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BILL ANALYSIS

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

Date Completed: 11-20-12

CONTENT

Senate Bill 1294 (S-2) 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 $1.5 billion in aggregate over 18 years to a proposed Michigan Health and Wellness Foundation.
-- 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.
-- 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 services would be accessible without unreasonable delay.
-- If BCBSM did not have sufficient participating providers to provide a covered benefit as of January 1, 2014, require BCBSM to ensure that a member obtained the service for not more than what a participating provider would charge, 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.

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

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

-- Beginning January 1, 2016, require the Board to disburse 60% of the total amount of Foundation money eligible for disbursement to subsidize Medigap coverage until January 1, 2022, or until a nonprofit mutual disability insurer discontinued offering supplemental coverage to Medicare enrollees, whichever occurred first.

-- Limit the amount available for disbursement to half of the money contributed to the Foundation each year.

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

<u>Senate Bill 1293 (S-2)</u> 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 (S-2), 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; 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 to the proposed Foundation.

-- If another person or entity acquired a greater than 50% beneficial ownership interest in the nonprofit mutual disability insurer, require the insurer or the acquiring person or entity to pay the Foundation 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.

-- 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%.

In addition, the bill would add language applicable to insurers and HMOs similar to that in Senate Bill 1294 (S-2) 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 sufficient provider networks and contracts with providers, proximity to members, and open enrollment periods.

The bills are tie-barred.

Senate Bill 1294 (S-2)

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 (S-2) 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 $1.5 billion over a period of up to 18 years to the proposed Michigan Health and Wellness Foundation (described below).

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 that existed on the date of the merger. 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.

"Most favored nation clause" would mean 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 covered under the plan or product.
-- Offered to each covered individual the option to purchase any other plan or product currently being offered in the nongroup 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 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, BCBSM would have 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 (S-2) 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.)

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.

Provider Network & Accessibility

Beginning January 1, 2014, the bill would require BCBSM to establish and maintain a provider network in a manner that was sufficient in numbers and types of providers and facilities to ensure that all covered health care services to members would be accessible without unreasonable delay. Members would have to have access to

emergency services 24 hours per day, seven days per week. The BCBSM service area could not be created in a manner that was designed to discriminate against individuals because of age, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status. Blue Cross Blue Shield of Michigan would have to ensure that its networks met these requirements by the end of the first year of initial operation of the network and at all times after the first year.

Also, beginning January 1, 2014, BCBSM would have to maintain contracts with the number and types of affiliated providers that were sufficient to ensure that covered services were available to BCBSM members without unreasonable delay. The Commissioner would have to determine what was sufficient under this requirement and as could be established by reference to reasonable criteria used by BCBSM, including provider-member ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of members requiring technologically advanced or specialty care.

On or after January 1, 2014, if BCBSM had an insufficient number or type of participating providers to provide a covered benefit, it would have to ensure that a member obtained the service at no greater cost to the member than if the service were obtained from a participating provider, or make other arrangements acceptable to the Commissioner.

In addition, beginning January 1, 2014, BCBSM would have to establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of a member. In determining whether BCBSM was in compliance with this requirement, the Commissioner would have to give due consideration to the relative availability of health care providers in the service area.

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 & Wellness Foundation

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

The Board could not currently be, or within the preceding 12 months have been, employed by or under contract employment with, or be receiving or have received employment compensation from, a carrier, producer, health care provider, or third-party administrator, or an affiliate or subsidiary of such an entity.

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:

-- Two members from a list of at least five individuals recommended by the Senate Majority Leader.
-- Two members for a list of at least five 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 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.

In addition, the Board would have to include one member each representing the business community, organized labor, and small business.

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

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.

Foundation 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 and Wellness Foundation, and would be organized to receive and administer funds for the public welfare.

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.
-- Promote, through grants to programs or entities, the progress of the science and art of health care in Michigan.
-- Improve access to and the cost and quality of health care services in Michigan.
-- Promote wellness and improve the physical, mental, and emotional health 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.
-- Solicit and accept any gift, grant, legacy, or endowment of money or in-kind donations of goods and services from the Federal government, the State of Michigan, other state government, local government, or any private source to further its purposes.
-- Plan, promote, coordinate, and fund programs designed to prevent illness, disability, or death due to foodborne disease.
-- Support programs to reduce inefficiencies in the State's health care delivery system through the use of technology, collaboration or coordination of entities providing health care services, or education of health care consumers.
-- Support programs that assisted minor children to live healthy lifestyles and protected them from abuse and neglect.

In addition, the Foundation 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 Foundation 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 Foundation 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. To implement the program, the Board would have to develop a means test to determine if an applicant was eligible for the subsidy.

Beginning January 1, 2016, the Board would have to disburse 60% of the total amount of Foundation money eligible for disbursement under the bill to subsidize the cost of individual Medigap coverage, subject to the means test. This requirement would not apply after December 31, 2021, or after a nonprofit mutual disability insurer discontinued offering supplemental coverage to Medicare enrollees as provided in the Insurance Code, whichever occurred first.

Executive Director. The bill would require the Board to appoint an executive director of the Foundation. The executive director would be the Foundation'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.

To ensure the Foundation's efficient operation, the executive director could seek assistance and support as required in the performance of his or her duties from appropriate State departments, agencies, and offices. Upon request of the executive director, the department, agency, or office could provide assistance and support to him or her.

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

Financial Matters. The Board would have to provide for a system of financial accounting, controls, audits, and reports. The Foundation's books, records, and accounts would be subject to audit.

The Board also would have to provide for the Foundation's investment policy in its bylaws. Subject to the policy, all money received by the Foundation could be invested in bonds or other obligations of, or guaranteed as to principal and interest by, the United States, the State of Michigan, or a political subdivision of Michigan.

More than half of the money contributed to the Foundation each year, including any interest and earnings but not including any unrealized gains or losses on those contributions, would have to be available for disbursement by the Foundation upon Board approval.

Money from the Foundation could be used as matching funds for a Federal grant.

Senate Bill 1293 (S-2)

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 (S-2)), 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. 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 (S-2)). 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 Foundation, and be administered in a manner consistent with the Supervision of Trustees for Charitable Purposes Act.

In the event of a transaction or series of transactions that resulted in another person or entity acquiring a greater than 50% beneficial ownership interest in the nonprofit disability mutual insurer, the insurer or the acquiring person or entity would have to make a payment for the benefit of the people of Michigan 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, 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.

"Beneficial ownership interest" would mean actual ownership or the right, directly or indirectly, to control voting power associated with ownership interests in 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 (S-2) 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 (S-2) 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 (S-2). 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%.

Provider Networks; Open Enrollment

The bill would add to the Code language applicable to insurers and HMOs similar to that in Senate Bill 1294 (S-2) regarding the establishment and maintenance of sufficient provider networks and contracts with affiliated providers, as well as the establishment of open enrollment periods.

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 on 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 policy 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 individual at least 90 days before the discontinuation.
-- Offered to each covered individual the option to purchase any other plan or product currently being offered in the nongroup 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.

While there has been public discussion of a $1.5 billion payment by BCBSM over 18 years to the State to support health care, neither bill reflects this proposed payment. Therefore, there is no information on how these annual payments would be

used or any information on whether such payments would 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, though.

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
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