
Senate Committee: Health Policy
House Committee: Insurance

Complete to 12-2-04

A SUMMARY OF SENATE BILL 1150 AS REPORTED FROM HOUSE COMMITTEE

The bill would amend the Insurance Code (MCL 500.3515 et al.) to do the following in regard to health maintenance organization (HMO) contracts:

-- Specify that an enrollee's coinsurance for basic health services and copayments for inpatient hospital services and facility-based outpatient surgical services, excluding deductibles, could not exceed 50 percent of the HMO's reimbursement to an affiliated provider, and could not be based on the provider's standard charge for the service. (Presently, this 50 percent provision applies to copayments for basic health services, which also are required to be "nominal".)

-- Limit an enrollee's annual aggregate out-of-pocket costs for coinsurance and copayments to $5,000 for an individual and $10,000 for a family per year.

-- Require the maximum out-of-pocket costs to be adjusted annually to the greater of the annual average percentage change in the medical care consumer price index, or the maximum annual out-of-pocket expenses for a high deductible health plan under the Internal Revenue Code.

-- Require the maximum out-of-pocket costs to be adjusted to an amount "warranted by current market conditions" upon petition by an HMO to the commissioner of the Office of Financial and Insurance Services (OFIS). The term "current market conditions" includes higher coinsurances and copayments being used in the same or similar products marketed by other health insurers.

-- Allow an HMO contract to have separate out-of-pocket costs under a prudent purchaser contract (PPO) for services provided by a nonaffiliated provider of up to twice the out-of-pocket costs for services provided by an affiliated provider (excluding emergency services or services performed by nonaffiliated providers that were authorized by the HMO).

-- Provide that an HMO participating in a state or federal health program would have to meet the solvency and financial requirements of the code, but would not have to offer benefits or services in excess of the program's requirements. (This requirement would not apply to state or federal employee health programs.)

FISCAL IMPACT:

The state and local units of government could have changes in health care costs if they adopt changes in co-pay and co-insurance amounts.

POSITIONS:

The following organizations indicated support for the bill to the House Committee on Insurance at its 12-1-04 meeting: The Michigan Association of Health Plans; the Small Business Association of Michigan; the Michigan Chamber of Commerce; the Michigan Nurses Association; the Michigan Primary Care Association; the Michigan Osteopathic Association; America's Health Insurance Plans (AHIP); the Cape Health Plan; Priority Health; and Health Plus of Michigan.

The following indicated their opposition to the bill: the International Union—UAW; the Michigan Psychiatric Association; the Service Employees International Union (SEIU); and the Michigan Federation of Teachers and School-Related Personnel.

The Office of Financial and Insurance Services (OFIS) indicated neutrality.

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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.