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BILL ANALYSIS

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Senate Bill 1293 (Substitute S-2 as reported)
Senate Bill 1294 (Substitute S-2 as reported)
Sponsor: Senator Joe Hune
Committee: Insurance

CONTENT

Senate Bill 1294 (S-2) would amend the Nonprofit Health Care Corporation Reform Act to do the following:

-- Prohibit the formation of a health care corporation in Michigan after the bill took effect.
-- Authorize Blue Cross Blue Shield of Michigan (BCBSM) to establish, own, operate, and merge with a nonprofit mutual disability insurer, upon adoption of a plan of merger by 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.
-- 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 in an aggregate amount of $1.5 billion for up to 18 years to the Michigan Health and Wellness Foundation (described below).
-- Provide that the merger would be the dissolution of BCBSM, and the surviving nonprofit mutual disability insurer would assume the performance of all BCBSM contracts and policies.
-- 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.
-- 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.
-- 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 (S-2).
-- Increase from 10% to 30% the amount of a premium rebate BCBSM may offer for group and nongroup wellness coverage.
-- Beginning January 1, 2014, require BCBSM to establish and maintain a provider network and maintain contracts with affiliated providers in a manner that was sufficient to ensure that all covered health care services to members would be accessible without unreasonable delay, including access to emergency services 24 hours per day, seven days per week.
-- If BCBSM had an insufficient number or type of participating providers to provide a covered benefit as of January 1, 2014, require BCBSM to ensure that a member obtained the service at not greater cost than if it were obtained from a participating provider, or make other arrangements acceptable to the Commissioner.

-- Require BCBSM to establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to a member's business or personal residence, beginning January 1, 2014.
-- 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.
-- During an open enrollment period, prohibit BCBSM from denying or conditioning the issuance or effectiveness of a certificate or discriminating in its pricing on the basis of health status, claims experience, receipt of health care, or medical condition.

The bill also would create the Michigan Health and Wellness Foundation Board and require it to incorporate the Foundation under the Nonprofit Corporation Act. The Foundation would be organized to receive and administer funds for the public welfare. The Governor would have to appoint the Board with the advice and consent of the Senate. The Foundation would have to do all of the following:

-- Plan, promote, coordinate, and fund programs that would benefit the health and wellness of Michigan residents and that were designed to prevent illness, disability, or death due to foodborne disease.
-- Promote the progress of the science and art of health care in Michigan through grants to programs or entities.
-- Improve access to and the cost and quality of health care services in Michigan.
-- Promote wellness of Michigan residents through development and support of programs that promoted a healthier lifestyle and encouraged proper nutrition and physical activity.
-- Support programs that assisted senior citizens and individuals with disabilities to live healthy and independent lifestyles and that protected vulnerable individuals from abuse and neglect.
-- Support programs to reduce inefficiencies in the State's health care delivery system.

The Board could not disburse Foundation money to subsidize the cost of individual Medigap coverage purchased by senior citizens, except to those who demonstrated a financial need. The Board would have to disburse half of the total amount of Foundation money eligible for disbursement to subsidize Medigap coverage, subject to a means test developed by the Board. This requirement would not apply after December 31, 2021, or after a nonprofit mutual disability insurer discontinued offering supplemental coverage to Medicare enrollees, whichever occurred first.

Not more than half of the money contributed to the Foundation each year, including any interest and earnings but excluding any unrealized gains or losses, would be available for disbursement. Foundation money could be used as matching funds for a Federal grant.

Senate Bill 1293 (S-2) 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.
-- Require the nonprofit mutual disability insurer to offer supplemental coverage to Medicare enrollees as provided under Senate Bill 1294 (S-2), and require the insurer to continue offering the supplemental coverage to current or new eligible policyholders at the same rates as offered to subscribes by BCBSM on the bill's effective date.

-- Require the nonprofit mutual disability insurer to give the Commissioner notice before taking any action to change its nonprofit status or sell, transfer, lease, exchange, option, or convey assets that resulted in a change in control of the insurer; and to submit with the notice an independent valuation certifying the insurer's fair market value.
-- Provide that benefits paid by the nonprofit mutual disability insurer to an insured or provider 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; and 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 for the benefit of the people of Michigan to the proposed Foundation.
-- If a transaction resulted in another person or entity acquiring a greater than 50% beneficial ownership interest in the nonprofit mutual disability insurer, require the insurer or the acquiring person or entity to make payment for the benefit of the people of the State to the Foundation in an amount equal to the greater of the acquisition price or the fair market value of the insurer and its subsidiaries.
-- 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.
-- Require an insurer or health maintenance organization (HMO) to take certain actions before discontinuing a plan or product in the nongroup or group market for disability insurance, or discontinuing all coverage in that market.
-- Prohibit an insurer or HMO from issuing plans in a market for five years after withdrawing from that market.
-- 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 if he or she gave the insurer written notice.
-- Prohibit an insurer or HMO from using or enforcing a most favored nation clause in any provider contract without the Commissioner's prior approval, beginning February 1, 2013.
-- Increase from 10% to 30% the amount of a premium rebate an insurer or HMO may offer for group, individual, and family wellness coverage.
-- Add language applicable to insurers and HMOs similar to that in Senate Bill 1294 (S-2) regarding the establishment and maintenance of a sufficient provider networks and proximity to members and open enrollment periods.
-- Require the Commissioner to establish minimum standards for the frequency and duration of open enrollment periods, and apply them uniformly to all insurers.
-- For a policy or certificate issued or renewed on or after January 1, 2014, require the premium rate charged by an insurer, HMO, or BCBSM in the individual or small group market to based only on the following factors: whether the policy or certificate covered an individual or family; the rating area; age, except that the rate could not vary by more than three to one for adults for all plans other than child-only plans; and tobacco use, except that the rate could not vary by more than 1.5 to one.
-- Require premiums for a small employer health benefit plan to be determined only by use of those rating factors.
-- Include premiums charged by BCBSM or an HMO in a provision prohibiting premiums charged by a commercial carrier 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%.
-- Require a small employer carrier to take certain actions before discontinuing a plan or product in the small employer group market.

The bills are tie-barred.

MCL 500.2213b et al. (S.B. 1293) Legislative Analyst: Julie Cassidy
550.218 et al. (S.B. 1294)

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.

Senate Bill 1294 (S-2) would provide for the creation of the Michigan Health and Wellness Foundation, which would oversee and allocate a $1.5 billion payment by BCBSM over 18 years to support health care. While the Foundation's board would be appointed by the Governor with the advice and consent of the Senate, its decisions to disburse funds would not be subject to the appropriations process. Therefore, there would be no direct fiscal impact due to the creation of the Foundation. The bill would allow the executive director of the Foundation to seek assistance and support from State departments and this cooperation could lead to a minor administrative fiscal impact.

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, however, what those effects might be and how easily they could be attributed to a reorganization of BCBSM.

Additional costs to the Department of Licensing and Regulatory Affairs would be relatively minor, as the costs associated with regulating BCBSM as a nonprofit mutual would be largely identical to regulating it as it is currently organized. Under the bills, however, the Office of Financial and Insurance Regulation (OFIR) would have to approve any "most favored nation" clauses included in insurer-provider contracts, develop standards to ensure that provider networks were sufficient to provide covered services to those insured, and approve open enrollment periods. To the extent that these would be new responsibilities for OFIR, some new, but likely minor, costs would be associated.

Date Completed: 10-17-12 Fiscal Analyst: Steve Angelotti
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