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BILL ANALYSIS

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Senate Bill 234 (Substitute S-2 as reported)
Senate Bill 236 (Substitute S-1 as reported)
Senate Bills 237 and 238 (as reported without amendment)
Senate Bill 460 (Substitute S-1 as reported)
Sponsor: Senator Bev Hammerstrom (Senate Bills 234 & 236)
Senator Tony Stamas (Senate Bill 237)
Senator Gilda Z. Jacobs (Senate Bill 238)
Senator Bruce Patterson (Senate Bill 460)
Committee: Health Policy

Date Completed: 5-23-03

RATIONALE

The United States is virtually unique in the way that health care insurance is primarily provided to its citizens through employers. Companies and workers rely on a system in which health insurance is part of an overall benefits package that may attract and retain employees. Large companies with young, healthy employees have the greatest economic advantage in this system because their pool of employees represents a lower insurance risk than the exposure that small companies, or those with older workers, face. In a small business with 20 workers, for example, one employee diagnosed with diabetes or cancer could cause the business owner's premium rates to triple the following year. Faced with this increase, the owner could search for less costly insurance but find that other insurers had adopted similar pricing strategies in order to compete for low-risk customers. Reportedly, rates for companies with similar demographics can vary by as much as 400%, based solely on the medical conditions of members of the group. The small business owner, then, can choose to pass part of the increase onto the employees, or agree with the insurer to exclude the sick employee from coverage. This option--the practice of an insurer's choosing to cover only the healthiest employees--is commonly known as "cherry picking" or "adverse selection". Adverse selection is legal in Michigan because employees excluded from group coverage can pay for individual polices through Blue Cross and Blue Shield of Michigan (BCBSM), which must, by statute, provide coverage to all individuals who can afford to pay its premiums, regardless of their health status.

The practice of pricing policies for high-risk groups at elevated rates to encourage nonrenewal, known among its detractors as "dumping", is a response, in part, to Title 27 of the Federal Health Insurance Portability and Accountability Act (HIPAA), enacted in 1996. Among other measures to reform group health insurance, that Act requires carriers to renew policies at the insured's request except under certain conditions.

Reportedly, when commercial carriers raise their rates high enough, many Michigan employers turn to BCBSM for group coverage. Although not the insurer of last resort for groups, BCBSM does issue group policies, but is prohibited from using age, medical condition, claims experience, or other "case characteristics" to determine rates. Under the Nonprofit Health Care Corporation Reform Act, the State statute that governs BCBSM, the company must use "community based rating" to set its rates, which means that both low-risk and high-risk classes are factored into the rating, spreading the expected medical costs across the entire community. It is these restrictions on its pricing that, according to BCBSM, cause its rates actually to rise as the number of younger, healthier people leave its risk pool for cheaper insurers, or abandon insurance altogether, because they cannot afford it. As they exit BCBSM's pool, it becomes older and sicker, and then rates rise

for the community as a whole. Rates for small business insurance at BCBSM are currently, on average, 30% higher than the cost of commercial insurance.

Michigan has not been alone in these circumstances confronting the small insurance market. In the 1990s, following the enactment of HIPAA, the National Association of Insurance Commissioners (NAIC) released a model act, aimed at controlling rapid premium increases in the small group market. Since then, 47 states reportedly have enacted insurance reform based on this model act. Some of the states adopted the act's "rate band" provisions, which require a carrier to set its premiums based on a middle "index rate", which represents an average price for an average customer. The index rate becomes the midpoint of the band, and carriers are prohibited from setting rates too far below or too far above that midpoint. Price adjustments based on certain case characteristics, such as health and claims experience, must be contained in the rate band, while other case characteristics, such as age, industry, and gender, may be considered outside of the rate band.

To date, Michigan has not adopted similar legislation in part because of BCBSM's role as the insurer of last resort. Some people believe that adverse selection and dumping are large contributors to spiraling costs in the small group market, and that BCBSM's rating restrictions prevent it from offering a competitively priced product to its small businesses.

CONTENT

Senate Bill 234 (S-2) would amend the Nonprofit Health Care Corporation Reform Act to do the following:

-- Provide that BCBSM would be subject to Chapter 37 (Small Employer Group Health Coverage) of the Insurance Code (proposed by Senate Bill 460).
-- Allow BCBSM to remedy a deficiency in surplus with planwide viability contributions by subscribers at rates prescribed by the bill.
-- Require BCBSM to maintain a surplus not greater than 200% of the authorized control level under risk-based capital assessments, multiplied by five.
-- Allow BCBSM to establish up to eight rate bands based on age for nongroup conversion coverage that includes prescription drug coverage.
-- Require the Commissioner of the Office of Financial and Insurance Services (OFIS) to hold a hearing on a proposed certificate or rate, and allow the Attorney General to request a hearing on a rate filing.
-- Apply current nongroup rate filing and approval requirements to nongroup Medicare supplemental coverage.
-- Require BCBSM, until 2007, to report financial information in the manner other insurers are required to report.
-- Permit BCBSM to acquire insurers authorized to sell disability insurance.
-- Exempt BCBSM's funds and property from utility usage taxes and fees.

Senate Bill 236 (S-1) would amend the Act to permit BCBSM to use an application form for long-term coverage that was designed to elicit an applicant's complete health history. The bill provides that BCBSM could charge a different rate based on age for the same long-term care coverage if the rate differential were based on sound actuarial principles and a reasonable classification system, and were related to actual and credible loss statistics or, for new coverages, related to reasonably anticipated experience. Also, BCBSM could condition the granting of long-term care coverage based on answers given on the long-term care application, pursuant to underwriting standards established by BCBSM. The sale of long-term care insurance would not be tax-exempt.

Senate Bill 237 would amend the Act to require BCBSM to establish, and offer to provide or include, prescription drug coverage in at least one nongroup and group conversion certificate. This requirement would not apply to a certificate that provided only for catastrophic health benefits. The bill would apply to certificates issued or renewed on or after one year following the date the bill was enacted.

Senate Bill 238 would amend the Act to permit BCBSM to enter into contracts with health care facilities in Michigan or health facilities in any other jurisdiction. (Currently, the Act permits BCBSM to enter into contracts with health care

facilities, but does not specify the location of those facilities.) The Act provides that contracts with health care facilities are subject to Sections 504 to 518 of the Act. Under the bill, this provision would apply to contracts with health care facilities licensed in Michigan. (Sections 504 to 518 pertain to goals of reimbursement arrangements with health care providers; BCBSM consultation with provider classes; transmission of provider class plans to the Commissioner; the Commissioner's determination of whether BCBSM has achieved the goals; appeals; standards for provider class plans; and BCBSM reports for provider classes.)

Senate Bill 460 (S-1) would create Chapter 37, "Small Employer Group Health Coverage", in the Insurance Code to govern the rates charged to small employers (employers of between two and 50 employees) and to sole proprietors for health benefit plans. The bill would do the following:

-- Allow small employer carriers to establish up to 10 geographic areas in the State for use in adjusting rates.
-- Provide that the premiums charged for a health benefit plan to small employers in a geographic area could not vary by more than 40% from the "index rate" for that plan in a rating period.
-- For policies issued before the bill's effective date and renewed in 2004, 2005, or 2006, phase in the maximum rate variance until December 31, 2006.
-- Permit any carrier covering a sole proprietor or small employer who had previously been self-insured to charge an additional premium of up to 33% for two years.
-- Require BCBSM to cover sole proprietors.
-- Provide that BCBSM could use only industry and age to determine premium rates, and restrict all other carriers to industry, age, and health status.
-- Limit the rate increase in a geographic area for a new rating period to the sum of an annual percentage adjustment in the rating index (which could not exceed 15%) plus an adjustment for an employer's industry, age, and/or health status.
-- Permit the OFIS Commissioner to suspend the rate requirements for a carrier due to its financial condition, or to enhance marketplace efficiency and fairness.
-- Allow a small employer carrier to deny coverage to a small employer of 10 or fewer eligible employees if the small employer failed to enroll 100% of its employees with the carrier.
-- Prohibit carriers who discontinued issuing small employer plans in a geographic area from issuing any additional small employer plans in that geographic area for five years.
-- Require coverage to be renewable except for specific reasons, unless a carrier ceased to renew all health benefit plans in a geographic area.
-- Require that carriers provide for late enrollment, special enrollment periods, and dependent special enrollment coverage, and limit carriers' ability to impose a pre-existing condition exclusion for a sole proprietor.
-- Require the Commissioner to determine annually whether there existed a reasonable degree of competition in the small employer carrier health market.

The bill would take effect on January 1, 2004.

Senate Bills 234 (S-2) and 460 (S-1) are tie-barred to each other. Senate Bills 236, 237, and 238 are tie-barred to Senate Bill 234.

A more detailed description of Senate Bill 234 (S-2) and Senate Bill 460 (S-1) follows.

Senate Bill 234 (S-2)

Unimpaired Surplus

Under the bill, BCBSM would have to possess and maintain an unimpaired surplus in an amount determined adequate by the Commissioner to comply with Section 403 of the Insurance Code (which requires authorized insurers to be safe, reliable, and entitled to public confidence). The Commissioner would have to follow the risk-based capital requirements as developed by the NAIC in order to determine whether BCBSM was in compliance with Section 403.

If BCBSM filed a risk-based capital report indicating that its surplus was less than the amount determined adequate by the Commissioner, BCBSM would have to prepare

and submit a plan for remedying the deficiency in accordance with risk-based capital requirements adopted by the Commissioner. Among the remedies that BCBSM could employ would be planwide viability contributions to surplus by subscribers. If those contributions were employed, they would have to be made in accordance with the following:

-- If BCBSM's surplus were less than 200% but more than 150% of the "authorized control level" under risk-based capital requirements, the maximum contribution rate would be .5% of the rate charged to subscribers for the benefits provided.
-- If BCBSM's surplus were 150% or less than the authorized control level under risk-based capital requirements, the maximum contribution rate would be 1% of the rate charged to subscribers for the benefits provided.
-- The actual contribution rate charged would be subject to the Commissioner's approval.

Further, BCBSM would be prohibited from maintaining a surplus in an amount equal to or greater than 200% 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 was more than this for two successive calendar years, BCBSM would have to file a plan for approval by the Commissioner to adjust its surplus to a level below the maximum amount. If the Commissioner disapproved of BCBSM's plan, he or she would have to formulate an alternate plan and forward it to BCBSM. Immediately upon receiving approval of its plan, or upon receiving the alternate plan, BCBSM would have to begin implementation of the plan.

("Authorized control level" would mean the number determined under the risk-based capital formula in accordance with the instructions developed by the NAIC, and adopted by the Commissioner.)

The bill would repeal Section 205 of the Act. Under Section 205, BCBSM must maintain a contingency reserve within a prescribed range of a "target contingency reserve level". Contributions to the contingency reserve consist of two components: an actuarially based contribution for risk, and a contribution for planwide viability. For all group and nongroup subscribers, the viability contribution rate is 1% of the established rate if the reserve is below 65% of the target. For small group and nongroup subscribers, the contribution rate is .5% of the established rate if the reserve is between 65% and 95% of the target. For medium and large group subscribers, the contribution rate is .5% if the reserve is between 65% and 105% of the target. The contribution rate is 0% for small group and nongroup subscribers if the reserve is over 95% of the target, and 0% for medium and nongroup subscribers if the reserve exceeds 105% of the target.

The bill would replace various references to the contingency reserve with references to the unimpaired surplus.

Small Employer Group Health Coverage

Under the bill, BCBSM would be subject to Chapter 37 of the Insurance Code (proposed by Senate Bill 460). To the extent that a provision of the Nonprofit Health Care Corporation Reform Act concerning health coverage, including premiums, rates, filings, and coverages, conflicted with Chapter 37, Chapter 37 would supercede the Act.

Investments

Under the Act, BCBSM may buy, sell, and otherwise deal in bonds and other obligations, shares, or other securities issued by a domestic, foreign, or alien insurer, as long as the activity will not result in BCBSM's owning or controlling 10% or more of the voting securities of the insurer. The Act also states that, except where expressly authorized by statute, BCBSM may not indirectly engage in any investment activity that it may not engage in directly, and may not guarantee or become surety upon a bond or other undertaking securing the deposit of public money. The bill would delete those provisions. Under the bill, BCBSM could continue to deal in bonds and other obligations, shares, or other securities of a domestic, foreign, or alien insurer, as long as the activity satisfied Chapter 9 of the Insurance Code (which regulates domestic insurers' reserves and investments).

Certificate & Rate Filings

The Act requires BCBSM to submit to the Commissioner a copy of any new or revised certificate along with applicable proposed rates and rate rationale. The certificate and proposed rates must be considered approved and effective 30 days after filing, except as

otherwise provided. The Commissioner may subsequently disapprove any certificate deemed approved. The bill would delete these provisions.

Under the bill, 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 60 days expired. This provision would be subject to Section 608 of the Act (which concerns rates charged to nongroup subscribers). The bill would allow the Commissioner subsequently to disapprove any certificate or rate change.

As currently provided, the proposed language would be subject to the requirement that the Commissioner exempt from prior approval, certificates resulting from a collective bargaining agreement.

In addition, the bill would require the Commissioner to schedule a hearing within 30 days after receiving a written request from BCBSM, and the revised certificate, revised proposed certificate, or proposed rate would not take effect until approved by the Commissioner after the hearing. Within 30 days after the hearing, the Commissioner would have to give BCBSM written notice of the disposition of the certificate or rate, together with his or her findings of fact and conclusions.

The bill also would require the Commissioner, upon receiving a rate filing, to notify the Attorney General and give him or her a copy of the proposed rate revision. Upon making a written request for a hearing within 30 days after receiving this notice, the Attorney General would have to have an opportunity for an evidentiary hearing to determine whether the proposed rate met the Act's requirements. The request would have to identify the issues that the Attorney General asserted were involved and what portion of the rate filing was requested to be heard. If the Attorney General requested a hearing, the Commissioner could not approve, approve with modifications, or disapprove a filing until the hearing had been completed and an order issued.

Medicare Supplemental Rates

Under the Act, the rates charged to nongroup subscribers must be filed in accordance with Section 610 (which governs the filing of information and materials relative to a proposed rate) and are subject to the prior approval of the Commissioner. Under the bill, these provisions would apply to the rates charged to nongroup Medicare supplemental subscribers, instead of nongroup subscribers.

The bill would delete provisions concerning the filing of the methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers; requiring the Commissioner to approve, disapprove, or modify and approve the methodology and definitions; and requiring BCBSM to refile for approval every three years.

Under Section 610, subject to several exceptions, a filing of information and materials relative to a proposed rate must be made at least 120 days before its proposed effective date. The Commissioner must take certain actions within 30 days after information and materials are filed, and must give notice about the proposed rate revision to people who requested notice within the previous two years. Under the bill, these requirements would apply to information and materials relative to a proposed nongroup Medicare supplemental rate.

Other Provisions

Nongroup Coverage. The bill specifies that the rates charged to nongroup subscribers for a certificate that included prescription drug coverage under Section 401i (proposed by Senate Bill 237) could include up to eight rate differentials based on age, provided that the differentials would be supported by sound actuarial principles and a reasonable classification system, and were related to actual and credible loss statistics, or, for new coverages, reasonably anticipated experience. The rate bands could be applied in up to 10 geographic areas in the State, with each area at least one entire county. The rates in each geographic area could not vary from the arithmetic average of the high and low rate by more than 60%. (Under Section 401i, proposed by Senate Bill 237, BCBSM would be required to provide prescription drug coverage for at least one nongroup and one group conversion certificate.)

Financial Reporting. Until January 1, 2007, BCBSM would be required to report financial information in conformity with sound actuarial practices and statutory accounting principles, including approved permitted practices, in the same manner as designated by the Commissioner for other carriers under the Insurance Code.

Acquisitions. The bill would permit BCBSM to own or control part or all of an insurer authorized to sell disability insurance, provided that the transaction satisfied Chapter 13 of the Insurance Code (which governs domestic insurer holding companies). The bill would prohibit BCBSM from acquiring other insurers.

Other Jurisdictions. The Act permits BCBSM to enter into participating contracts for reimbursement with professional heath care providers practicing legally in the State for health care services that the providers may legally perform. The bill also would permit BCBSM to enter into participating contracts for reimbursement with health care practitioners practicing legally in any other jurisdiction for health care services that the practitioners may legally perform.

Senate Bill 460 (S-1)

Application of Chapter 37

The bill would create Chapter 37 in the Insurance Code, which would apply to any health benefit plan providing coverage to two or more employees of a small employer. It would not apply to individual health insurance policies subject to policy form and premium rate approval by the OFIS Commissioner.

Under the bill, BCBSM would have to provide, upon request, a health benefit plan to a sole proprietor. Chapter 37 would apply to BCBSM's provision of a health benefit plan to a sole proprietor, and to any other small employer carrier that elected to provide a health benefit plan to a sole proprietor. "Small employer carrier" would mean either a carrier that offered health benefit plans covering the employees of small employer, or BCBSM when it covered of a sole proprietor. A carrier would be a person that provided health benefits, coverage, or insurance in Michigan, including a health insurance company authorized to do business in Michigan, BCBSM, a health maintenance organization (HMO), a multiple employer welfare arrangement, or any other person providing a plan of health benefits, coverage, or insurance subject to State insurance regulation.

The bill would define "small employer" as any person, firm, corporation, partnership, limited liability company, or association actively engaged in business that, on at least 50% of its working days during the current or preceding calendar year, employed at least two but not more than 50 eligible employees. An "eligible employee" would be an employee who worked on a full-time basis with a normal workweek of 30 or more hours. An employer could choose to make a full-time employee with a normal workweek of 17.5 to 30 hours an "eligible employee" if the eligibility criterion were applied uniformly among all of the employer's employees and without regard to health status-related factors. In determining the number of eligible employees, companies that were affiliated companies or that were eligible to file a combined State tax return would be considered one employer.

"Sole proprietor" would mean an individual who was a sole proprietor or sole shareholder in a trade or business through which he or she earned at least 50% of his or her taxable income and for which he or she had filed the appropriate Internal Revenue Service form 1040, schedule C or F, for the previous tax year. A sole proprietor would have to be a resident of Michigan who was actively employed in the operation of the business, working at least 30 hours per week in at least 40 weeks out of the calendar year.

"Health benefit plan" or "plan" would mean an expense-incurred hospital, medical, or surgical policy or certificate, BCBSM certificate, or HMO contract. A health benefit plan would not include accident-only, credit, dental, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

Health Benefit Plan Rates

Geographic Areas. A carrier could establish up to 10 geographic areas in the State for use in adjusting rates for health benefit plans subject to Chapter 37. A geographic area would have to include at least one entire county. If the geographic area included additional counties or portions of counties, they would have to be contiguous with at least one other county or

portion of another county in that geographic area. The bill would require BCBSM to establish geographic areas that covered all counties in the State.

Premium Rates. The following provisions would apply to premium rates for a health benefit plan subject to Chapter 37.

1) For determining the premium rates within a geographic area for a small employer or sole proprietor, BCBSM and an HMO could use only industry and age, and all other carriers could use only industry, age, and health status.

2) The rate charged for a health benefit plan during a rating period to small employers or sole proprietors located in a geographic area could not vary from the index rate by more than 40%.

3) For a sole proprietor, a small employer carrier's rate could be 25% higher than the rate charged to small employers in that geographic area.

4) The percentage increase in the rates charged to a small employer or sole proprietor in a geographic area for a new rating period could not exceed the sum of the annual percentage adjustment (not more than 15% annually and adjusted pro rata for rating periods shorter than one year) in the area's index rate for the health benefit plan, plus an adjustment due to the employer's industry, age, and/or health status, as applicable. The bill specifies that this provision would not prohibit an adjustment due to change in coverage.

Health benefit plan options, number of family members covered, and Medicare eligibility could be used to establish a small employer's or sole proprietor's premium.

("Index rate" would mean the arithmetic average during a rating period of the lowest premium rate and the highest premium rate charged for each health benefit plan offered by each small employer carrier to small employers or sole proprietors in a geographic area. "Premium rate" would mean all money paid by a small employer, a sole proprietor, eligible employees, or eligible persons as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan. "Rating period" would mean the calendar period for which premium rates established by a small employer carrier would be assumed to be in effect, as determined by the small employer carrier.)

Rate Index Phase-In. For a plan issued before the bill's effective date and renewed in 2004, 2005, or 2006, the premium rate would be subject to the maximum variance shown in Table 1, instead of the 40% maximum index rate variance described above, until December 31, 2006.

Table 1

Maximum Variance from Index Rate			
	Year of Renewal		
	2004	2005	2006
BCBSM or HMO	25%	30%	35%
Other Carriers	75%	60%	55%

Additional Premium for Self-Insured. Beginning one year after the bill's effective date, if a small employer or sole proprietor had been self-insured for health benefits immediately before applying for a plan subject to Chapter 37, a carrier could charge an additional premium of up to 33% of the premium rate described above, for not more than two years.

Suspension of Requirements. Upon a filing for suspension by a small employer carrier, the Commissioner, after consulting with the Attorney General, could suspend all or any part of the premium rates requirements that applied to one or more small employers for one or more rating periods, if the Commissioner found either that the suspension was reasonable in light of the carrier's financial condition or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

Composite Rates. A small employer carrier would have to apply all rating factors consistently with respect to all small employers and sole proprietors in a geographic area. Except for health benefit plan options, number of family members, and Medicare eligibility, a small employer carrier would have to bill a small employer group only with a composite rate, and could not bill so that one or more employees in a small employer group were charged a higher

premium than another employee in that same group was charged.

Sole Proprietor Coverage

Open Enrollment. A small employer carrier could apply an open enrollment period for sole proprietors. If a carrier did so, the open enrollment period would have to be offered for at least one month, once a year.

Available Plans. A small employer carrier would not be required to offer or provide to a sole proprietor all health benefit plans available to small employers who were not sole proprietors; however, carriers would be required to offer to all sole proprietors all health benefit plans available to any sole proprietor.

Pre-Existing Condition. A small employer carrier could exclude or limit coverage for a sole proprietor for a condition only if the condition or limitation related to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months before enrollment and the exclusion or limitation did not extend for more than six months after the effective date of the plan. A small employer carrier would be prohibited from imposing a pre-existing condition exclusion for a sole proprietor because of pregnancy, or for a child covered under any creditable coverage within 30 days of birth, adoption, or placement for adoption, provided that the child did not experience a significant break in coverage and provided that the child was adopted or placed for adoption before he or she turned 18.

("Creditable coverage" would mean any of the following: a group health plan; a health benefit plan; Part A or Part B of Title 18 of the Social Security Act (Medicare); Title 19 of the Social Security Act (Medicaid); Chapter 55 of Title 10 of the United States Code (health care to the armed forces, the commissioned corps of the National Oceanic and Atmospheric Administration, and the public health service); a medical care program of the Indian health service or of a tribal organization; a state health benefits risk pool; a health plan offered under the Employees Health Benefits Program, Chapter 89 of Title 5 of the United States Code (Federal employees); a public health plan, which would mean a plan established or maintained by a state, county, or other political subdivision of a state that provided health insurance coverage to individuals; or a health benefit plan for members of the Peace Corps.)

Small Employer Enrollment

Waiting Period. A small employer carrier would be prohibited from offering or selling to small employers a health benefit plan that contained a waiting period applicable to new enrollees or late enrollees. (A "waiting period" would be the period that had to pass with respect to a potential enrollee before he or she was eligible to be covered for benefits under the terms of the plan. A waiting period would not be considered a gap in coverage for purposes of calculating periods of creditable coverage.)

A small employer carrier could offer or sell to small employers other than sole proprietors a plan that provided for an "affiliation period" that would have to expire before coverage became effective for a new enrollee or a late enrollee if all of the following were met:

-- The affiliation period was applied uniformly to all new and late enrollees and dependents of the new and late enrollees of the small employer, and without regard to any health status-related factor.
-- The affiliation period did not exceed 60 days for new enrollees or 90 days for late enrollees.
-- The carrier did not charge any premiums for the enrollee during the affiliation period.
-- The coverage issued was not effective for the enrollee during the affiliation period.

Late Enrollees. A health benefit plan offered to a small employer by a small employer carrier would have to provide for the acceptance of late enrollees.

Special Enrollment Period. A small employer carrier would have to permit an employee or an eligible, nonenrolled dependent of the employee, to enroll for coverage under the terms of the small employer health benefit plan during a special enrollment period, if all of the following applied:

-- The employee or dependent was covered under a group health plan (as defined in the bill) or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent.
-- The employee stated in writing at the time coverage was previously offered that

coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the small employer or carrier, if applicable, required such a statement and notified the employee of the requirement and its consequences at that time.

-- The employee's or dependent's coverage either was under a COBRA continuation provision and that coverage had been exhausted, or was not under a COBRA continuation provision but had been terminated as a result of loss of eligibility for coverage, including because of a legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions toward that other coverage had been terminated. In either case, under the terms of the health benefit plan, the employee would have to request enrollment within 30 days after the exhaustion of coverage or termination of coverage or employer contribution. If an employee requested enrollment under this provision, the enrollment would be effective by the first day of the first month beginning after the date the request was received. ("COBRA" would mean the Consolidated Omnibus Budget Reconciliation Act of 1985).

Dependent Special Enrollment. A small employer carrier that made dependent coverage available under a health benefit plan would have to provide for a dependent special enrollment period, during which the person could be enrolled under the plan as a dependent of the individual or, if not otherwise enrolled, the individual could be enrolled under the plan. For a birth or adoption of a child, the spouse of the individual could be enrolled as a dependent if the spouse were otherwise eligible for coverage. This would apply only if both of the following occurred: 1) The individual was a participant under the plan, or had met any applicable affiliation period and was eligible to be enrolled under the plan, but failed to enroll during a previous enrollment period, and 2) the person became a dependent of the individual through marriage, birth, adoption, or placement for adoption.

The special enrollment period would have to be at least 30 days long, and begin on the later of the date dependent coverage was made available, or the date of the marriage, birth, adoption, or placement for adoption. If an individual sought to enroll a dependent during the first 30 days of this period, the coverage of the dependent would have to be effective as follows: for marriage, not later than the first day of the first month beginning after the date the completed request for enrollment was received; for a dependent's birth, the date of birth; or for adoption or placement for adoption, the date of adoption or placement.

Minimum Participation Rule. Requirements used by a small employer carrier in determining whether to provide coverage to a small employer would have to be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier. A small employer carrier could deny coverage to a small employer of 10 or fewer eligible employees if the small employer failed to enroll with the carrier 100% of its employees seeking health care coverage through the small employer.

Renewal

A small employer carrier that offered health coverage in the small employer group market in connection with a health benefit plan would have to renew the plan or continue it in force at the option of the small employer or sole proprietor. Guaranteed renewal would not be required, however, in cases of the following: fraud or intentional misrepresentation of the small employer or, for coverage of an insured individual, fraud or misrepresentation by the individual or his or her representative; lack of payment; the carrier no longer offered that particular type of coverage in the market; or the sole proprietor or small employer moved outside the geographic area.

Discontinuation of Plans

If a small employer carrier decided to discontinue offering all small employer health benefit plans in a geographic area, all of the following would apply:

-- The carrier would have to notify the Commissioner and each small employer covered by the carrier in the geographic area of the discontinuation at least 180 days before the date of discontinuation.

-- All small employer health plans issued or delivered for issuance in the geographic area would be discontinued and all current health benefit plans in the geographic area would not be renewed.

-- The carrier would be prohibited from

issuing or delivering for issuance any small employer plans in the geographic area for five years, beginning on the date the last small employer plan in the geographic area was not renewed.

-- The carrier could not issue or deliver for issue for five years any small employer plan in an area that was not a geographic area where the carrier was issuing or delivering for issuance small employer plans on the date notice was given. The five-year period would begin on the date notice was given.

After consultation with the Attorney General, the Commissioner could suspend the final two prohibitions if he or she determined that a suspension was reasonable in light of the financial condition of the carrier, or if the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

The bill would require BCBSM to renew all health benefit plans in a geographic area.

Marketing

Every small employer carrier would have to offer to small employers all health benefit plans it marketed to small employers in Michigan. A small employer carrier would be considered to be marketing a health benefit plan if it offered that plan to a small employer not currently receiving a health benefit plan from that carrier. A small employer carrier would have to issue any health benefit plan to any small employer that applied for the plan and agreed to make the required premium payments, and to satisfy the other reasonable provisions of the health benefit plan consistent with the other provisions in Chapter 37.

Contract

Small employer carriers would have to provide all of the following to a small employer upon request and upon entering into a contract with the small employer:

-- The extent to which premium rates for a specific small employer were established or adjusted due to industry, age, or health status of the employees or dependents of the small employer.

-- The provisions concerning the carrier's right to change premium rates and the factors, including industry, age, or health status, that affected changes in rates.

-- The provisions relating to renewability of coverage.

Description of Practices

Each small employer carrier would have to maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation demonstrating that its rating methods and practices were based upon commonly accepted actuarial assumptions and were in accordance with sound actuarial principles.

Every March 1, each small employer carrier would have to file with the Commissioner an actuarial certification (with aggregate data that excluded personal health information) that the carrier was in compliance with this requirement and that its rating methods were actuarially sound. ("Actuarial certification" would mean a written statement by a member of the American Academy of Actuaries, or another individual acceptable to the Commissioner, that a small employer carrier was in compliance with the premium rating provisions of the Chapter 37, based on the person's examination, including a review of the appropriate records and the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable health benefit plans.) The carrier would have to keep a copy of the certification at its principal place of business.

A small employer carrier would have to make this information and documentation available to the Commissioner upon request.

The bill specifies that these provisions would be in addition to, and not in substitution of, the applicable filing provisions in the Insurance Code and in the Nonprofit Health Care Corporation Reform Act.

Health Market Competition

By January 1, 2006, and each January 1 thereafter, the Commissioner would have to make a determination as to whether a reasonable degree of competition in the small employer carrier health market existed on a statewide basis. If the Commissioner determined that a reasonable degree of competition did not exist, he or she would have to hold a public hearing and 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 be based on relevant economic tests, including those listed below. The findings in the report 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 on which the report was based 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 small employer carrier health market. The supplemental report and certification would have to be issued by December 15, immediately following the release of the initial report, and would have to be supported by substantial evidence.

The Commissioner would have to consider all of the following for purposes of determining whether a reasonable degree of competition existed:

-- The extent to which any carrier controlled all or a portion of the small employer carrier health benefit plan market.
-- Whether the total number of carriers writing small employer health benefit plan coverage in the State was sufficient to provide multiple options to small employers.
-- The disparity among small employer health benefit plan rates and classifications to the extent that those classifications resulted in rate differentials.
-- The availability of small employer health benefit plan coverage to small employers in all geographic areas and all types of business.
-- 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.

BCBSM

The bill specifies that BCBSM would be subject to Section 619 of the Nonprofit Health Care Corporation Reform Act. (Section 619 authorizes 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 is not authorized under the Act.)

HMO: Off-Label Drugs

Under the bill, a health maintenance organization contract currently required to provide coverage for an off-label use of an FDA-approved drug and the reasonable cost of supplies necessary to administer the drug, would be required to do so only if the HMO provided pharmaceutical coverage.

Effective Date

The provisions of Chapter 37 would apply to each health benefit plan for a small employer or sole proprietor that was delivered, issued for delivery, renewed, or continued in the State on or after the bill's effective date of January 1, 2004. For this purpose, the date a health benefit plan was continued would be the first rating period beginning on or after this effective date.

MCL 550.1107 et al. (S.B. 234)
MCL 550.1420a et al. (S.B. 236)
Proposed MCL 550.1401i (S.B. 237)
MCL 550.1501 (S.B. 238)
MCL 500.3406q et al. (S.B. 460)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The bills propose a number of reforms essential to restoring stability to the small group health insurance market in Michigan. Permitting BCBSM to employ some additional insurance underwriting practices while moderating the ability of commercial carriers to set any price for their product would strike a careful balance between the need for a competitive marketplace and the need for

affordable health insurance. Under Senate Bill 460 (S-1), rate bands would be phased in for both commercial carriers and BCBSM, thus allowing both groups to determine where they wanted to compete in the market. For example, if an insurer set its midpoint too low, it could attract too many companies with high risk; too high, it could drive away companies with low risk. Further, the bill would allow BCBSM to use, for the first time, industry and age as factors when setting rates, and would restrict commercial carriers to industry, age, and health status. These would be judicious allowances and restrictions that should enable all insurers to establish rates based on a reasonable degree of risk represented by a particular group, yet still would require that BCBSM insure anyone who can afford to pay, regardless of his or her health status. Adverse selection and dumping on the part of any insurer would be limited by these measures, as well as the minimum participation rule also found in Senate Bill 460 (S-1). This rule would permit a small employer carrier to deny coverage to a company with 10 or fewer eligible employees if the employer did not enroll 100% of those employees seeking coverage in that plan.

Senate Bill 460 (S-1) would align the definition of a small group (from two to 50 employees) with the definition employed by HIPAA and would relieve all insurers of including sole proprietors in the small group risk pool. At the same time, BCBSM would have to provide coverage for these sole proprietors, guaranteeing them coverage, albeit at a potentially higher rate for two years. Since sole proprietors can cost an insurer up to 50% more than the cost of an employee in a small group, allowing carriers to charge them more for a limited time would make sound financial sense without unduly burdening those business owners.

Opposing Argument

The bills would grant BCBSM privileges that would extend it beyond its original mission as the insurer of last resort. If BCBSM were granted the freedom to establish premiums based on the characteristics of a group, acquire disability insurance companies, and avoid utility usage taxes and fees, this tax-exempt corporation could become a monopoly. Currently, BCBSM's market share of all health insurance premiums sold is at least 50% and as high as 70%. This is not surprising, given that the company owns Preferred Provider Organization of Michigan (PPOM), Blue Care Network, (the largest HMO in Michigan), and the Accident Fund. Additionally, BCBSM owns an "exclusive franchise" under the Nonprofit Health Care Corporation Reform Act, as no other nonprofit health care corporation exists. To prevent BCBSM from becoming a monopoly, the State should force it to divest PPOM, the company's most recent acquisition, and to permit the business associations with which it partners to offer products in addition to those of BCBSM. (Currently, BCBSM has the right to insist on exclusive contracts with these associations.) The State also should require BCBSM to offer a statewide Medicaid HMO, in return for some of the benefits granted the organization under the bills.

Potentially, the bills would increase Blue Cross and Blue Shield's power in this State while placing more restrictions on for-profit, independent commercial carriers. Forcing commercial carriers to set their rates within a "rate band" would raise insurance prices for the young, many of whom cannot afford higher premiums and who are likely to go uninsured if they feel the price for a policy is too high. This would be opposite the desired effect by again shrinking the risk pool, leaving only the high-risk, high-cost insured in the pool. Rate bands are a type of price fixing, and market economics dictate that price fixing will simply drive for-profit insurers out of the State, hence reducing the competition, increasing BCBSM's monopolistic threat, and creating a true health care crisis. In Colorado, more than 10 carriers left the state in 2002 as a result of NAIC model act legislation. More than 17,000 people whose small business employers buy coverage through those carriers were given 60 days' notice to find new health coverage. A similar problem looms for Michigan.

Response: Rate bands are not supported by carriers that desire to insure only good risk, because rate bands require carriers to offer coverage across the entire risk spectrum. The claim that rate bands have reduced competition in some states seems inaccurate; information from the Small Business Association states that rate bands have resulted in more competition but, in some cases, from fewer carriers. The overall goal of insuring more people at lower costs with a wider variety of products has been met in

most of the states (31, according to information from the Detroit Regional Chamber of Commerce, compiled from U.S. Census Bureau data) that have enacted rate bands. Further, BCBSM does not have a monopoly on small business health care. While its market share in Michigan is high, the market share in the small employer segment is significantly lower: According to Dun & Bradstreet, a research firm for business, BCBSM's market share in the 1-99 employee segment is 20.4% of all firms, and 36.5% of firms with insurance.

Opposing Argument

Michigan's current insurance system outperforms that of other states. According to the President of Physicians Health Plans Shared Services, a Kaiser Family Foundation study found that Michigan employers provide coverage more than employers in most other states and pay a greater share of the costs than employers in most other states. Additionally, the proportion of insured in Michigan, 72.3%, is one of the highest in the country, second only to New Hampshire. This information seems to indicate that the small business market is working well and that insurers and HMOs are providing a good value to their customers.

Opposing Argument

The bills would not address the following principal reasons that health insurance is so expensive: increased use of expensive technologies and pharmaceuticals, an aging population, increasing obesity, and the Federal government's underfunding of Medicare and Medicaid programs, which are administered by the states. By failing to address these factors, the bills would not reduce the cost of health care.

Legislative Analyst: Claire Layman

FISCAL IMPACT

Senate Bill 234 (S-2)

Together with Senate Bill 460 (S-1), this bill would alter the current process by which the State regulates Blue Cross and Blue Shield of Michigan and other health benefit carriers. If this change resulted in an increased cost to the Office of Financial and Insurance Services, the assessment would be adjusted accordingly; therefore, these bills would be revenue neutral.

Senate Bill 236 (S-1)

As this bill apparently would not make it any more or less likely that a person would decide to obtain a long-term care insurance plan (or affect the availability of long-term care plans), it should have no direct fiscal impact on State or local publicly funded health care programs.

Senate Bills 237 & 238

It appears that these bills would have no direct fiscal impact on State or local publicly funded health care plans.

Senate Bill 460 (S-1)

Any additional responsibilities from this bill would be covered with revenue generated through regulatory assessments.

Fiscal Analyst: Maria Tyszkiewicz
John Walker

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