
CHANGES IN HMO ENROLLMENT RELATED TO INCREASED CONSUMER COST-SHARING PROVISIONS IN MCL 500.3515—ANNUAL REPORT, 2008

Michigan Office of Financial and Insurance Regulation

prepared for

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Office of Financial and Insurance Regulation
State of Michigan
Department of Energy, Labor and Economic Growth

prepared by

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Acknowledgements

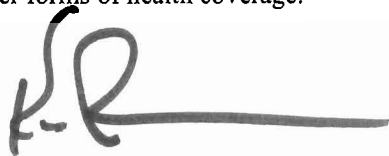
The author thanks Marlene Bukoski of the Michigan Office of Financial and Insurance Regulation for help in compiling and interpreting insurance company data and Richard Murdock of the Michigan Association of Health Plans, several Michigan health plan officials and executives, and insurance agents for helping the author better understand the insurance market in Michigan.

Determination

For the calendar year ending December 31, 2008, the Commissioner concludes that:

- (a) Public Act 306 of 2005 gave HMOs greater flexibility in the way they could structure their benefit plans;
- (b) It was expected that allowing HMOs to offer benefit plans with greater consumer cost-sharing would lower premiums; and
- (c) Lowering premiums would make HMOs more attractive to employers and employees and increase HMO enrollment;
- (d) While the greater flexibility that HMOs now have to include higher cost-sharing provisions in the plans they offer has not prevented them from losing enrollment, absent this flexibility, they might have experienced greater enrollment losses;
- (e) The loss of business, which was caused in part by a rise in health care costs was exacerbated by Michigan's economic recession, and the loss was experienced by other health carriers as well;
- (f) Trying to help mitigate the effects of the economy, some employers have reduced, eliminated, or turned to less costly forms of coverage.

Based upon the above conclusions that are supported by the data and findings in this report, the Commissioner has determined that greater co-payment and co-insurance levels allowed by the amendatory act that added this subsection have not increased the number of employers who have contracted for health maintenance organization services and that these levels have not increased the number of enrollees receiving health maintenance organization services. However, without this flexibility, health maintenance organizations could be less competitive in the future relative to other forms of health coverage.



Ken Ross
Commissioner

6-1-09

Date

Introduction

Public Act 306, enacted by the Michigan Legislature in 2005, gave health maintenance organizations (HMOs) greater flexibility in the way they could structure their benefit plans. Upon the enactment of the legislation, HMOs were permitted to market policies that require enrolled people to pay more of the cost at the time they consume health services. Specifically, the act allowed HMOs to impose higher copayments and higher coinsurance. The specific language was as follows:

Sec. 3515. (2) A health maintenance organization may have health maintenance contracts with deductibles. A health maintenance organization may have health maintenance contracts that include copayments, stated as dollar amounts for the cost of covered services, and coinsurance, stated as percentages for the cost of covered services. Coinsurance for basic health services, excluding deductibles, shall not exceed 50% of a health maintenance organization's reimbursement to an affiliated provider for providing the service to an enrollee and shall not be based on the provider's standard charge for the service. This subsection does not limit the commissioner's authority to regulate and establish fair, sound, and reasonable copayment and coinsurance limits including out of pocket maximums.

The legislation also required the commissioner to prepare an annual report to determine whether giving HMOs this greater flexibility increased their ability to attract new employers and to increase enrollment. The specific language is as follows:

Sec. 3515. (3) By May 15, 2008, and by each May 15 after 2008, the commissioner shall make a determination as to whether the greater copayment and coinsurance levels allowed by the amendatory act that added this subsection have increased the number of employers who have contracted for health maintenance organization services and whether these levels have increased the number of enrollees receiving health maintenance organization services. In making this determination, the commissioner shall hold a public hearing by February 1, 2008, and may hold a public hearing thereafter, shall seek the advice and input from appropriate independent sources, including, but not limited to, all health maintenance organizations operating in this state and with enrollees in this state, and shall issue a report delineating specific examples of copayment and coinsurance levels in force and suggestions to increase the number of persons enrolled in health maintenance organizations.

The purpose of this second annual report is to meet the legislative requirement for an assessment of the effects of giving HMOs more latitude in defining benefit packages.

Understanding of the Context

When HMOs first developed in Michigan and elsewhere, they tended to be integrated systems with closed physician panels, organized and operated in a way to allow them to closely track physician practice patterns, monitor utilization, and control costs. Their use of expensive medical services, particularly hospital days, was generally significantly lower than traditional fee-for-service medicine, so they were often able to offer coverage that was less costly and more comprehensive than standard indemnity health plans. From a price stand-

point, they could compete well with more traditional health insurance. Thus, the thinking was that significant consumer cost-sharing through the use of deductibles, copayments, and coinsurance was not necessary to control costs. In fact, they were viewed as being counter-productive by discouraging patients from utilizing preventive and other health maintenance services that were highly beneficial, cost effective, and a hallmark of the HMO approach to care delivery. Hence, the early HMOs did not have any significant degree of cost-sharing, and that principle was built into the original Michigan HMO laws, which severely limited the extent to which HMOs could impose consumer cost-sharing requirements.

But over time, some of the price advantages enjoyed by HMOs dissipated. Indemnity plans were largely replaced by preferred provider organizations (PPOs), which had a price advantage over indemnity plans because they aggressively negotiated with physicians and other providers to get discounted prices, and they adopted some of the techniques used by HMOs to reduce high utilization of services. PPOs were less costly than indemnity plans, but they did not place the restrictions on provider choice that are characteristic of HMOs. As a result HMOs (as well as indemnity plans) lost some market share. At the same time, non-HMO insurers were increasing the extent of consumer cost-sharing in their benefit plans as a way of trying to create incentives for consumers to be more economical in their use of medical services and to lower premiums. More recently, advocates of consumer-directed health plans and health savings accounts (HSAs) promoted benefit plans that included high deductibles and other consumer cost-sharing. Because insurers pay less of the bill and consumers pay more, premiums are lower, which is attractive to employers.

These developments, along with the legal prohibition on significant consumer cost-sharing, put HMOs at a price disadvantage, for which they sought legislative relief. The legislature apparently concluded that if HMOs were to be able to offer competitive premiums, they needed to have the ability to develop benefit plans that included significant consumer cost-sharing.¹ The result, in Michigan, was the passage of provisions of several pieces of legislation that permitted HMOs to market benefit plans with more consumer cost-sharing.

The first effort to give HMOs greater flexibility to require enrollees to pay more of the cost of services was the passage of Public Act 621 in 2002. That legislation for the first time gave HMOs the authority to sell plans that included significant deductibles, and it also allowed “nominal” copayments:

Sec. 3515 (2). A health maintenance organization may have health maintenance contracts with deductibles. A health maintenance organization may have health

¹ There are essentially three kinds of consumer cost-sharing. *Deductibles* refer to amounts that consumers must pay out of pocket for medical services as a whole before the insurance coverage pays anything. Sometimes, however, coverage will pay for some services, such as preventive care, before consumers have exceeded the deductible amount. *Coinsurance* and *copayments* apply at the time when an insured person consumes a particular medical service. Copayments are fixed-dollar amounts per service, whereas coinsurance is a percentage of the service cost.

maintenance contracts with copayments that are required for specific health maintenance services. Copayments for services required under section 3501(b), excluding deductibles, shall be nominal, shall not exceed 50% of a health maintenance organization's reimbursement to an affiliated provider for providing the service to an enrollee, and shall not be based on the provider's standard charge for the service. A health maintenance organization shall not require contributions be made to a deductible for preventative health care services. As used in this subsection, "preventative health care services" means services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness, or disability.

In addition to allowing HMOs for the first time to offer policies with deductibles, this provision of the law allowed HMOs to have copayments, but they had to be "nominal."

Three years later, in 2005, the passage of Public Act 306 further extended HMOs' flexibility to establish health plans that required consumer cost-sharing. Section 500.3515 (see page 1) permitted HMOs to market benefit plans with not just the "nominal" copayments that were previously permitted but unrestricted copayments, as well as coinsurance. (Prior to the new law, OFIR guidelines defined "nominal" as meaning that out-of-pocket maximums could not exceed \$3,000 for an individual and \$6,000 per family.)

The expectation was that allowing HMOs to offer benefit plans with greater consumer cost-sharing would lower premiums, making HMOs more attractive to employers and their employees and thereby increasing enrollment in HMOs.

The 2005 legislation that made the changes with respect to copayments and coinsurance also required that a study be done to determine whether the expected results in fact occurred. In addition, the study was to delineate specific examples of payment and coinsurance levels in force and to suggest what additional steps might be taken to increase enrollment in HMOs. Fulfilling that requirement is the reason for this study, which is a follow-up study to the one completed last year.

Methodology

The apparent purpose of the legislative change was to allow HMOs to compete more effectively with non-HMO plans that were selling policies with greater consumer cost-sharing. These plans require consumers to pay more of the cost of medical services they consume, so, of course, the premiums are lower, making them more attractive to employers and perhaps to employees as well. If the legislation were to achieve its intended purpose, HMOs would be expected to gain enrollment relative to the rest of the market and to reverse or moderate the trend of falling commercial HMO enrollment, which began in 2000.

To gather data to assess the effects of the changed law, the Office of Financial and Insurance Regulation (OFIR) in 2007 and again in 2008 required Michigan HMOs to complete a special form (FIS 0323) to report enrollment changes subsequent to the time the law went into effect in 2005. The HMOs were asked to report how the ability to market plans that included

more consumer copayments and coinsurance (not deductibles) affected sales of their commercial business, that is, sales to employer groups both large and small. They were also asked to report the number of new plans sold that took advantage of the new flexibility, as well as the number of people enrolled in these new plans. (Enrollment in self-insured plans is not included in the reports, because the legislation was not applicable to this sector of the market, which is technically not insurance.)

The legislation also required OFIR to hold a public hearing on this issue in the initial year (2008), but the hearing was made permissive thereafter. This year OFIR did not hold a hearing.

Findings: Changes in HMO Enrollment

It is evident that giving HMOs greater flexibility to market policies with higher out-of-pocket costs for coinsurance and copayments has not produced an increase in commercial coverage sales for HMOs. On the contrary, since the time HMOs gained approval for higher consumer out-of-pocket liabilities, both the number of employer groups buying HMO coverage and the number of enrollees in HMOs have declined substantially. As shown in Table 1 and as reported in last year's study, during the first 21 months (12/31/05 to 9/30/07) after the legal change became effective, the number of employers buying HMO coverage fell by 10.1 percent (from 22,326 to 20,078), and enrollment fell by 5.2 percent (from 1,651,540 to 1,565,045).

The next year produced further declines in enrollment, although the number of employer groups remained essentially constant (increasing by 0.5 percent). Between 9/30/07 and 9/30/08 enrollment fell by 9.7 percent, or by 153,018 enrollees.

For the two reporting periods (totaling 33 months), the number of employers with HMO coverage fell 10.6 percent, to 19,963, and enrollment for HMO commercial coverage declined by 14.2 percent, to 1,417,424.

One reason that the greater flexibility to offer policies with higher coinsurance and copayments than previously allowed has not led to increased sales is that the HMOs have apparently not felt that there is a high demand for such policies—at least until now—and so few have marketed them aggressively, if they offer them at all. As shown in the right-most column in Table 1, only a minority of HMOs has developed products that take advantage of the increased flexibility.² In some respects this is not surprising because the OFIR policy with

² Although the form on which HMOs were required to report data ask for data on "Increases in the number of employers and employees . . . that resulted from greater flexibility in the annual copayment and coinsurance levels," some of the HMOs reported data on increases resulting from the use of higher *deductibles*. We tried to check with the insurers to correct for such errors but suspect that some of the reported data still includes changes due to higher deductibles and not just higher coinsurance and copayments.

Table 1. HMO Reports of Changes in Enrollment Due to 2005 Legislative Changes Related to Coinsurance and Copayments, 2005- 2008

First Reporting Period (21 Months): 12/31/05 to 9/30/07

Health Plan	Commercial Employer Groups					Commercial Enrollees					Response to New Law Provisions
	12/31/05	9/30/07	Change	% Change	Increase Due to Law Change	12/31/05	9/30/07	Change	% Change	Increase Due to Law Change	
Blue Care Network of Michigan	7,450	7,928	478	6.4%		430,120	476,857	46,737	10.9%		No high cost-sharing plans
Grand Valley Health Plan	269	187	-82	-30.5%	1	15,546	9,689	-5,857	-37.7%	2	1 certificate, 12 riders; 8 not sold
Health Alliance Plan #95844	2,412	2,010	-402	-16.7%		453,837	408,877	-44,960	-9.9%		10 offered, none sold
HealthPlus of Michigan, Inc.	819	714	-105	-12.8%	0	83,590	72,198	-11,392	-13.6%	0	
M-CARE	1,652	575	-1,077	-65.2%		180,549	121,307	-59,242	-32.8%		No new products
Paramount Care of Michigan, Inc.	255	297	42	16.5%	14	7,081	7,165	84	1.2%	126	Offered 3 plans
Physicians Health Plan of Mid-Michigan	1,219	877	-342	-28.1%	0	72,755	49,231	-23,524	-32.3%	0	
Physicians Health Plan of South Michigan	1,063	623	-440	-41.4%		28,004	17,461	-10,543	-37.6%		No high cost-sharing plans created
Physicians Health Plan of Southwest Michigan	30	0	-30	-100.0%		707	0	-707	-100.0%		
Priority Health	6,847	6,495	-352	-5.1%	0	370,199	391,011	20,812	5.6%	0	1 plan for specific employer, but not sold
Total Health Care USA, Inc.	310	372	62	20.0%		9,152	11,249	2,097	22.9%		Not clear, maybe 1 plan
Totals	22,326	20,078	-2,248	-10.1%	15	1,651,540	1,565,045	-86,495	-5.2%	128	

Second Reporting Period (12 Months): 9/30/07 to 9/30/08

Health Plan	Commercial Employer Groups					Commercial Enrollees					Response to New Law Provisions
	9/30/07	9/30/08	Change	% Change	Increase Due to Law Change	9/30/07	9/30/08	Change	% Change	Increase Due to Law Change	
Blue Care Network of Michigan	8,503	8,064	-439	-5.2%	0	598,164	526,616	-71,548	-12.0%	0	No high cost-sharing products
Grand Valley Health Plan	180	152	-28	-15.6%	3	7,996	6,825	-1,171	-14.6%	42	
Health Alliance Plan #95844	1,690	1,467	-223	-13.2%	0	403,432	387,849	-15,583	-3.9%	0	Several policies approved but not sold
HealthPlus of Michigan, Inc.	714	606	-108	-15.1%	0	82,316	80,341	-1,975	-2.4%	0	Several policies approved but not sold
M-CARE*	0	0	0	—		0	0	0	—		
McLaren Health Plan	138	273	135	97.8%	25	2,427	5,282	2,855	117.6%	173	
Paramount Care of Michigan, Inc.	262	278	16	6.1%	16	7,165	5,749	-1,416	-19.8%	82	
Physicians Health Plan of Mid-Michigan	877	668	-209	-23.8%	0	49,231	41,581	-7,650	-15.5%	0	
Physicians Health Plan of South Michigan	623	0	-623	-100.0%	0	17,461	0	-17,461	-100.0%		
Physicians Health Plan of Southwest Michigan	0	0	0	—		0	0	0	—		
Priority Health	6,495	7,969	1,474	22.7%	0	391,001	347,095	-43,906	-11.2%	0	New products filed, effective 1/1/09
Total Health Care USA, Inc.	372	486	114	30.6%	50	11,249	16,086	4,837	43.0%	1,040	
Totals	19,854	19,963	109	0.5%	94	1,570,442	1,417,424	-153,018	-9.7%	1,337	

*M-CARE was absorbed by BCNM, and enrollment is counted in their 9/30/07 in this table but was reported separately in the previous table.
 Note: Some insurers reported different figures for 9/30/07 on the forms submitted in the two years; so data do not match precisely in some instances.

Two Reporting Periods Combined (33 Months): 12/31/05 to 9/30/08

Health Plan	Commercial Employer Groups					Commercial Enrollees				
	12/31/05	9/30/08	Change	% Change	Increase Due to Law Change	12/31/05	9/30/08	Change*	% Change	Increase Change
Blue Care Network of Michigan	7,450	8,064	614	8.2%		430,120	526,616	96,496	22.4%	
Grand Valley Health Plan	269	152	-117	-43.5%	4	15,546	6,825	-8,721	-56.1%	44
Health Alliance Plan #95844	2,412	1,467	-945	-39.2%		453,837	387,849	-65,988	-14.5%	
HealthPlus of Michigan, Inc.	819	606	-213	-26.0%		83,590	80,341	-3,249	-3.9%	
M-CARE	1,652	0	-1,652	-100.0%		180,549	0	-180,549	-100.0%	
McLaren Health Plan	0	273	273	—		0	5,282	5,282	—	
Paramount Care of Michigan, Inc.	255	278	23	9.0%	30	7,081	5,749	-1,332	-18.8%	208
Physicians Health Plan of Mid-Michigan	1,219	668	-551	-45.2%		72,755	41,581	-31,174	-42.8%	
Physicians Health Plan of South Michigan	1,063	0	-1,063	-100.0%		28,004	0	-28,004	-100.0%	
Physicians Health Plan of Southwest Michigan	30	0	-30	-100.0%		707	0	-707	-100.0%	
Priority Health	6,847	7,969	1,122	16.4%		370,199	347,095	-23,104	-6.2%	
Total Health Care USA, Inc.	310	486	176	56.8%	50	9,152	16,086	6,934	75.8%	1,040
Totals	22,326	19,963	-2,363	-10.6%	84	1,651,540	1,417,424	-234,116	-14.2%	1,292

*Total does not add to total for previous two years because some insurers reported different amounts for 9/30/07 for the two reporting years

respect to out-of-pocket payments was quite permissive even before the legislative change. OFIR permitted the sale of policies that set limits on out-of-pocket costs for copayments and coinsurance as high as \$3,000 per individual and \$6,000 per family. Only recently have HMOs begun to design policies that go beyond these limits.

As would be expected given this background, the HMOs do not report many customers buying the new products with higher coinsurance and copayments. In the two periods combined, the HMOs indicated that 109 employers bought the new products, which translates to 1,456 enrollees, or only 0.1 percent of total HMO commercial enrollment.

Interpreting the Findings

Of course, it would be a mistake to assume that the greater flexibility *caused* HMOs to lose business during the period under review. In the first place, not many HMOs aggressively marketed plans that took advantage of the new law, and even those that did continued to market plans with lower levels of consumer cost-sharing. Secondly, a review of enrollment in commercial health coverage plans of other types shows that they, too, have suffered declines in the number of employers covered and the number of employees enrolled.³ (It is important to recall that all of these data exclude self-insured employers' health plans.)

As shown in Figures 1 and 2, the number of covered lives in HMO group coverage declined by about 497,600 lives between 2000 and 2008.⁴ This represents an annual rate of decline of 3.8 percent and a total decline of 27 percent. Figure 2 shows that the change has varied appreciably from year to year, with the largest drop, nearly 12 percent, in the most recent year.

However, the commercial carriers experienced an even more severe decline in enrollment, as shown in Figure 3 below. Between 2002 and 2008, the carriers' enrollment declined by almost 535,900 lives, which was an annual rate of decline of 12.3 percent and a total decline of 54 percent.

Blue Cross and Blue Shield of Michigan also experienced enrollment declines in (non-HMO) employer-based enrollment, as shown in Figure 4. The number of covered lives fell by almost 619,000 between 2001 and 2008, which represented an annual rate of decline of 6.9 percent and a total decline of 35 percent.

³ The starting year for the various forms of commercial coverage in the figures below vary by type of insurer. The differences were necessary because of data problems for some of the earlier years that could not be corrected.

⁴ The numbers in these figures do not match the numbers in Table 1. In part this is because the ending periods for the years are different, during a period of declining enrollment. Table 1 numbers are as of September 30, whereas the numbers in this figure are as of December 30. But it also appears that some HMOs report enrollment data differently for the two different OFIR reporting requirements.

Figure 1

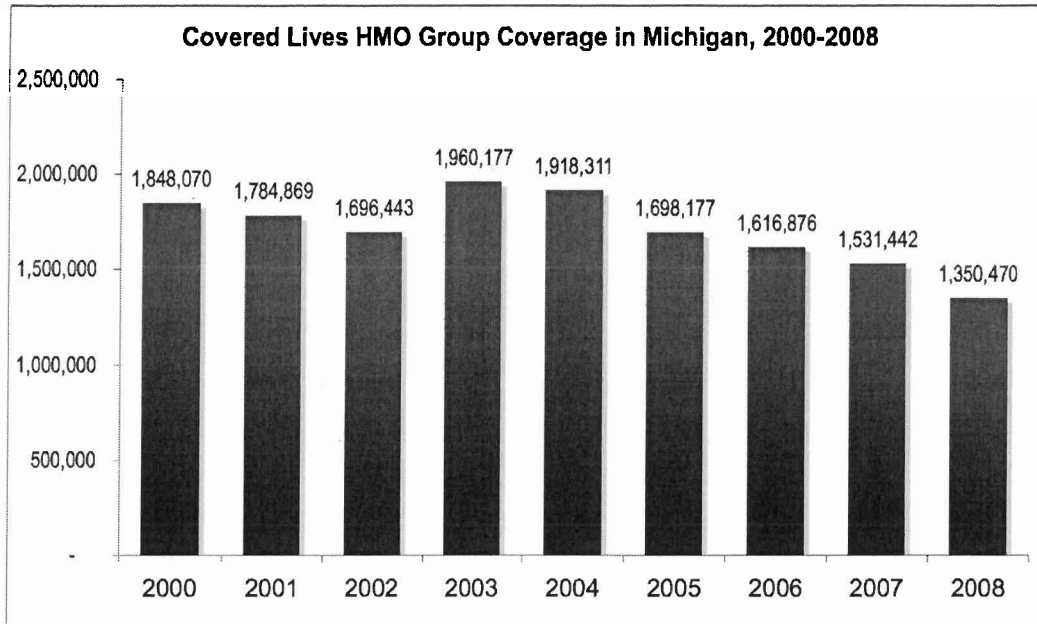
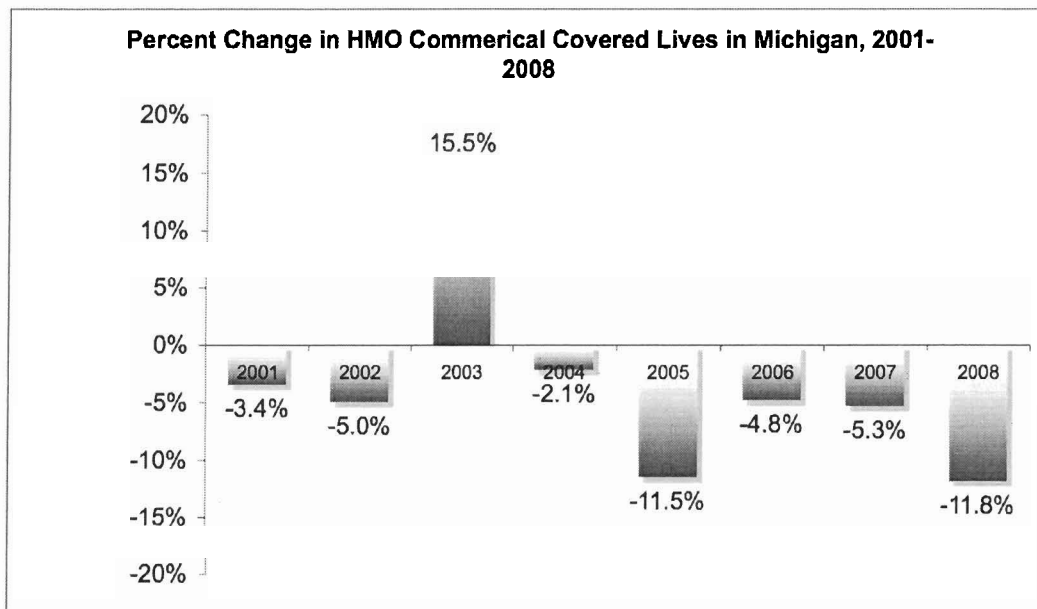


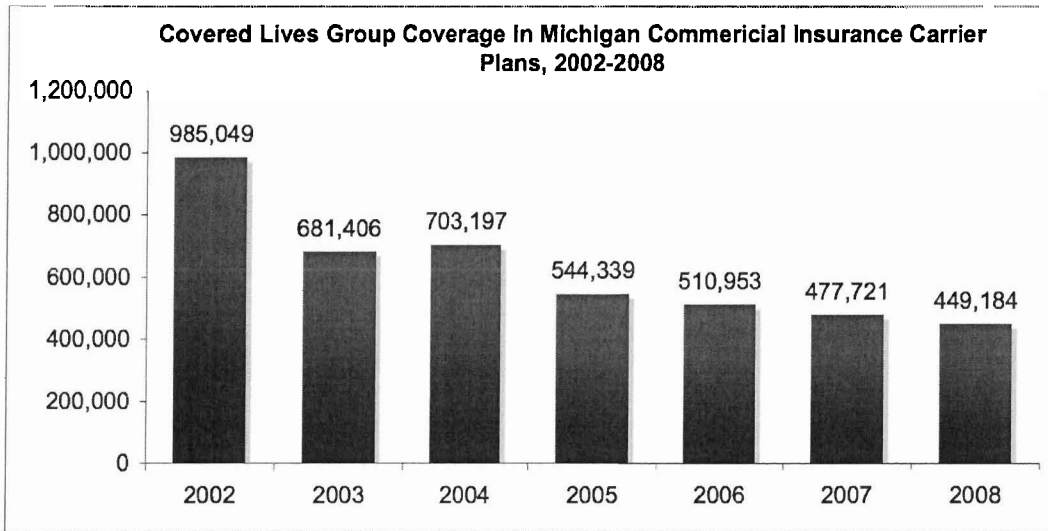
Figure 2



Note: The numbers in Figures 1 and 2 do not match the numbers in Table 1. In part this is because the ending periods for the years are different, during a period of declining enrollment. Table 1 numbers are as of September 30, whereas the numbers in this figure are as of December 30. But it also appears that some HMOs report enrollment data differently for the two different OFIR reporting requirements.

Source: Calculations by Health Management Associates based on data collected by the Michigan Office of Financial and Insurance Regulation on Form FIS 0322, "Michigan Health Insurance Enrollment, Premiums and Losses."

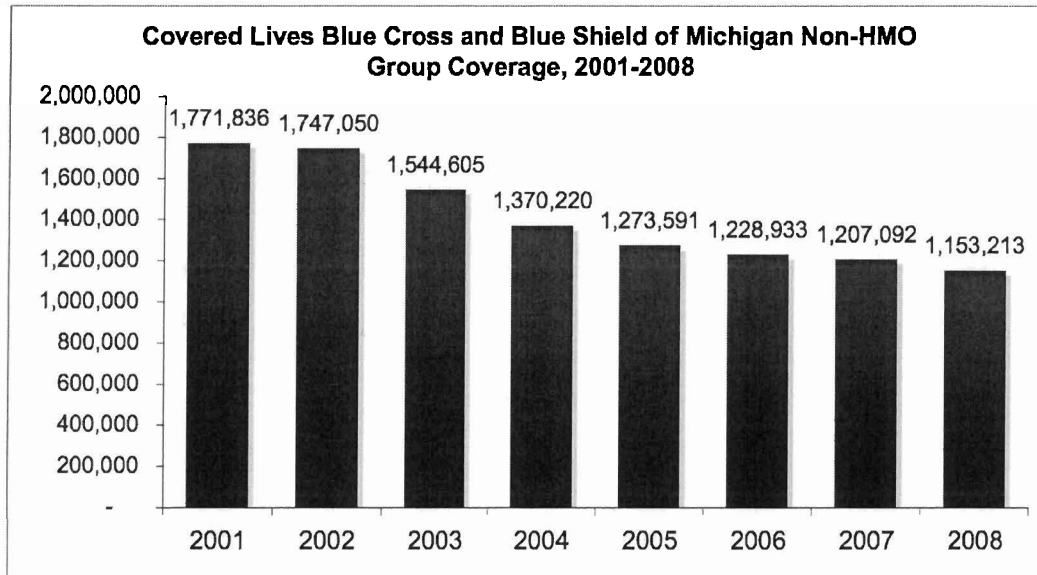
Figure 3



Note: Because of changes in the way data were collected and reported prior to 2006, these data do not include covered lives for BCS Life Insurance Company, which sells most of its coverage in partnership with Blue Cross and Blue Shield of Michigan and whose customer base is composed primarily of school districts. The number of covered lives for 2006 for BCS Life Insurance was 100,070 in 2006, 99,922 in 2007, and 96,744 in 2008, which represented 37 percent of total commercial group covered lives in 2008 (when BCS Life is included in the denominator).

Source: Calculations by Health Management Associates based on data collected by the Michigan Office of Financial and Insurance Regulation on Form FIS 0322, "Michigan Health Insurance Enrollment, Premiums and Losses."

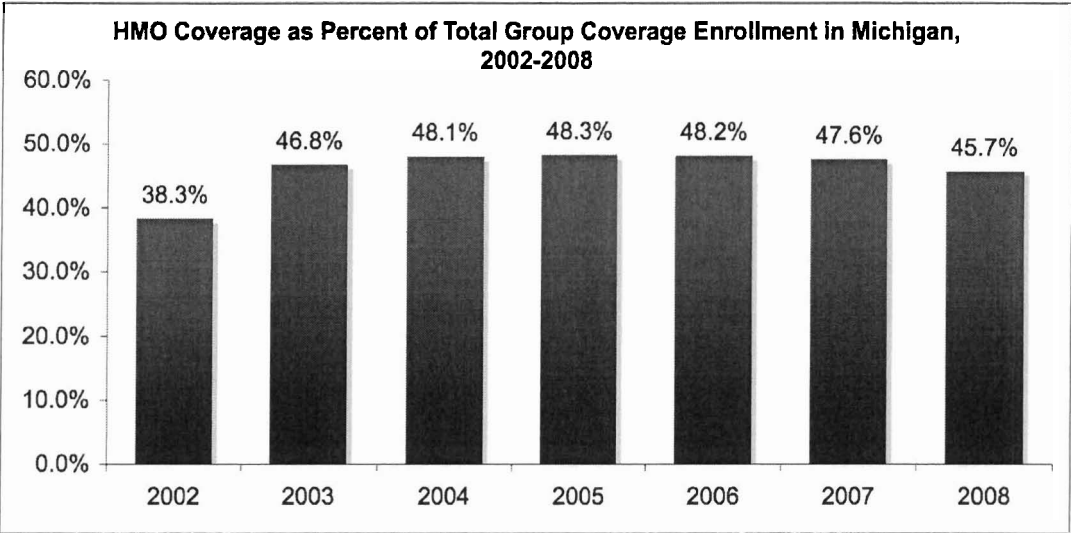
Figure 4



Source: Calculations by Health Management Associates based on data collected by the Michigan Office of Financial and Insurance Regulation on Form FIS 0322, "Michigan Health Insurance Enrollment, Premiums and Losses."

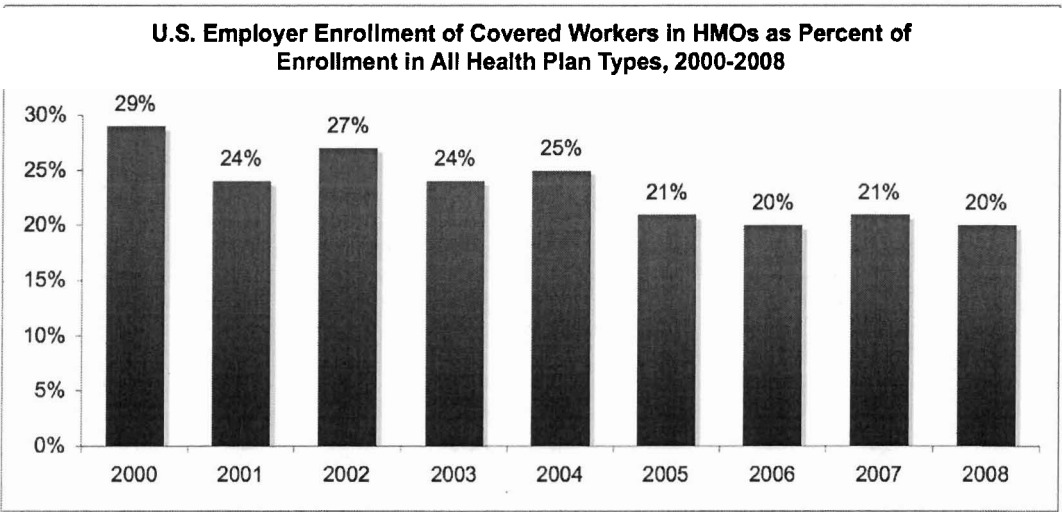
Although all forms of commercial coverage in Michigan have experienced drops in enrollment, HMOs have recently accounted for a diminishing portion of the total market. As shown in Figure 5, HMO enrollment as a proportion of total commercial enrollment coverage grew through 2005 but has been declining since. In 2008, HMOs accounted for about 46 percent of total employer-based coverage in the state (excluding self-insured coverage).

Figure 5



Source: Calculations by Health Management Associates based on data collected by the Michigan Office of Financial and Insurance Regulation on Form FIS 0322, "Michigan Health Insurance Enrollment, Premiums and Losses."

Figure 6



Source: Kaiser Family Foundation and Health Research & Education Trust, *Annual Survey of Employer Health Benefits, 2008*, www.kff.org.

As Figure 6 illustrates, Michigan has not been alone in experiencing a decline in HMO-based coverage. For the nation as a whole during the period from 2000 to 2008, HMOs accounted for a decreasing proportion of total employer coverage, although the proportion has held more-or-less steady for the last four years. (The relatively small proportion of HMO enrollment for the nation compared to the larger figure for Michigan reflects the fact that the national data include self-insured plans, whereas the Michigan data includes only fully insured plans.)

Responses from HMO Officials

The legislative language that mandates this study specifies that it should delineate “suggestions to increase the number of persons enrolled in health maintenance organizations.” In light of this requirement, we interviewed several HMO officials and an insurance broker to get their perspective on why HMO enrollment has been declining and what might be done to ameliorate the problem. They report that, in part, the decline is due to the Michigan’s deteriorating economic environment. As economic conditions have worsened, some employers who offered coverage have gone out of business, fewer of the remaining employers are offering coverage of any kind, and a number of those who continue to do so are no longer contributing to dependent coverage. As employers cut back on their full-time work forces and rely more on contract workers, more people are having to turn to the individual market for coverage. Traditionally, HMOs have not been strong competitors in the individual market. In addition, some large employers that previously offered Michigan-based HMOs along with other health plans have consolidated coverage offerings and are now offering coverage only through national carriers.

HMO officials generally agree that HMOs have probably lost some customers to PPOs. As health care premiums have continued to rise at a rate that exceeds overall economic growth even when the economy is healthy, employers have increasingly sought ways to limit what they pay for coverage. One insurance broker serving primarily employers with 100 or fewer workers reported that every single employer he serves reduced benefits when renewing health coverage in the last year or so. Even though HMOs are now able to match the cost-sharing features of PPO coverage to help lower the premium price, HMOs do not have the same flexibility to adjust benefits to bring down the cost to employers. The list of mandated benefits for HMOs is more extensive than what is required of other forms of health coverage.

HMO officials are strong supporters of the greater flexibility granted to HMOs to develop benefit packages with relatively higher consumer cost-sharing. Even though few benefit packages are offered and sold that include cost-sharing provisions that exceed the previously allowed limits, the HMOs believe that this flexibility is necessary if they are to remain competitive in the future as health care costs continue to escalate. To this point, HMOs

have relied more on higher deductibles as a way of designing less costly benefit plans, but they are also developing options that include copayments and coinsurance at higher levels than was common in the past.

Several HMO officials noted that in the last several years their companies have created subsidiaries that offer PPO coverage. They report that the ability to offer both types of plans together has helped to make their HMO offerings more saleable. Employers are sometimes reluctant to force all employees into an HMO, but they will often offer HMO coverage if they can give their employees the option of PPO coverage as well.

Because part of the study objective is to determine if there are ways to make HMOs more successful in gaining enrollment, we asked HMO officials what they thought would improve HMOs' competitive position. The officials generally believe that they could be more competitive relative to other forms of coverage if the law were altered to allow them more flexibility in benefit design, specifically in deciding which services are included in the benefit package. HMOs compete with PPOs, indemnity insurers, and self-insurance—forms of coverage that can offer less comprehensive benefits, which, of course, translates to lower premiums. HMOs would be in a better competitive position, according to HMO officials, if they were not required to offer such extensive coverage. As an example, they note that it is difficult to persuade a young, unmarried male that he should buy HMO coverage that includes maternity benefits, when he can save money by buying PPO coverage that does not include such coverage and, therefore, has a lower premium.

There is certainly some truth to the argument that HMO coverage would be more appealing to some employers if HMOs could offer less costly coverage by excluding some services they are now required to include in the benefit package. At the same time, it is worth recalling that HMO enrollment in Michigan has, at least until recently, fallen less rapidly than enrollment other forms of employer coverage. So the limited benefit flexibility has not kept HMOs from holding their own during most recent years.

Those who wish to preserve the status quo with respect to benefit mandates also point out that part of what makes HMOs HMOs is the comprehensive benefit package; if the benefit distinctions were lifted, one could argue that the difference between an HMO and a PPO would become even more blurred than it is at present.

Some HMO officials disagree with this argument, saying that there would be much in the way of important distinctions that would remain. Most importantly, at least some HMO models would continue to be the only form of coverage that relies on a physician to serve as "gatekeeper" and care manager, someone who is responsible for the overall integration and management of the patient's care, including referrals to physician specialists. Many would argue that having someone serve this function—which is part of what has now come to be called a "medical home"—helps to ensure better-integrated, higher-quality, and more

cost-effective care. Moreover, unlike other forms of insurance, HMOs typically go through an accreditation and credentialing process that verifies they are meeting care delivery quality standards. The HMOs argue that the price penalty HMOs pay for having to meet the extensive benefit mandates in effect closes off to many potential buyers the opportunity to purchase this better integrated, high-quality delivery system that HMOs can offer, especially in the individual market.

The critics of the insurer arguments for reducing benefit mandates also point out that there is an offsetting cost advantage enjoyed by HMOs: they do not have to pay premium taxes. This gives them a price advantage not available to traditional insurers (although Blue Cross and Blue Shield of Michigan benefits from a similar tax advantage).

Conclusion

The greater flexibility that HMOs now have to include higher cost-sharing provisions in the plans they offer has not prevented them from losing enrollment, but without this flexibility, they would probably be worse off. Part of the loss of business reflects a trend experienced by all forms of insurance: as health care costs have continued to rise at rates substantially exceeding the rate of overall economic growth, employers have found premiums less affordable. The economic recession, especially as severe as it is in Michigan, has exacerbated the problem. In response, some employers have cut back on or even eliminated coverage, while others have turned to less expensive forms of coverage, including coverage with less comprehensive benefits. In the last year or so, HMOs seem to be faring somewhat worse than other forms of commercial coverage; their share of the market has declined. HMO officials generally believe that they could be more competitive if they could design and offer coverage packages with less comprehensive service benefits.