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BILL ANALYSIS

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Senate Bill 1242 (Substitute S-1)
Senate Bill 1243 (Substitute S-1)
Sponsor: Senator Jason E. Allen (Senate Bill 1242)
Senator Tom George, M.D. (Senate Bill 1243)
Committee: Health Policy

Date Completed: 6-23-10

CONTENT

Senate Bill 1242 (S-1) 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 Federal 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-1) would amend the Nonprofit Health Care Corporation Reform Act to make Blue Cross Blue Shield of Michigan (BCBSM) subject to the 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-1)

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 (described below, under **BACKGROUND**).

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 individual and small group health benefit plans.

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 provided 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.

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, including 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.
-- 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.

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-1)

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 age, 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. The variation in rates based on age could not exceed a ratio of three to one.

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

BACKGROUND

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.

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

Senate Bill 1242 (S-1)

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 Michigan 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. The Board also would also be charged with periodic reporting beginning in 2013 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-1)

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

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