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STATE OF MICHIGAN
OFFICE OF FINANCIAL AND INSURANCE REGULATION
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
STANLEY "SKIP" PRUSS, DIRECTOR

KEN ROSS
COMMISSIONER

**Annual Report on Group Employer Market Effects on HMOs as a Result of Increased
Flexibility in Cost-Sharing Under MCL 500.3515**

A Market Study issued by Commissioner Ken Ross

May 2010

Determination

For the calendar year ending December 31, 2009, the Commissioner concludes that:

- a) Greater copayment and coinsurance levels allowed under PA 306 have not increased the number of employers who have contracted for HMO services.
- b) Greater copayment and coinsurance levels allowed under PA 306 have not increased the number of enrollees in the HMO employer group health benefit market.
- c) HMOs have taken advantage of the flexibility of cost-sharing limits with the introduction of innovative products to create a market that is appealing to employers.
- d) The experience of HMOs in the employer group health market may be a regional phenomenon.

Based on the above conclusions that are supported by the data and findings in this report, the Commissioner has determined that greater copayment and coinsurance levels allowed by the amendatory act that provided greater flexibility to HMOs in this area have not increased the number of employer groups and enrollees receiving health maintenance organization services. However, HMOs have been developing products that take advantage of the flexibility in cost-sharing afforded by enactment of PA 306.



Ken Ross
Commissioner

May 28, 2010
Date

Office of Financial and Insurance Regulation

Historically, government regulated insurance, securities, and financial institutions (banks, consumer finance companies and credit unions), separately. A Depression-era federal law known as the Glass Steagall Act (adopted in response to the bank failures following the 1929 stock market crash) specifically prohibited a bank from offering securities and insurance products or engaging in commercial banking. The federal Financial Services Modernization Act of 1999, also known as the Graham Leach Bliley Act (GLBA) repealed the Glass Steagall Act barriers and allowed financial services holding companies to engage in any activity financial in nature so long as it did not cause a safety or soundness issue to the overall financial system.

With changing complexities in insurance, banking and securities, the old-fashioned regulatory model could not keep pace with the marketplace. Michigan became the first state to coordinate the regulation of insurance, financial institutions and securities into one governmental agency, under a single Commissioner, consistent with financial services modernization. Effective April 2000, the Office of Financial and Insurance Services (OFIS) was created by executive order to consolidate the Bureaus of Insurance and Financial Institutions, and the Securities Division of the former Corporations, Securities and Land Development Bureau. The creation of OFIS allowed Michigan regulators to become adept at interpreting and regulating complex financial service entities that did not exist a few years ago.

On February 1, 2008, Governor Granholm signed Executive Order 2008-02, which became effective April 6, 2008. The order changed the official name of OFIS to the Office of Financial and Insurance Regulation (OFIR) to reflect its regulatory and consumer protection focus.

Today, OFIR is responsible for the regulation of Blue Cross Blue Shield Michigan, 26 HMOs, 127 state chartered and savings banks, approximately 174 domestic and 1427 foreign insurance companies, 216 credit unions, 1,858 investment advisers, 2,036 securities broker-dealers, 6172 consumer finance lenders, 171,443 insurance producers, and 123,604 securities agents. OFIR licenses, registers, or charters these entities, conducts safety, soundness, and compliance examinations, and protects and educates Michigan consumers of financial services. Through adaptability and consumer communication, the Commissioner and staff of the OFIR strive to be the preeminent financial regulators in the United States.

OFIR is headed by Commissioner Ken Ross who was appointed by Governor Jennifer M. Granholm effective February 22, 2008.

Introduction

During the 2005-2006 legislative session, Public Act 306 of 2005 (PA 306) was passed. The Act amended the Michigan Insurance Code, specifically MCL 500.3515, in part, to eliminate the requirement that copayments under a Health Maintenance Organization (HMO) contract be nominal. Previously, an HMO could have contracts that required copayments for *specific* health maintenance services but copayments had to be nominal for *basic health services* such 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; outpatient mental health services, not fewer than 20 visits per year; intermediate and outpatient care for substance abuse; diagnostic laboratory and diagnostic and therapeutic radiological services; home health services; and preventive health services.

Under PA 306, HMO contracts were permitted to include copayments stated as dollar amounts, and coinsurance stated as percentages, for the cost of services. Coinsurance for basic health services, excluding deductibles, could now be up to 50% of an HMO's reimbursement to an affiliated provider, but could not be based on the provider's standard charge for the service.

Also included in PA 306 was that beginning on May 15, 2008, the Commissioner of the Office of Financial and Insurance Services is required to make an annual determination as to whether the greater copayment and coinsurance levels allowed by the Act have increased the number of employers who have contracted for HMO services, as well as the number of HMO enrollees. PA 306 requires the consideration of the following elements:

- 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 that the Commissioner considers relevant.

Data Collection

Data was collected and analyzed from two Michigan-specific reporting forms, FIS 0322 and FIS 0323. Michigan requires all insurers with any type of accident and health authority under the Michigan Insurance Code to submit Michigan form FIS 0322. On the FIS 0322, carriers report the number of policies in force, member months, number of lives insured, direct premiums written, and direct losses paid. Data from the FIS 0322 was used to show the HMO market trend from 2002 through 2009. In 2009 OFIR revised the reporting form in an effort to capture more accurate data. The revision requires carriers to provide more detailed information relative to coverage types.

The FIS 0323 is a reporting form specifically designed for HMOs to report employer health business as a result of enactment of PA 306. On the FIS 0323 HMOs report changes in commercial employer groups and enrollees in the last two prior years.

This report also relies on information and data provided by Michigan employers as published in the Kaiser Family Foundation and Health Research & Educational Trust Employer Health Benefits 2009 Annual Survey. The compilation of data as a result of the Survey provides a plethora of verifiable Michigan employer information.

Data Analysis

Seven HMOs reported an increase in employer group business as well as an increase in HMO enrollees in 2009 attributable to the flexibility of copayments brought about by PA 306. However, one HMO reported a loss of 280 employer groups and 27,003 enrollees. Table 1A below, compares the employer group market experience between 2008 and 2009 as reported on the FIS 0323.

Table 1A

Health Plan	Commercial Employer Groups					Commercial Enrollees				
	9/30/2008	9/30/2009	Change	% of Change	Increase Due to Law Change	9/30/2008	9/30/2009	Change	% of Change	Increase Due to Law Change
Blue Care Network of MI	8,064	7,279	-785	-9.7%	1	526,616	486,104	-40,512	-7.7%	5,229
Grand Valley Health Plan	162	118	-34	-22.4%	4	6,825	6,130	-695	-10.2%	285
Health Alliance Plan of Michigan	1,467	1,187	-280	-19.1%	-280	387,849	360,846	-27,003	-7.0%	-27,003
Health Plus of Michigan, Inc.	806	570	-36	-5.9%	3	80,341	63,773	-16,568	-20.6%	41
McLaren Health Plan	273	459	186	68.1%	33	5,282	8,646	3,364	63.7%	271
Paramount Care of Michigan, Inc.	338	291	-47	-14.0%	7	5,757	4,964	-793	-13.8%	63
Physicians Health Plan of Mid-Michigan	654	465	-189	-28.9%	0	41,581	40,985	-596	-1.4%	0
Priority Health	7,969	8,466	497	6.2%	181	347,095	352,334	5,239	1.5%	11,045
Total Health Care USA, Inc.	595	734	139	23.4%	86	16,514	19,500	2,986	18.1%	1,719
TOTALS	20,118	19,569	-549	-2.7%	35	1,417,860	1,343,282	-74,578	-5.3%	-8,350

Table 1B illustrates the trend in the employer group HMO market. The chart shows the employer group and group enrollee market for a 45 month period. The initial period reflects the date PA 306 went into effect (December 21, 2005) compared to the data reported for the 2009 HMO market experience. Table 1b shows that overall; HMOs are attributing an increase of 86 employer groups to the greater flexibility of cost-sharing limits. Even though enactment of PA 306 has increased the interest of some employers, on the whole, there has been a loss of 2.4% of employer groups and a loss of 7.5% of enrollees since 2005.

Table 1B – 45 Months After PA 306

Health Plan	Commercial Employer Groups					Commercial Enrollees				
	12/31/2005	9/30/2009	Change	% of Change	Net Change Due to Law Change	12/31/2005	9/30/2009	Change	% of Change	Net Change Due to Law Change
Blue Care Network of Michigan	7,450	7,279	-171	2.3%	1	430,120	486,104	55,984	13.0%	5,229
Grand Valley Health Plan	269	118	-151	56.1%	8	15,546	6,130	-9,416	-60.6%	329
Health Alliance Plan of MI	2,412	1,187	-1,225	-50.8%	-280	453,837	360,846	-92,991	-20.5%	-27,003
Health Plus of Michigan, Inc.	819	570	-249	-30.4%	3	83,590	63,773	-19,817	-23.7%	41
Paramount Care of MI, Inc.	255	291	36	14.1%	37	7,081	4,964	-2,117	-29.9%	271
Physicians Health Plan of Mid-Michigan	1,219	465	-754	-61.9%	0	72,756	40,985	-31,770	-43.7%	0
Priority Health	6,847	8,466	1,619	23.6%	181	370,199	362,334	-7,865	-4.8%	11,045
Total Health Care USA, Inc.	310	734	424	136.8%	136	9,152	19,500	10,348	113.1%	2,759
TOTALS	19,581	19,110	-471	-2.4%	86	1,442,280	1,334,636	-107,644	-7.5%	-7,329

HMOs have the opportunity to provide narrative information relative to marketing. The following section provides the narrative responses received on the FIS 0323 for 2009:

- Grand Valley Health Plan did not create or use any new products that exceed the previously approved limits of \$3000/\$6000.
- Blue Care Network of Michigan does not actively market a product with increased annual copayment and coinsurance levels; this type of plan is only available to large groups, upon request.
- Health Alliance Plan (HAP) did not apply for any new riders or products having annual copayments and coinsurance limits exceeding \$3000 for individuals and \$6000 for families in 2009. Each regular group (51+ eligible employees) is offered a HMO product with a deductible as an alternative plan at renewal. Health Alliance Plan has offered HMO plans with deductibles to the small group reform market (2 to 50 eligible employees) since 2005.
- Paramount has not developed any new products since March 2006, when it began offering its Multi Access Plan (MAP) product with higher deductibles and out-of-pocket limits, ranging from in-network services with a deductible of \$1000/single to \$2000/family and \$2000/single to \$4000/family for maximum out-of-pocket limits. For services received out-of-network; a deductible at \$5000/single and \$10,000/family and maximum out-of-pocket limits at \$5000/single and \$10,000 family.

- HealthPlus of Michigan, Inc., launched its SaverPlus HMO plans in September 2008. Some plans offer deductible options greater than \$3000 for individuals and \$6000 for families. These products are being offered as riders. HealthPlus of Michigan, Inc., reports that six employer groups are covered under the SaverPlus plans with higher deductibles.
- Physicians Health Plan of Mid-Michigan did not introduce any new plans in 2009 that had higher copayment and coinsurance levels.
- Priority Health first offered plans with deductibles of \$4,000/single and \$8,000/family and \$5,000/single and \$10,000 family in January 2009. Of the 181 groups that purchased higher deductible plans, 146 were existing Priority Health customers that switched to the new plans. Priority Health also indicated that most employers that purchase higher deductible plans couple the plan with a Health Reimbursement Account (HRA).
- Total Health Care USA has modified and made available to employers a point-of-service option with an increased level of benefits as well as increased annual copayment and coinsurance levels. These products offer both flexibility and cost saving opportunities; and have been available since May 2009. The “Low Deductible Plan” offers, for in-network services a \$0 deductible for both single and family enrollees as well \$0 coinsurance. For out-of-network services, the deductible is \$1,000/single and \$2,000/family with maximum out-of-pocket costs being \$10,000/single and \$20,000/family. The “High Deductible Plan” offered by Total Health Care USA has cost sharing options that range between \$1,000 per person or \$2,000 per family for in-network services to \$15,000 per person and \$30,000 per family for out-of-network services.

As the responses above indicate, HMOs are taking advantage of the flexibility in cost-sharing by developing products that give employers a variety of cost-sharing options.

The data from the FIS 0322 provides a broader picture of HMOs in the group market. From 2002 through 2009, there was a decline in HMO activity in the large and small group employer health markets. In 2002 there were 27 HMOs writing group coverage; in 2009 there were 16. The number of lives in the group HMO market has fluctuated throughout the same span of years, but in 2002 there were 1,572,982 enrolled lives and in 2009 there were 1,279,813 lives. A common measure used by HMO entities is that of “member months.” A member month is a data term meaning the actual number of members the HMO had in a particular month. In 2002 the reported member months for HMOs was 18,430,464 and in 2009 it was 15,424,094. The tables below illustrate some aspects of the group employer market from 2002 through 2009.

Table 2A: HMOs reporting group business

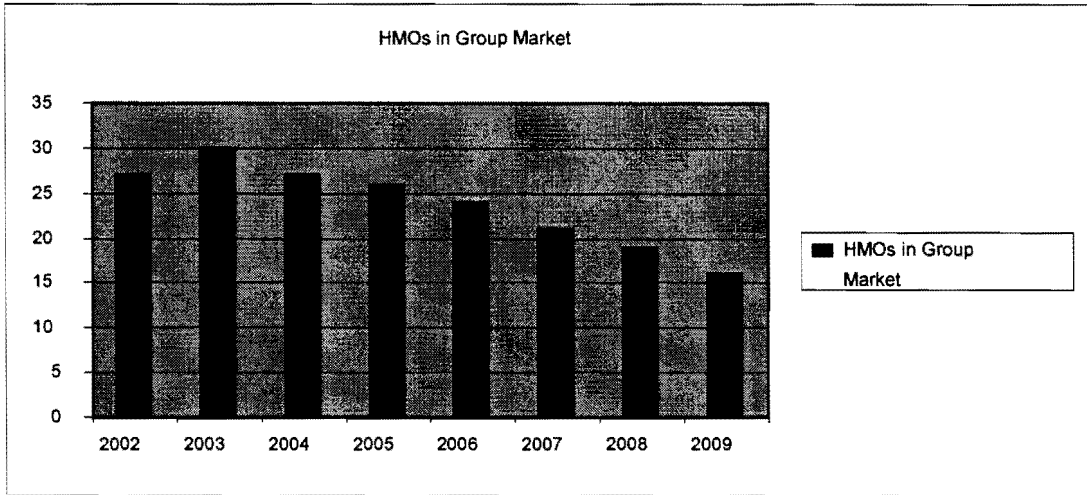


Table 2B: HMOs writing small group business

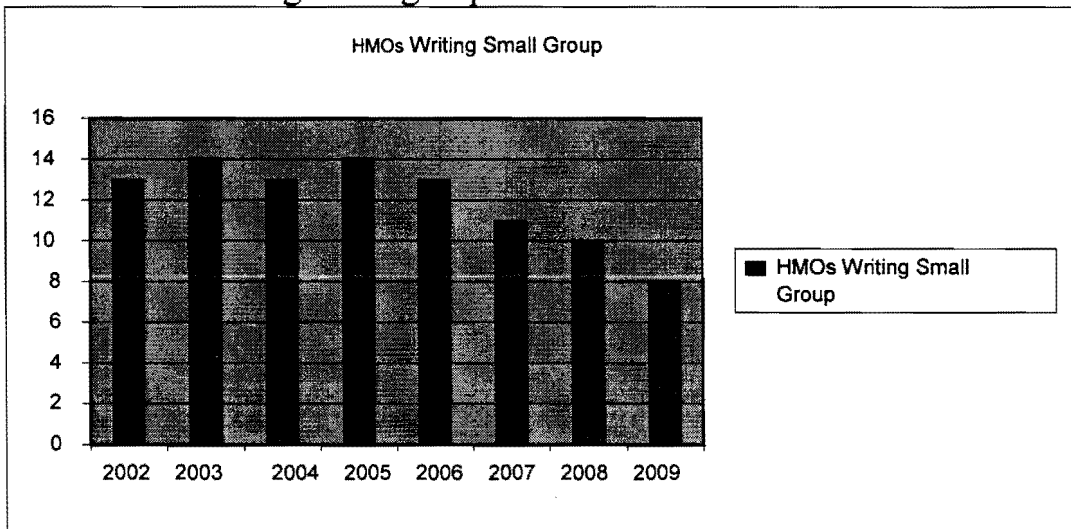
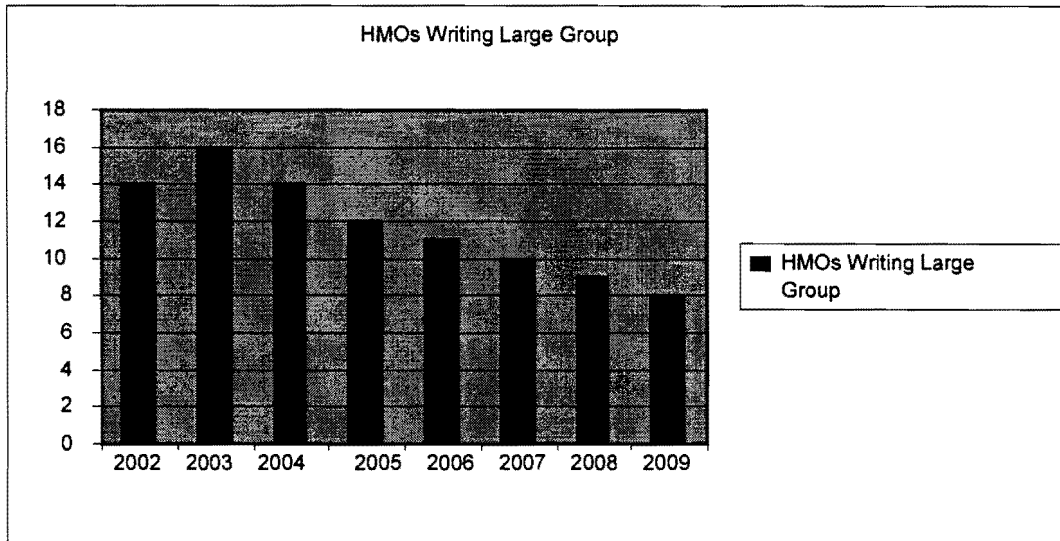


Table 2C: HMOs writing large employer groups



As can be seen in the tables above, HMOs writing large employer groups have shown a steady decline since 2002. The small group market appears to have remained stable until 2005, when a steady decline began; the year PA 305 was enacted.

Table 2D illustrates the number of enrollees in HMOs from 2002 through 2009. Aside from the large spike in enrollments in 2003, the number of lives has remained relatively steady with a gradual decline in enrollees since 2006 and 2007, after enactment of PA 306.

Table 2D: Number of enrollees, including dependents as reported on the FIS 0322

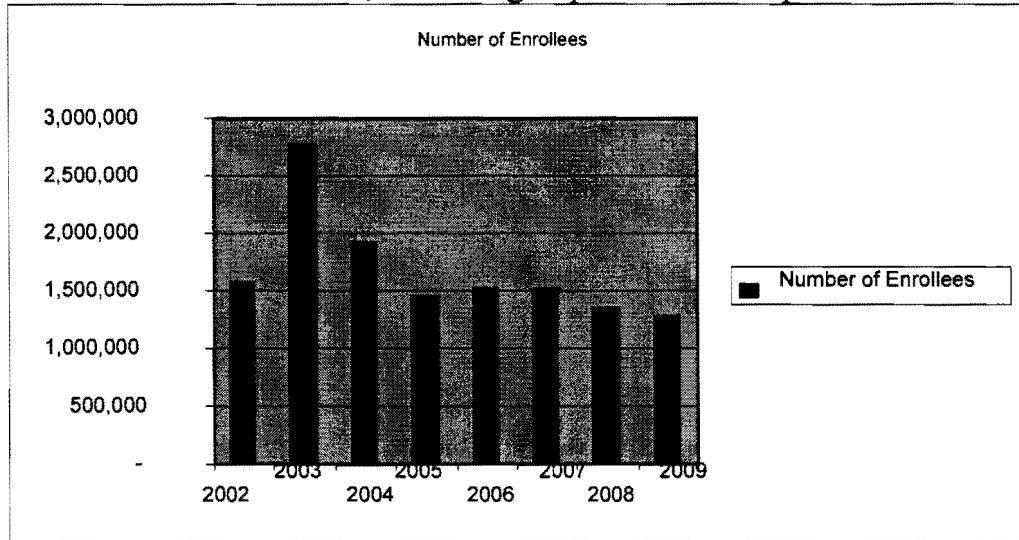
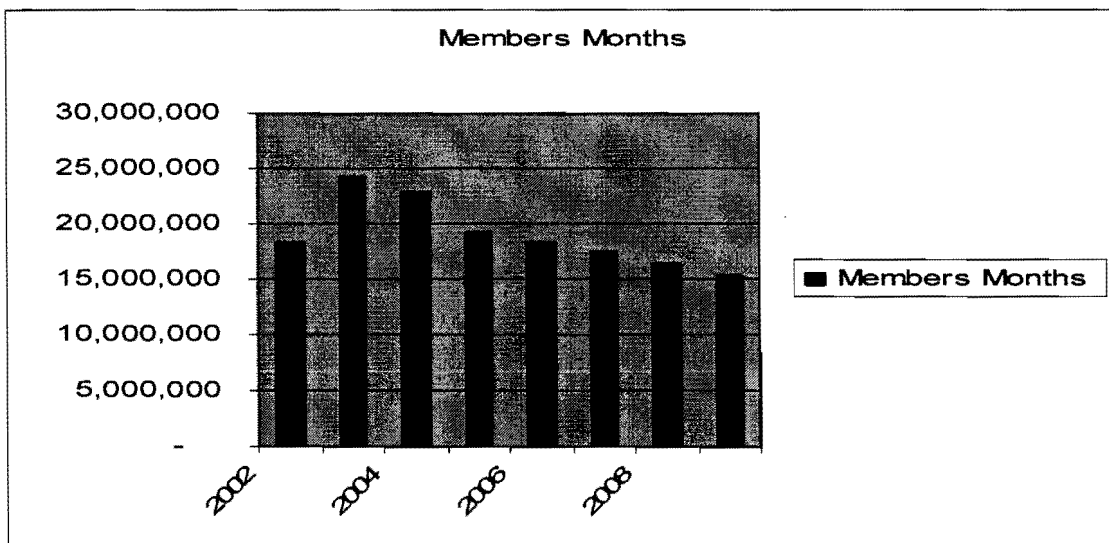


Table 2E below, provides an illustration of measurement using member months. Again, this is the actual number of members the HMO had in a particular month. This measure shows a steady decline in HMO activity in the large and small employer group health benefit market.

Table 2E: Data of Member Months as reported on the FIS 0322



The data presented in these tables draws one to conclude that greater copayment and coinsurance levels that were introduced through PA 306 did not increase the number of employers who have contracted for HMO services and it did not increase the number of HMO enrollees.

The data collected from the FIS 0322 and FIS 0323, as illustrated in the market trend tables, do not show if there has been a greater presence of HMOs in the individual market or of that in the government programs markets. They also do not provide a cause for the decline in the HMO employer group market. However, it does indicate that enactment of PA 306 has not, as of 2009, had a large impact on the employer group market.

The Kaiser Family Foundation and Health Research & Educational Trust Employer Health Benefits 2009 Annual Survey indicates that 60% of workers are enrolled in preferred provider insured plans, followed by HMOs with 20%, high deductible plans represents 8% of the group employer market, with conventional plans representing 1% of the market. Further, it found that plan enrollment patterns differ across regions. HMO enrollment is significantly higher in the West with 31% of the market and is significantly lower in the Midwest at only 10%. The data from the Kaiser survey is consistent with the data results from the FIS 0322.