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BILL ANALYSIS

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Senate Bills 234, 238, and 460 (as enrolled) **PUBLIC ACTS 59, 60, & 88 of 2003**
House Bills 4280 and 4281 (as enrolled) **PUBLIC ACTS 58 & 41 of 2003**
Sponsor: Senator Bev Hammerstrom (Senate Bill 234)
Senator Gilda Z. Jacobs (Senate Bill 238)
Senator Bruce Patterson (Senate Bill 460)
Representative David B. Robertson (House Bill 4280)
Representative David Farhat (House Bill 4281)
Senate Committee: Health Policy
House Committee: Health Policy

Date Completed: 9-17-03

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 insurance premiums 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.

Until recently, Michigan had not adopted similar legislation in part because of BCBSM's role as the insurer of last resort. Some people believe, however, that BCBSM's rating restrictions have prevented it from offering a competitively priced product to its small businesses. Also, many believe that adverse selection and dumping are large contributors to spiraling costs in the small group market, as a whole.

CONTENT

Senate Bill 234 amended the Nonprofit Health Care Corporation Reform Act to do the following:

-- Provide that BCBSM is subject to Chapter 37 (Small Employer Group Health Coverage) of the Insurance Code (created by Senate Bill 460).
-- Permit BCBSM to deny coverage to subscriber groups of less than 100, if the cost of coverage would be at least 50% more per subscriber than the cost per subscriber for the whole group.
-- Allow BCBSM to establish up to eight rate bands based on age for nongroup and group conversion coverage that includes prescription drug coverage (under a pilot project required by House Bill 4281).
-- Permit BCBSM to acquire insurers authorized to sell disability insurance.
-- 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 remedy a deficiency in surplus with planwide viability contributions by subscribers at rates prescribed by the bill.
-- Require BCBSM to report financial information in the manner other insurers are required to report.

Senate Bill 238 amended the Nonprofit Health Care Corporation Reform Act to permit BCBSM to enter into contracts with health care facilities in Michigan or health facilities in any other jurisdiction. (Previously, the Act permitted BCBSM to enter into contracts with health care facilities, but did not specify the location of those facilities.) The bill states, "It is the intent of the legislature that contracts with health facilities outside of Michigan expand access to health care without reducing access to Michigan licensed health facilities." The bill specifies that contracts with health care facilities licensed in Michigan are subject to Sections 504 to 518 of the Act (which pertain to goals of reimbursement arrangements with health care providers; BCBSM consultation with provider classes; transmission of provider class plans to the Commissioner of the Office of Financial and Insurance Services (OFIS); 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, effective January 23, 2004, creates 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 does the following:

-- Allows small employer carriers to establish up to 10 geographic areas in the State for use in adjusting rates.
-- Provides that the premiums charged for a health benefit plan to small employers in a geographic area must not vary by more than 35% (for health maintenance organizations (HMOs) and BCBSM) or 45% (for commercial

carriers) from the "index rate" for that plan in a rating period.

- **-- For policies issued by commercial carriers before the bill's effective date and renewed in 2004, 2005, or 2006, phases in the maximum rate variance until December 31, 2006.**
- **-- Permits a carrier covering a sole proprietor or small employer who has previously been self-insured to charge an additional premium of up to 33% for two years.**
- **-- Requires BCBSM to cover sole proprietors.**
- **-- Provides that BCBSM may use only industry and age to determine premiums; HMOs may use only industry, age, and group size; and commercial carriers may use only industry, age, group size, and health status.**
- **-- Limits 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 may not exceed 15%) plus an adjustment for an employer's industry, age, group size, and/or health status.**
- **-- Permits the OFIS Commissioner to suspend the rate requirements for a carrier due to its financial condition, or to enhance marketplace efficiency and fairness.**
- **-- Allows a small employer carrier to deny coverage to a small employer that fails to enroll a certain percentage of its employees with the carrier.**
- **-- Prohibits carriers who discontinue issuing small employer plans in a geographic area from issuing any additional small employer plans in that geographic area for five years.**
- **-- Requires coverage to be renewable except for specific reasons, unless a carrier ceases to renew all health benefit plans in a geographic area.**
- **-- Requires that carriers provide for late enrollment, special enrollment periods, and dependent special enrollment coverage, and limits carriers' ability to impose a pre-existing condition exclusion for a sole proprietor.**
- **-- Requires the Commissioner to determine annually whether there exists a reasonable degree of competition in the small employer carrier health market.**

<u>House Bill 4280</u> amended the Nonprofit Health Care Corporation Reform Act to permit BCBSM to use an application form for long-term care coverage that is designed to elicit the complete health history of an applicant. Also, BCBSM may charge a different rate based on age for the same long-term care coverage if the rate differential is based on sound actuarial principles and a reasonable classification system, and is related to actual and credible loss statistics or, for new coverage, is related to reasonably anticipated experience. The bill provides that, if BCBSM offers long-term care coverage in Michigan, the sale of that coverage is not exempt from taxation by this State or any political subdivision of the State.

<u>House Bill 4281</u> amended the Nonprofit Health Care Corporation Reform Act to do the following:

- **-- Require that, by January 1, 2004, BCBSM establish and offer to provide or include prescription drug coverage in at least one nongroup and at least one group conversion certificate as a pilot project.**
- **-- Limit the prescription drug co-pay to a maximum of 50% of the BCBSM-approved amount for payment of prescription drugs, with a per-prescription co-pay between $10 and $100.**
- **-- Require the coverage to include an annual per-person benefit maximum of at least $2,500.**
- **-- Require BCBSM to issue to the Commissioner a final report on the claims experience and ongoing viability of the project by July 1, 2006.**
- **-- Require the Commissioner, by December 1, 2006, to determine if the prescription drug benefit program should be terminated, altered, or continued indefinitely.**

Senate Bill 234 took effect on July 23, 2003. Senate Bill 238 and the House bills took effect July 15, 2003.

Senate Bills 234 and 460 were tie-barred to each other. Senate Bill 238 and House Bills 4280 and 4281 were tie-barred to Senate Bill 234.

A more detailed description of Senate Bill 234, Senate Bill 460, and House Bill 4281 follows.

Senate Bill 234

Small Employer Group Health Coverage

Under the bill, BCBSM is subject to Chapter 37 of the Insurance Code (created 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, conflicts with Chapter 37, Chapter 37 supercedes the Act.

Investments & Acquisitions; Disability Insurance

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 does not result in BCBSM's owning or controlling 10% or more of the voting securities of the insurer. Under the bill, for an activity that occurred before the bill's effective date of July 23, 2003, the activity also must not result in BCBSM's having control of the insurer, either before or after the bill's effective date. (The bill defines "control" with reference to the definition in Section 115 of the Insurance Code.)

Beginning on the bill's effective date and subject to Section 218, the activity must not result in BCBSM's owning or controlling part or all of the insurer unless the transaction satisfies Chapter 13 of the Insurance Code and the insurer being acquired is only authorized to sell disability insurance. (Section 218 of the Act prohibits BCBSM from taking any action to change its nonprofit status; dissolving, merging, mutualizing, or taking any other action that results in a change in control of BCBSM; or selling, transferring, leasing, exchanging, optioning, or conveying assets in a manner that results in a change in its control. Chapter 13 of the Insurance Code governs domestic insurer holding companies.) (The bill defines "disability insurance" with reference to the definition in Section 606 of the Insurance Code.)

For activities occurring either before or after the bill's effective date, the authority to engage in these transactions is subject to Chapter 9 of the Insurance Code (which regulates domestic insurers' reserves and investments).

Previously, the Act prohibited BCBSM, except where expressly authorized by statute, from indirectly engaging in any investment activity that it could not engage in directly, and prohibited BCBSM from guaranteeing or becoming surety upon a bond or other undertaking securing the deposit of public money. The bill deleted those provisions.

Minimum Participation; Denial of Coverage

The Act permits BCBSM to deny coverage to an individual who is not enrolled in a group greater than a minimum size, as established by sound underwriting requirements. Also, BCBSM may deny coverage to an individual who is not enrolled in a group that has contracted for coverage or does not meet requirements for coverage contained in a particular contract.

The bill added authority for BCBSM to deny coverage to an individual belonging to a group of under 100 subscribers if the group has failed to enroll enough of its eligible members with BCBSM, except as otherwise provided in Section 3709 of the Code. (Section 3709 is created by Senate Bill 460, and is described below under the subheading "Minimum Participation Rule".) A denial may be made only if BCBSM determines that the cost for the portion of the group applying for coverage would be at least 50% more, on a per-subscriber basis, than the per-subscriber cost for the whole group. The denial must not be based on the health status of any individual in the group, or his or her dependent, but may be based on one or more of the following: The contract-holder for the group applying for coverage is also offering a self-funded health benefit plan; the group applying for coverage consists entirely of the contract holder's retiree business segment; or the average individual age of the members of the group applying for coverage is either 50% higher or 10 years higher than the average individual age for the whole group. A denial must be based on sound actuarial principles.

Within seven business days after denying coverage to a group that has failed to enroll enough of its members, BCBSM must notify the Commissioner and give him or her the

information used to determine the denial. Within seven business days after receiving the notice, the Commissioner must determine, based on the bill's standards for denial of coverage, whether to approve or disapprove BCBSM's denial. The Commissioner must promptly notify BCBSM of his or her determination. The denied contract-holder or BCBSM may appeal the Commissioner's decision in circuit court.

By May 14, 2005, and every two years thereafter, the Commissioner must report to the Senate and House standing committees on insurance issues on all of the following regarding the minimum participation rule: the number of denials BCBSM made each calendar year; the number of denials approved and the number disapproved by the Commissioner; summaries of the types of group approved and disapproved; and the number of decisions of the Commissioner that have been appealed and the results of the appeals.

Unimpaired Surplus

Under the bill, BCBSM must 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 must follow the risk-based capital requirements as developed by the NAIC in order to determine whether BCBSM is in compliance with Section 403.

If BCBSM files a risk-based capital report indicating that its surplus is less than the amount determined adequate by the Commissioner, BCBSM must 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 may employ are planwide viability contributions to surplus by subscribers. Those contributions, if used, must be made according to the following:

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

Further, the bill prohibits BCBSM 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 files a risk-based capital report indicating that its surplus is more than this for two successive calendar years, BCBSM must file a plan for approval by the Commissioner to adjust its surplus to a level below the maximum amount. If the Commissioner disapproves of BCBSM's plan, he or she has to formulate an alternate plan and forward it to BCBSM. Immediately upon receiving approval of its plan, or upon receiving the alternate plan, BCBSM must begin implementation of the plan.

(The bill defines "authorized control level" as 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 repealed Section 205 of the Act. Under Section 205, BCBSM had to maintain a contingency reserve within a prescribed range of a "target contingency reserve level". Contributions to the contingency reserve consisted 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 was 1% of the established rate if the reserve was below 65% of the target. For small group and nongroup subscribers, the contribution rate was .5% of the established rate if the reserve was between 65% and 95% of the target. For medium and large group subscribers, the contribution rate was .5% if the reserve was between 65% and 105% of the target. The contribution rate was 0% for small group and nongroup subscribers if the reserve was over 95% of the target, and 0% for medium and nongroup subscribers if the reserve exceeded 105% of the target.

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

Other Provisions

Rate Bands. The bill specifies that the rates charged to nongroup and group conversion subscribers for a certificate that includes prescription drug coverage under Section 401i (added by House Bill 4281) may include up to eight rate differentials based on age. Blue Cross and Blue Shield of Michigan must file its rates for the prescription drug coverage in the same manner and under the same requirements as provided in Section 607 of the Act (which, in part, requires the Commissioner to approve or disapprove any new or revised rates).

Long-Term Care Coverage. The bill permits a subsidiary of BCBSM to condition the granting of long-term care coverage based on answers given on an application under Section 422a of the Code. (That section was created by House Bill 4280 and permits BCBSM to use an application designed to elicit the health history of an applicant for long-term care coverage, and to vary rates based on age.)

Financial Reporting. The bill requires BCBSM to report financial information in conformity with sound actuarial practices and statutory accounting principles in the same manner as designated by the Commissioner for other carriers under the Insurance Code. Until January 1, 2007, BCBSM may use approved permitted practices for the sole purpose of effectuating the transfer to statutory accounting principles.

Advertising; Condition of Sale. The bill prohibits BCBSM from including advertising for a subsidiary's services or products in a bill for its own services or products. Also, BCBSM may not condition the sale of, or vary the terms or conditions of, any product sold by BCBSM or a subsidiary of BCBSM, on the purchase of any other BCBSM product or subsidiary product.

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 permits BCBSM to enter into participating contracts for reimbursement with health care practitioners practicing legally in any other jurisdiction for health care services that the providers or practitioners may legally perform. Previously, the Act specified that contracts with health care providers were subject to Sections 404 to 518 of the Act. Under the bill, this provision applies to contracts with health care providers licensed in Michigan.

Senate Bill 460

Application of Chapter 37

Chapter 37 of the Insurance Code, which the bill creates, applies to any health benefit plan providing coverage to two or more employees of a small employer. Chapter 37 also applies to BCBSM's provision of a health benefit plan to a sole proprietor, and requires BCBSM to make a health benefit plan available to a sole proprietor upon request. In addition, Chapter 37 applies to any other small employer carrier that elects to provide a health benefit plan to a sole proprietor.

Chapter 37 does not apply to individual health insurance policies subject to policy form and premium rate approval by the OFIS Commissioner, or to a health benefit plan sponsored by a small employer that is an Archer medical savings account and that meets all requirements of Section 220 of the Internal Revenue Code.

The bill defines "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 and preceding calendar years, employed at least two but not more than 50 eligible employees. An "eligible employee" is an employee who works on a full-time basis with a normal workweek of 30 or more hours. An employer may choose to make a full-time employee with a normal workweek of 17.5 to 30 hours an "eligible employee" if the eligibility criterion is 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 are affiliated companies or that are eligible to file a combined State tax return will be considered one employer.

"Small employer carrier" means either a carrier that offers health benefit plans covering the employees of a small employer,

or BCBSM when it covers a sole proprietor. A carrier is a person that provides health benefits, coverage, or insurance in Michigan, including a health insurance company authorized to do business in Michigan; BCBSM; a health maintenance organization; a multiple employer welfare arrangement; or any other person providing a plan of health benefits, coverage, or insurance subject to State insurance regulation.

"Sole proprietor" means an individual who is a sole proprietor or sole shareholder in a trade or business through which he or she earns at least 50% of his or her taxable income, as defined in Section 30 of the Income Tax Act (MCL 206.30), excluding investment income, and for which he or she has filed the appropriate Internal Revenue Service form 1040, schedule C or F, for the previous tax year. A sole proprietor must be a resident of Michigan who is 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" means an expense-incurred hospital, medical, or surgical policy or certificate, BCBSM certificate, or HMO contract. A health benefit plan does not include accident-only, credit, dental, or disability income insurance; coverage issued as a supplement to liability insurance; long-term care insurance; coverage only for a specified disease or illness; workers' compensation or similar insurance; or automobile medical-payment insurance.

Commercial Carrier Exemption

The bill allows an exemption to Chapter 37 for a commercial carrier (a small employer carrier other than BCBSM or an HMO) whose capital and surplus, as concerns policyholders as of December 31, 2003, and as shown on the annual financial statement filed with the Commissioner, is $18 million or less, if the carrier had policyholders residing in Michigan before June 1, 2003. The carrier must file a request for exemption with the Commissioner, who must determine if an exemption is warranted. This exemption is effective for three years, as long as the commercial carrier experiences no disproportionate growth in premium volume in business written, or changes in the carrier's pattern, location, or contours of insurance business that indicate the carrier is using its exemption to take unfair competitive advantage of competing small employer carriers that do not file for the exemption. A carrier may reapply for an exemption every three years.

The Commissioner must not grant an exemption to any carrier that directly (or indirectly through one or more intermediaries) controls, is controlled by, or is under common control with a carrier whose surplus, as it concerns policyholders, exceeds $18 million. A carrier admitted to do business in Michigan after June 1, 2003, is not eligible for an exemption.

Health Benefit Plan Rates

Geographic Areas. A carrier may establish up to 10 geographic areas in the State for use in adjusting premiums for health benefit plans subject to Chapter 37. A geographic area must include at least one entire county. If the geographic area includes additional counties or portions of counties, they must be contiguous with at least one other county or portion of another county in that geographic area. The bill requires BCBSM to establish geographic areas that cover all counties in the State.

Premiums & Rating Factors. The following provisions apply to premiums for a health benefit plan subject to Chapter 37.

1) For determining the premiums within a geographic area for a small employer or sole proprietor, BCBSM may use only industry and age; an HMO may use only industry, age, and group size; and commercial carriers may use only industry, age, group size, and health status.

2) Blue Cross and Blue Shield of Michigan and HMOs are prohibited from charging a premium for a health benefit plan during a rating period to small employers or sole proprietors located in a geographic area that varies from the index rate for that plan by more than 35%.

3) Commercial carriers may not charge a premium for a health benefit plan during a rating period to small employers or sole proprietors located in a geographic area that varies from the index rate for that plan by more than 45%.

4) For a sole proprietor, a small employer carrier may charge an additional premium of up to 25% above the premiums otherwise allowed (as described in items 2 and 3).

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

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

(The bill defines "index rate" as the arithmetic average during a rating period of the base premium and the highest premium charged per employee for each health benefit plan offered by each small employer carrier to small employers and sole proprietors in a geographic area. "Premium" means 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. "Base premium" means the lowest premium charged for a rating period under a rating system by a small employer carrier to small employers for a health benefit plan in a geographic area. "Rating period" means the calendar period for which premiums established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.)

Index Rate Phase-In. For a plan issued by BCBSM or an HMO before the bill's effective date of January 23, 2004, and renewed in 2004, the premiums charged must not be higher than 15% above the index rate, or lower than 35% below the index rate. Subsequent renewals are subject to the 35% index rate.

For plans issued by commercial carriers before January 23, 2004, and renewed in 2004 or 2005, the premiums charged are subject to the following, instead of the 45% index rate variance described above: For a renewal occurring on or after January 23, 2004, and through December 31, 2004, the premiums must not vary from the index rate by more than 70%; for a renewal occurring in 2005, the premiums must not vary by more than 55%. Subsequent renewals are subject to the 45% index rate.

Additional Premium for Self-Insured. Beginning January 23, 2005, if a small employer or sole proprietor has been self-insured for health benefits immediately before applying for a plan subject to Chapter 37, a carrier may charge an additional premium of up to 33% of the premium allowed by the index rate, for not more than two years.

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

Composite Rates. A small employer carrier must 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 must bill a small employer group only with a composite rate, and may not bill so that one or more employees in a small employer group are charged a higher premium than another employee in that group is charged.

Sole Proprietor Coverage

Open Enrollment. A small employer carrier may apply an open enrollment period for sole proprietors. If a carrier does so, the open enrollment period must be offered at least once a year and be at least one month long.

Available Plans. The bill specifies that a small employer carrier is not required to offer or provide to a sole proprietor all health benefit plans available to small employers who are not sole proprietors; however, carriers must offer to all sole proprietors all health benefit plans in a geographic area that are available to any sole proprietor in that geographic area.

Pre-Existing Condition. A small employer carrier may exclude or limit coverage for a sole proprietor for a condition only if the exclusion or limitation relates 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 does not extend for more than six months after the effective date of the plan. A small employer carrier is prohibited from imposing a pre-existing condition exclusion for a sole proprietor that elates to pregnancy as a pre-existing condition.

A small employer carrier also may not impose a pre-existing condition exclusion for a sole proprietor with regard to a child covered under any creditable coverage within 30 days of birth, adoption, or placement for adoption, provided that the child does not experience a significant break in coverage and that the child was adopted or placed for adoption before turning 18. A period of creditable coverage for this purpose may not be counted for enrollment of an individual under a health benefit plan if, after this period and before the enrollment date, there was a 63-day waiting period, during all of which the individual was not covered under any creditable coverage.

("Creditable coverage" means health benefits, coverage, or insurance provided under 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 means a plan established or maintained by a state, county, or other political subdivision of a state that provides health insurance coverage to enrolled individuals; or a health benefit plan for members of the Peace Corps.)

Small Employer Coverage & Enrollment

Marketing. Every small employer carrier must make available to small employers all health benefit plans it markets to small employers in Michigan. A small employer carrier will be considered to be marketing a health benefit plan if it offers that plan to a small employer not currently receiving a health benefit plan from that carrier. A small employer carrier must issue any health benefit plan to any small employer that applies for the plan and agrees to make the required premium payments, and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with Chapter 37.

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

A small employer carrier may offer or sell to small employers, other than sole proprietors, a plan that provides for an "affiliation period" that must expire before coverage becomes effective for a new enrollee or a late enrollee, if all of the following are met:

-- The affiliation period is 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 does not exceed 60 days for new enrollees or 90 days for late enrollees.
-- The carrier does not charge any premiums for the enrollee during the affiliation period.
-- The coverage issued is 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 must provide for the acceptance of late enrollees.

Special Enrollment Period. A small employer

carrier must permit an employee or an eligible, nonenrolled dependent of an 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 apply:

-- 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 has been exhausted, or was not under a COBRA continuation provision and that other coverage has 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 have been terminated. In either case, under the terms of the health benefit plan, the employee must request enrollment within 30 days after the exhaustion of coverage or termination of coverage or employer contribution. If an employee requests enrollment under this provision, the enrollment is effective by the first day of the first month beginning after the date the request is received. ("COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985.)

Dependent Special Enrollment. A small employer carrier that makes dependent coverage available under a health benefit plan must provide for a dependent special enrollment period, during which the person may be enrolled under the plan as a dependent of the individual or, if not otherwise enrolled, the individual may be enrolled under the plan. For a birth or adoption of a child, the spouse of the individual may be enrolled as a dependent if the spouse is otherwise eligible for coverage.

These provisions apply only if both of the following occur: 1) The individual is a participant under the plan or has met any applicable affiliation period and is eligible to be enrolled under the plan, but failed to enroll during a previous enrollment period, and 2) the person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

The dependent special enrollment period must be at least 30 days long, and begin on the later of the date dependent coverage is made available, or the date of the marriage, birth, adoption, or placement for adoption. If an individual seeks to enroll a dependent during the first 30 days of this period, the coverage of the dependent must 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 is received; for a dependent's birth, as of the date of birth; or for adoption or placement for adoption, the date of the adoption or placement.

Minimum Participation Rule

A small employer carrier may deny coverage to a small employer if the employer fails to enroll enough of its employees to meet the minimum participation rules established by the carrier under sound underwriting requirements. A minimum participation rule may require a small employer to enroll a certain number or percentage of employees with the small employer carrier as a condition of coverage. A minimum participation rule is subject to the following:

-- For a small employer of 10 or fewer eligible employees, a carrier may require enrollment of up to 100% of its employees seeking health care coverage through the employer.
-- For a small employer of 11 to 25 eligible employees, the carrier may require enrollment of up to 75% of the employees seeking coverage through the employer.
-- For a small employer of 26 to 50 eligible employees, the carrier may require enrollment of up to 50% of the employees seeking health care coverage through the employer.

Except as provided above, requirements used by a small employer carrier in determining whether to provide coverage to a small employer must be applied uniformly among all small employers applying for coverage or

receiving coverage from the small employer carrier. If a small employer carrier waives a minimum participation rule for a small employer, the carrier may not later enforce that minimum participation rule for that small employer.

Renewal

A small employer carrier that offers health coverage in the small employer group market in connection with a health benefit plan must renew the plan or continue it in force at the option of the small employer or sole proprietor. Guaranteed renewal is 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; noncompliance with minimum participation requirements; the carrier no longer offers that particular type of coverage in the market; or the sole proprietor or small employer moves outside the geographic area.

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

Discontinuation of Plans

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

-- At least 180 days before the date of discontinuation, the carrier must give notice of the discontinuation to the Commissioner and each small employer covered by the carrier in the geographic area.
-- All small employer health plans issued or delivered for issuance in the geographic area must be discontinued and all current health benefit plans in the geographic area must not be renewed.
-- The carrier is 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 is not renewed.
-- For five years the carrier may not issue or deliver for issuance 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 to the Commissioner and small employers. The five-year period begins on the date notice was given.

Upon a request for suspension by a small employer carrier, and after consultation with the Attorney General, the Commissioner may suspend the final two prohibitions if he or she determines that a suspension is reasonable in light of the financial condition of the carrier and that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

Provision of Information to Employers

Small employer carriers must 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 premiums for a specific small employer are established or adjusted due to any permitted characteristic and rating factors of the employer's employees and their dependents.
-- The provisions concerning the carrier's right to change premiums permitted characteristics, and any rating factors that affect changes in premiums.
-- The provisions relating to renewability of coverage.

Description of Practices

Each small employer carrier must 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 are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

Every March 1, each small employer carrier must file with the Commissioner an actuarial certification that the carrier is in compliance with this requirement and that its rating methods are actuarially sound. ("Actuarial certification" means a written statement by a member of the American Academy of Actuaries, or another individual acceptable to the Commissioner, that a small employer carrier is in compliance with the rating provisions of 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 premiums for applicable health benefit plans.) The carrier must keep a copy of the certification at its principal place of business.

A small employer carrier must make the required information and documentation available to the Commissioner upon request.

The bill specifies that these provisions are 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 May 15, 2007, and each May 15 thereafter, the Commissioner must make a determination as to whether a reasonable degree of competition in the small employer carrier health market exists on a statewide basis. In making this determination, the Commissioner must hold a public hearing in 2007, and may hold a public hearing thereafter; must seek advice and input from appropriate independent sources; and must issue a report delineating specific classifications and kinds or types of insurance, if any, where competition does not exist and any suggested statutory or other changes necessary to increase or encourage competition. The report must be based on relevant economic tests, including those listed below. The findings in the report may not be based on any single measure of competition, but appropriate weight must be given to all measures of competition.

If the results of the report are disputed or if the Commissioner determines that circumstances on which the report was based have changed, the Commissioner must issue a supplemental report that includes a certification of whether a reasonable degree of competition exists in the small employer carrier health market. The supplemental report and certification must be issued by December 15 immediately following the release of the initial report, and supported by substantial evidence.

The Commissioner must consider all of the following for purposes of determining whether a reasonable degree of competition exists:

-- The extent to which any carrier controls 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 is 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 result 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 is not excessive, inadequate, or unfairly discriminatory.
-- Any other factors the Commissioner considers relevant.

The reports and certifications must 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 is 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 an 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

Chapter 34 of the Code requires an HMO contract to provide coverage for an off-label use of a Federal Food and Drug Administration-approved drug and the reasonable cost of supplies medically necessary to administer it. Under the bill, this requirement applies only to an HMO contract that provides pharmaceutical coverage.

Effective Date

The provisions of Chapter 37 apply to each health benefit plan for a small employer or sole proprietor that is delivered, issued for delivery, renewed, or continued in the State on or after the bill's effective date of January 23, 2004. For this purpose, the date a health benefit plan is continued is the first rating period beginning on or after the bill's effective date.

House Bill 4281

Pilot Project

Beginning January 1, 2004, BCBSM must establish and offer to provide or include prescription drug coverage in at least one nongroup certificate and at least one group conversion certificate as a pilot project. The pilot project must continue through December 1, 2006. While in pilot project status, it is not subject to the guaranteed renewal provisions that apply to other group and nongroup certificates under Section 401e of the Act. (Section 401e requires that, at the option of an individual or a group sponsor, BCBSM renew or continue in force its coverage. Guaranteed renewal is not required in cases of fraud, lack of payment, or intentional misrepresentation, if BCBSM no longer offers the coverage in the market, or if the individual or group moves outside of BCBSM's service area.)

Coverage

Under the pilot project, a certificate that includes prescription drug coverage must contain all of the following:

-- At a minimum, a prescription drug benefit that includes a co-pay of not more than 50% 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 per prescription.
-- An annual per-person benefit maximum of at least $2,500.
-- A provision that members will be entitled to purchase prescription drugs at a discount under the affinity program offered by BCBSM, once their annual per-person maximum has been reached.

Report to the Commissioner; Commissioner's Determination

The bill requires BCBSM to issue to the Commissioner by July 1, 2005, an interim report regarding the claims experience of the market segment under the bill and the ongoing viability of the pilot project. By July 1, 2006, BCBSM must issue a final report on the claims experience and viability.

By December 1, 2006, the Commissioner must determine if the certificates providing prescription drug coverage under the pilot project provide a useful benefit to its subscribers in an actuarially sound manner. If the Commissioner determines that a certificate does so, he or she must order the termination of the pilot project designation, and order the program to continue indefinitely. In this case, the certificate will be subject to the guaranteed renewability provisions of Section 401e. If the Commissioner determines that a certificate does not provide a useful benefit in an actuarially sound manner, he or she must do one of the following: 1) order the termination of the pilot project and terminate the offering of prescription drug coverage in the nongroup and group conversion certificates, or 2) order an adjustment of the pilot project to operate in an actuarially sound manner and order that the pilot project continue for a specified time period. This order of adjustment may revise the bill's requirements regarding minimum and maximum co-pays, benefit maximums, and the purchasing of drugs at a discount. If the Commissioner orders an adjustment, he or she must evaluate the project after two years of operation and make another determination of whether the certificates provide a useful benefit in an actuarially sound manner.

MCL 550.1204 et al. (S.B. 234)
MCL 550.1501 (S.B. 238)
MCL 500.3406q et al. (S.B. 460)
MCL 550.1420a et al. (H.B. 4280)
MCL 550.1401i (H.B. 4281)

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 make a number of reforms essential to restoring stability to the small group health insurance market in Michigan. By permitting BCBSM to employ some additional insurance underwriting practices, while moderating the ability of commercial carriers to set any price for their product, the bills strike a careful balance between the need for a competitive marketplace and the need for affordable health insurance. For example, BCBSM will be free to use, for the first time, age and industry to set its premiums, while commercial carriers will be restricted to using certain characteristics to determine their prices. While it may seem inequitable to allow commercial carriers to use four factors while BCBSM is limited to two, BCBSM enjoys some

advantages because of its tax exemptions and its larger market share, which allow it to negotiate better payment rates with provider and facilities.

Further, the bills will establish parity among carriers by allowing BCBSM, HMOs, and commercial carriers to price their policies using rate bands. Rate bands will allow carriers to determine where they want to compete in the market: 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. A three-year phase-in period for commercial carriers should allow an appropriate adjustment period for this new provision. These are 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 require that BCBSM insure anyone who can afford to pay, regardless of his or her health status.

The minimum participation rule found in Senate Bill 460 also should reduce adverse selection and dumping. This rule permits a small employer carrier to deny coverage to a company with 50 or fewer eligible employees if the employer does not enroll a certain percentage of those employees who are seeking coverage in that plan. A commercial carrier, then, may not choose to cover 40 healthy employees and leave the 10 sick employees to BCBSM. By limiting participation rules to those employees who are seeking coverage through their employer, the bill also will prevent an insurer from requiring participation by employees who have coverage through a spouse or who choose to have no health insurance.

Senate Bill 460 aligns the definition of a small group (from two to 50 employees) with the definition employed by HIPAA, thus relieving all insurers of including sole proprietors in the small group risk pool. At the same time, BCBSM must provide coverage for these sole proprietors, 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 makes sound financial sense without unduly burdening those business owners. Also, a steeper initial charge should discourage sole proprietors from shifting in and out of the market based on their fluctuating need for health coverage, which reportedly has been a problem.

Because Senate Bill 460 requires carriers to use "composite rates" when billing small employers, employees in a small group will not be charged differing amounts for their insurance. This should counteract the trend of employers' requiring an employee with covered dependents to pay more than that paid by those without covered dependents, or requiring the sick to pay more than the healthy. This bill restores a fundamental principal of group insurance, which is that all members in an insurance pool share the risk, and hence the cost, of the insurance equally.

Response: The bills do 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 the Medicare and Medicaid programs, which are administered by the states. By failing to address these factors, the bills will not effectively reduce the cost of health care.

Supporting Argument

House Bill 4281 requires something from BCBSM in return for the freedoms extended to it under the other bills: a prescription benefit in one nongroup and group conversion certificate. Many sole proprietors apply for group coverage, rather than nongroup, because nongroup coverage does not contain a prescription drug benefit. House Bill 4281 will make nongroup coverage more attractive for sole proprietors. Since older people tend to use more prescription drugs than younger people do, Senate Bill 234 wisely allows BCBSM to use an age differential for certificates that include the drug benefit.

Supporting Argument

House Bill 4280 permits BCBSM to obtain a long-term care insurance applicant's health history, and allows BCBSM to use age as a factor in determining rates for long-term coverage. The Nonprofit Health Care Corporation Reform Act does allow BCBSM to sell long-term care insurance, but did not specifically permit rating by age. Because long-term care insurance is a benefit used by people near the end of their lives, the demand for it is greater as a person ages. A lower premium for young adults will give them an

incentive to purchase coverage. Similarly, by explicitly permitting it to elicit the health history of applicants for long-term care coverage, the bill enables BCBSM to determine which product is best suited to them.

Opposing Argument

The bills grant BCBSM privileges that extend it beyond its original mission as the insurer of last resort. Now that BCBSM has 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 may 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 could increase Blue Cross and Blue Shield's power in this State while placing more restrictions on for-profit, independent commercial carriers. Setting commercial carriers' rates within a "rate band" will 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 will have 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 that have enacted rate bands (31 states, according to information from the Detroit Regional Chamber of Commerce, compiled from U.S. Census Bureau data). 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.

Further, BCBSM is subject to some additional restrictions under Senate Bill 234: The company is prohibited from including BCBSM subsidiary advertising in a bill for its own services, and BCBSM must not condition the sale of its products on the sale of any of its other products. These new rules are an appropriate check on BCBSM's power as the only nonprofit health care corporation in Michigan.

Opposing Argument

The legislation is unnecessary because Michigan's insurance system already 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 do in most other states and pay a greater share of the costs. 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.

Legislative Analyst: Claire Layman

FISCAL IMPACT

Senate Bill 234

Together with Senate Bill 460, this bill alters the process by which the State regulates Blue Cross and Blue Shield of Michigan and other health benefit carriers. If this change results in an increased cost to the Office of Financial and Insurance Services, the assessment will be adjusted accordingly; therefore, these bills will be revenue neutral.

Senate Bill 238

It appears that this bill will have no direct fiscal impact on State or local publicly funded health care plans.

Senate Bill 460

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

House Bill 4280

As this bill apparently will not make it any more or less likely that a person will 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.

House Bill 4281

It appears that this bill will have no direct fiscal impact on State or local publicly funded health care plans.

Fiscal Analyst: Maria Tyszkiewicz

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