Legislative Analysis

Mary Ann Cleary, Director
Phone: (517) 373-8080
http://www.house.mi.gov/hfa

CONVERT BCBSM TO NONPROFIT MUTUAL INSURER

Senate Bill 61
Sponsor: Sen. Joe Hune

Senate Bill 62
Sponsor: Sen. Virgil Smith

House Committee: Insurance
Senate Committee: Insurance

Complete to 2-6-13

A REVISED SUMMARY OF SENATE BILLS 61 & 62 AS PASSED BY THE SENATE

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 61 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 62 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. No new health care corporation could be formed under the act on or after the bill's effective date. (MCL 500.2213b et al.)

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 have to specify that the surviving entity (the mutual insurer) "shall use its best efforts" to make annual social mission contributions to a newly created entity, called the Michigan Health Endowment Fund, in an amount of up to $1.56 billion over a period of up to 18 years, beginning in April 2014. The insurance company would be considered to be making its "best effort" if it makes the annual social mission contribution when its surplus is at least 375% of the authorized control level under risk-based capital requirements.

- The Fund would be required to have "a significant focus" on: infant mortality, wellness programs and fitness programs, access to healthy food, technology enhancements, health-related transportation needs, and foodborne illness prevention.

- The Fund 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). Subject to the approval of the Attorney General, the Insurance Commissioner would have to develop a means test for subsidy eligibility.

- Beginning August 1, 2016, and ending December 31, 2021, the Fund board would have to disburse $120 million to subsidize the cost of individual Medigap coverage.

(A more detailed description of the Fund's purposes, organization structure, and disbursement schedules are provided later.)

- 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.

- The insurer or acquirer would have to make a payment to the Health Endowment Fund 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, if certain transactions occurred, including if the insurer allows person or group of persons acting in concert to beneficially acquire more than 50% of the voting power association with ownership interests in the nonprofit mutual insurer. The payment provision would also apply if the insurer demutualized; converted to a mutual holding company; disposed of all or substantially all of its assets; merged into an entity without being the surviving entity; or moved its principal executive office out of state; redomesticated to another state.

- 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 January 1, 2014, the use of "most favored nation" clauses in provider contracts, including a contract in effect on that date.

  The bills also prohibit the use or enforcement of a most favored nation clause beginning February 1, 2013, without prior approval by the commissioner.

  (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 non-group or group 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 that, at a minimum satisfied any network adequacy requirements imposed by the insurance commissioner under federal law.

- Insurers and corporations would have to establish reasonable open enrollment periods, subject to the commissioner's approval, for all disability policies and certificates offered, delivered, issued for delivery, or renewed in Michigan on or after January 1, 2014.

- During an applicable open enrollment period, 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 Endowment Fund

As described earlier, Senate Bill 61 provides, in a new Part 6A of the Nonprofit Health Care Corporation Reform Act, for the creation of the Michigan Health Endowment Fund. 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.

Fund Board

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

- One from a list of three or more recommended by the State Senate Majority Leader.
- One from a list of three 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.

An individual who is an employee, officer, or board member of a health care corporation; a lobbyist affiliated with a health care corporation; or an employee of a health insurer, health care provider, or third-party administrator would not be eligible to serve on the board.

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

Conflict of Interest Policy
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 his or her interest to the board before the board takes action on the matter. The board would record the member's disclosure in the minutes of the board meeting. If a member or a person's in the member's immediate family, individually or organizationally, would derive a direct and specific benefit from a decision of the board, that member would have to recuse himself or herself from the discussion and vote on the issue.

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.

Fund Purposes
The purpose of the Fund is to support programs that improve the quality of health care while reducing costs to state residents and to benefit the health and wellness of minor children and seniors throughout the state with a significant focus on:

- infant mortality
- wellness programs and fitness programs
- access to healthy food
- technology enhancements
- health-related transportation needs
- foodborne illness prevention

Grants
The Fund could award grants that promote the purpose of the Fund, as described above, and would have to establish a comprehensive and competitive process to award grants. The board could not award a grant longer than three years in duration.

Fund Disbursements
The board could expend a portion of the money contributed to the fund in each year according to the following schedule:

- Years 1 through 4: 80%
- Years 5 through 8: 67%
- Years 9 through 12: 60%
- Years 13 through 18: 25%

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

The board could expend money received from any source in a fiscal year that was in excess of the amount required to maintain the accumulated principal goals (not including any interest, earnings, or unrealized gains or losses on those funds) on the reasonable administrative costs of the Fund and for specified Fund purposes.

As noted earlier, beginning August 1, 2016, and ending December 31, 2021, the Fund board would have to disburse $120 million to subsidize the cost of individual Medigap coverage.

Audits & Audit Committee
The board would be required to have an audit of the Fund conducted by an independent public accountant firm. 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. The auditor's audit report and findings would have to be submitted to the board.

The executive director of the Fund would have to review and certify the reports of the external auditor; make the external auditor reports available to the board and the general public; and develop and implement corrective actions to address weaknesses identified in an audit report.

Among other things, the Fund would have to submit a report annually to the Governor, Senate and House Appropriations committees, and the Senate and House standing committees on health policy on its accounting of activities, receipts, and expenditures.

FISCAL IMPACT:

Senate Bills 62 and 61 would have a positive fiscal impact on the state government, if Blue Cross Blue Shield converts into a nonprofit mutual disability insurer, to the extent that these bills would eliminate Blue Cross Blue Shield of Michigan's (BCBSM) exemption from state and local taxes, alter the state's regulatory oversight of BCBSM, and establish the Michigan Health Endowment Fund (MHEF) as a nonprofit corporation.

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 61, BCBSM would be liable for state and local taxation. The collection of these taxes (insurance premiums tax, sales and use taxes, and local property tax) would increase state and local revenue by approximately $90 million in the initial year. Beyond the initial year, the level of taxes paid depends primarily on the growth of gross insurance premiums. Local units where BCBSM owns real property include Detroit, Grand Rapids, Lansing, Southfield, Marquette, Utica, and New Hudson.

Under current law (1980 PA 350) the Attorney General has the authority to disapprove the bylaws and certain investment and ownership activities of BCBSM, appeal OFIR determinations regarding BCBSM's Provider Class Plans, and is granted legal standing to request a hearing regarding BCBSM rate filings. Under SB 61 the Attorney General would no longer possess those statutory prerogatives. Any cost savings for the Department of Attorney General associated with the absence of statutory prerogatives pertaining to BCBSM would likely be minor. SB 61 would also have a positive, yet likely minor, fiscal impact on the Office of Financial and Insurance Regulation (OFIR). The OFIR Commissioner possesses the statutory authority to review and approve rates for all health insurers, HMOs, and BCBSM, and would retain this authority regardless of whether SBs 62 and 61 are enacted. However, to the extent that SB 61 could result in an expedited rate review process, by eliminating the Attorney General's legal standing in BCBSM rate filings, it would reduce the expenditures of OFIR for BCBSM rate hearings.

If BCBSM's board of directors voted to convert into a nonprofit mutual disability insurer as permitted by SB 61, BCBSM would be required to "use its best efforts" to contribute "up to" $1.56 billion to the Michigan Health Endowment Fund (MHEF) which would be created under SB 61 for a period of "up to" 18 years beginning in April 2014. The MHEF would be organized as a nonprofit corporation, incorporated and governed by a board of

directors, administered by an executive director, staffed by private employees, and not subject to the state appropriation process.

The present value of the maximum of $1.56 billion in total contributions, based on BCBSM's projections of payments and assuming 3.0% annual inflation, is approximately $1.12 billion in 2012 dollars. Furthermore, SB 61 stipulates that annual disbursements by the MHEF would be limited to prescribed percentages of BCBSM's annual contributions, incrementally decreasing every four years, and would exclude interest and investment earnings. The purpose of these spending limitations is to facilitate the creation of an endowment of at least $750 million which would have to be maintained in perpetuity. Between August 1, 2016, and December 31, 2021, the MHEF would be required to disburse $120 million to subsidize Medicare Supplemental Insurance (Medigap coverage) for seniors, subject to a means test developed by the OFIR Commissioner and approved by the Attorney General.

SB 62 stipulates that if BCBSM, after converting into a nonprofit mutual disability insurer, is dissolved or wound up, any residual value would be distributed to the MHEF. This would also be true if BCBSM, after converting into a nonprofit mutual disability insurer does any of the following:

- demutualizes,
- converts to a mutual holding company,
- sells or otherwise disposes of a substantial portion of its assets,
- merges into another entity and is not the surviving entity,
- moves its principal executive offices out of Michigan,
- redomesticates outside of Michigan,
- or permits a person(s) to control more than 50% of voting power associated with ownership interests, then BCBSM or the acquiring entity would be required to make a payment to the MHEF in an amount equal to the greater of either the acquisition price or the fair market value as determined by an independent valuation.

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.

Legislative Analyst: Chris Couch
Fiscal Analyst: Paul Holland
Ben Gielczyk
Bethany Wicksall

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