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BILL ANALYSIS

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Senate Bill 1242 (Substitute S-3 as reported)
Senate Bill 1243 (Substitute S-3 as reported)
Sponsor: Senator Jason E. Allen (S.B. 1242)
Senator Tom George, M.D. (S.B. 1243)
Committee: Health Policy

Date Completed: 7-2-10

RATIONALE

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act. The Act contains significant changes, which will take effect over the next several years, aimed at reducing the number of uninsured and underinsured Americans. The Act includes tax credits for qualifying small businesses and individuals and families meeting certain income requirements to cover a percentage of their health care costs, and provides for the creation of state-based exchanges through which qualifying individuals and small businesses may purchase health insurance policies meeting prescribed standards. The Act also expands Medicaid eligibility and creates new regulations for private insurers, including guaranteed policy renewal and the prohibition of pre-existing condition exclusions and annual and lifetime limits on the dollar value of coverage. In addition, the Act requires all individuals to maintain minimal essential health care coverage or pay a tax penalty; and requires employers with more than 50 full-time employees to offer affordable coverage to workers or pay a penalty for employees who receive tax credits for insurance through an exchange.

Since the Federal legislation was enacted, questions have arisen regarding funding, how states should structure required programs, and the proper role of the Federal government. It has been suggested that a recommendation board should be created to examine the Patient Protection and Affordable Care Act and its repercussions for Michigan.

In a related matter, Blue Cross Blue Shield of Michigan (BCBSM), the State's nonprofit health insurer, is required to employ community rating when setting rates. Some people believe that BCBSM should be allowed to consider certain individual factors, such as tobacco use, in the individual market.

CONTENT

Senate Bill 1242 (S-3) would add Chapter 37A (MI-Health) to the Insurance Code to create the MI-Health Recommendation Board and require it to review and analyze the Patient Protection and Affordable Care Act, and make related recommendations on legislative and other action to the Governor and the Legislature.

Senate Bill 1243 (S-3) would amend the Nonprofit Health Care Corporation Reform Act to make BCBSM subject to proposed Chapter 37A; and allow BCBSM to use differentials based on specific factors in setting rates.

The bills are described below in further detail.

Senate Bill 1242 (S-3)

Board Creation

The bill would create the MI-Health Recommendation Board within the Office of Financial and Insurance Regulation. The bill provides that the Board would be the official State agency for providing review and

analysis of the Patient Protection and Affordable Care Act.

The Board would have to consist of 17 members, including the following people or their designees, who would serve as ex officio nonvoting members:

-- The Director of the Department of Community Health.
-- The Director of the Department of Human Services.
-- The Commissioner of Financial and Insurance Regulation.
-- The Deputy Director for Medical Services Administration.
-- The Director of the Department of Technology, Management, and Budget.

In addition, the Board would have to include four members appointed by the Governor with the advice and consent of the Senate, four members appointed by the Senate Majority Leader, and four members appointed by the Speaker of the House.

The members appointed by the Governor would have to include a member in good standing of the American Academy of Actuaries who was not employed by a carrier, hospital, or health professional; one who represented Blue Cross Blue Shield of Michigan; one who represented consumer advocacy groups; and one who represented a consumer who was covered currently by an individual or small group health benefit plan and was a member of the general public and not employed by a carrier, hospital, or health professional.

The members appointed by the Senate Majority Leader would have to include a health economist who was not employed by a carrier, hospital, or health professional; one who represented health professionals; one who represented carriers who were not health maintenance organizations (HMOs) or BCBSM; and one who represented self-insured plans.

The members appointed by the Speaker of the House would have to include one who represented HMOs, including those that provide coverage under the State's Medicaid program, but not an HMO owned by BCBSM; one who represented large group health benefit plans; one who represented a health information technology expert; and one who represented hospitals.

(Under the bill, "carrier" would mean a person who provides health benefits, coverage, or insurance under a health benefit plan in Michigan. For the purposes of proposed Chapter 37A, the term would include a health insurance company authorized to do business in this State, BCBSM, an HMO, or any other person providing a plan of health benefits, coverage, or insurance subject to State insurance regulation.

"Health benefit plan" would mean a group, individual, or nongroup expense-incurred hospital, medical, or surgical policy or certificate, BCBSM certificate, or HMO contract. 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- or vision-only insurance; worker's compensation or similar insurance; or automobile medical-payment insurance.)

The members first appointed to the Board would have to be appointed within 30 days after the bill took effect. Appointed members would serve for terms of four years or until a successor was appointed, whichever was later; the members first appointed, however, would serve terms of one, two, three, or four years.

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 member for incompetence, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause.

The first Board meeting would have to be called by the Commissioner, who would serve as the chairperson. After the first meeting, the Board would have to meet at least monthly, or more frequently at the call of the chairperson or if requested by nine or more members. 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.

Board Responsibilities

The Board would have to protect the State's interests under the Patient Protection and Affordable Care Act, as well as study changes proposed under that Act. The study would have to include a review and analysis of all of the following:

-- Opportunities available for the State to maintain control over health care in Michigan, legislation necessary to permit the State to opt out of provisions of the Patient Protection and Affordable Care Act, and legislation needed for Michigan to comply with that Act.
-- Recommendations for the smooth establishment of health insurance exchanges as described by the Act.
-- The role of the State, carriers, and producers in health insurance exchanges.
-- The ability of changes proposed under the Act to reduce the number of uninsured.
-- Funding requirements and all grant opportunities.
-- All litigation outcomes on court decisions concerning State mandates required by the Act and recommendations for State action as a result of those outcomes.
-- Federal actions concerning health care reform and how they would affect the State both positively and negatively.
-- Costs of the Act on the State, businesses, and individuals, including the projected fees paid by employees and employers and the methodology used to establish their costs.
-- Executive agencies' duties and responsibilities required under the Act.
-- The affordability of health care and health insurance in Michigan as a result of the Act, including an analysis of health care provider provisions that could affect the health care market adversely.
-- The legislative and executive obligations under the Medicaid provisions of the Act, including information on the costs of compliance to the State and the effects that the Medicaid provisions would have on the State budget.

The recommendations for the establishment of health insurance exchanges would have to include the participation of carriers in the exchanges, the benefits offered by carriers, the rules and standards for insurance products, and the rating standards to be established for the products.

Within six months after the bill took effect and by March 23 each year after that, the Board would have to report its findings, along with any recommendations for legislative or other action, to the Governor and to the Senate and House of Representatives standing committees on health and insurance issues.

By June 1, 2013, the Board would have to report to the Governor and to the specific standing committees on the impact the changes implemented and proposed under the Patient Protection and Affordable Care Act had or could have on BCBSM. The Board also would have to make recommendations on the continued role and status of BCBSM. By June 1, 2015, the Board would have to provide a follow-up report that examined the impact on BCBSM since the 2013 report was issued and make recommendations on its continued role and status. Both reports would have to contain recommendations for legislative or other action, as well as recommendations on the continued role and status of BCBSM.

Senate Bill 1243 (S-3)

The bill provides that a health care corporation (BCBSM) would be subject to Chapter 37A of the Insurance Code.

Effective January 1, 2011, the rates charged for BCBSM certificates could include rate differentials based only on tobacco use, body mass index, and other healthy 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 certificates.

Proposed MCL 500.3751-500.3755 (S.B. 1242)
Proposed MCL 550.1220 & 550.1401k (S.B. 1243)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The recently enacted Patient Protection and Affordable Care Act is an extensive, complex piece of legislation with serious implications for the State of Michigan and its residents. The Act requires states to take certain actions regarding the health insurance market over the next several years. These actions will affect access to, as well as the cost of, health insurance. Some people have questioned the constitutionality of the Act, and several state Attorneys General, including Michigan's, have sued the Federal government to block implementation. A comprehensive review of the legislation is necessary to identify the State's legal responsibilities, if any; decide how best to meet any State obligations; and evaluate the potential impact on insurance affordability and accessibility. Although the Governor has appointed an advisory council to examine the Act and its implications for Michigan, no formal body has been established for this purpose. Legislators, who are directly accountable to the citizens who elected them, should be involved in the important decisions that will be made in the near future pertaining to health care reform. Senate Bill 1242 (S-3) would establish an official body to provide both the Governor and the Legislature with relevant information and recommendations regarding the Federal legislation and the State's role under it.

Response: In light of the Patient Protection and Affordable Care Act's aim of expanding access to health care, the proposed MI-Health Recommendation Board should include more consumer representatives.

Supporting Argument

Under current law, BCBSM must engage in community rating rather than underwriting in the individual market. Individual behavior, however, can have an impact on health status. Personal choices such as tobacco use, poor diet, and a sedentary lifestyle can lead to various problems that increase the cost of health care. By authorizing BCBSM to use differentials based on personal behavior in setting rates, Senate Bill 1243 (S-3) would give subscribers an incentive to adopt healthy choices.

Opposing Argument

Historically, people who cannot obtain affordable insurance from commercial carriers, such as the poor and those with pre-existing conditions, and who do not qualify for Medicaid have had to turn to nonprofit BCBSM for coverage, which is made affordable partly through the use of community rating. While the cost of health care is increased due in part to unhealthy lifestyle choices, allowing BCBSM to apply rate differentials to individuals, as proposed by Senate Bill 1243 (S-3), would be contrary to its charitable mission as the insurer of last resort. In practice, the bill could further penalize people who already have difficulty paying for health coverage. Furthermore, BCBSM's current financial status indicates that it is not suffering unsustainable losses as a result of community rating; allowing the use of rate differentials is not necessary at this time.

Also, the rate factors prescribed in the bill could be inconsistent with certain provisions of the Patient Protection and Affordable Care Act. For example, the Federal legislation prohibits rating based on body mass index. In addition, it is questionable whether the proposed rate differentials would be effective in changing people's behavior.

Response: The conflicting provisions of the Federal legislation will not take effect for several years. Until then, it would be prudent to give BCBSM some flexibility in setting rates, especially if it would encourage subscribers to adopt habits that improve their health.

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

Senate Bill 1242 (S-3)

The bill would increase the administrative responsibilities and costs of the Office of Financial and Insurance Regulation (OFIR) within the Department of Energy, Labor, and Economic Growth. The bill would create the MI-Health Recommendation Board within OFIR to study the changes the Federal health reform legislation will have on the State. The Board would be required to report its recommendations for legislative or other actions needed within six months of its creation and annually thereafter. Also, beginning in 2013, the Board would be charged with periodic reporting on the impact of Federal health care reform changes on a Michigan health care corporation. This would require increased staff time and additional expenses for the

preparation and distribution of the required reports. There also would be costs for reimbursing the necessary expenses of Board members. The amount of these costs is unknown. The bill would not make any appropriation for staff or expenses for supporting the Board. Current administrative expenses of OFIR for insurance regulation are funded both by regulatory fees on the insurance industry set according to a statutory formula and by insurance agent fees.

Senate Bill 1243 (S-3)

The bill would have no fiscal impact on State or local government.

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.