Legislative Analysis

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CONVERT BCBSM TO NONPROFIT MUTUAL INSURER

Senate Bills 1293 & 1294
Sponsor: Sen. Joe Hune
House Committee: Insurance
Senate Committee: Insurance

Complete to 11-21-12

A SUMMARY OF SENATE BILLS 1293 & 1294 AS PASSED BY THE SENATE 10-17-12

Together, the two bills would allow Blue Cross and Blue Shield of Michigan (BCBSM) to become a nonprofit mutual disability insurance company.

Currently, BCBM's governing statute describes the organization as "a tax-exempt charitable and benevolent institution."

Senate Bill 1294 would amend the Nonprofit Health Care Corporation Reform Act, which currently governs the operations of BCBSM. That bill would allow BCBSM to establish, own, operate, and merge with a nonprofit mutual disability insurer. (MCL 550.1218 et al.)

Senate Bill 1293 would amend the Insurance Code, under which the new mutual insurance company would be regulated. That bill would allow the new insurer to be formed with nonprofit status through a merger with BCBSM. (MCL 500.2213b et al.) No new health care corporation could be formed under the act on or after the bill's effective date.

The merger would dissolve the health care corporation, and the surviving nonprofit mutual insurer would then assume the performance of all contracts and policies of the merged corporation existing on the date of the merger. The legislation would allow the nonprofit mutual insurer to retain and use trade names in use prior to the merger (e.g., "Blue Cross" and "Blue Shield").

Both BCBSM and the newly created nonprofit mutual disability insurer would be required to offer health care benefits to all Michigan residents, regardless of health status, until January 1, 2014. (That is the date at which the federal Affordable Care Act essentially requires all health insurers to offer health insurance to an individual regardless of health status or pre-existing conditions.)

Currently the funds and property of BCBSM— as "a charitable and benevolent institution"—are exempt from taxation by the state or any political subdivision of the state. After the merger the new nonprofit insurance company would not enjoy this tax-exempt status. Premium rates for the new insurer would be regulated under the Insurance Code in the same way as the rates of other insurance companies. The current special rate

regulation regimen that is required only of BCBSM, including the active participation of the state Attorney General, would no longer apply.

Other key elements in the two-bill package include:

- The merger would be effective upon (1) the adoption of a plan of merger by the majority of the boards of directors of both the health care corporation and the nonprofit mutual disability company and (2) the approval of the plan of merger by the Commissioner of the Office of Financial and Insurance Regulation. (The health care corporation directors could serve as the incorporators, directors, or officers of the newly formed nonprofit mutual insurance company.)

- The insurer resulting from the merger would have to continue to provide coverage to the individual and small health group markets in the state and could, at its option, continue to provide any product offered to subscribers of the previous nonprofit health care corporation.

- The plan of merger would specify that the surviving entity "shall use its best efforts" to make annual social mission contributions to a newly created entity, called the Michigan Health and Wellness Foundation, in an amount of up to $1.5 billion over a period of up to 18 years, beginning in April 2014. (A more detailed description of this foundations purposes and organization structure are provided later.)

- Up to one-half of the money contributed each year to the new foundation would be available for disbursement upon approval of the foundation board. Generally speaking, money is to be disbursed for programs related to the health and wellness of state residents and the quality and efficiency of health care.

- The foundation board would be required to implement a program to subsidize the cost of individual Medicare supplemental, or "Medigap," coverage to help senior citizens who demonstrate financial need to purchase this coverage (which supplements—or fills the gaps in— coverage available through the federal Medicare program). The board would have to disburse 60% of the total foundation money eligible for disbursement to subsidize the cost of individual Medigap coverage from January 1, 2016, to December 31, 2121, or until the nonprofit mutual insurer discontinued offering Medicare supplemental coverage, whichever occurred first.

- Regarding Medicare supplemental coverage, until July 1, 2016, the new nonprofit mutual insurer would have to (1) continue to offer the coverage to current or new eligible policyholders at the same rates offered to subscribers on the effective date of the legislation, and (2) continue all cost transfers authorized for senior citizens under the Nonprofit Health Care Corporation Reform Act as of the legislation's effective date.

- If another person or entity acquired more than a 50% beneficial interest in the nonprofit mutual insurer, the insurer or acquirer would have to make a payment to the Health and Wellness Foundation in an amount equal to the greater of (1) the acquisition price or (2) the fair market value as determined by an independent valuation by a person agreed upon by the OFIR commissioner, the attorney general, and the insurer.

- In the event of the dissolution or winding up of the nonprofit mutual, any residual value remaining after the satisfaction of claims would have to be distributed to the Health and Wellness Foundation.

- A nonprofit mutual disability insurer could not convert its status to a stock insurer under Chapter 59 of the Insurance Code or reorganize under Chapter 60.

Both bills contain similar regulatory provisions, applying both to a nonprofit health care corporation, a nonprofit mutual insurance company formed by a merger, as well as other insurers and health maintenance organizations . These include the following.

- The bills would prohibit, as of February 1, 2013, the use of "most favored nation" clauses in provider contracts unless the clause had been filed with and approved by the OFIR commissioner. Any such clause in a provider contract on that date would be unenforceable without commissioner approval.

  (These are clauses that prevent a provider from contracting with another party to provide services at a lower rate; require a provider to accept a lower payment or reimbursement rate than specified in a contract if the provider accepts a lower rate from another party; requires a provider to terminate or renegotiate an existing provider contract if the provider agrees to provide services to another party at a lower rate; or requires a provider to disclose its contractual payment or reimbursement rates to other providers.)

- Premium rates charged after January 1, 2014, by an insurance company, nonprofit health care corporation, or health maintenance organization (HMO) in the individual or small group market, for small employers, or for individual conversion policies could only be based on the following factors: whether the policy covers an individual or a family; the rating area; age, except that the premium rate could not vary by more than 3 to 1 for adults for all plans other than child-only plans; and tobacco use, except that premium rates could not vary by more than 1.5 to 1.

- The bills would require certain actions be taken before discontinuing a particular plan or product in the nongroup or group market or discontinuing all coverage in that market. These actions include providing notice to the OFIR commissioner and offering covered individuals the option to purchase any other plan or product offered by the company without excluding or limiting coverage for a pre-existing condition and/or without providing a waiting period.

- A corporation, insurer, or HMO that discontinued providing all coverage in the nongroup or group market would be prohibited from issuing plans in the group or nongroup market for five years after withdrawing from that market.

- The amount of a premium rebate that could be offered for group and nongroup wellness coverage would be increased from 10% to 30%.

- Beginning January 1, 2014, corporations and insurers would have to establish and maintain a provider network and maintain contracts with the number and types of affiliated providers sufficient to ensure that all covered health care services to members are accessible without unreasonable delay, including access to emergency services 24 hours per day, seven days per week. A service area could not be created in a manner designed to discriminate against individuals because of age, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status.

- Beginning January 1, 2014, an insurer or corporation that had an insufficient number or type of participating providers to provide a covered benefit would be required to ensure that customer obtained the service at not greater cost than if it were obtained from a participating provider, or make other arrangements acceptable to the commissioner.

- Adequate arrangements to ensure reasonable proximity of participating providers to a member's business or personal residence would have to be established and maintained, beginning January 1, 2014.

- Insurers and corporations would be allowed to establish reasonable open enrollment periods, subject to the commissioner's approval, for policies and certificates offered or renewed in Michigan, beginning January 1, 2014.

- A company offering coverage during an open enrollment period could not deny or condition the issuance of a certificate or policy or discriminate in its pricing on the basis of health status, claims experience, receipt of health care, or medical condition.

Michigan Health and Wellness Foundation

As described earlier, Senate Bill 1294 provides, in a new Part 6A of the Nonprofit Health Care Corporation Reform Act, for the creation of the Michigan Health and Wellness Foundation. This would be a nonprofit corporation organized under the Nonprofit Corporation Act on a nonstock, directorship basis to receive and administer funds for the public welfare.

Foundation Board

The foundation would be organized and operated by a 13-member board appointed by the Governor with the advice and consent of the State Senate. The following initial members would be appointed:

** Two from a list of five or more recommended by the State Senate Majority Leader.

** Two from a list of five or more recommended by the Speaker of the Michigan House of Representatives.

** One from a list of three or more recommended by the Senate Minority Leader.

** One from a list of three of more recommended by the House Minority Leader.

** One representing the interests of minor children.

** One representing the interest of senior citizens.

** Two members representing the general public.

** One member representing the business community.

** One representing organized labor.

** One representing small businesses.

No member could currently be or within the immediately preceding 12 months have been employed by, under contract employment with, or received employment compensation from a carrier, producer, health care provider, or third party administrator, or by an affiliate of one of them.

Members would serve four-year terms, but the initial terms would be staggered. Seven members would constitute a quorum for business, and an affirmative vote of seven members would be required for official action. The board would appoint a chief executive officer who could employ staff with board approval. The board would determine compensation for the executive director and staff. The board itself would serve without compensation, although they could receive reimbursement for actual and necessary expenses.

Board Meetings

The business of the board would have to be conducted at meetings that are held in Michigan in a place available to the general public and open to the public. However, the board could establish reasonable rules and regulations to minimize disruption of a meeting. The board could meet in closed session to consider certain personnel issues, to consult with its attorney, or to comply with federal and state privacy or confidentiality rules and regulations.

Notices of meetings would have to be provided at least 10 days and no more than 60 days before a meeting; notice would have to be provided at its principal office and on its internet website. Minutes would have to be available for inspection by the public and be made available at the reasonable estimated cost of printing and copying.

Foundation Purposes

In addition to the Medicare supplemental subsidy program described earlier, the foundation would be required to do the following:

- Plan, promote, coordinate, and fund programs that will benefit the health and wellness of state residents.
- Promote, through grants to programs or entities, the progress of the science and art of health care in Michigan.
- Improve access to and the cost and quality of health care services in the state.
- Promote wellness and improve the physical, mental, and emotional health of state through development and support of programs that promote a healthier lifestyle and encourage proper nutrition and physical activity.
- Support programs that assist senior citizens and individuals with disabilities to live healthy and independent lifestyles and that protect vulnerable individuals from abuse and neglect.
- Solicit and accept any gift, grant, legacy, or endowment of money or in-kind donations of goods and services from the federal government, the state, other state government, local government, or any private source to further its purposes under this section.
- Plan, promote, coordinate, and fund programs that are designed to prevent illness, disability, or death due to foodborne disease.
- Support programs to reduce inefficiencies in the health care delivery system through the use of technology, collaboration or coordination of entities providing health care services, or education of health care consumers.
- Support programs that assist minor children to live healthy lifestyles and protect minor children from abuse and neglect.

FISCAL IMPACT:

Assuming Blue Cross Blue Shield would convert into a nonprofit mutual insurer under the bills, Senate Bills 1293 and 1294 would have a positive fiscal impact on the state government by eliminating Blue Cross Blue Shield of Michigan's (BCBSM) exemption from state and local taxes, altering the state's regulatory oversight of BCBSM, and establishing a charitable Health and Wellness Foundation.

Elimination of Tax Exemption

Under current law (1980 PA 350), BCBSM is exempt from state and local taxation. If BCBSM's Board of Directors voted to convert into a nonprofit mutual disability insurer as permitted by SB 1294, BCBSM would be liable for state and local taxation. Based on information reported by BCBSM, the collection of these taxes (insurance premiums tax,

sales and use taxes, and local property taxes) would increase state and local revenue by approximately $90 million in the initial year—roughly $85 million to the state and $5 million to local units of government. Beyond the initial year, the level of taxes paid depends primarily on the growth of gross insurance premiums. Local units that BCBSM owns real property in include Detroit, Grand Rapids, Lansing, Southfield, Marquette, Utica, and New Hudson.

Altering Regulatory Oversight

Under current law (1980 PA 350) the Attorney General has the authority to disapprove the bylaws and certain investment and ownership activities of BCBSM and appeal OFIR determinations regarding BCBSM's Provider Class Plans, and is granted legal standing to request a hearing regarding BCBSM rate filings. Under SB 1294, the Attorney General would no longer possess the above statutory prerogatives. This could reduce administrative costs for the Department of Attorney General, although any savings would likely be relatively small.

SB 1294 would have a positive, but also likely relatively small, fiscal impact on the Office of Financial and Insurance Regulation (OFIR). OFIR possess the statutory authority to review and approve rates for all health insurers, HMOs, and BCBSM, and would retain this authority regardless of whether SBs 1293 and 1294 are enacted. However, to the extent that SB 1294 could result in an expedited rate review process, by eliminating the Attorney General's (AG) legal standing in BCBSM rate filings, it would reduce the expenditures of OFIR for BCBSM rate hearings.

Establishment of Foundation

If BCBSM's Board of Directors voted to convert into a nonprofit mutual disability insurer as permitted by SB 1294, BCBSM would be required to "use its best efforts" to contribute "up to" $1.5 billion to a Health and Wellness Foundation that would be created under SB 1294 for a period of "up to" 18 years beginning in 2014. The present value of the maximum of $1.5 billion in total contributions, based on BCBSM's projections of payments and assuming 3.0% annual inflation, is approximately $1.075 billion in 2012 dollars. Furthermore, SB 1294 stipulates that annual disbursements by the Foundation would be limited to 50% of BCBSM's annual contributions, including interest and investment earnings, to facilitate the creation of an endowment. For the years between 2016 and 2021, 60% of annual disbursements from the HWF would be required to subsidize Medicare Supplemental Insurance (Medigap coverage) if BCBSM continued to offer Medigap coverage, subject to a yet undefined means testing. The Health and Wellness Foundation would be an independent nonprofit organization, staffed by private employees, and not subject to the appropriation process, but would be overseen by a state-appointed board.

State Health Insurance Costs

The bills would appear to have no fiscal impact on health insurance costs for the State of Michigan because the health care plans administered by the Civil Service Commission for both active and retired employees are self-funded. According to the Office of

Retirement Services (ORS), the retiree plans under its administration are also self-funded, and their premium rates are determined by the plan actuary rather than BCBSM.

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