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BILL ANALYSIS

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Senate Bill 1150 (Substitute S-1 as reported without amendment)
Sponsor: Senator Bill Hardiman
Committee: Health Policy

Date Completed: 6-7-04

RATIONALE

Health care costs are of increasing concern to employers who wish to offer health care benefits to their employees. According to a recent *Detroit News* article (5-21-04), health care premiums are rising by about 15% every year. Often, employers pass on some of the cost 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, at least 20 visits per year for outpatient mental health services, a specified level of intermediate and outpatient care for substance abuse, diagnostic laboratory and diagnostic and therapeutic radiological services, home health services, and preventive health services. Some employers cannot afford such inclusive coverage, however, but do not have the option to purchase a more narrowly tailored package through an HMO. It has been suggested that allowing HMOs to offer a less inclusive, less expensive policy might mitigate the financial pressure on employers who are considering eliminating health care coverage for their workers.

CONTENT

The bill would amend the Insurance Code to delete a requirement that a health maintenance contract include basic health services, but specify that the contract would have to include "preventive health care services"; revise the definition of that term; and require an HMO to market and offer a set of health maintenance contracts that included basic health services.

The Code defines "health maintenance contract" as a contract between an HMO and a subscriber or group of subscribers to provide, when medically indicated, designated health maintenance services, including, at a minimum, basic health services (defined above). The bill would delete the requirement that a health maintenance contract include basic health services, and instead require that it include preventive health care services as defined in Section 3515 of the Code, which the bill would amend. The bill also would delete preventive health services from the definition of "basic health services".

Under Section 3515, "preventive health care services" is defined as services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness, or disability. The bill specifies that the term would not include services that were specifically excluded by terms of a health maintenance contract. The bill also would add to the definition age-specific, periodic health examinations and screenings as recommended by the United States Preventive Services Task Force or its successor, and as approved by the Commissioner of the Office of Financial and Insurance Services; and all routine, age-specific immunizations as recommended by the Advisory Committee on Immunization Practices or its successor, and as approved by the Commissioner. (The bill specifies that this provision would not require the

immunizations recommended or required as a result of employment or international travel or by other third parties.) The Commissioner could not require the inclusion in preventive health services of any health examination and screening that was not an age-specific, periodic health examination and screening A or B classification recommendation by the Task Force, or the inclusion of any immunization that was not a routine, age-specific immunization recommended by the Advisory Committee.

The bill would require an HMO to market and offer a set of health maintenance contracts that included basic health services.

MCL 500.3501 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 recent survey of southeastern Michigan business leaders by John Bailey and Associates, 75% of the respondents said the cost of health insurance is causing them to consider cutting health benefits for their employees. When this occurs, employees who cannot afford to purchase insurance on their own either must go without coverage, or turn to the Medicaid system. If HMOs were allowed to offer a "barebones" contract, more people would have health care coverage and fewer would seek expensive care in an emergency room on a crisis-by-crisis basis, which drives up costs throughout the health care system. According to a *Detroit News* article (5-11-04), 80% of Michigan's 1.2 million uninsured residents work in jobs that do not provide health coverage or pay enough for them to afford individual benefits. The bill would give employers who feel overburdened by the cost of a comprehensive health plan an alternative to dropping coverage for their employees altogether.

Health maintenance organizations are hindered by an outdated regulatory statute. The legislation governing HMOs was enacted in 1974, and was based on a model that significantly differs from today's managed care industry. Over the years, the definition of "basic health services" has become so broad that HMOs sometimes must cover services that probably are not medically necessary, and customers are forced to pay for coverage they might not need or want. Providers of other forms of health insurance have the flexibility to design their benefits packages. Many offer as options the services included under "basic health services", and consumers pay for them accordingly.

The current law creates a disincentive for HMOs, especially those that would prefer to operate under a common benefits structure nationwide, to do business in Michigan. Many small business owners understand that they must offer a certain level of coverage to attract quality workers, but cannot afford packages containing "frills" such as ambulance service or after-hours urgent care. They cannot get *any* coverage from an HMO, however, that does not include these services.

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 based on the specific needs and budget constraints of their customers, the bill would create a more competitive health care environment and help promote business and job growth.

Opposing Argument

The underlying concept of an HMO is management of care through primary caregivers within small provider networks. Consumers expect HMOs to focus on the total management of their health. Under the narrow parameters proposed by the bill, however, HMOs could offer very minimal coverage, in contrast to the comprehensive coverage on which consumers rely. Health maintenance organizations already may require co-pays and deductibles; if they also were released from their obligation to provide basic health services, they no longer would be true HMOs. Consumers expect an HMO, by definition, to cover all medically necessary hospital and physician services. It simply would be misleading to market under the HMO label policies that excluded the staples of managed care.

The term "basic health services" includes, for example, at least 20 outpatient mental health visits and $2,968 per year for substance abuse treatment. Under the bill, HMOs would not have to provide even this level of coverage for mental health and addictive disorders. Furthermore, the bill specifies that the term "preventive services" would not include any service that was specifically excluded by the terms of the contract. Thus, an HMO could develop a policy that included as much or as little as it wanted. The bill could create guesswork and confusion for physicians, who know that, under the current law, virtually anything they order will be covered. Rather than providing minimal coverage to people who currently have no coverage, the bill could force into the Medicaid system people who now rely on the basic health services in an HMO contract, which would raise costs for the State.

The bill also would intrude on the doctor-patient relationship. Under the bill, the term "preventive services" would include only age-specific, periodic examinations and screenings as recommended by the U.S. Preventive Services Task Force, and age-specific, routine immunizations as recommended by the Advisory Committee on Immunization Practices. Services that were not routine or age-specific would not have to be covered, and the Commissioner could not require them to be included. Decisions regarding screenings and immunizations, however, should be made by physicians on an individual basis, not by HMOs.

The current regulatory statute does not place an undue burden on HMOs to continue providing the quality care for which they are known. The statute was modernized significantly in 2000, when it was moved from the Public Health Code to the Insurance Code, and again in 2002 to allow HMOs to add a greater range of employee cost-sharing options to their product lines. Moreover, HMOs already may set guidelines to determine which services are medically indicated. Patients who disagree with an HMO's guidelines may appeal to the Commissioner under the Patient's Right to Independent Review Act.

Furthermore, options for less comprehensive health care coverage already exist in the marketplace through personal provider organizations (PPOs) and traditional health plans. Employers may offer, and individuals may choose, narrowly focused health coverage; it is not necessary to eliminate minimal guarantees for consumers and change the fundamental nature of HMOs.

Response: Although the bill would eliminate basic health services from the services HMOs are required to cover, it would enhance the definition of "preventive services". 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 increased focus on preventive services would 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 financial and physical costs. The bill could encourage some people to adopt healthy lifestyles, rather than living irresponsibly, becoming ill, and relying on an extensive health care plan.

Regardless of the specific services included in their contracts, HMOs are responsible for quality and accountability. The bill would not change the core mission of an HMO, which is to provide affordable, high-quality coverage. Furthermore, the bill still would require HMOs to offer packages that included basic health services for employers who wanted that coverage. The characteristics that make HMOs different from other forms of insurance are their focus on care management, disease prevention and management, the coordination of information, and accreditation standards that ensure a certain level of quality. The bill would strike an appropriate balance between affordability and concern for patient health.

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 contain 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: Dana Patterson

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