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BILL ANALYSIS

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Senate Bills 1293 and 1294 (as enrolled) *(vetoed)*
Sponsor: Senator Joe Hune
Senate Committee: Insurance
House Committee: Insurance

Date Completed: 12-20-12

CONTENT

Senate Bill 1294 would amend the Nonprofit Health Care Corporation Reform Act to do the following:

-- Authorize Blue Cross Blue Shield of Michigan (BCBSM) to establish, own, operate, and merge with a nonprofit mutual disability insurer, under certain conditions.
-- Require BCBSM to include in the merger plan that, beginning in April 2014, the surviving entity of the merger would use its best efforts to make annual social mission contributions of up to $1.56 billion in aggregate over 18 years to a proposed Michigan Health Endowment Fund.
-- Prohibit BCBSM from using or enforcing a "most favored nation clause" in any provider contract, beginning February 1, 2013, unless the clause were approved by the Commissioner of the Office of Financial and Insurance Regulation.
-- Prohibit BCBSM from using or enforcing a most favored nation clause, beginning January 1, 2014.
-- Require BCBSM to take certain actions before discontinuing a plan or product in the nongroup or group market, or discontinuing all coverage in that market.
-- Prohibit BCBSM from issuing plans in the group or nongroup market for five years after withdrawing from that market.
-- Require BCBSM to offer health care benefits to all Michigan residents, regardless of health status, until January 1, 2014.
-- Prohibit a qualified health plan offered through an American health benefit exchange from providing coverage for elective abortion.
-- Prohibit a BCBSM certificate offered outside the exchange from providing elective abortion coverage except by an optional rider.
-- Establish requirements that an employer would have to meet in order to purchase an optional rider providing coverage for elective abortion.
-- Require the premium for a BCBSM group conversion certificate to be determined only by using rating factors prescribed by the Insurance Code (as provided in Senate Bill 1293).
-- Increase from 10% to 30% the amount of a premium rebate BCBSM may offer for group and nongroup wellness coverage, and allow a larger rebate with the Commissioner's approval.
-- Beginning January 1, 2014, require BCBSM to establish and maintain a provider network that satisfied Federal network adequacy requirements.
-- Provide that a BCBSM certificate issued or renewed on or after January 1, 2014, would be subject to the certificate issuance and rate filing requirements of the Insurance Code.
-- Allow BCBSM to establish reasonable open enrollment periods, subject to

the Commissioner's approval, for certificates offered or renewed in Michigan, beginning January 1, 2014.

-- Create the Michigan Health Endowment Fund Board, and require it to incorporate the Fund as a nonprofit corporation to receive and administer funds for the public welfare.

-- Provide that the Fund's purpose would be to benefit the health and wellness of minor children and seniors in Michigan.

-- Prohibit the Board from disbursing Fund money to subsidize the cost of individual Medigap coverage, except to those who demonstrated a financial need through a means test developed by the Commissioner.

-- From January 1, 2016, through December 31, 2021, require the Board to disburse $120.0 million to subsidize Medigap coverage.

-- Establish an 18-year schedule for the expenditure of Fund money.

-- Once the accumulated principal in the Fund reached $750.0 million, require the Board to maintain that amount for investment to provide an ongoing income to the Fund.

-- Prohibit the formation of a nonprofit health care corporation in Michigan after the bill took effect.

Senate Bill 1293 would amend the Insurance Code to do the following:

-- Authorize the formation of a nonprofit domestic mutual insurer.

-- Allow BCBSM to merge with a nonprofit mutual disability insurer, and require the resulting insurer to continue as a nonprofit entity and provide coverage to the individual and small group health markets.

-- Prohibit a nonprofit domestic mutual insurer formed under the bill from converting its status to a stock insurer or reorganizing.

-- Require the nonprofit mutual disability insurer to offer supplemental coverage to Medicare enrollees, as provided under Senate Bill 1294, at the same rates as offered by BCBSM on the amendment's effective date.

-- Provide that benefits paid by the nonprofit mutual disability insurer that were not cashed within a prescribed time period would escheat to the State.

-- Allow a nonprofit mutual disability insurer to permit entities holding administrative services agreements with it to be members with voting rights.

-- Prohibit a member of the nonprofit mutual disability insurer from having an interest in, or residual rights to, the insurer's assets; receiving surplus dividends; or being required to pay capital assessments by the insurer.

-- In the event of the insurer's dissolution or winding up, require any residual value to be distributed to the proposed Fund.

-- Require the nonprofit mutual disability insurer to offer health care benefits to all Michigan residents regardless of health status, until January 1, 2014.

-- Eliminate a prohibition against BCBSM's ceasing to renew all small employer group health benefit plans in a geographic area.

-- Allow the Commissioner to extend the time period in which he or she may disapprove an individual or family disability insurance policy form by up to 30 days.

-- For a policy or certificate issued or renewed on or after January 1, 2014, require the premium rate charged by an insurer, a health maintenance organization (HMO), or BCBSM in the individual or small group market to be based only on specific factors.

-- Require premiums for a small employer health benefit plan to be determined only by use of the prescribed rating factors.

-- Prohibit premiums charged by BCBSM or an HMO for a plan to small employers or sole proprietors in a given geographic area from varying from the index rate for that plan by more than 45%.

Also, if the insurer's status as a nonprofit mutual disability insurer were changed, or if the insurer disposed of its assets, moved to another state, or allowed another person or group to beneficially own more than 50% of the voting power, the bill would require the insurer or the acquiring person or entity to pay the Fund an amount equal to the

greater of the acquisition price or the fair market value of the insurer and its subsidiaries.

In addition, the bill would add language applicable to insurers and HMOs similar to that in Senate Bill 1294 regarding the following:

- **-- Discontinuation of a plan or product, or of all coverage, in the nongroup, group, or small employer market.**
- **-- The use or enforcement of most favored nation clauses.**
- **-- Premium rebates for wellness coverage.**
- **-- The establishment and maintenance of adequate provider networks.**
- **-- Coverage for elective abortion.**

The bills are tie-barred.

Senate Bill 1294

Merger with Nonprofit Mutual Disability Insurer

The Nonprofit Health Care Corporation Reform Act prohibits BCBSM from dissolving, merging, consolidating, mutualizing, or taking any other action that results in a change in direct or indirect control of BCBSM. Under the bill, this prohibition would apply except as otherwise provided in Section 220.

The bill would add Section 220 to authorize BCBSM to establish, own, operate, and merge with a nonprofit mutual disability insurer formed under Chapter 58 of the Insurance Code (General Mutual Insurers (Domestic), which Senate Bill 1293 would amend). The surviving entity of the merger would be the nonprofit mutual disability insurer. The merger would be exempt from the application of Sections 1311 through 1319 of the Insurance Code. (Those sections contain provisions that apply generally to mergers with or acquisitions of domestic insurers.)

The merger would be effective upon completion of adoption of a plan of merger by the majority of the boards of directors of both BCBSM and the nonprofit mutual disability insurer, and approval of the plan by the Commissioner of the Office of Financial and Insurance Regulation.

Blue Cross Blue Shield of Michigan would have to include in the merger plan that beginning in April 2014, the surviving entity of the merger would use its best efforts to make annual social mission contributions in an aggregate amount of up to $1.56 billion over a period of up to 18 years to the Michigan Health Endowment Fund (described below). The nonprofit mutual disability insurer would be considered to be making its best effort if it made the annual contribution when its surplus was at least 375% of the authorized control level under risk-based capital requirements.

If the merger plan were adopted, the boards of directors would have to submit it to the Commissioner for his or her consideration. The Commissioner would have to make a determination to approve or disapprove the plan within 90 days after receiving it, and could not unreasonably withhold approval.

The directors of BCBSM could serve as incorporators of the corporate body of, directors of, or officers of the insurer formed through the merger.

A merger would be the dissolution of BCBSM, and the surviving nonprofit mutual disability insurer would assume the performance of all BCBSM contracts and policies in existence on the date of the merger, including the participating hospital agreement, and its definition of certificate that excludes as covered services benefits provided pursuant to automobile no-fault or worker's compensation coverage, and all related contract obligations that resulted from orders relating to hospital provider class plans that were issued by the Commissioner after July 1, 2012. The officers of BCBSM, however, could perform any act or acts necessary to close the affairs of BCBSM after the merger date.

Most Favored Nation Clause

Beginning February 1, 2013, the bill would prohibit BCBSM from using a "most favored nation clause" in any provider contract, including one in effect on that date, unless the clause had been filed with and approved by the Commissioner. Beginning on that date, BCBSM could not enforce a most favored nation clause without the Commissioner's prior approval.

Beginning January 1, 2014, BCBSM could not use a most favored nation clause in any

provider contract, including one in effect on that date.

The bill would define "most favored nation clause" as a clause that does any of the following:

-- Prohibits, or grants BCBSM an option to prohibit, a provider from contracting with another party to provide health care services at a lower rate than the payment or reimbursement rate specified in the contract with BCBSM.
-- Requires, or grants BCBSM an option to require, a provider to accept a lower payment or reimbursement rate if the provider agrees to provide services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with BCBSM.
-- Requires, or grants BCBSM an option to require, termination or renegotiation of an existing provider contract if a provider agrees to provide services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with BCBSM.
-- Requires a provider to disclose, to BCBSM or its designee, the provider's contractual payment or reimbursement rates with other parties.

Discontinuation of Coverage by BCBSM

The bill would prohibit BCBSM from discontinuing to offer a particular plan or product in the nongroup or group market unless it did all of the following:

-- Gave at least 90 days' advance notice of the discontinuation to the Commissioner and each individual or group, as applicable, covered under the plan or product.
-- Offered to each covered individual or group, as applicable, the option to purchase any other plan or product currently being offered in the nongroup or group market by BCBSM without excluding or limiting coverage for a preexisting condition or providing a waiting period.
-- 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 or products.

In addition, BCBSM could not discontinue offering all coverage in the nongroup or group market unless it did both of the following:

-- Notified the Commissioner and each covered individual or group, as applicable, of the discontinuation at least 180 days before coverage expired.
-- Discontinued all health benefit plans issued in the nongroup or group market from which BCBSM withdrew and did not renew coverage under those plans.

If BCBSM discontinued offering all coverage, it could not provide for the issuance of any health benefit plans in the nongroup or group market from which it withdrew for five years after the date of the discontinuation of the last plan not renewed.

Offering Coverage & Rating Factors

Until January 1, 2014, the bill would require BCBSM to offer health care benefits to all Michigan residents regardless of health status.

Notwithstanding Section 410a(8), for a certificate delivered, issued for delivery, or renewed in Michigan on or after January 1, 2014, the premium for a group conversion certificate under Section 410a would have to be determined only by using the rating factors set forth in Section 3474a (which Senate Bill 1293 would add).

(Section 410a prescribes requirements for a group certificate. Subsection (8) requires the premium for a group conversion certificate to be determined using the aggregate experience for all such certificates issued in Michigan by BCBSM and in accordance with premium rates applicable to the age, class of risk, and the type and amount of coverage provided. An individual's experience under a group conversion certificate is not an acceptable basis for establishing his or her rate for his or her certificate.)

Elective Abortion Coverage

Under the bill, a qualified health plan offered through an American health benefit exchange pursuant to the Federal Patient Protection and Affordable Care Act and the Federal Health Care and Education Reconciliation Act could not provide coverage for elective abortion. The bill

provides that it would not prohibit an individual, organization, or employer participating in a qualified health plan offered through an American health benefit exchange from purchasing optional supplemental coverage for elective abortion outside of the exchange, as described below.

("Elective abortion" would mean the intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus. The term would not include the prescription or use of a drug or device intended as a contraceptive. It also would not include the intentional use of an instrument, drug, or other substance or device by a physician to terminate a woman's pregnancy if the woman's physical condition, in the physician's reasonable medical judgment, necessitated termination of the pregnancy to avert her death.)

A BCBSM group or nongroup certificate offered outside of an American health benefit exchange could not provide elective abortion coverage except by an optional rider for which the purchaser had paid an additional premium.

An employer could purchase an optional rider to provide coverage for an elective abortion if the employer notified each employee that elective abortion would be included as a rider to his or her health coverage and the coverage could be used by a minor or dependent female without notice to the employee.

The bill would not require BCBSM or an employer to provide or offer to provide an optional rider for elective abortion coverage.

The elective abortion provisions would not apply to benefits provided under Title XIX of the Social Security Act (which pertains to Medicaid).

The bill states that it would not create a right to abortion. Notwithstanding any other provision regarding elective abortion, a person could not perform an abortion that was prohibited by law.

Wellness Coverage

The Act allows BCBSM to offer group or nongroup wellness coverage, which may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, and/or deductibles for participation in a health behavior wellness, maintenance, or improvement program. Any rebate of premium provided by BCBSM is presumed to be appropriate unless credible data demonstrate otherwise, but may not exceed 10% of paid premiums. Under the bill, the rebate could not exceed 30% of paid premiums, unless otherwise approved by the Commissioner.

Provider Network & Accessibility

Beginning January 1, 2014, the bill would require BCBSM to establish and maintain a provider network that, at a minimum, satisfied any network adequacy requirements imposed by the Commissioner pursuant to Federal law.

BCBSM Certificate Issuance & Rate Filing Requirements

A BCBSM certificate delivered, issued for delivery, or renewed in Michigan on or after January 1, 2014, would be subject to the policy and certificate issuance and rate filing requirements of the Insurance Code, including the rating factor requirements of proposed Section 3474a (described below).

Open Enrollment

For a certificate offered, delivered, issued for delivery, or renewed in Michigan on or after January 1, 2014, subject to the Commissioner's approval, BCBSM could establish reasonable open enrollment periods.

The Commissioner would have to establish minimum standards for the frequency and duration of open enrollment periods, and would have to apply them uniformly to all health care corporations.

Regarding coverage offered during an open enrollment period, the bill would prohibit BCBSM from denying or conditioning the issuance or effectiveness of a certificate, and from discriminating in the pricing on the basis of health status, claims experience, receipt of health care, or medical condition.

Michigan Health Endowment Fund

Fund Board. The bill would create the Michigan Health Endowment Fund Board to organize and govern the Fund. The Board would be the Fund's incorporator for the purposes of the Nonprofit Corporation Act.

Within 60 days after the bill took effect, the Governor would have to appoint the following initial Board members with the advice and consent of the Senate:

-- One member from a list of at least three individuals recommended by the Senate Majority Leader.
-- One member from a list of at least three individuals recommended by the Speaker of the House of Representatives.
-- One member representing the interests of minor children.
-- One member representing the interests of senior citizens.
-- Two members representing the general public.
-- One member representing the business community.
-- One member from a list of at least three individuals recommended by the House Minority Leader.
-- One member from a list of at least three individuals recommended by the Senate Minority Leader.

A Board vacancy would have to be filled in the same manner as the initial appointment. Of the initial members, three would serve for two-year terms, three for three-year terms, and three for four-year terms. Otherwise, a member would serve for a term of four years or until a successor was appointed, whichever was later.

The Board would have to adopt a conflict of interest policy. A Board member with a direct or indirect interest in any matter before the Fund would have to disclose that interest to the Board before it took any action on the matter. The Board would have to record the member's disclosure in the meeting minutes. If a Board member or a member of his or her immediate family, organizationally or individually, would derive a direct and specific benefit from a Board decision, that member would have to recuse himself or herself from the discussion and vote on the issue.

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

Board business would have to be conducted at a meeting that was open to the public and held in Michigan in a place that was available to the general public. At least 10 days and not more than 60 days before a meeting, the Board would have to provide public notice at its principal office and on its internet website. The Board would have to include in the notice the address where Board minutes could be inspected by the public. The Board could meet in a closed session for any of the following purposes:

-- To consider the hiring, dismissal, suspension, or disciplining of Board members, employees, or agents.
-- To consult with its attorney.
-- To comply with State or Federal law, rules, or regulations regarding privacy or confidentiality.

The Board would have to keep minutes of each meeting. The minutes would have to be open to public inspection, and the Board would have to make them available at the address designated on the public notice.

The Board would have to make copies available to the public at the reasonable estimated cost for printing and copying.

Fund Powers & Duties. The bill would require the Board to organize a nonprofit corporation, on a nonstock, directorship basis, under the Nonprofit Corporation Act. The corporation would be known as the Michigan Health Endowment Fund, and would be organized to receive and administer funds for the public welfare.

The Fund's purpose would be to benefit the health and wellness of minor children and seniors throughout the State with a significant focus in the following areas:

-- Infant mortality.
-- Wellness and fitness programs.
-- Access to healthy food.
-- Technology enhancements.
-- Health-related transportation needs.
-- Foodborne illness prevention.

The Fund could award grants for projects that would promote its purposes. The Board

would have to establish a comprehensive and competitive process to award grants. The Board could not award a grant that was longer than three years in duration.

The Fund would have the power and duties of a nonprofit corporation under the Nonprofit Corporation Act. If a conflict between a power or duty of the Fund under the bill conflicted with a power or duty under other State law, the bill's provisions would control.

Medigap Subsidy. The bill would require the Board to implement a program that disbursed Fund money to subsidize the cost of individual Medigap coverage to Michigan senior citizens who demonstrated a financial need in order to be able to purchase such coverage. Subject to approval by the Attorney General, the Commissioner would have to develop a means test to determine if an applicant was eligible for the subsidy.

From August 1, 2016, through December 31, 2021, the Board would have to disburse $120.0 million to subsidize the costs of individual Medigap coverage purchased by Michigan senior citizens, subject to the means test.

Executive Director. The bill would require the Board to appoint an executive director of the Fund. The executive director would be the Fund's chief executive officer and would serve at the pleasure of the Board. The executive director could employ staff as necessary with the Board's approval. The Board would have to determine the compensation of the executive director and staff and approve contracts.

The executive director would have to display on the Fund's website information relevant to the public, as defined by the Board, concerning the Fund's operations and efficiencies, as well as the Board's assessments of those activities.

Distribution & Balance of Fund. The Board could disburse money contributed to the Fund each year, excluding any interest, earnings, or unrealized gains or losses on those contributions, for the stated purposes of the Fund. The Board could spend a portion of the money contributed each year according to the following schedule:

-- Years one through four, 80%.
-- Years five through eight, 67%.
-- Years nine through 12, 60%.
-- Years 13 through 18, 25%.

On and after the date that the accumulated principal in the Fund reached $750 million, the Board would have to maintain that amount for investment to provide an ongoing income to the Fund. On and after that date, the Board could not allow the accumulated principal to fall below $750 million due to expenditures made for the Fund's purposes.

The Board could spend money received by the Fund from any source in a fiscal year that was in excess of the amount required to maintain the accumulated principal goals, excluding any interest, earnings, or unrealized gains or losses on those funds, on reasonable administrative costs and for the purposes of the Fund.

The Board could invest accumulated principal in the Fund only in securities permitted by Michigan law for the investment of assets of life insurance companies.

Fund Audit & Transparency Requirements. The Board would have to provide in the Fund's articles of incorporation or bylaws for a system of financial accounting, controls, audits, and reports. Annually, the Board would have to have an audit of the Fund conducted by an independent public accountant firm, and the audit report and findings would have to be submitted to the Board. The expense of a required audit would be considered a reasonable administrative cost.

The Board would have to appoint from its members an audit committee consisting of at least three members. At a minimum, the committee would have to contract with an independent auditing firm to provide an annual financial audit in accordance with applicable auditing standards.

The executive director would have to do the following:

-- Review and certify the external auditor's reports, and make them available to the Board and to the general public.
-- Develop and implement corrective actions to address weaknesses identified in an audit report.

The Fund would have to meet all of the financial transparency requirements:

-- Keep an accurate accounting of all activities, receipts, and expenditures and submit to the Governor, the Senate and House Appropriations Committees, and the Senate and House standing committees on health policy an annual report regarding those accountings.
-- Cooperate fully with any investigation conducted by the State or a Federal agency under the authority of State or Federal law to investigate the Fund's affairs, examine its assets and records, and require periodic reports in relation to the Fund's activities.

Senate Bill 1293

Nonprofit Mutual Disability Insurer

The Insurance Code provides that Chapter 58 applies only to domestic mutual insurers transacting property, casualty, disability, and other insurances, and to mutual holding companies resulting from the reorganization of those mutual insurers. Under the bill, the chapter also would apply to nonprofit mutual disability insurers.

The bill would authorize the formation with nonprofit status of a domestic mutual insurer. A nonprofit mutual disability insurer would have all powers of a mutual insurer organized under Chapter 58 unless expressly reserved. Such an insurer that had merged with BCBSM could not convert its status to a stock insurer under Chapter 59 (Conversion of Domestic Mutual Insurer to Domestic Stock Insurer) or reorganize under Chapter 60 (Reorganization of Mutual Insurers).

The bill would allow BCBSM to merge with a nonprofit mutual disability insurer (as set forth in Senate Bill 1294), where the surviving entity was governed by Chapter 58. The merger would be exempt from the application of Sections 1311 to 1319 of the Code. Notwithstanding any provision of the Code to the contrary, the resulting nonprofit mutual disability insurer would have to continue as a nonprofit entity, and continue to provide coverage to the individual and small group health markets in Michigan.

A nonprofit mutual disability insurer that merged with BCBSM could, at its option, continue to offer any product that was offered to BCBSM's subscribers.

The insurer also could offer supplemental coverage to Medicare enrollees as provided in Chapter 38 (as amended by Senate Bill 1294). Notwithstanding any other provision of the Code to the contrary and until July 31, 2016, both of the following would apply:

-- The insurer would have to continue to offer the supplemental coverage to current or new eligible policyholders who were Michigan residents, at the same rates as offered to BCBSM subscribers on the bill's effective date.
-- The insurer would have to continue all cost transfers as authorized under Section 609(5) of the Nonprofit Health Care Corporation Reform Act on the bill's effective date.

(Under that section, except for identified cost transfers, each line of business, over time, must be self-sustaining. There may be cost transfers, however, for the benefit of senior citizens and group conversion subscribers. Cost transfers for the benefit of senior citizens, in the aggregate, annually may not exceed 1% of the earned subscription income of BCBSM as reported in its most recent annual statement.)

Until January 1, 2014, the nonprofit mutual disability insurer would have to offer health care benefits to all Michigan residents regardless of health status.

Benefits paid by the nonprofit mutual disability insurer to an insured or provider by way of a check or other similar written instrument for the transmission or payment of money that was not cashed within the period prescribed in the Uniform Unclaimed Property Act would escheat to the State pursuant to that Act.

Under Chapter 58, every member of a company is entitled to one vote, or to a number of votes based upon the insurance in force, the number of policies held, or the amount of premiums paid, as provided in the bylaws. Under the bill, a nonprofit mutual disability insurer could permit entities holding administrative services agreements with it to be members, and could provide in its bylaws the basis for the number of votes the entities would have as members.

A member of a nonprofit mutual disability insurer that had merged with BCBSM could have no interest in, or residual rights to, the assets of the insurer; could not receive policy or surplus dividends; and could not be required to pay capital assessments by the insurer.

In the event of a dissolution or winding up of the nonprofit disability mutual insurer, any residual value remaining after satisfaction of claims from the insurer's estate would have to be distributed for the benefit of the people of Michigan to the proposed Michigan Health Endowment Fund, and be administered in a manner consistent with the Supervision of Trustees for Charitable Purposes Act.

The insurer or the acquiring person or entity would have to make a payment for the benefit of the people of Michigan to the Fund in the event of a transaction or series of transactions pursuant to which the insurer demutualized; converted to a mutual holding company; sold, transferred, or otherwise disposed of all or substantially all of its assets; merged into an entity and was not the surviving entity; moved its principal executive office out of Michigan; redomesticated to another state; or allowed or permitted a person or a group of people acting in concert to beneficially own greater than 50% of the voting power associated with ownership interests in the nonprofit disability mutual insurer. The payment would have to be in an amount equal to the greater of the acquisition price or the fair market value of the insurer and its subsidiaries, considered on a consolidated holding company basis at the time of the closing of the transaction or series of transactions, as determined by an independent valuation by a person or entity mutually agreed upon by the Attorney General, the Commissioner, and the insurer. The payment would have to be administered in a manner consistent with the Supervision of Trustees for Charitable Purposes Act, and would have to be in satisfaction of any claim or assertion that consideration was due with respect to the charitable assets of the insurer.

General: Discontinuation of Coverage

The bill would add to Chapter 22 (The Insurance Contract) of the Insurance Code provisions similar to those that Senate Bill 1294 would add to the Nonprofit Health Care Corporation Reform Act, regarding the discontinuation of a particular plan or product or all coverage in the group or nongroup market for disability insurance. The provisions under Senate Bill 1293 would apply to an insurer or HMO. They would not apply to a short-term or one-time limited duration policy or certificate of no longer than six months.

Under Chapter 22, a group policy may not be issued or delivered in Michigan unless a copy of the form has been filed with the Commissioner and he or she has approved it. Within 30 days after the filing of a policy form applicable to individual or family expense coverage, the Commissioner may disapprove the form for any of the following, subject to notice, hearing, and appeal requirements set forth in the Code:

-- The benefits provided under the policy are unreasonable in relation to the premium charged.
-- The policy contains a provision that is unjust, unfair, inequitable, misleading, or deceptive, or that encourages misrepresentation of the policy.
-- The policy does not comply with other provisions of law.

Under the bill, the Commissioner could extend the time period to disapprove the form by up to 30 days, if written notice were given to the insurer within 30 days after the filing.

Most Favored Nation Clause

The bill would add to the Code a prohibition against the use and enforcement of most favored nation clauses, similar to that applicable to BCBSM under Senate Bill 1294. These provisions would apply to an insurer or HMO.

Elective Abortion Coverage

The bill would add to the Code provisions similar to those in Senate Bill 1294 regarding elective abortion coverage. These provisions would apply to an insurer or HMO.

Wellness Coverage Rebates

The bill would increase the allowable rebate for group, individual, or family wellness coverage offered by an insurer from 10% of premiums to 30%, unless otherwise approved by the Commissioner.

Provider Networks

The bill would add to the Code language applicable to insurers and HMOs similar to that in Senate Bill 1294 regarding the establishment and maintenance of a provider network and contracts with affiliated providers.

Open Enrollment

Under Senate Bill 1293, beginning January 1, 2014, during an applicable open enrollment period, an insurer could not deny or condition the issuance or effectiveness of a policy and could not discriminate in the pricing of a policy on the basis of health status, claims experience, receipt of health care, or medical condition.

Subject to the Commissioner's approval, an insurer would have to establish reasonable open enrollment periods for all disability policies offered, delivered, issued for delivery, or renewed in Michigan on or after January 1, 2014. The Commissioner would have to establish minimum standards for the frequency and duration of open enrollment periods, and apply the standards uniformly to all insurers.

Rating Factors

The bill would add Section 3474a to the Code, to provide that the premium rate charged by an insurer, HMO, or BCBSM for coverage offered through a policy or certificate delivered, issued for delivery, or renewed in Michigan on or after January 1, 2014, in the individual or small group market could vary based only on the following factors:

-- Whether the policy or certificate covered an individual or family.
-- The rating area.
-- Age, except that the premium rate could not vary by more than three to one for adults for all plans other than child-only plans.
-- Tobacco use, except that the premium rate could not vary by more than 1.5 to one.

Also, the premium for an individual conversion policy delivered, issued for delivery, or renewed in Michigan on or after January 1, 2014, could be determined by using only these rating factors. (Under the Code, an individual who has been covered by a group disability policy may elect coverage under an individual conversion policy upon termination.)

Premiums: Small Employers & Sole Proprietors

Chapter 37 (Small Employer Group Health Coverage) allows an insurance carrier to establish up to 10 geographic areas in the State for the purpose of adjusting premiums for health benefit plans, and requires BCBSM to establish geographic areas that cover all of Michigan's counties. The Code specifies factors that may be used to determine premiums within a geographic area for a small employer or sole proprietor located within that area. For BCBSM, only industry and age may be used. For an HMO, only industry, age, and group size may be used.

The premiums charged for a health benefit plan during a rating period by BCBSM or an HMO to small employers or sole proprietors located in a given geographic area may not vary from the index rate for that plan by more than 35%. The premiums charged for a plan by a commercial carrier may not vary from the index rate for that plan by more than 45%. The bill would eliminate the 35% variance limit for premiums charged by BCBSM or an HMO. Instead, premiums charged for these plans issued by BCBSM or an HMO would be subject to the 45% variance limit that applies to plans issued by commercial carriers. For a health benefit plan delivered, issued for delivery, or renewed in Michigan on or after January 1, 2014, the premiums charged during a rating period to small employers would have to be determined only by using the rating factors prescribed in proposed Section 3474a.

("Index rate" means the arithmetic average during a rating period of the base premium and the highest premium charged per employee for each health benefit plan offered by each small employer carrier to small employers and sole proprietors in a geographic area.)

Small Group Market: Discontinuation of Coverage

Chapter 37 prohibits BCBSM from ceasing to renew all small employer group health benefit plans in a geographic area. The bill would delete this prohibition.

Under the bill, a small employer carrier could not discontinue offering a particular plan or product in the small employer group market unless the carrier did all of the following:

-- Notified the Commissioner and each covered small employer at least 90 days before the discontinuation.
-- Offered to each covered small employer the option to purchase any other plan or product currently being offered in the small employer group market by that carrier without excluding or limiting coverage for a preexisting condition or providing a waiting period.
-- 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 or products.

Mutual Insurer: Use of Name

Under Chapter 50 (Organization of Domestic Stock and Mutual Insurers), the articles of incorporation of a mutual insurer must contain the name by which the incorporation will be known. The name must include the word "mutual". Chapters 50 and 52 (Corporate Powers, Procedures of Stock and Mutual Insurers) also require an insurer to transact its business under its own name. Under the bill, however, a nonprofit mutual disability insurer into which BCBSM was merged or consolidated could retain and use trade names in use by BCBSM before the merger or consolidation.

MCL 500.2213b et al. (S.B. 1293)
550.1218 et al. (S.B. 1294)

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

The bills would have an indeterminate impact on the finances of State and local governments. The bills would allow Blue Cross Blue Shield of Michigan to merge with a nonprofit mutual health insurance company and therefore become subject to applicable State taxes. In its fiscal year 2010-11 annual financial report, BCBSM reported about $9.6 billion in underwritten premiums. Under the Income Tax Act, other insurance companies pay a 1.25% tax on premiums earned. Had BCBSM been required to pay tax on those premiums in fiscal year 2010-11, it would have resulted in approximately $120.0 million in additional income tax revenue. The Income Tax Act does, however, allow for various credits to an insurance company's income tax liability for other taxes paid. It is unknown what BCBSM's credits would have been, but they would have reduced that $120.0 million figure by some unknown amount.

The bills refer to payments by BCBSM to support health care, but neither bill specifies the amount of the proposed payments. The bills could create a board to disburse this money, but the disbursement would not be subject to the appropriations process.

The bills also could have some impact on the cost and types of plans offered by State and local governments. It is unknown at this time what those effects might be and how easily they could be attributed to a reorganization of BCBSM.

It is not expected that the bills would result in any additional cost to the Department of Licensing and Regulatory Affairs, as the Department's regulatory responsibilities toward BCBSM as a nonprofit mutual insurer would be largely the same as they are today toward BCBSM as it is currently organized.

Fiscal Analyst: Steve Angelotti
Josh Sefton

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