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BILL ANALYSIS

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Senate Bills 61 and 62 (as enacted) **PUBLIC ACTS 4 & 5 of 2013**
Sponsor: Senator Joe Hune
Senate Committee: Insurance
House Committee: Insurance

Date Completed: 9-24-15

CONTENT

Senate Bill 61 amended 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 the surviving entity of the merger will use its best efforts to make annual social mission contributions of up to $1.56 billion in aggregate over 18 years to the Michigan Health Endowment Fund.**
- **Provide that the merger subjects BCBSM to taxation under the General Property Tax Act beginning December 31, 2013.**
- **Prohibit BCBSM from using or enforcing a "most favored nation clause" in any provider contract, 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.**
- **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 62).**
- **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 approval of the Director of the Department of Insurance and Financial Services (DIFS).**
- **Beginning January 1, 2014, require BCBSM to establish and maintain a provider network that satisfies Federal network adequacy requirements.**
- **Provide that a BCBSM certificate issued or renewed on or after January 1, 2014, is subject to the certificate issuance and rate filing requirements of the Insurance Code.**
- **Allow BCBSM to establish reasonable open enrollment periods, subject to the DIFS Director's approval, for certificates offered or renewed in Michigan, beginning January 1, 2014.**
- **Allow the Michigan Health Endowment Fund to be incorporated on a nonstock, directorship basis as a charitable purpose nonprofit corporation to receive and administer funds for the public welfare; and create the board of the Fund.**
- **Require the Fund to disburse money to subsidize the cost of individual Medigap coverage to those who demonstrate a financial need through a means test developed by the DIFS Director.**
- **Require the Fund to disburse $120.0 million to subsidize Medigap coverage during the period prescribed in the bill.**
- **Establish an 18-year schedule for the expenditure of Fund money.**
- **Once the accumulated principal in the Fund reaches $750.0 million, require the Fund 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's effective date.

Senate Bill 62 amended 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 61, at the same rates as offered by BCBSM on the amendment's effective date.
-- 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.
-- Require the nonprofit mutual disability insurer to offer health care benefits to all Michigan residents regardless of health status, until January 1, 2014.
-- 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%.
-- In the event of the insurer's dissolution or winding up, require any residual value to be distributed to the Fund.
-- Allow the DIFS Director 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.
-- Provide that benefits paid by the nonprofit mutual disability insurer that are not cashed within a prescribed time period escheat to the State.

Also, if the insurer's status as a nonprofit mutual disability insurer is changed, or if the insurer disposes of its assets, moves to another state, or allows another person or group to beneficially own more than 50% of the voting power, the bill requires 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 added language applicable to insurers and HMOs similar to that in Senate Bill 61 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.

The bills took effect on March 18, 2013.

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 applies except as otherwise provided in Section 220.

The bill added 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 62 amended). The bill provides that the surviving entity of the merger is the nonprofit mutual disability insurer. The merger is 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 is 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 Director of the Department of Insurance and Financial Services.

The bill requires BCBSM to include in the merger plan that beginning in April of the first full calendar year after the plan's adoption, the surviving entity of the merger will 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 a nonprofit corporation (described below). The nonprofit mutual disability insurer will be considered to be making its best effort if it makes the annual contribution when its surplus is at least 375% of the authorized control level under risk-based capital requirements.

If the merger plan is adopted, the boards of directors must submit it to the DIFS Director for his or her consideration. The Director must make a determination to approve or disapprove the plan within 90 days after receiving it, and may not unreasonably withhold approval.

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

The bill provides that a merger is the dissolution of BCBSM, and the surviving nonprofit mutual disability insurer assumes 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 issued by the DIFS Director after July 1, 2012. The officers of BCBSM, however, may perform any act or acts necessary to close the affairs of BCBSM after the merger date.

If the merger becomes effective, the property of BCBSM is subject to the collection of general ad valorem taxes and applicable specific taxes under the General Property Tax Act beginning December 31, 2013. The bill provides that the Act does not confer an exemption from taxation on a nonprofit mutual disability insurer that merges with BCBSM.

Most Favored Nation Clause

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

Beginning January 1, 2014, BCBSM may not use a most favored nation clause in any provider contract, including one in effect on that date.

The bill defines "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 prohibits BCBSM from discontinuing to offer a particular plan or product in the nongroup or group market unless it does all of the following:

-- Gives at least 90 days' advance notice of the discontinuation to the DIFS Director and each individual or group, as applicable, covered under the plan or product.
-- Offers 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.
-- Acts uniformly without regard to any health status factor of enrolled individuals or individuals who might become eligible for coverage, in making the determination to discontinue coverage and in offering other plans or products.

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

-- Notifies the DIFS Director and each covered individual or group, as applicable, of the discontinuation at least 180 days before coverage expires.
-- Discontinues all health benefit plans issued in the nongroup or group market from which BCBSM withdrew and, except as otherwise allowed, does not renew coverage under those plans.

If BCBSM discontinues offering all coverage, it may 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 required BCBSM to offer health care benefits to all Michigan residents regardless of health status.

Notwithstanding Section 410a(8) of the Act, 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 must be determined only by using the rating factors set forth in Section 3474a of the Insurance Code (which Senate Bill 62 added).

(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.)

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. Previously, however, a rebate could not exceed 10% of paid premiums. Under the bill, the rebate may not exceed 30% of paid premiums, unless otherwise approved by the DIFS Director.

Provider Network & Accessibility

Beginning January 1, 2014, the bill requires BCBSM to establish and maintain a provider network that, at a minimum, satisfies any network adequacy requirements imposed by the Director pursuant to Federal law.

BCBSM Certificate Issuance & Rate Filing Requirements

Under the bill, a BCBSM certificate delivered, issued for delivery, or renewed in Michigan on or after January 1, 2014, is subject to the policy and certificate issuance and rate filing requirements of the Insurance Code, including the rating factor requirements of 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 DIFS Director's approval, the bill allows BCBSM to establish reasonable open enrollment periods.

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

Regarding coverage offered during an open enrollment period, the bill prohibits 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.

Health Endowment Fund Corporations

Fund Board. The bill added Part 6A to the Act to provide for health endowment fund corporations ("funds"), organized as nonprofit corporations. A health endowment fund corporation may not be incorporated in Michigan except under Part 6A.

Within 60 days after the incorporation of a fund, the Governor must appoint the following initial fund board members with the advice and consent of the Senate:

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

An individual is not eligible for a fund board appointment if he or she is an employee, officer, or board member of BCBSM, a lobbyist affiliated with BCBSM, or an employee of a health insurer, health care provider, or third-party administrator.

A board vacancy must be filled in the same manner as the initial appointment. Of the initial members, three must be appointed for two-year terms, three for three-year terms, and three for four-year terms. Otherwise, a member must be appointed for a term of four years or until a successor is appointed, whichever is later.

The bill requires a fund board to adopt a conflict of interest policy. A board member with a direct or indirect interest in any matter before the fund must disclose that interest to the board before it takes any action on the matter. 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 must recuse himself or herself from the discussion and vote on the issue.

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

Board business must be conducted at a meeting that is open to the public and held in Michigan in a place that is available to the general public. Between 10 and 60 days before a meeting, a board must provide public notice at its principal office and on its internet website. A board must include in the notice the address where board minutes may be inspected by the public. A board may 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 of the fund.
-- To consult with its attorney.
-- To comply with State or Federal law, rules, or regulations regarding privacy or confidentiality.

A board must keep minutes of each meeting. The minutes must be open to public inspection, and the board must make them available at the address designated on the public notice.

The board must make copies available to the public at the reasonable estimated cost for printing and copying.

Fund Powers & Duties. The bill allows a charitable purpose nonprofit corporation to be incorporated on a nonstock, directorship basis, under the Nonprofit Corporation Act consistent with Part 6A. If incorporated, the nonprofit corporation must be organized to receive and administer funds for the public welfare. The articles of incorporation must include the word "Michigan" and the phrase "Health Endowment Fund" in the fund's name. As soon as practicable after incorporation, the fund must apply for and make its best effort to obtain tax-exempt status under Section 501(c)(3) of the Internal Revenue Code (which exempts charitable nonprofit organizations from certain Federal taxes).

A fund's articles of incorporation must provide that the fund is organized for the purposes of supporting efforts that improve the quality of health care while reducing costs to Michigan residents; and benefitting the health and wellness of minor children and seniors throughout the State with a significant focus in the following areas:

-- Access to prenatal care and the reduction of infant mortality rates.
-- Health services for foster and adopted children.
-- Wellness and fitness programs.
-- Access to healthy food.
-- Access to mental health services.
-- Technology enhancements.
-- Health-related transportation needs.
-- Foodborne illness prevention.

Additionally, the articles of incorporation must provide that the fund's purposes include subsidizing the cost of individual Medigap coverage to Medicare-eligible individuals in Michigan who demonstrate a financial need in order to be able to purchase such coverage, as well as awarding grants for a term of up to three years for projects that will promote the fund's purposes. A fund board must establish a comprehensive and competitive process to award grants.

The bill provides that the Nonprofit Corporation Act applies to a health endowment fund corporation. If a provision relating to such a fund under Part 6A conflicts with other State law, Part 6A controls.

Also, the bill provides that a fund is a private, nonprofit corporation organized for charitable purposes and is not a State agency, governmental agency, or other political subdivision of the

State. A fund's money is held by the fund for purposes consistent with Part 6A and may not be deposited in the State Treasury. A board member is not a public officer of the State.

Medigap Subsidy. If a fund is eligible to receive social mission contributions under the bill, the fund must implement a program to disburse money to subsidize the cost of individual Medigap coverage to Medicaid-eligible individuals who demonstrate a financial need in order to be able to purchase such coverage. The DIFS Director must develop a means test to determine if an applicant is eligible for the subsidy and submit the test to the Attorney General for approval.

Additionally, if a fund is eligible to receive social mission contributions, beginning on the first day of the third August after the fund receives its initial social mission contribution and ending on the 31st day of the eighth December after that, the fund must disburse $120.0 million to subsidize the costs of individual Medigap coverage purchased by Medicare-eligible individuals, subject to the bill's requirements.

Executive Director. The bill requires a fund board to appoint an executive director to serve as the fund's chief executive officer, at the pleasure of the board. The executive director may employ necessary staff with the board's approval. The board must determine the compensation of the executive director and staff and approve contracts.

The executive director must 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. A fund may disburse money contributed to it each year, excluding any interest, earnings, or unrealized gains or losses on those contributions, for the stated purposes of the fund. The fund may spend a portion of the money contributed each year following the initial contribution 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 of money held by a fund reaches $750.0 million, the fund must maintain that amount for investment to provide an ongoing income to the fund. On and after that date, the fund's board may not allow the accumulated principal to fall below $750.0 million due to expenditures made for the fund's purposes.

A fund may spend money it receives from any source in a fiscal year that exceeds 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 investment of fund money and donations by the fund are under the exclusive control and discretion of the fund and are not subject to requirements applicable to public funds.

A fund may 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. A fund's articles of incorporation or bylaws must provide for a system of financial accounting, controls, audits, and reports. Annually, the fund's board must have an audit of the fund conducted by an independent public accountant firm, and the audit report and findings must be submitted to the board.

A fund's articles of incorporation or bylaws also must require the board to appoint from its members an audit committee consisting of at least three members, and for the committee to contract with an independent auditing firm to provide an annual financial audit in accordance with applicable auditing standards.

The executive director must 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.

Additionally, a fund's articles of incorporation or bylaws must require the fund to keep an accurate accounting of all activities, receipts, and expenditures and submit an annual report regarding those accountings to the board, the Governor, the Senate and House Appropriations Committees, and the Senate and House standing committees on health policy.

A fund and its directors, officers, and employees must 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 62

Nonprofit Mutual Disability Insurer

Under the bill, Chapter 58 of the Insurance Code applies to nonprofit mutual disability insurers, in addition to domestic mutual insurers transacting property, casualty, disability, and other insurances, and to mutual holding companies resulting from the reorganization of those mutual insurers.

The bill authorizes the formation with nonprofit status of a domestic mutual insurer. A nonprofit mutual disability insurer has all powers of a mutual insurer organized under Chapter 58 unless expressly reserved. Such an insurer that merges with BCBSM may 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 allows BCBSM to merge with a nonprofit mutual disability insurer (as set forth in Senate Bill 61), where the surviving entity is governed by Chapter 58. The merger is 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 must 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 merges with BCBSM may, at its option, continue to offer any product that was offered to BCBSM's subscribers.

The insurer also may offer supplemental coverage to Medicare enrollees as provided in Chapter 38. Notwithstanding any other provision of the Code to the contrary and until July 31, 2016, both of the following apply:

-- The insurer must continue to offer the supplemental coverage to current or new eligible policyholders who are Michigan residents, at the same rates as offered to BCBSM subscribers on the bill's effective date.
-- The insurer must 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 bill required the nonprofit mutual disability insurer to offer health care benefits to all Michigan residents regardless of health status.

The bill provides that 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 is not cashed within the period prescribed in the Uniform Unclaimed Property Act escheats 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 may permit entities holding administrative services agreements with it to be members, and may provide in its bylaws the basis for the number of votes the entities have as members.

The bill provides that a member of a nonprofit mutual disability insurer that has merged with BCBSM has no interest in, or residual rights to, the assets of the insurer; may not receive policy or surplus dividends; and may 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 must be distributed for the benefit of the people of Michigan to the Michigan Health Endowment Fund created under Part 6A of the Nonprofit Health Care Corporation Reform Act, and be administered in a manner consistent with the Supervision of Trustees for Charitable Purposes Act.

The bill requires the insurer or the acquiring person or entity 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 demutualizes; converts to a mutual holding company; sells, transfers, or otherwise disposes of all or substantially all of its assets; merges into an entity and is not the surviving entity; moves its principal executive office out of Michigan; redomesticates to another state; or allows 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 must 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 DIFS Director, and the insurer. The payment must be administered in a manner consistent with the Supervision of Trustees for Charitable Purposes Act, and must be in satisfaction of any claim or assertion that consideration is due with respect to the charitable assets of the insurer.

General: Discontinuation of Coverage

The bill added to Chapter 22 (The Insurance Contract) of the Insurance Code provisions similar to those that Senate Bill 61 added 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 62 apply to an insurer or HMO. They do 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 DIFS Director 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 Director may disapprove the form for specified reasons, subject to notice, hearing, and appeal requirements.

Under the bill, the Director may extend the time period to disapprove the form by up to 30 days, if written notice is given to the insurer within 30 days after the filing.

Most Favored Nation Clause

The bill added to the Code a prohibition against the use and enforcement of most favored nation clauses, similar to that applicable to BCBSM under Senate Bill 61. These provisions apply to an insurer or HMO.

Wellness Coverage Rebates

The bill increased 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 DIFS Director.

Provider Networks

The bill added to the Code language applicable to insurers and HMOs similar to that in Senate Bill 61 regarding the establishment and maintenance of a provider network and contracts with affiliated providers.

Open Enrollment

Under Senate Bill 62, beginning January 1, 2014, during an applicable open enrollment period, an insurer may not deny or condition the issuance or effectiveness of a policy and may 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 DIFS Director's approval, an insurer must 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 Director must establish minimum standards for the frequency and duration of open enrollment periods, and apply the standards uniformly to all insurers.

Rating Factors

The bill added 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 may vary based only on the following factors:

-- Whether the policy or certificate covers an individual or family.
-- The rating area.
-- Age, except that the premium rate may 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 may 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, may 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.

Previously, 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 could 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 eliminated the 35% variance limit for premiums charged by BCBSM or an HMO. Instead, premiums charged for these plans issued by BCBSM or an HMO are 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 must be determined only by using the rating factors prescribed in 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

Previously, Chapter 37 prohibited BCBSM from ceasing to renew all small employer group health benefit plans in a geographic area. The bill deleted this prohibition.

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

-- Notifies the DIFS Director and each covered small employer at least 90 days before the discontinuation.
-- Offers 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.
-- Acts uniformly without regard to any health status factor of enrolled individuals or individuals who may 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 is merged or consolidated may retain and use trade names in use by BCBSM before the merger or consolidation.

MCL 550.1218 et al. (S.B. 61)
500.2213b et al. (S.B. 62)

BACKGROUND

As provided for in Senate Bills 61 and 62, Blue Cross Blue Shield of Michigan transitioned to a nonprofit mutual insurance company on December 31, 2013.

The Michigan Health Endowment Fund was created following enactment of the legislation. In 2015, the Board of Directors approved the Fund's mission statement: "to improve the health of Michigan residents and reduce the cost of health care with special emphasis on the health and wellness of children and seniors".

According to the Fund's website (healthendowmentfund.org), BCBSM made its first payment of $100.0 million to the Fund in April 2014. The Fund has awarded nearly $38.0 million in grants since its establishment.

Currently, the Fund awards grants in two categories: local impact and community foundations. The purpose of Local Impact Grants is to support local nonprofit entities working on local health issues. Local governments are eligible for these grants, as are other organizations that meet the following criteria:

-- Are public charities under Section 501(c)(3) of the Internal Revenue Code.
-- Have a current certified financial audit.
-- Employ at least one full-time person.Have a maximum annual operating budget of $1.5 million.

Community Foundation Grants are aimed at assisting community foundations in improving the health of the regions they serve. To be eligible for a grant, an applicant must satisfy the following conditions:

-- Be a Michigan community foundation and be current with the Council on Foundations' national standards program.
-- Have a current certified financial audit.
-- Employ at least one full-time person.
-- Have a current solicitation license from the State of Michigan.

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

The bills will have an indeterminate impact on the finances of State and local governments. The bills will 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 payments, or makes disbursement of the money subject to the appropriations process.

The bills also may 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 may be attributed to a reorganization of BCBSM.

The bills were not expected to 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 are largely the same as they were toward BCBSM as it was previously organized.

Fiscal Analyst: Steve Angelotti
Josh Sefton

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