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SFA BILL ANALYSIS

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Senate Bill 460 (Substitute S-1 as reported)
Sponsor: Senator Bruce Patterson
Committee: Health Policy

Date Completed: 5-9-03

CONTENT

The bill 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 Blue Cross and Blue Shield of Michigan (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 Commissioner of the Office of Financial and Insurance Services (OFIS) 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.

Additionally, under the bill, a health maintenance organization (HM0) 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.

The bill would take effect on January 1, 2004, and is tie-barred to Senate Bill 234. (Senate Bill 234 (S-2) would amend the Nonprofit Health Care Corporation Reform

Act, which regulates BCBSM, to revise surplus, rate filing, and financial reporting requirements, and to specify that BCBSM would be subject to Chapter 37.)

Application of Chapter 37

The proposed chapter 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, an 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.)

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 500.3406q et al.

Legislative Analyst: Claire Layman

FISCAL IMPACT

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

Fiscal Analyst: Maria Tyszkiewicz

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