Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986
TDD: (517) 373-0543

House Bill 5282 (Substitute S-2)
House Bill 5283 (Substitute S-2)
Sponsor: Representative Virgil Smith (H.B. 5282)
Representative Edward Gaffney, Jr. (H.B. 5283)
House Committee: Insurance
Senate Committee: Health Policy

Date Completed: 4-23-08

CONTENT

House Bill 5282 (S-2) would add Chapter 37A (Individual Health Coverage Plans) to the Insurance Code to establish regulations for individual health insurance policies and certificates applicable to all carriers, i.e., insurers, health maintenance organizations (HMOs), and Blue Cross and Blue Shield of Michigan (BCBSM). Specifically, the bill would do the following:

-- Allow a carrier to establish a health questionnaire for applicants for individual coverage to fill out, and allow the carrier to refuse coverage if an applicant did not meet the carrier's established criteria.
-- Prohibit BCBSM, or an HMO during its open enrollment period, from refusing to cover an individual due to any past or current medical condition, history, or treatment.
-- Allow rate differentials for initial condition to be used only when coverage was issued initially.
-- Require a carrier to renew or continue an issued plan at the individual's option.
-- Require a carrier to take certain actions in order to discontinue a particular individual benefit plan.
-- Require a carrier to take certain actions in order to discontinue all coverage in the individual market; and prohibit the carrier from offering individual plans for five years.
-- Prohibit a carrier from discouraging an individual from seeking coverage due to his or her initial condition or claims experience; or providing for varied compensation to producers or the termination of an agreement with a producer based on an individual's initial condition or claims experience.
-- Require the Commissioner of the Office of Financial and Insurance Regulation (OFIR) annually to determine the statewide status of competition in the individual market and issue a report including suggested changes to promote competition.

House Bill 5283 (S-2) would amend the Nonprofit Health Care Corporation Reform Act to do the following:

-- Declare BCBSM to have a charitable and social mission.
-- Create the "Charitable and Social Mission Fund" within the State Treasury to provide subsidies for the cost of individual health coverage.
-- Require BCBSM to issue an annual report detailing how it fulfilled its charitable and social obligations.
-- Reduce BCBSM's maximum allowable surplus, and require excessive surplus funds to be deposited in the proposed Fund.
-- Provide that BCBSM would be subject to proposed Chapter 37A of the Insurance Code.

-- **Require the appointment of two additional public members to BCBSM's board of directors.**
-- **Require BCBSM to submit to the OFIR Commissioner and the Legislature every two years a report on its expenses.**
-- **Allow the rates charged for nongroup, group conversion, and Medicare supplemental coverage to include rate differentials based on the subscriber's health choices.**
-- **Reduce the timeline for rate filings and requested hearings under the Act.**

The bills are tie-barred to each other. They are described below in further detail.

House Bill 5282 (S-2)

Chapter 37A: Individual Health Coverage Plans

Scope of Chapter 37A. The proposed chapter would apply to any individual health benefit plan that was subject to policy form or premium approval by the OFIR Commissioner.

"Health benefit plan" or "plan" would mean an individual expense-incurred hospital, medical, or surgical policy, BCBSM certificate, or HMO contract. The term would not include accident-only, credit, or disability income insurance; long-term care insurance; Medicare supplemental coverage; coverage issued as a supplement to liability insurance; coverage only for a specified disease or illness; dental-only or vision-only insurance; worker's compensation or similar insurance; automobile medical-payment insurance; or Medicaid or Medicare coverage.

Application & Issuance. At the time of initial application, each individual seeking to be covered under an individual health benefit plan could complete a health questionnaire established by the carrier that was designed to elicit the health history of the applicant and of each individual who would be covered under the applicant's individual health benefit plan. A carrier, except as otherwise provided, could refuse coverage to an individual under an individual plan if, based on the responses to the questionnaire, he or she did not satisfy the criteria established for coverage by the carrier.

("Carrier" would mean a person that provided health benefits, coverage, or insurance to an individual in Michigan. For the purposes of Chapter 37A, the term would include a health insurance company authorized to do business in Michigan, BCBSM, an HMO, or any other person providing a plan of health benefits, coverage, or insurance subject to State insurance regulation. The term would not include an HMO that provided only Medicaid coverage.)

If a carrier established a health questionnaire, it would have to consult with, and receive the approval of, the OFIR Commissioner in developing it and would have to apply its use to each applicant uniformly.

Blue Cross and Blue Shield could not refuse coverage to an individual due to any past or current medical condition, history, or treatment. An HMO could not refuse coverage to an individual due to any medical condition, history, or treatment during its open enrollment period pursuant to Section 3537.

(Under Section 3537, an HMO must have an open enrollment period of at least 30 days during each consecutive 12-month period. During the open enrollment period, the HMO must accept up to its capacity individuals in the order in which they apply in a manner that does not unfairly discriminate on the basis of age, sex, race, health, or economic status.)

If a carrier refused coverage for an individual, it would have to give him or her a written notice of the rejection, the reasons for the rejection, and the availability of coverage from BCBSM or an HMO during an open enrollment period.

Notwithstanding any other provision of the Code, a health benefit plan could not be rescinded, canceled, or limited due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from the written information submitted on or with an application before the plan's contract was issued. This provision would not limit a plan's remedies upon a showing of intentional misrepresentation of material fact.

Rate differentials for initial condition could be used only when coverage was issued initially and could not be changed by a carrier at any time after issue as a result of subsequent changes in initial condition of individuals already covered under the plan. A carrier could use rate differentials based on initial condition for any individual who was added subsequently to the plan only at the time he or she was added.

("Initial condition" would mean the initial health condition at the time of application of the applicant and each individual who would be covered under his or her plan. The term also would mean the initial health condition at the time of enrollment of any individual added to the plan subsequently.)

Guaranteed Renewal. Except as otherwise provided, a carrier that had issued a health benefit plan would have to renew the plan or continue it in force at the individual's option.

A guaranteed renewal would not be required in cases of fraud, intentional misrepresentation of material fact, or lack of payment; if the carrier no longer offered that plan; if the carrier no longer offered coverage in the individual market; or if the individual moved outside the carrier's service area.

Discontinuation. A carrier could not discontinue offering a particular plan in the individual market unless it did all of the following:

-- Notified each individual covered under the plan of the discontinuation at least 90 days before the discontinuation date.
-- Offered to each individual in the individual market provided this plan, the option to purchase any other plan currently being offered in the individual market.
-- Acted uniformly without regard to any health status factor of enrolled individuals or individuals who could become eligible for coverage in making the determination to discontinue coverage and in offering other plans.

A carrier could not discontinue offering all coverage in the individual market unless it did all of the following:

-- Notified the Commissioner and each individual of the discontinuation at least 180 days before the coverage expired.
-- Discontinued all health benefit plans issued in the individual market and did not renew coverage under such plans.

If a carrier discontinued all coverage in the individual market, it could not provide for the issuance of any health benefit plans in the individual market for five years, beginning on the date of the discontinuation of the last plan not renewed.

The discontinuation provisions would not apply to a "short-term or 1-time limited duration benefit plan of no longer than 6 months", i.e., a plan that met all of the following criteria:

-- Was issued to provide coverage for a period of up to 185 days, except that the plan could permit a limited extension of benefits after the date it ended solely for expenses attributable to a condition for which a covered person incurred expenses during the term of the plan.
-- Was nonrenewable, although the carrier could provide coverage for one or more subsequent periods as described under the first criterion, if the total of the coverage periods did not exceed 185 days out of any 365-day period, plus any additional days permitted by the plan for a condition for which a covered person incurred expenses during the term of the plan.
-- Did not cover any preexisting conditions.
-- Was available with an immediate effect date, without underwriting, upon the carrier's receipt of a completed application indicating eligibility under the carrier's eligibility requirements, except that coverage that included optional benefits could be offered on a basis that did not meet this requirement.

Prohibited Action. A carrier could not, directly or indirectly, encourage or direct an individual to refrain from filing an application for a health benefit plan with the carrier because of his or her initial condition or claims experience.

A carrier also could not, directly or indirectly, encourage or direct an individual to seek coverage from another carrier because of his or her initial condition or claims experience, except as otherwise

provided in Section 3755(4) (which would require a carrier who refused coverage to an individual to notify him or her of the availability of coverage through BCBSM or an HMO during an open enrollment period).

In addition, a carrier could not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provided for or resulted in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the individual's initial condition or claims experience. This prohibition would not apply to a compensation arrangement that provided compensation to a producer on the basis of percentage of premium, if the percentage did not vary because of the individual's initial condition or claims experience.

A carrier could not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the initial condition or claims experience of the individual placed by the producer with the carrier.

Competition. By April 1, 2011, and by each subsequent April 1, the OFIR Commissioner would have to make a determination as to whether a reasonable degree of competition in the health benefit plan market existed on a statewide basis. In making this determination, the Commissioner would have to hold a public hearing in 2011 and could hold hearings after that; would have to seek advice and input from appropriate independent sources; and would have to issue a report delineating specific classifications and kinds or types of insurance, if any, where competition did not exist and any suggested statutory or other changes necessary to increase or encourage competition. The report would have to be based on relevant economic tests, including those specified in the bill (described below). Report findings could not be based on any single measure of competition, but appropriate weight would have to be given to all measures of competition.

If the results of the report were disputed or if the Commissioner determined that circumstances that the report was based on had changed, the Commissioner would have to issue a supplemental report that included a certification of whether a reasonable degree of competition existed in the health benefit plan market. The supplemental report and certification would have to be issued by the 15th of December immediately following the release of the initial report that this report supplemented and would have to be supported by substantial evidence.

For the purposes of making the determination and issuing the reports, the Commissioner would have to consider all of the following:

-- The extent to which any carrier controlled all or a portion of the health benefit plan market.
-- Whether the total number of carriers writing plan coverage in Michigan was sufficient to provide multiple options to individuals.
-- The disparity among plan rates and classifications to the extent that those classifications resulted in rate differentials.
-- The availability of coverage to individuals in all geographic areas.
-- The overall rate level that was not excessive, inadequate, or unfairly discriminatory.
-- Any other factors the Commissioner considered relevant.

The reports and certifications would have to be forwarded to the Governor, the Clerk of the House, the Secretary of the Senate, and all the members of the Senate and House standing committees on insurance and health issues.

Group Guaranteed Renewal

Under the Insurance Code, except as provided in Sections 2213b and 3539, an insurer and an HMO, respectively, must renew or continue in force a group policy or certificate at the option of the sponsor of the plan. Under the bill, this requirement would apply except as provided in those sections and Section 3711.

(Sections 2213b and 3539 provide that guaranteed renewal is not required in cases of fraud or intentional misrepresentation of material fact, lack of payment, if the insurer or HMO no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area. Section 3711 contains similar provisions applicable to small employer group policies.)

House Bill 5283 (S-2)

Charitable & Social Mission

The Nonprofit Health Care Corporation Reform Act provides that each corporation subject to it (BCBSM) is declared to be a charitable and benevolent institution and its funds and property are exempt from taxation by the State or any political subdivision of it. The bill would declare BCBSM to be a charitable and benevolent institution with a charitable and social mission, and its funds and property would be tax-exempt in recognition of this mission.

Charitable & Social Mission Fund

The bill would create the Fund within the State Treasury. The State Treasurer could receive money or other assets from any source for deposit into the Fund, and would have to direct its investment. The Treasurer would have to credit to the Fund interest and earnings from investments.

Money in the Fund at the close of the fiscal year would have to remain in the Fund and could not lapse to the General Fund. The OFIR Commission would be the administrator of the Fund for auditing purposes.

Fund money could be used only to maintain the health of Michigan citizens by expanding access to health care by providing subsidies for the cost of individual health coverage.

By April 1 of each year, BCBSM would have to file with the Commissioner, in a format he or she required, a report that provided for all of the following for the immediately preceding calendar year:

-- How BCBSM met its charitable and social mission obligations.
-- The amount BCBSM spent on its charitable and social mission obligations.
-- The amount of tax-exempt benefit obtained by BCBSM.

The Commissioner would have to require the report to be detailed with sufficient specificity to determine exactly how BCBSM met, and the amount it spent on, its charitable and social mission obligations.

Surplus

The Act requires BCBSM to possess and maintain unimpaired surplus in an amount determined adequate by the Commissioner to comply with Section 403 of the Insurance Code (which provides that an insurer is not authorized to do business in Michigan if it is not safe, reliable, and entitled to public confidence). The bill specifies that the surplus could not be excessive in light of BCBSM's charitable and social mission and obligation under the Act.

The bill would retain a requirement that the Commissioner follow the risk-based capital requirements as developed by the National Association of Insurance Commissioners to determine whether BCBSM is in adequate compliance with Section 403 of the Code.

Under the bill, if BCBSM filed a risk-based capital report that indicated that its surplus was excessive in light of its charitable and social mission and obligations under the Act, the Commissioner, after examining the surplus of BCBSM and its subsidiaries, would have to order any excess surplus deposited into the proposed Fund. An amount could not be ordered deposited into the Fund if it would impair BCBSM's surplus.

Currently, BCBSM may not maintain a surplus in an amount equal to or greater than 200% of the authorized control level under risk-based capital requirements multiplied by five. Under the bill, the amount would be multiplied by three, rather than five.

Currently, if BCBSM files a risk-based capital report indicating that its surplus is more than the allowable maximum surplus for two successive calendar years, it must file a plan for approval by the Commissioner to adjust its surplus to a level below the allowable maximum. If the Commissioner disapproves the plan, he or she must formulate an alternate plan and forward it to BCBSM. The corporation must begin implementation of the plan immediately upon receiving approval of its plan by the Commissioner or upon receiving the alternate plan. Under the bill, instead, if BCBSM filed a report indicating a surplus greater than that allowable maximum for two years, the Commissioner would have to require it to deposit into the Fund an amount that would

adjust the surplus to a level below the allowable maximum.

Individual Coverage

The bill would delete a requirement that, except as otherwise provided, BCBSM renew or continue in force a nongroup certificate at the option of the individual. The bill provides that BCBSM would be subject to proposed Chapter 37A of the Insurance Code (which would contain a guaranteed renewal provision applicable to all carriers).

BCBSM Board

Currently, the property and lawful business of BCBSM must be held and managed by a board of directors consisting of up to 35 members. Under the bill, the board could have up to 37 members.

Under the Act, four voting members (including two who are retired and at least 62 years old) must be representatives of the public appointed by the Governor by and with the advice and consent of the Senate. The bill would retain this requirement, and add that, effective January 1, 2009, two additional voting members would have to be representatives of the public. One would have to be appointed by the Senate Majority Leader and one would have to be appointed by the Speaker of the House of Representatives.

BCBSM Report

The bill would require BCBSM, by April 1, 2009, and biennially after that, to report to the OFIR Commissioner and to the Senate and House standing committees on health and insurance issues on all of the following for the previous two-year period:

-- All board of directors, officer, corporate body, committee, and advisory council expenses, including compensation and expenses for travel, lodging, food, and beverages.
-- All advertising expenditures.
-- All lobbying expenses.
-- All contracts between BCBSM and a director or officer or between BCBSM and any other corporation, firm, or association of which one or more of BCBSM's directors or officers were directors or officers or were otherwise interested and all information necessary to satisfy Section 306.

(Section 306 requires such contracts to be fair and reasonable to the corporation and the material facts as to the officer's or director's relationship or interest as to the contract to be disclosed or known to the board; and requires the board to approve or ratify the contract.)

Rate Differentials

Under the bill, the rates charged for nongroup, group conversion, and Medicare supplemental coverage could include rate differentials based on tobacco use and the subscriber's participation in covered health screenings and covered wellness programs.

Rate Filing

Currently, except as otherwise provided, a filing of information and materials relative to a proposed rate may not be made less than 120 days before its proposed effective date. Under the bill, the filing could not be made less than 60 days before the proposed effective date.

Within 30 days after a filing is made, the OFIR Commissioner must either give written notice to BCBSM, and to each person who has requested notice of those filings within the previous two years, that the filing is in material and substantial compliance with certain requirements and is complete; or give written notice to BCBSM that it has not yet complied with the prescribed requirements, stating specifically in what respects the filing fails to comply. Under the bill, the Commissioner would have to give the notice within 15 days after a filing was made. (The bill would retain a requirement that the Commissioner approve, approve with modifications, or disapprove the rate filing 60 days after receiving it, based upon whether the filing meets the Act's requirements. The bill also would retain a provision prohibiting the Commissioner from approving, approving with modifications, or disapproving a filing until a requested hearing has been completed and an order issued.)

Currently, within 10 days after the filing of a notice that BCBSM's filing is noncompliant, BCBSM must submit to the Commissioner any additional information and materials

that he or she requests. Within 10 days after receiving the additional information and materials, the Commissioner must determine whether the filing is in material and substantial compliance with the prescribed requirements. The bill would reduce both of these time periods to eight days.

The Act requires the Commissioner to make available forms and instructions for filing for proposed rates at least 180 days before the proposed effective date of the filing. Under the bill, the Commissioner would have to make the forms and instructions available at least 90 days before the proposed effective date.

Hearing

Currently, within 15 days after receiving a request for a hearing, the Commissioner must determine if the person who requested it has standing. Under the bill, the Commissioner would have to make the determination within eight days.

Currently, within 30 days after a request for a hearing is received, and upon at least 15 days' notice to all parties, the hearing must be commenced. The bill would reduce these time periods to 15 days and eight days, respectively.

Under the Act, each party to the hearing must be given a reasonable opportunity for discovery before and throughout the course of the hearing. The hearing officer, however, may terminate discovery at any time, for good cause shown. The hearing must be conducted in an expeditious manner. Under the bill, except for good cause shown, the hearing officer would have to render a proposal for decision within 30 days after the hearing began.

Currently, within 30 days after receiving a hearing officer's proposal for decision, the Commissioner must by order render a decision that includes a statement of findings. The bill would reduce this time period to eight days.

MCL 500.2213b et al. (H.B. 5282)
550.1102 et al. (H.B. 5283)

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

House Bill 5282 (S-2)

The bill would make changes to the individual health insurance market in the State of Michigan. Local governments and the State provide group health insurance to employees and the State also provides health care coverage to the indigent through the Medicaid program. Changes to the individual health insurance market would not directly affect group coverage or Medicaid. As such, the bill would have no direct fiscal impact on health care costs for State or local government. If reform of the individual health insurance market led to the coverage of more individuals, there would likely be a reduction in the amount of uncompensated care, which would reduce costs for publicly owned hospitals.

The bill would have an indeterminate fiscal impact on the Office of Financial and Insurance Regulation, which would have oversight responsibilities.

House Bill 5283 (S-2)

The bill would set up a Charitable and Social Mission Fund in the Department of Treasury. The Fund would receive revenue from excessive surplus revenue earned by Blue Cross and Blue Shield of Michigan as identified in a risk-based capital report filed by BCBSM. (House Bill 5284 (S-2) would direct that $100 million be deposited into the Fund, but House Bill 5283 (S-2) does not specify an amount.) The Fund would provide subsidies to individuals for the purchase of individual health insurance. These subsidies would increase the number of people in the State with health insurance, which would marginally reduce the amount of uncompensated care, especially for hospitals. As several hospitals in Michigan are owned by local units of government, a reduction in uncompensated care would lead to a reduction in costs for those units. A reduction in uncompensated care at the other publicly owned hospital, University Hospital in Ann Arbor, would lead to a reduction in costs for the University of Michigan.

The bill would require OFIR to administer the Fund, which would increase its administrative responsibilities and the administrative costs of the Office. The

administrative costs largely would depend on the level of activity in the Fund.

Fiscal Analyst: Steve Angelotti
Elizabeth Pratt
Maria Tyszkiewicz

S0708\s5282sa