House
Legislative
Analysis
Section

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BCBSM: SMALL GROUPS & OTHER REGULATORY AMENDMENTS

House Bill 4279 (Substitute H-3)
Sponsor: Rep. William O'Neil

House Bill 4280 (Substitute H-1)
Sponsor: Rep. David Robertson

House Bill 4281 (Substitute H-2)
Sponsor: Rep. David Farhat

House Bill 4282 (Substitute H-1)
Sponsor: Rep. Edward Gaffney

Committee: Health Policy
Complete to 5-27-03

A SUMMARY OF HOUSE BILLS 4279-4282 AS REPORTED BY THE HOUSE COMMITTEE ON HEALTH POLICY 5-22-03

House Bills 4279-4282 would amend the Nonprofit Health Care Corporation Act, also known as the Blue Cross Blue Shield Act, to ease certain statutory restrictions on Blue Cross and Blue Shield of Michigan. House Bill 4279, the primary bill in the package, is tie-barred to House Bill 4553, which would add a new section to the Insurance Code of 1956 to regulate health coverage made available to small employers by commercial insurers, Blue Cross and Blue Shield of Michigan, and health maintenance organizations (HMOs). There is a separate summary available from the House Legislative Analysis Section detailing the provisions of House Bill 4553.

House Bill 4279 would amend the Nonprofit Health Care Corporation Reform Act to do the following:

- provide that BCBSM would be subject to a new Chapter 37 of the Insurance Code (as proposed by House Bill 4553) dealing with health coverage for small employer groups, and specify that when there was a conflict between the BCBSM act and Chapter 37, Chapter 37 would supersede the BCBSM act;

- exempt BCBSM from state and local utility usage taxes and fees;

- require BCBSM to maintain unimpaired surplus in an amount determined adequate by the Commissioner of the Office of Financial and Insurance Services (OFIS), but not greater than 200 percent of the authorized control level under risk based capital requirements multiplied by five;

- allow BCBSM to remedy a deficiency in surplus with planwide viability contributions by subscribers at rates prescribed by the bill;

- require BCBSM to report financial information using statutory accounting principles;

• provide that BCBSM could include age as a factor when determining nongroup and group conversion rates for a certificate that included prescription drug coverage, under certain conditions (House Bill 4281, described later, addresses a proposed prescription drug pilot program);

• permit BCBSM to own or control an insurance company that was authorized only to sell long-term care insurance (House Bill 4280, described later, also addresses this);

• permit BCBSM to condition the granting of long-term care insurance coverage on an applicant's health history;

• permit BCBSM to enter into contracts with health care providers practicing legally in another jurisdiction (House Bill 4282, described later, also addresses this);

• require BCBSM to wait 60 days before a new certificate, a change to an existing certificate, or a rate charge change could take effect, unless approved by the commissioner before the 60-day period expired;

• allow BCBSM to request that the commissioner hold a hearing on a proposed certificate or rate, and allow the attorney general to request a hearing on a rate filing;

• apply current rate filing and approval requirements to nongroup Medicare supplemental coverage; and

• expand the authority of the attorney general to include enforcement of Chapter 37 of the Insurance Code (which would be created by House Bill 4553), and allow local units of government, state agencies, and other persons to bring actions to ensure enforcement of Chapter 37.

A more detailed description of the bills in this package follows.

House Bill 4279

Exemption from utility usage taxes and fees. The act declares that BCBSM is a charitable and benevolent institution and exempts its funds and property from state and local taxes. The bill would exempt BCBSM from utility usage taxes and utility usage fees imposed by the state or by any political subdivision of the state.

Adequate and unimpaired surplus. Section 205 requires BCBSM to maintain a contingency reserve of 65-150 percent of the target contingency reserve level. The target contingency reserve level is established by the commissioner each year according to a methodology set forth in the act. The contingency reserve is funded by subscribers' contributions for risk and contributions for planwide viability. While contributions for risk are determined as part of the normal rate-making process, rates for contributions for planwide viablility depend on the actual level of the contingency reserve and the type of subscriber. (Small group and nongroup subscribers stop making contributions for planwide viability once the actual contingency reserve exceeds 95 percent of the target level, and medium group and large group subscribers make contributions until the reserve exceeds 105 percent of the target level.) If the contingency reserve exceeds 150 percent of the target level, BCBSM must make adjustments to reduce its reserves. If the

contingency reserve exceeds the required range at the end of a calendar year, BCBSM must make adjustments to achieve the require range and must file with the commissioner a description of the adjustments.

Also, the commissioner is required to examine BCBSM's annual financial statement to determine whether the contingency reserve is outside the required range, and if it is outside the required range at the end of two successive calendar years, BCBSM must file a plan, with the commissioner, to adjust the contingency reserve to a level within the required range. If the commissioner disapproves the plan, he or she must formulate a plan and forward the plan to BCBSM, which then must implement it.

The bill would replace the act's contingency reserve provisions with a requirement that BCBSM possess and maintain "unimpaired surplus" in an amount determined adequate by the commissioner. Specifically, the commissioner would have to determine that BCBSM's unimpaired surplus was sufficient to put it in compliance with a section of the Insurance Code (Section 403) requiring insurers to be "safe, reliable, and entitled to public confidence". In making this determination, the commissioner would have to follow the risk-based capital requirements as developed by the National Association of Insurance Commissioners (NAIC).

If BCBSM filed a risk-based capital report that indicated that its surplus was less than the amount determined to be adequate, it would have to prepare and submit a plan for remedying the deficiency in accordance with risk-based capital requirements adopted by the commissioner. As part of its plan, BCBSM could propose that subscribers be required to make planwide viability contributions to surplus. The commissioner would have to approve the actual contribution rate for planwide viability contributions, subject to the following limits:

- If BCBSM's surplus was less than 200 percent but more than 150 percent of the "authorized control level" under risk-base capital requirements--i.e., the number determined under the risk-based capital formula in accordance with the instructions developed by the NAIC and adopted by the commissioner--the maximum contribution rate would be one-half of one percent of the rate charged to subscribers for the benefits provided.

- If BCBSM's surplus was 150 percent or less than the authorized control level under risk-based capital requirements, the maximum contribution rate would be one percent of the rate charged to subscribers for the benefits provided.

In any event, BCBSM could not maintain surplus in an amount that equaled or exceeded 200 percent of the authorized control level under risk-based capital requirements multiplied by five. If BCBSM filed a risk-based capital report indicating that its surplus exceeded this maximum allowable surplus for two successive calendar years, it would have to file a plan for approval by the commissioner to adjust its surplus to a level below the maximum allowable surplus. If the commissioner disapproved BCBSM's plan, the commissioner would be required to formulate an alternate plan and forward that alternate plan to BCBSM. BCBSM would have to begin implementation of the plan immediately upon receipt of approval of its plan by the commissioner or upon receipt of the commissioner's alternate plan.

The bill would replace various references to the act's current contingency reserve requirements with references to the proposed unimpaired surplus requirements.

Lines of business. Section 205 requires BCBSM to define at least five lines of business and to assign a risk factor to each line of business. The bill would eliminate these requirements.

Statutory accounting principles. Section 205 of the act requires BCBSM to record or estimate its liabilities at reasonable values "neither excessive nor inadequate, and in accordance with sound actuarial practices and generally accepted accounting principles to provide for the payment of all debts of the corporation."

The bill would repeal Section 205 and replace the requirement that BCBSM use "generally accepted accounting principles" with a requirement that it report financial information in conformity with sound actuarial practices and "statutory accounting principles" in the same manner designated by the commissioner for other carriers as specified in the Insurance Code. In addition, the bill would permit BCBSM to use approved permitted practices until January 1, 2007 to effectuate the transfer to statutory accounting principles. (For other changes relating to the repeal of Section 205 see "Adequate and unimpaired surplus" and "Lines of business" earlier in the summary.)

Investment of funds. Under current law, BCBSM may invest and reinvest its funds in, and engage in a variety of other investment-related activities with, entities other than domestic, foreign, or alien insurers. The bill would specify that BCBSM was subject to Chapter 9 (Investments) of the insurance code when investing in such entities.

Also, currently BCBSM may invest in domestic, foreign, and alien insurance companies under certain conditions, but such investments cannot result in BCBSM's owning or controlling ten percent or more of the voting securities of any insurance company. The bill would create an exception allowing BCBSM to own or control part or all of an insurance company authorized only to sell long-term care insurance. In that case, the long-term care insurer could not be exempt from taxation after the acquisition, would need to have a governing board separate from BCBSM's board of directors, and would have to transfer its domicile to Michigan as soon as possible after the acquisition (assuming it was not already domiciled here). The transaction would also have to satisfy the requirements of Chapter 13 of the Insurance Code, which regulates insurance holding companies.

Prohibit conditioning sale of one product on another. The bill would prohibit BCBSM from conditioning the sale or varying the terms or conditions of any product sold by BCBSM or a person controlled by BCBSM, by requiring the purchase of any other product from BCBSM or a person controlled by BCBSM.

Small group market requirements. Under the bill, BCBSM would be subject to Chapter 37 of the insurance code. (House Bill 4553 proposes to add Chapter 37, which would regulate small employer group health care coverage. For more see the HLAS summary of House Bill 4553 below.) The bill would state that to the extent that a provision of the BCBSM act concerning health coverage, including, but not limited to premiums, rates, filings, and coverages, conflicted with Chapter 37 of the Insurance Code, Chapter 37 would supersede the BCBSM act.

Prescription drug coverage for nongroup and group conversion subscribers. The rates charged to nongroup and group conversion subscribers for a certificate that included prescription drug coverage under House Bill 4281 could include rate differentials based on age, but could have no more than eight separate age bands. BCBSM would have to file its rates for such coverage in accordance with the requirements for other rate filings. (See "Rate filing and approval/disapproval" later in the summary.)

Conditions for long-term care coverage. The bill would allow BCBSM to condition the granting of long-term care coverage based on answers given on a required application and according to BCBSM's underwriting standards. (For more on the application and conditions under which BCBSM could charge different rates based on age for the same long-term care coverage, see the summary of House Bill 4280 later in the summary.)

Contracts for reimbursement. Under current law, BCBSM may enter into participating contracts for reimbursement with professional health care providers practicing legally in Michigan for health care services that the professional health care providers may legally perform. Contracts are subject to Part 5 of the act.

The bill would allow BCBSM to enter into contracts with health practitioners practicing legally in any other jurisdiction as well, as long as it did not do so "for the purpose of disadvantaging a Michigan health care provider or replacing a participating contract with a Michigan health care provider." The bill would specify that contracts with health practitioners practicing legally in Michigan were subject to Part 5.

Rate filing and approval/disapproval. Currently, BCBSM must submit a copy of any new or revised certificate to the commissioner along with applicable proposed rates and a rate rationale. Certificates and applicable proposed rates are considered approved and effective 30 days after filing with the commissioner, unless the commissioner disapproves them or approves them with modifications, according to conditions set forth in the act. The commissioner may subsequently disapprove any certificate that previously had been deemed approved. Finally, upon request, the commissioner may allow certificates and rates to be implemented prior to filing to allow implementation of a new certificate on the date requested.

The bill would specify instead that if BCBSM wanted to offer a new certificate, change an existing certificate, or change a rate charge, a copy of the proposed certificate, proposed revised certificate, or proposed rate would have to be filed with the commissioner and could not take effect until 60 days after the filing unless the commissioner approved the change in writing before the expiration of the 60-day period. (These requirements would not apply to rates and certificates for nongroup Medicare supplemental subscribers; see "Nongroup Medicare supplemental rates and timelines" later.) The commissioner could still disapprove the certificates or rates or approve them with modifications, according to the conditions currently set forth in the act, but the bill would specify that notices of approval, approval with modifications, or disapproval must be written notices. Also, the bill would specify that the commissioner could subsequently disapprove any certificate or rate charge. The commissioner could still allow certificates and rates to be implemented prior to filing to allow timely implementation of a new certificate.

Commissioner - hearing. The bill would require the commissioner to schedule a hearing not more than 30 days after receipt of a written request from BCBSM. A revised certificate, revised proposed certificate, or proposed rate could not take effect until approved by the commissioner after the hearing. Within 30 days after the hearing, the commissioner would have to notify BCBSM in writing of the disposition of the revised certificate, revised proposed certificate, or proposed rate, together with the commissioner's findings of fact and conclusions.

Attorney general - hearing. The bill would add a requirement that, upon receipt of a rate filing, the commissioner notify the attorney general and provide to the attorney general a copy of the proposed rate revision. Upon making a written request for a hearing within 30 days after receiving notice of the rate filing, the attorney general would have an opportunity for an evidentiary hearing to determine whether the proposed rates met the requirements of the act. The request would have to identify the issues that he or she asserted were involved and what portion of the rate filing was to be heard. If the attorney general requested an evidentiary hearing, the commissioner could not approve, approve with modifications, or disapprove a filing until the hearing had been completed and an order had been issued.

Prior approval and review of rating methodologies and definitions. Currently, the methodology and definitions of each rating system, formula, component, and factor used to calculate rates for BCBSM's group subscribers for each certificate must be filed with the commissioner and are subject to the commissioner's prior approval. The commissioner must approve, disapprove, or modify and approve the methodologies and definitions of each rating system, formula, component, and factor for each certificate, subject to the standard that the resulting rates for group subscribers must be equitable, adequate, and not excessive. Also, the commissioner may from time to time review BCBSM's records to determine proper application of a rating system, formula, component, or factor with respect to any group. BCBSM must refile for approval every three years. The bill would eliminate these provisions.

Section 619 - civil actions and relief. Currently, Section 619 of the act allows the attorney general to bring an action, or apply to the circuit court for a court order, to enjoin BCBSM from transacting business, receiving, collecting, or disbursing money, or acquiring, holding, protecting, or conveying property if that corporate activity was not authorized under the act. In addition, Section 619 allows the attorney general to apply to the circuit court for a court order enjoining an alleged violation of the act or other equitable or extraordinary relief to enforce the act. The bill would specify instead that the attorney general could bring an action, or apply to the circuit court for a court order to enjoin BCBSM from engaging in a corporate activity not authorized under the act *or under Chapter 37 of the Insurance Code*. Likewise, the attorney general could apply to the circuit court for a court order enjoining an alleged violation of the act *or Chapter 37 of the Insurance Code* or other equitable or extraordinary relief to enforce the act *or Chapter 37*.

Finally, Section 619 currently authorizes a political subdivision of the state, an agency of the state, or any person to bring an action in the Ingham County Circuit Court for declaratory and equitable relief against the commissioner or to compel the commissioner to enforce the act. Under the bill, such parties could also bring an action in the Ingham County Circuit Court to compel the commissioner to enforce Chapter 37 of the Insurance Code.

Nongroup medicare supplemental rates and timeline. The act prescribes a timeline for BCBSM to file all rate information and materials and for the commissioner to approve or disapprove the rates. Under the bill, the timeline would apply only to nongroup Medicare supplemental rates. Thus, rates charged to nongroup Medicare supplemental subscribers would have to be filed with the commissioner and would be subject to the commissioner's prior approval. However, the bill would eliminate a provision that would otherwise allow BCBSM to implement rates prior to approval in the event that BCBSM was participating with one or more "health care corporations"—that is, one or more other health care corporations incorporated under the act, of which there are currently none--to underwrite a group whose employees are located in several states.

Other provisions. In addition to the above changes, House Bill 4279 would:

- add limited liability companies to the act's definition of "person";

- update references to the Insurance Code, the Public Health Code, and the Business Corporation Act;

- update references to the (federal) Social Security Act; and

- delete references to the defunct Michigan Caring Program.

House Bill 4280 would amend the Nonprofit Health Care Corporation Act (MCL 550.1420a et al.) to allow Blue Cross Blue Shield of Michigan to use an application form for long-term care coverage that was designed to elicit the applicant's complete health history. As discussed earlier, House Bill 4279 would expressly permit BCBSM to condition the granting of long-term care coverage based on answers given on such an application. House Bill 4280 is tie-barred to House Bill 4279, meaning it could not take effect unless House Bill 4279 was also enacted.

BCBSM could charge a different rate based on age for the same long-term coverage if the rate differential was based on sound actuarial principles and a reasonable classification system, and was related to actual and credible loss statistics or, for new coverage, was related to reasonably anticipated experience.

If BCBSM offered long-term coverage in Michigan, the sale of that coverage would not be exempt from taxation by the state or any political subdivision of the state.

House Bill 4281 would amend the Nonprofit Health Care Reform Act (MCL 550.1401i) to add a requirement that, beginning January 1, 2004, BCBSM establish and offer to provide or include prescription drug coverage in at least one nongroup and group conversion certificate, as a pilot project. A certificate that included prescription drug coverage under the pilot project would have to include all of the following:

- at a minimum, a prescription drug benefit that included a co-pay of not more than 50 percent of BCBSM's approved amount for the payment of prescription drugs, with a minimum co-pay of $10 and a maximum co-pay of $100;

- an annual per person benefit maximum of no less than $2,500; and

- a provision that members were entitled to purchase prescription drugs at a discount under the Affinity program offered by BCBSM once their annual per person prescription drug benefit maximum had been reached. (As described by the Office of Financial and Insurance Services, the Affinity program allows eligible members to present their BCBSM identification card to participating pharmacies and purchase prescription drugs a discounted rate negotiated with pharmacies by BCBSM.)

The pilot project would have to continue through July 1, 2006 and would not be subject to the act's guaranteed renewability provisions.

Not later than July 1, 2005, BCBSM would have to issue an interim report to the Commissioner of the Office of Financial and Insurance Services regarding the claims experience of the nongroup and group conversion market and the ongoing viability of the pilot project. Not later than July 1, 2006, BCBSM would have to issue a final report with the same content. By September 30, 2006, the commissioner would have to determine if the nongroup and group conversion certificate providing the prescription drug benefit under the pilot project provided a useful benefit to its subscribers. If the commissioner determined that the benefit was not useful, he or she could order that the program be terminated and could terminate the offering of prescription drug coverage in the nongroup and group conversion certificates. If the commissioner determined that the benefit was useful, he or she could order that the program be continued indefinitely, though the certificates would then be subject to the act's guaranteed renewability provisions.

House Bill 4282 would amend the Nonprofit Health Care Reform Act (MCL 550.1501) to allow BCBSM to enter into contracts with health care facilities in Michigan or health facilities in any other jurisdiction. However, BCBSM could not enter into contracts with health facilities out of state "for the purpose of disadvantaging a Michigan licensed health care facility or replacing a contract with a Michigan licensed health care facility."

Currently, the act states only that BCBSM may enter into contracts with health care facilities and that those contracts are subject to requirements set forth in Part 5 of the act. The bill would specify that contracts with health care facilities in Michigan are subject to Part 5.

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