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BILL ANALYSIS

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House Bill 5282 (Substitute S-5 as passed by the Senate)
House Bill 5283 (Substitute S-4 as passed by the Senate)
Sponsor: Representative Virgil Smith (H.B. 5282)
Representative Edward Gaffney (H.B. 5283)
House Committee: Insurance
Senate Committee: Health Policy

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CONTENT

House Bill 5282 (S-5) would add Chapter 37A (Individual Health Coverage Plans) to the Insurance Code to establish regulations for individual health insurance policies and certificates applicable to all carriers, i.e., insurers, health maintenance organizations (HMOs), and Blue Cross and Blue Shield of Michigan (BCBSM). Specifically, the bill would do the following:

-- Prohibit BCBSM, or an HMO during its open enrollment period, from refusing to cover an individual due to any past or current medical condition, history, or treatment.
-- Require a carrier to renew or continue an issued plan at the individual's option.
-- Require a health benefit plan rate filing to include a loss ratio guarantee, and cap the loss ratio for a carrier that was not BCBSM or an HMO at 60%.
-- Require an insurer annually to submit to the Commissioner of the Office of Financial and Insurance Regulation (OFIR) information showing the actual loss ratio for the rating period, and require BCBSM also to submit this information to the Attorney General.
-- Require a carrier to issue refunds or rate credits to individuals in a plan if the actual loss ratio did not equal or exceed the loss ratio guarantee.
-- Authorize the Attorney General to bring an action or apply for a court order to enforce a rate credit order for a BCBSM plan.
-- Allow a carrier to establish geographic areas for adjusting health benefit plan premiums.
-- Allow a carrier to exclude or limit coverage for a condition only if medical advice, diagnosis, care, or treatment for the condition were recommended or received in the six months before the enrollment and the exclusion or limitation did not extend for more than six months after the effective date of the policy or contract.
-- Require a carrier to take certain actions in order to discontinue a particular individual benefit plan.
-- Require a carrier to take certain actions in order to discontinue all coverage in the individual market; and prohibit the carrier from offering individual plans for five years.
-- Prohibit a carrier from discouraging an individual from seeking coverage due to his or her health status or claims experience; or providing for varied compensation to producers or the termination of an agreement with a producer based on an individual's health status or claims experience.

The bill also would require the OFIR Commissioner, by October 1, 2009, to determine the statewide status of

competition in the individual market and conduct a feasibility study and provide recommendations concerning the establishment of a health coverage risk pool for high-risk individuals; and issue a report to the Governor and the Legislature.

House Bill 5283 (S-4) would amend the Nonprofit Health Care Corporation Reform Act to do the following:

-- Require BCBSM to issue an annual report detailing how it fulfilled its charitable and social obligations.
-- Provide that BCBSM would be subject to proposed Chapter 37A of the Insurance Code.
-- Require the appointment of two additional public members to BCBSM's board of directors.
-- Allow the rates charged for nongroup, group conversion, and Medicare supplemental coverage to include rate differentials based on the subscriber's health choices.
-- Reduce the time line for rate filings, requested hearings, and OFIR petitions under the Act.

The bills are tie-barred to each other and would take effect on October 1, 2008. They are described below in further detail.

House Bill 5282 (S-5)

Chapter 37A: Individual Health Coverage Plans

Scope of Chapter 37A. The proposed chapter would apply to any individual health benefit plan that was subject to policy form or premium approval by the OFIR Commissioner.

"Health benefit plan" or "plan" would mean an individual expense-incurred hospital, medical, or surgical policy, BCBSM certificate, or HMO contract, and would include a health benefit plan sold directly to an individual under a group trust or certificate. The term would not include accident-only, credit, or disability income insurance; long-term care insurance; Medicare supplemental coverage; coverage issued as a supplement to liability insurance; coverage only for a specified disease or illness; dental-only or vision-only insurance; worker's compensation or similar insurance; automobile medical-payment insurance; Medicaid coverage; or Medicare, Medicare Advantage, or Medicare Part D.

"Premium" would mean all money paid by an individual as a condition of receiving coverage from a carrier.

Rates & Loss Ratios. Rates for a health benefit plan would have to be filed as otherwise required by law, except that the filing would have to include a written loss ratio guarantee, which would have to equal or exceed 60% for a carrier that was not an HMO or BCBSM.

"Loss ratio" would mean the ratio at the time of rate filing, or at a time of subsequent rate revisions, of the expected future benefits during the rating period based on a credible premium volume over a reasonable period of time with proper weight given to trends and other relevant factors. Statistical data related to expected future benefits would have to be given to the OFIR Commissioner upon request from carriers for health benefit plans sold or to be sold in Michigan when available.

"Rating period" would mean the calendar period for which premiums established by a carrier were assumed to be in effect, as determined by the carrier.

"Carrier" would mean a person that provided a health benefit plan to an individual in Michigan. For the purposes of Chapter 37A, the term would include a health insurance company authorized to do business in Michigan, BCBSM, an HMO, and any other person providing a plan of health benefits, coverage, or insurance subject to State insurance regulation. The term would not include an HMO that provided only Medicaid coverage.

Within four months after the end of a 12-month rating period, a carrier would have to submit to the Commissioner, and BCBSM also would have to submit to the Attorney General, information that showed the actual loss ratio for the rating period for all plans, including those that had been or would be closed to new applicants.

If the actual loss ratio for all plans in a line of business did not equal or exceed the filed written loss ratio guarantee, the Commissioner would have to order the

carrier to issue rate credits or refunds to individuals currently in a plan in that line of business. The credits or refunds would have to be in an amount that would result in a minimum loss ratio for the rating period equal to the applicable written loss ratio guarantee for the line of business. A carrier could not be ordered to issue a refund in an amount that was less than $25 per individual applicant. The rate credits or refunds would have to be issued within 90 days after the Commissioner's order. The claims experience of any line of business not determined to be credible would have to be combined with other similar individual lines of business for purposes of determining loss ratios.

For a plan issued by BCBSM, the Attorney General could bring an action or apply to the circuit court for a court order to enforce an order requiring rate credits.

Geographic Areas. In addition to what was otherwise permitted or required by law, for adjusting premiums for individual health benefit plans, a carrier could establish up to five geographic areas in Michigan and BCBSM could establish geographic areas so that all counties in Michigan were covered. A carrier could not establish geographic areas for any Medicare supplement plan.

"Geographic area" would mean an area in this State that included at least four entire counties, established by a carrier and used for adjusting premiums for an individual plan. Each county in the geographic area would have to be contiguous with at least one other county in that geographic area.

Application & Issuance. If a carrier refused coverage for an individual, it would have to give him or her a written notice of the rejection, the reasons for the rejection, and the availability of coverage from BCBSM or from an HMO during an open enrollment period.

Blue Cross and Blue Shield could not refuse coverage to an individual except as otherwise provided under Section 401 of the Nonprofit Health Care Corporation Reform Act. (That section prohibits BCBSM from refusing to issue a certificate except while the individual, based on a transaction or occurrence involving BCBSM, is serving a sentence arising out of a charge of fraud, is satisfying a civil judgment, or is making restitution pursuant to a voluntary payment agreement with BCBSM.)

An HMO could not refuse coverage to an individual during its open enrollment period except as otherwise permitted under Chapter 35 of the Insurance Code. (Under Chapter 35, which governs HMOs, an HMO must have an open enrollment period of at least 30 days during each consecutive 12-month period. During the open enrollment period, the HMO must accept up to its capacity individuals in the order in which they apply in a manner that does not unfairly discriminate on the basis of age, sex, race, health, or economic status.)

Exclusion or Limitation of Coverage. Currently, for an individual covered under an individual policy or certificate, or for an individual covered under a group policy or certificate covering two to 50 individuals, an insurer may exclude or limit coverage 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 12 months after the policy's or certificate's effective date. For an individual covered under a nongroup contract, an HMO may exclude or limit coverage 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 contract's effective date. The bill would delete these provisions.

Under the bill, a carrier could exclude or limit coverage under a plan for a condition only if the exclusion 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 policy's effective date.

Notwithstanding that provision, a carrier could not exclude or limit coverage for a preexisting condition or provide a waiting period if all of the following applied:

-- The individual's most recent health care coverage before applying for coverage

with the carrier was under a group health plan (i.e., a group health benefit plan that covered two or more insureds, subscribers, members, enrollees, or employees).
-- The person was covered continuously before applying for coverage with the carrier under one or more health plans for an aggregate of at least 18 months with no break in coverage that exceeded 62 days.
-- The person was no longer eligible for group coverage and was not eligible for Medicare or Medicaid.
-- The person did not lose eligibility for coverage for failure to pay any required contribution or for an act to defraud any carrier.
-- If the person were eligible for continuation of health coverage from that group health plan pursuant to the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, he or she had elected and exhausted the coverage.

Rescission, Cancellation, & Limitation of Plan
Notwithstanding any other provision of the Code, a health benefit plan could not be rescinded, canceled, or limited due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from the written information submitted on or with an application before the plan's contract was issued. This provision would not limit a plan's remedies upon a showing of intentional misrepresentation of material fact.

Guaranteed Renewal. Except as otherwise provided, a carrier that had issued a health benefit plan would have to renew the plan or continue it in force at the individual's option at a premium rate that did not take into account the claims experience or any change in the health status of any covered person that occurred after the initial issuance of the plan.

A guaranteed renewal would not be required in cases of nonpayment of premiums, fraud, or intentional misrepresentation of material fact; if the carrier no longer offered that plan; if the carrier no longer offered coverage in the individual market; or if the individual moved outside the carrier's service area.

Discontinuation. A carrier could not discontinue offering a particular plan in the individual market unless it did all of the following:

-- Notified each individual covered under the plan of the discontinuation at least 90 days before the discontinuation date.
-- Offered to each individual in the individual market provided this plan, the option to purchase any other plan currently being offered in the individual market.
-- Acted uniformly without regard to any health status factor of enrolled individuals or individuals who could become eligible for coverage, in making the determination to discontinue coverage and in offering other plans.
-- Made no adjustment in the health status factor applied to individuals moving from a discontinued plan of that carrier to another plan of that carrier.

A carrier could not discontinue offering all coverage in the individual market unless it did both of the following:

-- Notified the Commissioner and each individual of the discontinuation at least 180 days before the coverage expired.
-- Discontinued all health benefit plans issued in the individual market and did not renew coverage under such plans.

If a carrier discontinued all coverage in the individual market, it could not provide for the issuance of any health benefit plans in the individual market for five years, beginning on the date of the discontinuation of the last plan not renewed.

The discontinuation provisions would not apply to a "short-term or 1-time limited duration benefit plan of no longer than 6 months", i.e., a plan that met all of the following criteria:

-- Was issued to provide coverage for a period of up to 185 days, except that the plan could permit a limited extension of benefits after the date it ended solely for expenses attributable to a condition for which a covered person incurred expenses during the term of the plan.
-- Was nonrenewable, although the carrier could provide coverage for one or more subsequent periods described under the first criterion, if the total of the coverage

periods did not exceed 185 days out of any 365-day period, plus any additional days permitted by the plan for a condition for which a covered person incurred expenses during the term of the plan.
-- Did not cover any preexisting conditions.
-- Was available with an immediate effect date, without underwriting, upon the carrier's receipt of a completed application indicating eligibility under the carrier's eligibility requirements, except that coverage that included optional benefits could be offered on a basis that did not meet this requirement.

Prohibited Action. A carrier could not, directly or indirectly, encourage or direct an individual to refrain from filing an application for a health benefit plan with the carrier because of his or her initial condition or claims experience.

A carrier also could not, directly or indirectly, encourage or direct an individual to seek coverage from another carrier because of his or her health status or claims experience, except as otherwise provided in Section 3766 (which would require a carrier who refused coverage to an individual to notify him or her of the availability of coverage through BCBSM or an HMO).

In addition, a carrier could not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provided for or resulted in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the individual's health status or claims experience. This prohibition would not apply to a compensation arrangement that provided compensation to a producer on the basis of percentage of premium, if the percentage did not vary because of the individual's health status or claims experience.

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 health status or claims experience of the individual placed by the producer with the carrier.

Competition. By October 1, 2009, the OFIR Commissioner would have to determine whether a reasonable degree of competition in the health benefit plan market existed on a statewide basis, and conduct a feasibility study and provide recommendations concerning the establishment of a health coverage risk pool for high-risk individuals. In making this determination, the Commissioner would have to seek advice and input from appropriate independent sources and could retain qualified accounting and actuarial consultants.

The Commissioner would have to 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. Report findings could not be based on any single measure of competition, but appropriate weight would have to be given to all measures of competition. The report would have to be based on relevant economic tests, including all of the following:

-- The extent to which any carrier controlled all or a portion of the health benefit plan market.
-- Whether the total number of carriers writing plan coverage in Michigan was sufficient to provide multiple options to individuals.
-- The disparity among plan rates and classifications to the extent that those classifications resulted in rate differentials.
-- The availability of coverage to individuals in all geographic areas.
-- The overall rate level that was not excessive, inadequate, or unfairly discriminatory.
-- Any other factors the Commissioner considered relevant.

The Commissioner also would have to report on all of the following:

-- The impact that the creation of a high-risk pool would have on the individual health coverage market, on the small and large health coverage markets, and on premiums paid by insureds, enrollees, and subscribers.
-- The number of individuals and dependents the high-risk pool could reasonably cover at various premium levels, along with cost estimates for such coverage.
-- An analysis of various sources of funding and a recommendation as to the best source of funding for the future anticipated deficits of the high-risk pool.

-- Cost-containment measures and risk-reduction practices, along with opportunities for delivery of cost-effective health care services through the high-risk pool.

The reports 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.

HMO Regulations Conflicting with Chapter 37A

Under the Code, an HMO contract and its rates, including any deductibles, copayments, and coinsurances, between the organization and its subscribers must be fair, sound, and reasonable in relation to the services provided, and the procedures for offering and terminating contracts may not be unfairly discriminatory. An HMO contract and its rates may not discriminate on the basis of race, color, creed, national origin, residence within the HMO's approved service area, lawful occupation, sex, handicap, or marital status (subject to certain conditions). The OFIR Commission may approve a rate differential based on sex, age, residence, disability, marital status, or lawful occupation, if it is supported by sound actuarial principles and a reasonable classification system, and is related to the actual and credible loss statistics or reasonably anticipated experience for new coverages. A healthy lifestyle is not subject to the Commissioner's approval and need not be supported by sound actuarial principles and a reasonable classification system, or be related to loss statistics or reasonably anticipated experience.

The methodology used to determine prepayment rates by category rates charged by the HMO and any changes to either the methodology or the rates must be filed with and approved by the Commissioner before becoming effective. An HMO must submit supporting data used in the development of a prepayment rate or rating methodology and all other data sufficient to establish the financial soundness of the prepayment plan or rating methodology. The Commissioner annually may require a schedule of rates for all subscriber contracts and riders. All submissions must note the changes of rates previously filed or approved.

Except as otherwise provided, if an HMO desires to change a contract it offers to enrollees or to change a rate charged, a copy of the proposed revised contract or rate must be filed with the Commissioner and will not take effect until 60 days after the filing, unless the Commissioner approves the change before that period expires. If the Commissioner considers the proposed revised contract illegal or unreasonable in relation to the services provided, he or she must notify the HMO within 60 days, specifying the reasons for disapproval or approval with modifications. The Commissioner must schedule a hearing within 30 days after receiving a written request from the HMO, and the revised contract or rate will not take effect until approved by the Commissioner after the hearing. Within 30 days, the Commissioner must notify the HMO of the disposition of the revised contract or rate.

At least 30 days before the effective date of a proposed change in an HMO contract or rate, the HMO must issue to each subscriber or group who will be affected by it a clear written statement of the extent and nature of the proposed change. If the Commissioner has approved a proposed change before the 60-day deadline, the HMO immediately must notify each affected subscriber or group.

Under the bill, these provisions would not apply to the extent that they conflicted with proposed Chapter 37A.

Group Guaranteed Renewal

Under the Insurance Code, except as provided in Sections 2213b and 3539, an insurer and an HMO, respectively, must renew or continue in force a group policy or certificate at the option of the sponsor of the plan. Under the bill, this requirement would apply except as provided in those sections and Section 3711.

(Sections 2213b and 3539 provide that guaranteed renewal is not required in cases of fraud or intentional misrepresentation of material fact, lack of payment, if the insurer or HMO no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area. Section 3711 contains similar provisions applicable to small employer group policies.)

House Bill 5283 (S-4)

Charitable & Social Mission

The Nonprofit Health Care Corporation Reform Act provides that each corporation subject to it (BCBSM) is declared to be a charitable and benevolent institution and its funds and property are exempt from taxation by the State or any political subdivision of it.

Under the bill, by April 1 of each year, BCBSM would have to file with the Commissioner, in a format he or she approved, a report that detailed in the aggregate and by county how BCBSM met its charitable and social mission obligations for the immediately preceding calendar year, including all of the following:

-- What, if any, subsidies were issued to assist with the cost of individual health coverage to Michigan residents.
-- What, if any, efforts were made to expand or enhance access to health care by augmenting or creating health care programs and augmenting public health care programs that delivered health services.
-- What, if any, programs were created, expanded, or otherwise supported to inform and educate Michigan residents about public health issues and that empowered communities to address those issues by becoming more effective at identifying and articulating health care needs and implementing solutions.
-- What, if any, measures were taken to maintain and promote health science research and health care provider education.

The report also would have to be submitted to the Senate and House standing committees on health and insurance issues.

Individual Coverage

The bill would delete a requirement that, except as otherwise provided, BCBSM renew or continue in force a nongroup certificate at the option of the individual. The bill provides that BCBSM would be subject to proposed Chapter 37A of the Insurance Code (which contains a guaranteed renewal provision applicable to all carriers).

Exclusion & Limitation of Coverage

The bill would delete provisions allowing BCBSM to exclude or limit coverage for six months for a preexisting condition. (Similar provisions would be enacted in proposed Chapter 37A.)

BCBSM Board

Currently, the property and lawful business of BCBSM must be held and managed by a board of directors consisting of up to 35 members. Under the bill, the board could have up to 37 members.

Under the Act, four voting members (including two who are retired and at least 62 years old) must be representatives of the public appointed by the Governor by and with the advice and consent of the Senate. The bill would retain this requirement, and add that, effective January 1, 2009, two additional voting members would have to be representatives of the public. One would have to be appointed by the Senate Majority Leader and one by the Speaker of the House of Representatives.

Rate Differentials

Under the bill, the rates charged for nongroup, group conversion, and Medicare supplemental coverage could include rate differentials based on tobacco use and the subscriber's participation in covered health screenings and covered wellness programs.

Rate Filing

Currently, except as otherwise provided, a filing of information and materials relative to a proposed rate may not be made less than 120 days before its proposed effective date. Under the bill, the filing could not be made less than 60 days before the proposed effective date.

Within 30 days after a filing is made, the OFIR Commissioner must either give written notice to BCBSM, and to each person who has requested notice of those filings within the previous two years, that the filing is in material and substantial compliance with certain requirements and is complete; or give written notice to BCBSM that it has not yet complied with the prescribed requirements, stating specifically in what respects the filing fails to comply. Under the

bill, the Commissioner would have to give the notice within 15 days after a filing was made. (The bill would retain a requirement that the Commissioner approve, approve with modifications, or disapprove the rate filing 60 days after receiving it, based upon whether the filing meets the Act's requirements. The bill also would retain a provision prohibiting the Commissioner from approving, approving with modifications, or disapproving a filing until a requested hearing has been completed and an order issued.)

Currently, within 10 days after the filing of a notice that BCBSM's filing is noncompliant, BCBSM must submit to the Commissioner any additional information and materials that he or she requests. Within 10 days after receiving the additional information and materials, the Commissioner must determine whether the filing is in material and substantial compliance with the prescribed requirements. The bill would reduce both of these time periods to eight days.

The Act requires the Commissioner to make available forms and instructions for filing for proposed rates at least 180 days before the proposed effective date of the filing. Under the bill, the Commissioner would have to make the forms and instructions available at least 90 days before the proposed effective date.

Hearing

Currently, within 15 days after receiving a request for a hearing, the Commissioner must determine if the person who requested it has standing. Under the bill, the Commissioner would have to make the determination within eight days.

Currently, within 30 days after a request for a hearing is received, and upon at least 15 days' notice to all parties, the hearing must be commenced. The bill would reduce these time periods to 15 days and eight days, respectively.

Under the Act, each party to the hearing must be given a reasonable opportunity for discovery before and throughout the course of the hearing. The hearing officer, however, may terminate discovery at any time, for good cause shown. The hearing must be conducted in an expeditious manner. Under the bill, except for good cause shown, the hearing officer would have to render a proposal for decision within 30 days after the hearing began.

Currently, within 30 days after receiving a hearing officer's proposal for decision, the Commissioner must by order render a decision that includes a statement of findings. The bill would reduce this time period to eight days.

OFIR Petition

Currently, within 75 days after a rate filing is received, BCBSM may petition the OFIR Commission, who must make a determination with respect to interim rates and must order them in the amount prescribed in the Act. The bill would delete the reference to the 75-day time period, and instead allow BCBSM to petition the Commissioner immediately if a hearing were requested in a nongroup rate filing.

MCL 500.2213b et al. (H.B. 5282)
MCL 550.1301 et al. (H.B. 5283)

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

House Bill 5282 (S-5)

The bill would make changes to the individual health insurance market in the State of Michigan. Local governments and the State provide group health insurance to employees and the State also provides health care coverage to the indigent through the Medicaid program. Changes to the individual health insurance market would not directly affect group coverage or Medicaid. As such, the bill would have no direct fiscal impact on health care costs for State or local government. If reform of the individual health insurance market led to the coverage of more individuals, there would likely be a reduction in the amount of uncompensated care, which would reduce costs for publicly owned hospitals.

The bill would have an indeterminate fiscal impact on the Office of Financial and Insurance Regulation, which would have oversight responsibilities.

House Bill 5283 (S-4)

The bill would require a report by Blue Cross and Blue Shield of Michigan on its charitable and social mission activities. The filing of such a report would result in negligible costs to the OFIR Commissioner.

The bill would allow for differential rates based on users' tobacco use and participation in health screenings and wellness programs. To the extent that these rates resulted in changes in health behaviors, health care cost reductions could occur.

Fiscal Analyst: Steve Angelotti

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