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BILL ANALYSIS

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Senate Bills 579 through 582 (as introduced 5-14-09)
Sponsor: Senator Tom George (S.B. 579)
Senator John Pappageorge (S.B. 580)
Senator Mark C. Jansen (S.B. 581)
Senator Ron Jelinek (S.B. 582)
Committee: Health Policy

Date Completed: 6-1-09

**CONTENT**

**Senate Bill 579 would enact the "MI-Health Act" to do the following:**

**-- Create MI-Health to facilitate the availability, choice, and purchase of eligible plans by eligible individuals.**
**-- Prescribe the membership, powers, and duties of the Cover Michigan Board, which would govern MI-Health.**
**-- Require MI-Health to offer eligible health coverage plans that had been approved by the Board.**
**-- Allow MI-Health, with the Board's permission, to offer a health care plan that did not provide specific types of coverage otherwise required by law.**
**-- Allow all Michigan residents to apply to purchase health coverage through the MI-Health.**
**-- Require MI-Health to provide subsidies to assist eligible individuals in purchasing health coverage.**
**-- Prescribe eligibility criteria for premium assistance payments.**
**-- Require the Board to encourage the use of incentives to provide health promotion, chronic care management, and disease prevention.**
**-- Create the "MI-Health Fund" and require premium contribution payments and surcharges to be deposited into the Fund.**
**-- Require all health insurance carriers and third-party administrators to pay a health access surcharge, which would have to be deposited in into the proposed MI-Health Fund.**
**-- Require the Cover Michigan Board to report annually to the Governor, the, Legislature, and the Auditor General on MI-Health activities, receipts, and expenditures.**
**-- Require the Board to report to the Legislature on whether the plans offered through MI-Health were affordable and competitive.**
**-- Require the Board to conduct an annual study of MI-Health and its enrollees and submit to the Legislature a report based on the data collected.**

**Senate Bill 580 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:**

**-- Require a carrier to renew or continue an issued plan at the individual's option.**
**-- 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 condition or claims experience.**

**-- Create the Michigan Claims Board within the Office of Financial and Insurance Regulation (OFIR).**

**-- Create the "Michigan Claims Fund", and require Fund money to be spent to reimburse carriers for up to 90% of $250,000 in claims paid on behalf of an enrollee annually.**

**-- Require each carrier to pay an annual assessment into the Michigan Claims Fund.**

**-- Require a carrier's premium rates to recognize the availability of reimbursement from the Fund.**

**-- Require the Michigan Claims Board to report annually to the Governor and the Legislature on the amount of assessments collected and claims paid.**

**Senate Bill 581 would amend the Nonprofit Health Care Corporation Reform Act to do the following:**

**-- Require the OFIR Commissioner to assess a fee on BCBSM equal to the local tax and Michigan Business Tax that it would have had to pay if it were subject to taxation.**

**-- Require the fee to be deposited into the proposed MI-Health Fund.**

**-- Provide that BCBSM would be subject to proposed Chapter 37A of the Insurance Code.**

**-- 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 and requested hearings under the Act.**

**Senate Bill 582 would amend the Public Health Code to authorize revenue from quality assurance assessments on hospitals to be spent on the subsidization of the proposed MI-Health program.**

The bills are tie-barred to each other. They are described below in further detail.

## Senate Bill 579

Part I: MI-Health

Establishment & Purpose of MI-Health. The bill would create MI-Health within the Department of Community Health (DCH). MI-Health would have to exercise its prescribed statutory duties, powers, and functions independently of the DCH Director. MI-Health would be responsible for facilitating the availability, choice, and purchase of eligible health coverage plans by eligible individuals.

("Eligible health coverage plan" would mean any individual or nongroup contract, policy, or certificate of health, accident, and sickness insurance or coverage issued by a carrier that met the eligibility requirements established by the Cover Michigan Board and that was offered through MI-Health. The term would not include a contract, policy, or certificate that provided coverage only for dental, vision, specified accident or accident-only coverage, credit, disability income, hospital indemnity, short-term or one-time limited duration policy or certificate of up to six months, long-term care insurance, Medicare supplement, coverage issued as a supplement to liability insurance, and specified disease insurance that was purchased as a supplement and not as a substitute for an eligible health coverage plan. The term also would exclude coverage arising out of a worker's compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault, coverage under a plan through Medicare, and coverage issued under Federal law to members and former members of the uniformed services and their dependents,

and any coverage issued as a supplement to that coverage.

"Carrier" would mean a health insurer, HMO, or health care corporation (i.e., BCBSM).

"Eligible individual" would mean an individual who was a Michigan resident who met the eligibility requirements prescribed in the proposed Act. "Resident" would mean a person living in Michigan, including a qualified alien, or a person who was not a U.S. citizen but who was otherwise permanently residing in the U.S. under color of law; provided, however, that the person had not moved to Michigan for the sole purpose of securing health coverage under the Act.)

Cover Michigan Board. MI-Health would be governed by a board of directors called the Cover Michigan Board, which would consist of the following 13 members:

-- The DCH Director or his or her designee.
-- The Director of the Department of Human Services or his or her designee, who would serve as an ex officio nonvoting member.
-- The OFIR Commissioner or his or her designee.
-- The Deputy Director for Medical Services Administration or his or her designee, who would serve as an ex officio nonvoting member.
-- Three members appointed by the Governor with the advice and consent of the Senate, including one who was a member in good standing of the American Academy of Actuaries, one health economist, and one representative of BCBSM.
-- Three members appointed by the Senate Majority Leader, including a representative of HMOs (but not an HMO owned by BCBSM), a representative of low-income health care advocacy organizations, and a representative of health professionals.
-- Three members appointed by the Speaker of the House, including a representative of the general public, a representative of health insurers, and a representative of hospitals.

The members first appointed to the Board would have to be appointed within 30 days after the proposed Act took effect. Appointed members would serve for terms of four years or until a successor was appointed, whichever was later, except that the members first appointed would serve staggered terms. If a vacancy occurred, it would have to be filled for the unexpired term in the same manner as the original appointment. An appointed member would be eligible for reappointment. The Governor could remove a Board member for incompetency, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause.

The DCH Director would serve as chairperson and would have to call the first Board meeting. After the first meeting, the Board would have to meet at least monthly, or more frequently at the call of the chairperson of if requested by at least seven members. Seven members would constitute a quorum for the transaction of business at a meeting. An affirmative vote of seven members would be necessary for official Board action. The Board would be subject to the Open Meetings Act and the Freedom of Information Act.

Board members would serve without compensation, but could be reimbursed for their actual and necessary expenses incurred in the performance of their official duties as Board members.

The Board would have to develop a plan of operation for MI-Health, which would have to include all of the following:

-- The establishment of procedures for MI-Health operations.
-- The establishment of procedures and criteria for the approval of eligible health coverage plans.
-- The establishment of procedures for the enrollment of individuals in plans.
-- The establishment of procedures for appeals of eligibility decisions.
-- The establishment and management of a system of collecting and depositing into the MI-Health Fund all premium payments made by, or on behalf of, MI-Health enrollees, including any premium payments made by enrollees, employers, unions, or other organizations.
-- The establishment and management of a system for remitting premium assistance payments to carriers.
-- The establishment and management of a system for remitting premium contribution payments to carriers.

-- The establishment of a plan for publicizing the existence of MI-Health and its eligibility requirements and enrollment procedures.
-- The development of criteria for determining that certain health coverage plans would no longer be made available through MI-Health.

The plan of operation also would have to develop a standard application form for individuals seeking to purchase or obtain health coverage through MI-Health, and for eligible individuals who were seeking a premium assistance payment. The application form would have to include information necessary to determine an applicant's eligibility, previous and current health coverage, and payment method.

("Premium assistance payment" would mean a payment of health coverage premiums the Board made to a plan on behalf of a MI-Health enrollee who was an eligible individual. "Premium contribution payment" would mean a payment an enrollee or an employer on an enrollee's behalf made toward an eligible health coverage plan.)

The Board also would have to do all of the following:

-- Determine each applicant's eligibility for purchasing health coverage offered by MI-Health, including eligibility for premium assistance payments.
-- Publish each year the premiums for eligible health coverage plans.
-- Seek and receive any funding from the Federal government, State departments or agencies, private foundations, and other entities.
-- Contract with professional service firms as necessary and fix their compensation.
-- Contract with companies that provided third-party administrative and billing services for health coverage products.
-- Adopt bylaws for the regulation of its affairs and the conduct of its business.
-- Approve the use of its trademarks, brand names, seals, logos, and similar instruments by participating carriers, employers, or organizations.
-- Enter into interdepartmental agreements.

Additionally, the Board annually would have to review the publication of the income levels for the Federal poverty guidelines and devise a schedule of a percentage of income for each 50% increment of the Federal poverty level at which an individual could be expected to contribute a percentage of income toward the purchase of heath coverage and examine any contribution schedules, such as those set for government benefits programs. The report would have to be published annually. Before publication, the schedule would have to be reported to the House and Senate standing committees on Appropriations, health, and insurance issues.

Eligible Health Coverage Plans; Rates. MI-Health could offer only eligible health plans that the Board had approved. Each plan offered through MI-Health would have to contain a detailed description of benefits offered, including maximums, limitations, exclusions, and other benefit limits. Each plan would have to reimburse health care professionals and health facilities at Medicare reimbursement rates.

A plan could not be offered through MI-Health if it excluded an individual from coverage because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.

MI-Health would have to offer a variety of health coverage plans. To be approved by the Board, a plan would have to meet all requirements of health coverage plans required under State law, rule, and regulation except that, in order to satisfy the goal of universal health care coverage in Michigan, the Board could permit a plan provided through MI-Health not to provide for the following coverage or offerings required under certain sections of the Insurance Code and the Nonprofit Health Care Corporation Reform Act:

-- Prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy or the removal of a body part due to illness or injury.
-- Mental health services provided by the DCH or a county community mental health board when appropriate services cannot be delivered otherwise, or if the provider is designated by a court order.
-- Hospice care.
-- Breast cancer diagnostic, outpatient treatment, and rehabilitative services,

and breast cancer screening mammography coverage.
-- Drugs used in antineoplastic therapy.
-- Routine obstetrical and gynecologic services.
-- Pediatric services for a dependent minor.
-- Programs to prevent the onset of clinical diabetes; related equipment, supplies, and educational training; and related pharmaceuticals.
-- Off-label drug use.
-- Obstetrical and gynecologic services performed by a physician or a nurse midwife.
-- Inpatient, outpatient, and intermediate substance abuse treatment.

In determining the coverage or offerings that did not have to be provided, the Board would have to determine whether real cost savings would be achieved and affordability maximized.

Benefits provided in eligible health coverage plans for MI-Health would have to include wellness services, inpatient services, outpatient services and preventive care, and value-based pharmaceutical benefit.

With regard to adjusting premiums for an eligible plan, a carrier could establish up to five geographic areas of the State, and BCBSM would have to establish geographic areas that covered all counties in Michigan.

The rates charged to individuals for eligible plans could include rate differentials based only on age, tobacco use, body mass index, and other health behaviors and only 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.

Eligible health coverage plans would be subject to Part II of the proposed Act, concerning the health access surcharge.

The Board would have to approve as eligible a plan that it determined satisfied the proposed requirements, provided good value to residents, and provided quality medical benefits and administrative services.

The Board could remove a plan from being offered through MI-Health only after notice to the carrier.

Premiums & Subsidies. MI-Health would have to provide subsidies to assist eligible individuals in purchasing eligible plans. Subsidies could be paid only on behalf of an individual who was enrolled in an eligible plan, and would have to be made under a sliding-scale premium contribution payment schedule for enrollees.

Premium assistance payments would have to be made as provided in the proposed Act and under a schedule set annually by the Board in consultation with the DCH. The schedule would have to be published annually. If amounts in the MI-Health Fund were insufficient to meet the projected costs of enrolling new individuals, the Board would have to impose a cap on enrollment in MI-Health and notify the Governor and the legislative standing committees on Appropriations, health, and insurance issues.

An enrollee with a household income that did not exceed 200% of the Federal poverty level would be responsible only for a copayment toward the purchase of each pharmaceutical product and for use of emergency room services in acute care hospitals for nonemergency conditions equal to that required of enrollees in the Medicaid program. The Board could waive copayments upon a finding of substantial financial or medical hardship. The premium could not exceed 5% of the enrollee's gross household income, and no other premium, deductible, or other cost sharing could apply to the enrollee.

An enrollee with a household income that exceeded 200% but did not exceed 300% of the Federal poverty level would be responsible for a premium contribution payment, and copayments, deductibles, and other cost-sharing measures, that were reasonably established so as to encourage and promote maximum enrollment.

An uninsured individual would be eligible to participate in MI-Health if all of the following conditions were met:

-- The individual's household income did not exceed the Federal poverty levels established in the proposed Act.
-- The individual had been a Michigan resident for the previous six months.
-- The individual was not eligible for any government program, Medicaid,

Medicare, or the State Children's Health Insurance Program (SCHIP).
-- The individual had not accepted a financial incentive from his or her employer to decline the employer's subsidized health coverage plan.
-- In the last six months the individual's or family member's employer had not provided health coverage for which the individual was eligible.

The last condition would not apply if health coverage were not provided due to the individual's or family member's loss of employment, loss of eligibility for coverage due to loss of employment hours, or loss of dependency status.

Incentives. The Board would have to encourage eligible plans to use incentives to provide health promotion, chronic care management, and disease prevention. Incentives could include rewards, premium discounts, or rebates, or otherwise waive or modify copayments, deductibles, or other cost-sharing measures. Incentives would have to be available to all similarly situated individuals and be designed to promote health and prevent disease. Incentives could not be used to impose higher costs on an individual based on a health factor.

Written Determination. A resident who applied to MI-Health would have the right to receive a written determination of eligibility and, if eligibility were denied, a written denial detailing the reasons for the denial and the right to appeal any eligibility decision, provided the appeal was conducted pursuant to the process established by the Board.

Interagency Agreements. The Board would have to enter into interagency agreements with the Department of Treasury to verify income data for participants in the Program. The written agreements would have to permit the Board to provide a list of individuals participating in or applying for an eligible plan, including any applicable members of their households, who would be counted in determining eligibility, and to furnish relevant information, including name, Social Security number, if available, and other data required to assure positive identification. The Department of Treasury would have to furnish the requested information, including name, Social Security number, and other data to ensure positive identification, name and identification number of employer, and amount of wages received and gross income from all sources.

Surcharge. The Board could apply a surcharge to all eligible health coverage plans, which could be used only to pay actual administrative and operational expenses of MI-Health and so long as the surcharge was applied uniformly to all eligible plans. A surcharge could not be used to pay any premium assistance payments.

Carrier Reports. Each carrier offering an eligible health coverage plan would have to furnish such reasonable reports as the Board determined necessary, including detailed loss-ratio and experience reports that identified administrative cost and medical charge trends.

MI-Health Fund. The MI-Health Fund would be created within the State Treasury. Premium contribution payments and surcharges collected under MI-Health would have to be deposited into the Fund. The health access surcharge collected under Part II also would have to be deposited into the Fund. The State Treasurer could receive money or other assets from any source for deposit into the Fund, and would have to direct its investment. The Treasurer would have to credit to the Fund interest and earnings from Fund investments. Money in the Fund at the close of the fiscal year would remain in the Fund and would not lapse to the General Fund. Fund money could be spent only as provided in the proposed Act. The DCH would be the Fund administrator for auditing purposes.

Board Reports. The Board would have to keep an accurate account of all MI-Health activities and all of its receipts and expenditures, and would have to report annually at the end of the fiscal year to the Governor, the House and Senate standing committees on Appropriations, health, and insurance issues, and the Auditor General. The Auditor General could investigate the affairs of MI-Health, severally examine its properties and records, and prescribe methods of accounting and the rendering of periodical reports. MI-Health would be subject to annual audit by the Auditor General.

Part II: Health Access Surcharge

All carriers and third-party administrators would have to pay a health access surcharge that could not exceed 1.8% on all paid claims. The surcharge would apply to paid claims beginning July 1, 2010. Surcharge payments would have to be made monthly to the MI-Health Fund beginning August 2010. They would be due at least 15 days after the end of the month, and would accrue interest at 12% per year on or after the due date, except that surcharge payments for third-party administrators for groups of up to 500 members could be made annually at least 60 days after the close of the plan year.

After notice and hearing, the Commissioner could suspend or revoke the certificate of authority of any carrier to transact insurance in Michigan or the license of any third-party administrator to operate in Michigan if the carrier or administrator failed to pay a health access surcharge.

"Paid claims" would mean all payments made by third-party administrators or carriers, including those made pursuant to a service contract for administrative services or cost plus arrangements under the Nonprofit Health Care Corporation Reform Act, for health and medical services provided under individual, nongroup, and group policies, certificates, or contracts, delivered, issued for delivery, or renewed in Michigan that insured or covered Michigan residents. If a carrier or third-party administrator were contractually entitled to withhold certain amounts from payments due to providers of health and medical services in order to help ensure that the providers could fulfill any financial obligations they could have under a managed care risk arrangement, the full amounts due the providers before application of such withholds would have to be reflected in the calculation of paid claims. "Paid claim" would not include any of the following:

-- Claims-related expenses and general administrative expenses.
-- Payments made to qualifying providers under a "pay for performance" or other incentive compensation arrangement if the payments were not reflected in the process of claims submitted for services rendered to specific covered individuals.
-- Claims paid for services rendered to nonresidents of Michigan.
-- Claims paid under retiree health benefit plans that were separate from and not included within benefit plans for existing employees.
-- Claims paid for services rendered to people covered under a benefit plan for Federal employees.
-- Claims paid for services rendered outside of Michigan to a Michigan resident.

"Paid claims" also would not include claims paid by carriers and third-party administrators with respect to dental, vision, specified accident or accidental only coverage, credit, disability income, hospital indemnity, long-term care insurance, Medicare supplement, coverage issued as a supplement to liability insurance, or specified disease insurance, except that claims paid for dental services covered under a medical policy would be included.

"Claims-related expenses" would include payments for utilization review, care management, disease management, risk assessment, and similar administrative services intended to reduce the claims paid for health and medical services rendered to covered individuals, usually either by attempting to ensure that needed services were delivered in the most efficacious manner possible or by helping those covered individuals to maintain or improve their health.

"Claims-related expenses" also would include payments made to or by organized groups of providers of health and medical services in accordance with managed care risk arrangements or network access agreements that were unrelated to the provision of services to specific covered individuals.

"Health and medical services" would include any services included in the furnishing of medical care, dental care to the extent covered under a medical insurance policy, pharmaceutical benefits, or hospitalization, including services provided in a hospital or other medical facility; ancillary services, including ambulatory services; physician and other practitioner services, including services provided by a physician's assistant, nurse practitioner, or midwife; and behavioral health services, including mental health and substance abuse services.

Part III: Reports

Board Report. Within 18 months after the proposed Act took effect, the Board would have to report on whether the health coverage plans offered through MI-Health were affordable and competitively priced in the individual market. In making this determination, the Board would have to consider all of the following:

-- The extent to which any carrier controlled all or a portion of the health coverage plan market.
-- Whether the total number of carriers offering eligible health coverage plans in Michigan was sufficient to provide multiple options to individuals.
-- Whether underwriting needed to be expanded or restricted for MI-Health eligible health coverage plans.
-- The availability of eligible plans to individuals in all geographic areas.
-- The overall rate level that was not excessive, inadequate, or unfairly discriminatory.

The report would have to be forwarded to the Governor, the Clerk of the House of Representatives, the Secretary of the Senate, and all members of the Senate and House standing committees on insurance and health issues.

Board Study. Within two years after MI-Health began operation and every year after that, the Board would have to conduct a study of MI-Health and the people enrolled in eligible plans, and submit a written report to the Governor and the legislative standing committees on Appropriations, health, and insurance issues on the status and activities of MI-Health based on data collected in the study. The report would have to be available to the general public upon request. The study would have to review all of the following for the immediately preceding year:

-- The operation, administration, and costs of MI-Health.
-- The number of MI-Health enrollees and the total amount of premium assistance payments made under each eligible plan.
-- The amount and reasonableness of the surcharge and its impact on premiums.
-- Other information the Board considered pertinent.

The study also would have to review what health coverage plans were available to individuals through MI-Health and the experience of those plans, including any adverse selection trends. The experience of the plans would have to include data on the number of enrollees in the plans, plans' expenses, claims statistics, and complaints data. Health information obtained under the proposed Act would be subject to the Federal Health Insurance Portability and Accountability Act or regulations promulgated under that Act (45 CFR Parts 160 and 164).

## Senate Bill 580

MI-Health Waiver

Under the bill, if the Cover Michigan Board (proposed by Senate Bill 579) determined that certain provisions of the Insurance Code requiring the following coverages or offerings should be waived as provided in the proposed MI-Health Act, those coverages or offerings would not have to be provided or offered in an eligible health care plan:

-- Prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy or the removal of a body part due to illness or injury.
-- Mental health services provided by the DCH or a county community mental health board when appropriate services cannot be delivered otherwise, or if the provider is designated by a court order.
-- Hospice care.
-- Breast cancer diagnostic, outpatient treatment, and rehabilitative services, and breast cancer screening mammography coverage.
-- Drugs used in antineoplastic therapy.
-- Routine obstetrical and gynecologic services.
-- Pediatric services for a dependent minor.
-- Programs to prevent the onset of clinical diabetes; related equipment, supplies, and educational training; and related pharmaceuticals.
-- Off-label drug use.
-- Obstetrical and gynecologic services performed by a physician or a nurse midwife.
-- Inpatient, outpatient, and intermediate substance abuse treatment.

HMO Contracts

The Code requires all HMO contracts to include basic health maintenance services. Under the bill, this requirement would not apply to HMO contracts that were eligible health coverage plans under the proposed MI-Health Act.

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 an eligible health coverage plan under the proposed MI-Health Act. 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; or Medicaid or Medicare coverage.

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.

"Carrier" would mean a person that provided health benefits, coverage, or insurance 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, or 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.

Rescission, Cancellation, & Limitation of Plan. Notwithstanding any other provision of the Code, a carrier could not rescind, cancel, or limit a health benefit plan due to the carrier's failure to complete medical

underwriting and resolve all reasonable questions arising from the written information submitted on or with an application before the issuing the plan's contract. This provision would not limit a carrier's remedies upon a showing of intentional misrepresentation of material fact.

Rate Differentials. Rate differentials for health conditions could be used only when coverage was issued initially and could not be changed by a carrier at any time after issue as a result of subsequent changes in health conditions of individuals already covered under the health benefit plan. A carrier could use rate differentials based on health conditions for any person who was added subsequently to the plan only at the time he or she was added.

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. A guaranteed renewal would not be required in cases of fraud, intentional misrepresentation of material fact, or lack of payment; 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 effective 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 health 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 condition or claims experience.

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

Michigan Claims Board. The bill would create the Michigan Claims Board within OFIR. The Board would consist of the OFIR Commissioner and the following six members, appointed by him or her:

-- One member representing BCBSM.
-- One member representing HMOs, but not HMOs owned by BCBSM.
-- One member representing commercial carriers (i.e., carriers other than BCBSM or HMOs).
-- One member representing the general public.
-- One member who was a health economist.
-- One member who was in good standing with the American Academy of Actuaries.

The members first appointed would have to be appointed within 14 days after the effective date of proposed Chapter 37A. Members would serve for terms of four years or until a successor was appointed, whichever was later, except that the first appointed members would serve staggered terms.

The Governor could remove a Board member for incompetency, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause.

The Commissioner would have to call the first meeting, at which the Board would have to elect from among its members a chairperson and other officers as it considered necessary or appropriate. After the first meeting, the Board would have to meet at least quarterly, or more frequently at the call of the chairperson or if requested by at least four members.

Four members would constitute a quorum for the transaction of business at a Board meeting. Four members present and serving would be required for official Board action. The Board would be subject to the Open Meetings Act and the Freedom of Information Act.

Board members would serve without compensation, but could be reimbursed for their actual and necessary expenses incurred in the performance of their official duties as Board members.

Michigan Claims Fund. The bill would create the Fund within the State Treasury. Money in the Fund could be used only as provided in the bill. The State Treasurer could receive money or other assets from any source for deposit into the Fund, and would have to direct the Fund's investment. The State Treasurer would have to credit to the Fund interest and earnings from investments. Money in the Fund at the close of the fiscal year would remain in the Fund and would not lapse to the General Fund. The Commissioner would be the administrator of the Fund for auditing purposes.

Fund money would have to be spent to reimburse carriers for eligible claims. A carrier would be eligible to receive reimbursement for 90% of claims it paid between $25,000 and $250,000 in a calendar year on behalf of a covered enrollee. Each carrier would have to submit a request for reimbursement on a form prescribed by the Claims Board by April 1 following the end of the calendar year for which the request was being made. Claims would be eligible for reimbursement only for the calendar year in which they were paid. Once claims paid on behalf of a covered enrollee reached $250,000 in a given calendar year, no further claims on behalf of that enrollee in that year would be eligible for reimbursement. Carriers could be required to submit claims data in connection

with the reimbursement request as the Board considered necessary to distribute money and oversee the operation of the Claims Fund. The Board could require that the data be submitted on a per enrollee, aggregate basis or categorical basis.

If the total amount requested for reimbursement by all carriers for a calendar year exceeded funds available for distribution for claims paid by all carriers during that year, the Board would have to provide for the pro rata distribution of the available funds. Each carrier would be eligible to receive only the proportionate amount of the available funds as its total eligible claims paid bore to the total eligible claims paid by all carriers.

If funds available for distribution for claims paid by all carriers during a calendar year exceeded the total amount requested for reimbursement by all carriers, any excess funds would be carried forward, would not revert to the General Fund, and would have to be made available for distribution in the next calendar year.

As a condition of transacting business in Michigan, each carrier engaged in writing a health benefit plan would have to pay an annual assessment into the Michigan Claims Fund as provided in the bill. The total assessment in a calendar year would be the sum of the estimate of total reimbursement to be made for claims paid in the same year plus the estimated cost of administering the Fund for that year. By April 1 of each year, the Claims Board would have to determine the total assessment and notify carriers of their assessment. A carrier's assessment would have to be determined by the Board and be apportioned on an equitable basis among all carriers of health benefit plans in proportion to their respective shares of the total premiums. Within 90 days after the assessment notice was issued, each carrier would have to pay the amount of its assessment to the Fund.

The premium rates a carrier established for a health benefit plan would have to recognize the availability of reimbursement from the Fund.

Board Report. The Claims Board would have to keep an accurate account of all Michigan Claims Fund receipts and expenditures and report annually by October 1, beginning in 2010, to the Governor and to all members of the House and Senate standing committees on Appropriations, health, and insurance issues, on the amount of assessments collected and claims paid.

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.)

Disability Insurance Policy Guaranteed Renewal

Under the Code, except as provided in Section 2213b, an insurer that delivers, issues for delivery, or renews in Michigan an expense-incurred hospital, medical, or surgical individual policy under Chapter 34 (Disability Insurance Policies) must renew or continue in force the policy at the option of the individual. Under the bill, this requirement would not apply to a health benefit plan as defined in proposed Chapter 37A.

## Senate Bill 581

BCBSM Fee

Under the bill, by April 1 of each year, beginning in 2010, the OFIR Commissioner would have to assess on BCBSM a fee that could not exceed the amount of local tax and tax levied under the Michigan Business Tax Act that BCBSM would have been required to pay in the immediately preceding calendar year if it were subject to those taxes. The fee would have to be deposited into the proposed MI-Health Fund within 30 days after the assessment was issued.

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.)

Rate Differentials

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

MI-Health Waiver

Under the bill, if the Cover Michigan Board (proposed by Senate Bill 579) determined that certain provisions of the Nonprofit Health Care Corporation Reform Act requiring the following coverages or offerings should be waived as provided in the proposed MI-Health Act, those coverages or offerings would not have to be provided or offered in an eligible health care plan:

-- Prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy or the removal of a body part due to illness or injury.
-- Mental health services provided by the DCH or a county community mental health board when appropriate services cannot be delivered otherwise, or if the provider is designated by a court order.
-- Hospice care.
-- Breast cancer diagnostic, outpatient treatment, and rehabilitative services, and breast cancer screening mammography coverage.
-- Drugs used in antineoplastic therapy.
-- Routine obstetrical and gynecologic services.
-- Pediatric services for a dependent minor.
-- Programs to prevent the onset of clinical diabetes; related equipment, supplies, and educational training; and related pharmaceuticals.
-- Off-label drug use.
-- Obstetrical and gynecologic services performed by a physician or a nurse midwife.
-- Inpatient, outpatient, and intermediate substance abuse treatment.

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 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 render a decision that includes a statement of findings. The bill would reduce this time period to eight days.

**Senate Bill 582**

The Public Health Code requires the DCH to assess fees and other assessments for health facility and agency licenses and certificates of need on an annual basis according to a schedule. The schedule prescribes a quality assurance assessment for hospitals at a fixed or variable rate that generates funds *not more than* the maximum allowable under Federal matching requirements, after consideration for increased Medicaid reimbursement rates. Under the bill, this rate would have to generate funds that were *equal to* the maximum allowable under the Federal matching requirements, after consideration for increased Medicaid reimbursement rates.

The Code provides that the quality assurance dedication is an earmarked assessment that, together with all Federal matching funds attributable to it, may be used only for particular purposes and under specific conditions. The bill would include among these purposes the subsidization of MI-Health under the proposed MI-Health Act.

MCL 500.2213b et al. (S.B. 580)
550.1401e et al. (S.B. 581)
333.20161 (S.B. 582)

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**FISCAL IMPACT**

Senate Bills 579, 580, 581, and 582 would create and implement a health insurance program known as MI-HEALTH.

Senate Bill 579 would establish the MI-HEALTH program. Coverage would be available for those without health insurance who have incomes less than 300% of the Federal Poverty Level (FPL). For those under 200% of the FPL, there would be limited cost-sharing. The bill would allow more extensive cost-sharing measures for those between 200% and 300% of the FPL.

Coverage for individuals would be provided by MI-HEALTH providers. Benefits offered by MI-HEALTH providers could be more limited than the mandated minimum benefits required under the Insurance Code, so per-person costs would be lower than for the typical insured individual in Michigan.

Senate Bill 579 would impose a surcharge on carriers and third party administrators of up to 1.8% of all paid claims made on behalf of those with private health insurance in the State. It is difficult to obtain a precise estimate of how much such a surcharge would bring in. One must make estimates for the number of people covered by private health insurance as well as the average amount of paid claims per person per year.

Information from the Kaiser Family Foundation indicates that there are

approximately 6.1 million people in Michigan with private health insurance. The State of Maine has a similar tax on paid claims. Past data on that tax, combined with a Kaiser estimate of the number in Maine with private health insurance and assumptions about inflation since the data collection, indicate that paid claims per person per year in Maine are approximately $3,000. Assuming 6.1 million individuals with private health insurance and average paid claims of $3,000 per person per year in Michigan, a 1.8% surcharge would bring in $329.4 million per year.

Given the level of health care coverage associated with jobs in Michigan, it is possible that average paid claims are significantly higher than in a state like Maine, so the estimate certainly could be greater than $329.4 million. On the other hand, Michigan would have the option of charging a rate lower than 1.8% and revenue from a lower rate would be reduced in proportion to the rate.

Senate Bill 579 also would include a surcharge on health plans offering MI-HEALTH services to cover the costs of administering the program. There are not sufficient data to estimate those costs, though they should be minimal in comparison to the overall size of the program.

Senate Bill 580 would set up a Michigan Claims Fund to reimburse insurers for claims between $25,000 and $250,000 for a covered individual. The rate would be set so the revenue would be equal to expenses. While this is a significant aspect of the proposed program, it would not have a direct fiscal impact on State or local government.

Senate Bill 580 would increase the administrative responsibilities for Office of Financial and Insurance Regulation (OFIR) located within the Department of Energy, Labor, and Economic Growth (DELEG). The bill would create the Michigan Claims Board within OFIR and the Michigan Claims Fund, which would be created in the Department of Treasury but administered by DELEG/OFIR. The Office of Financial and Insurance Regulation would be responsible for oversight and direct management of the Fund, including providing reimbursement to the carriers for claims paid under this program, and reviewing claims information to determine reimbursement eligibility. The Board also would be required to submit an annual report to the Governor and Legislature regarding all revenue and expenditures from the Fund.

These additional responsibilities would require the hiring of additional staff and possibly additional expenditures for an information technology system necessary to track claims and reimbursement data. The total costs of this program to OFIR are unknown and would largely depend on the number of carriers that participated and as well as claims volume. Funding to cover these costs would be available through the assessments paid by the carriers in the State writing health benefit plans. Assessments would be determined by the Board and would be based on estimates for annual reimbursements made for claims paid plus any estimated costs for administering the Claims Fund.

Senate Bill 581 would require Blue Cross and Blue Shield of Michigan (BCBSM) to make a payment to the State equivalent to the local and State taxes BCBSM would face if it were subject to the Michigan Business Tax. One study, by the Anderson Economic Group, estimated that such a payment would be approximately $120.0 million per year. That estimate was disputed by BCBSM, which has argued that the revenue would be considerably less.

Senate Bill 581 would reduce the scheduled time frame for rate filings and hearings by half. To the extent that this expedited schedule required OFIR to hire additional staff, additional costs could be incurred to meet these proposed deadlines.

Senate Bill 582 would increase the hospital quality assurance assessment rate to the maximum allowed by Federal law. The Federal maximum is currently 5.5%. Such an increase would increase quality assurance assessment revenue by approximately $180.0 million per year.

As noted above, it is difficult to estimate precisely the amount of revenue that could be brought in to support MI-HEALTH. The estimates above would lead to revenue, assuming a 1.8% tax on paid claims, of approximately $600.0 million per year. This

estimate easily could vary up or down by $100.0 million.

Advocates for the bills have noted that uncompensated and undercompensated care provided by hospitals imposes a cost of roughly $2.0 billion in charges or approximately $1.0 billion in actual costs incurred. They point out that the losses from uncompensated care could well result in increased rates being paid by firms or individuals who purchase group or individual health insurance. They argue that expansion of health coverage would result in a reduction in uncompensated care and thus could potentially reduce the cost of private health insurance. In the case of State and local employees, this could result in a reduction in employee benefit costs.

Data reported to the State indicate that hospitals lost about $602.2 million on services to patients in 2007. A reduction in uncompensated care would certainly bring the hospitals as a group closer to a break-even point, but would not necessarily make them profitable on services to patients. Therefore, it would remain to be seen whether a reduction in uncompensated care, by itself, would lead to a significant reduction in health care premiums, and no adjustment was made for this possible effect on State and local employee costs.

Enrollment for the program would be capped if there were not enough money to cover every eligible person. It is likely that the money set aside for coverage would be fully spent on expanding health insurance coverage to at least some of the eligible population.

Proponents of the bill package have pointed out that the State would likely seek a Federal Medicaid waiver to expand Medicaid to cover adults under 200% of the FPL. This would allow the approximately $600.0 million in revenue to be matched with Federal Medicaid match dollars. If a waiver were granted and Federal match money were received to cover people up to 200% of the FPL, the total available revenue for the program would be approximately $1.6 billion. While the present Medicaid match rate, due to the passage of the American Recovery and Reinvestment Act (ARRA), is over 70%, costs to cover new eligibility groups must be reimbursed at the base Medicaid match rate, which will be 63.19% in FY 2009-10; thus, the match dollars would be about $1.0 billion.

Kaiser estimates that there are about 700,000 uninsured individuals in Michigan with income under 200% of the FPL. Other estimates are that about half the uninsured in Michigan are under 200% of the FPL, which would equate to about 550,000 individuals. With Federal match dollars it would be possible to provide health care coverage to most or perhaps even all of the uninsured population under 200% of the FPL. The number of people covered would depend on the package of benefits, the reimbursement rates to providers, and the health care needs of the covered population. The cost per individual for the cohort between 200% and 300% of poverty would be less due to the cost-sharing permitted in the legislation.

In summary, the provisions in Senate Bills 579, 580, 581, and 582 would increase State revenue by hundreds of millions of dollars, with a best guess of State-generated revenue in the range of $600.0 million. This revenue, along with any Federal Medicaid match dollars, would be spent on the MI-HEALTH program to expand health insurance coverage to presently uninsured populations. There also would be indeterminate administrative costs incurred by DELEG, but those costs would be on a much smaller scale than the revenue.

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