Legislative Analysis

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**INDIVIDUAL HEALTH BENEFIT PLANS;
INDUSTRY-SUPPORTED GUARANTEED ACCESS PLAN**

**House Bill 5282 (Substitute H-1)
Sponsor: Rep. Virgil Smith**

**House Bill 5283 without amendment
Sponsor: Rep. Edward Gaffney, Jr.
Committee: Insurance**

Complete to 5-9-08

A PRELIMINARY SUMMARY OF HOUSE BILLS 5282 & 5283 AS PASSED BY THE HOUSE

House Bill 5282 would amend the Insurance Code to create a new Chapter 37A to regulate individual (as opposed to group) health benefit plans. The bill would apply to plans (including Medicare supplement plans) that are subject to policy form or premium approval by the Insurance Commissioner.

The bill applies to hospital, medical, surgical, and dental policies of commercial insurers; contracts of health maintenance organizations (HMOs); and certificates of a nonprofit health care corporation (meaning Blue Cross Blue Shield of Michigan). It would not apply to accident-only, credit, or disability income insurance; coverage that is a supplement to liability insurance; specific disease or illness coverage; worker's compensation; or automobile medical payment insurance.

House Bill 5283 would amend the Nonprofit Health Care Corporation Reform Act, which regulates Blue Cross and Blue Shield of Michigan, to specify that BCBSM is subject to the new Chapter 37A. The bill says that if a provision in the Nonprofit Health Care Corporation Act dealing with individual health coverage (including premiums, rates, and filings) conflicts with the new Chapter 37A, then Chapter 37A would control.

This means that the individual health benefit plans of Blue Cross Blue Shield would no longer be subject to the regulations in the Nonprofit Health Care Corporation Reform Act. Under that act, among other things, BCBSM is required to seek prior approval of rates; is prohibited from basing rates on health status (that is, "adjusted community rating" is required); is prohibited, generally speaking, from refusing coverage to any applicant; and can only exclude pre-existing conditions for more than six months after the effective date of the certificate. These restrictions would be modified under House Bills 5282 and 5283, as described later.

The two bills are tie-barred, meaning neither could take effect unless both were enacted.

Following is a description of major features of House Bill 5282.

Initial Application/Health Questionnaire. At the time of initial application for an individual health benefit plan, an individual would have to complete a health questionnaire established by the carrier. A carrier (other than Blue Cross and Blue Shield) could refuse coverage if based on the responses on the questionnaire, the individual does not satisfy criteria for coverage. The carrier would have to provide written notice of rejection. An individual refused coverage would be eligible for a guaranteed-access health benefit plan from Blue Cross Blue Shield (as described later).

Blue Cross Blue Shield could not refuse coverage to an individual due to any past or current medical condition, history, or treatment. It could, however, based on responses on the questionnaire, provide coverage only under a guaranteed-access health benefit plan. BCBSM would have to consult with the commissioner of the Officer of Financial and Insurance Regulation (OFIR) in developing the questionnaire and the guaranteed access health benefit plans.

Exclusions and Limitations for Preexisting Conditions. A carrier could exclude or limit coverage for a preexisting condition only if it was 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 12 months after the effective date of the policy.

However, a carrier could not exclude or limit coverage for a preexisting condition or provide a waiting period if all of the following applied: (1) the most recent health care coverage of the individual was under a group health plan; (2) the individual was continuously covered prior to application for coverage for an aggregate of at least 18 months with no break that exceeded 62 days; (3) the individual was no longer eligible for group coverage nor Medicare or Medicaid; (4) the individual did not lose eligibility due to failure to pay a required contribution or for an act to defraud a carrier; and (5) if the individual was eligible for coverage under a continuation of benefits provision (or Cobra), he or she had elected and exhausted the coverage.

Guaranteed Renewal. A carrier that had issued a health benefit plan would have to renew or continue it in force at the option of the individual. This would not apply in cases of nonpayment of premium, fraud, intentional misrepresentation of material fact, if the carrier no longer offered the coverage in the individual market, or if the individual moved out of the carrier's service area. (The guaranteed renewal provision would not apply to Medicare supplement plans.)

Carrier Discontinuation of Plan. A carrier could not discontinue offering a particular plan in the individual market unless it did all of the following: (1) provided notice to each covered individual at least 90 days prior to the date of discontinuance; (2) offered to each individual the option to purchase any other plan the carrier offered in the individual market; and (3) acted uniformly without regard to any health status factor of enrolled individuals (or eligible individuals) in making the determination to discontinue coverage and offer other plans.

Carrier Discontinuation of All Coverage. A carrier could not discontinue offering all coverages in the individual market unless it did all of the following: (1) provided notice to the commissioner and to each covered individual at least 180 days prior to the date of the expiration of coverage; and (2) discontinued all health benefit plans issued in the individual market and did not renew coverage under such plans. If a carrier discontinued all coverage it could not provide for the issuance of any individual health benefit plans for five years after the date of the last plan discontinued and not renewed.

Short-term Plans. Short-term or one-time limited duration benefit plans of no more than six months would not be subject to the provisions dealing with guaranteed renewal or discontinuation of plans.

Rate Filings for Individual Health Benefit Plans. Rates charged to individuals for health benefit plans would have to be filed with the commissioner and could not take effect until 60 days after the filing (unless the commissioner approved the filing within 60 days). The filing would have to include an actuarial certification that the benefits are reasonable in relation to the premium charged and that the premium is adequate, equitable, and not excessive. The filing would have to show the anticipated loss ratio or plan premium. (The bill specifies what is to be contained in an actuarial certification, including formulas and assumptions, expected claim costs, morbidity and mortality tables or experience studies, carrier experience on similar plans, and lapse rate experience.)

Except for guaranteed-access health benefit plans, benefits provided would be presumed reasonable, and the premiums presumed adequate, equitable, and not excessive if the anticipated loss ratio equals or exceeds 70 percent. For guaranteed-access plans, these presumptions would apply if the premium did not exceed 150 percent of the weighted average premium associated with an "initial condition rating factor of two" charged by the five carriers with at least 50 percent of the individual market. The weighted average premium is for an equivalent health benefit plan adjusted for the differences in the actuarial value of benefits, age, and geography.

(The term "initial condition" refers to the initial health condition at the time of the application of the applicant and each individual to be covered under the applicant's health benefit plan. Carriers would be permitted under the bill to establish up to 10 rating tiers to reflect rate differentials for initial condition based on answers on the health questionnaire.)

Liability for Guaranteed-Access Plans. Blue Cross Blue Shield would be required to assume full liability for all administrative expenses for guaranteed-access health benefit plans and for the claim expenses of such plans up to 35 percent above the minimum loss ratio for plans that are not guaranteed-access plans. BCBSM would have to file annual reports with the insurance commissioner regarding the premiums, administrative expenses, claims experience, and losses for all guaranteed-access health benefit plans. The OFIR commissioner would prescribe the form of the report and the report would have to be filed separately and not be included in any other report of BCBSM.

Beginning two years after the effective date of the new Chapter 37A, all carriers would have to assume full liability for all excess losses in the guaranteed-access plans. Excess losses would be all claims losses over 35 percent above the minimum loss ratio for health benefit plans that are not guaranteed-access plans. Each carrier would be required to pay its proportionate share of such losses based on the carrier's market share (in the individual market).

The commissioner would determine each carrier's proportionate share and would issue assessment notices to carriers, and carriers would pay their assessments to the commissioner. When collected, the commissioner would pay the assessments into a Guaranteed Access Fund created in the State Treasury. Money in the fund, which would be managed by the State Treasurer, could be used only as permitted under the new chapter and to pay BCBSM to offset all excess losses in guaranteed-access plans. The commissioner could not issue an assessment to any carrier until the excess loss equaled or exceeded $10 million. The commissioner would be entitled to reimbursement of the actual costs of administering the process.

Actual Loss Ratio Report; Payments of Excess Amounts in Rebates. No later than four months after the end of a 12-month rating period, a carrier would have to submit information to the commissioner showing the actual loss ratio for the rating period for all health benefit plans, including those that have been or will be closed to new applicants. If the actual loss ratio for all plans in a line of business does not equal or exceed 70 percent, the commissioner would order the carrier to issue rate credits or refunds to individuals currently in a plan in that line of business in an amount that will result in a minimum loss ratio of 70 percent for the line of business. A carrier could not be required to issue a refund in an amount that is less than $100 per individual applicant.

(The separate lines of business referred to would be: (1) Medicare supplement plans; (2) required group conversion plans; and (3) all other health benefit plans.)

Insurance Commissioner Reimbursement. The insurance commissioner would be entitled to reimbursement for the actual costs of administering the rate filing, guaranteed-access liability activities, and rate activities related to actual loss ratio reporting.

Adjusting Premiums Based on Geography, Age, and Initial Condition. For adjusting premiums, a carrier could establish up to 10 geographic areas in the state. (A geographic area would have to include at least one entire county. If a geographic area consisted of one county and additional counties or portions of counties, then the counties or portions of counties would have to be contiguous with at least one other county or portion of another county in the geographic area.)

Rates charged to individuals could include rate differentials based on age and initial condition if the differentials were supported by sound actuarial principles and a reasonable classification system and were related to actual and credible loss statistics (or reasonably anticipated experience in the case of new plans). Premiums resulting from these rate factors could not vary from the index rate for the plan by more than 80 percent.

(The "index rate" would be the arithmetic average during a rating period of the base premium and the highest premium charged to an individual for each plan offered by each carrier within a geographic area.) However, rate differentials based on age could not be used for Medicare supplement plans.

Carriers could establish up to 10 rating tiers to reflect rate differentials for initial condition based on the answers given on the carrier's application. (The application would be designed to elicit the health history of the applicant and each individual to be covered under the plan.) The differentials would have to be supported by sound actuarial principles and a reasonable classification system and were related to actual and credible loss statistics (or reasonably anticipated experience in the case of new plans). The variation in rates resulting from initial condition could not exceed a two-to-one ratio.

Rate differentials for initial condition could be used only when coverage is initially issued and could not be used at any time after issue as a result of subsequent changes in initial condition of covered individuals. Rate differentials for initial condition could be used for individuals subsequently added to a plan at the time of the addition. Initial condition rating could not be used with any Medicare supplement plan.

Other Adjustments. Plan options, number of family members covered, Medicare eligibility, and tobacco use could also be used to establish premiums. The maximum surcharge for tobacco use could not exceed 35 percent of the premium.

Limit on Premium Increases. The percentage increase in premiums charged to an individual in a geographic area for a new rating period could not exceed the sum of the annual percentage adjustment in the geographic area's index rate for the plan and any adjustments made for age and initial condition. The adjustment for age and initial condition could not exceed 10 percent annually and would be adjusted pro rata for rating periods of less than one year. (These provisions do not prohibit adjustments based on change in coverage, options, number of family members, Medicare eligibility, and tobacco use.)

Prohibited Actions. A carrier or producer (e.g., an agent) could not, directly or indirectly, engage in any of the following: (1) encouraging or directing an individual to refrain from filing an application for a health benefit plan with the carrier because of the initial condition or claims experience of the individual; or (2) encouraging or directing an individual to seek coverage from another carrier because of the initial condition or claims experience of the individual.

Further, a carrier could not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the initial condition or claims experience of the individual. However, this would not apply to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided the percentage does not vary because of the initial condition or claims experience of the individual.

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

Individuals Enrolled in BCBSM Nongroup or Group Conversion Plans. An individual enrolled in a BCBSM nongroup or group conversion plan "A" through "G" on the effective date of the new Chapter 37A could remain in that plan but could not change enrollment to another plan in the "A" through "G" category. An individual not enrolled in one of those plans on the effective date of the new chapter would not be eligible to enroll in one. Rates to individuals in those plans would be determined under a system of community rating and could not be adjusted for any of the rate factors found in the bill (geography, age, initial condition). Rates would be filed for these plans in the same manner for other health benefit plans. The rate filing would have to include an actuarial certification that benefits provided are reasonable in relation to premiums charged.

Benefits provided would be presumed reasonable for nongroup plans "A" through "G" if the percentage increase in premiums are not greater than the projected percentage change in annual claims cost for all nongroup health benefit plans plus 10 percent. For group conversion plans, reasonableness would be based on the projected change for all nongroup conversion plans, plus 10 percent.

FISCAL IMPACT:

A fiscal analysis is in process.

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■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.