



MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

TO: Senator Tom George, Chairman, Senate Health Policy Committee
Stacey Hettiger, Senate Majority Policy Office

FROM: David Finkbeiner, Senior Vice President, Advocacy

DATE: November 29, 2007

SUBJECT: **Individual Health Insurance Market Reform, House Bill 5282-85**

Thank you for the opportunity to suggest changes to the Individual Health Insurance Market Reform package. In consultation with the MHA Board of Directors, the MHA developed amendatory language to protect hospitals' negotiated payment systems with Blue Cross Blue Shield of Michigan (BCBSM) from being used in other lines of insurance that BCBSM might transact, and reduce the length of time an individual would remain without coverage due to a pre-existing condition. The MHA also seeks amendments to allow for public oversight of the guaranteed health benefit plans proposed to cover high-risk insureds, and to provide the Office of Financial and Insurance Services the resources to regulate this new system of individual health insurance rates and benefits. Listed below are the specific proposals. If you have any questions about these proposed amendments please contact Laura Appel, Senior Director, MHA, at 517/703-8606 or lappel@mha.org.

House Bill 5282 (H-1):

Amend page 15, line 21, following "THAN" by page striking "12" and inserting "6".

Amend page 25, following line 19 by inserting:

Sec. 3774. (1) THE OFFICE OF FINANCIAL AND INSURANCE SERVICES SHALL BE RESPONSIBLE FOR MONITORING AND EVALUATING INDIVIDUAL HEALTH COVERAGE PLANS TO ASSURE, AT A MINIMUM, ALL OF THE FOLLOWING:

(A) THAT EXCLUSION OR LIMITATION OF COVERAGE IN INDIVIDUAL HEALTH BENEFIT PLANS OCCURS ONLY AS ALLOWED BY THIS CHAPTER.

(B) THAT A CARRIER DOES NOT DISCONTINUE OFFERING A PARTICULAR PLAN OR COVERAGE IN THE INDIVIDUAL MARKET UNLESS THE CARRIER MEETS ALL CRITERIA CONTAINED IN THIS CHAPTER.

SPENCER JOHNSON, PRESIDENT

CORPORATE HEADQUARTERS ♦ 6215 West St. Joseph Highway ♦ Lansing, Michigan 48917 ♦ (517) 323-3443 ♦ Fax (517) 323-0946
CAPITOL ADVOCACY CENTER ♦ 110 West Michigan Avenue, Suite 1200 ♦ Lansing, Michigan 48933 ♦ (517) 323-3443 ♦ Fax (517) 703-8620
www.mha.org

(C) THAT ALL ACTUARIAL CERTIFICATIONS MEET THE REQUIREMENTS OF THIS CHAPTER.

(D) THAT THE CERTIFICATIONS ARE SUPPORTED BY DATA AND INFORMATION MADE AVAILABLE TO THE COMMISSIONER.

(E) THAT RATE FILINGS SHOW THE ANTICIPATED LOSS RATIO OR PLAN PREMIUM AND THAT SUCH RATIOS OR PREMIUMS ARE REASONABLE, AS SPECIFIED IN SECTION 3763.

(2) NOT EARLIER THAN 24 MONTHS AFTER BUT NOT LATER THAN 36 MONTHS AFTER THE EFFECTIVE DATE OF THIS AMENDATORY ACT, THE OFFICE OF FINANCIAL AND INSURANCE SERVICES SHALL SUBMIT A WRITTEN REPORT TO THE LEGISLATURE ON THE AVAILABILITY AND AFFORDABILITY OF INDIVIDUAL HEALTH INSURANCE PLANS IN THE STATE, THE ACTUAL PERCENTAGE OF THE INDIVIDUAL MARKET REPRESENTED BY INDIVIDUAL INSURERS, AND THE ACTUAL PERCENTAGE OF THE TOTAL HEALTH INSURANCE MARKET REPRESENTED BY INDIVIDUAL HEALTH COVERAGE PLANS. IN THE REPORT REQUIRED UNDER THIS SUBSECTION, THE OFFICE OF FINANCIAL AND INSURANCE SERVICES SHALL PROVIDE RECOMMENDATIONS REGARDING CHANGES TO THE INDIVIDUAL HEALTH INSURANCE MARKET.

(2) NO LATER THAN 6 MONTHS OF THIS AMENDATORY ACT, THE OFFICE OF FINANCIAL AND INSURANCE SERVICES SHALL APPOINT AN ADVISORY PANEL TO REVIEW AND MAKE RECOMMENDATIONS REGARDING THE STRUCTURE AND OPERATIONS OF GUARANTEED-ACCESS HEALTH BENEFIT PLANS. THE PANEL SHALL CONSIST OF A MINIMUM OF EIGHT MEMBERS AND SHALL INCLUDE THE FOLLOWING:

- (A) THE COMMISSIONER OR HIS OR HER DESIGNEE.
- (B) ONE INDIVIDUAL REPRESENTING HOSPITALS.
- (C) ONE INDIVIDUAL REPRESENTING DOCTORS OF MEDICINE OR DOCTORS OF OSTEOPATHIC MEDICINE AND SURGERY.
- (D) ONE MEMBER REPRESENTING COMMERCIAL INSURERS.
- (E) ONE MEMBER REPRESENTING HEALTH MAINTENANCE ORGANIZATIONS.

(F) ONE MEMBER REPRESENTING A NONPROFIT HEALTH CARE CORPORATION.

(G) TWO MEMBERS REPRESENTING THE GENERAL PUBLIC.

(3) THE PANEL SHALL MEET ANNUALLY AND CONSIDER, AT A MINIMUM, ALL OF THE FOLLOWING:

(A) EXCESS LOSSES FOR THE GUARANTEED-ACCESS HEALTH BENEFIT PLANS.

(B) THE PROPORTIONATE SHARE OF EXCESS LOSSES FOR EACH CARRIER IN THE INDIVIDUAL MARKET.

(C) THE PREMIUMS, ADMINISTRATIVE EXPENSES, CLAIMS EXPERIENCE, AND LOSSES FOR ALL GUARANTEED-ACCESS HEALTH BENEFIT PLANS.

(D) THE REASONABLENESS OF PREMIUMS FOR GUARANTEED-ACCESS HEALTH BENEFIT PLANS, AS DEFINED BY SECTION 3763.

(4) NO LATER THAN 24 MONTHS AFTER THE EFFECTIVE DATE OF THIS CHAPTER, THE PANEL SHALL ISSUE ITS FIRST REPORT ON THE STATUS OF GUARANTEED-ACCESS HEALTH BENEFIT PLANS TO THE COMMISSIONER. THE PANEL SHALL SUBMIT SIMILAR REPORTS ON A BIENNIAL BASIS THEREAFTER. IN THE REPORTS REQUIRED BY THIS SUBSECTION, THE PANEL SHALL INCLUDE ITS RECOMMENDATIONS ON CHANGES TO GUARANTEED-ACCESS HEALTH PLANS OFFERED IN THE STATE.

(5) TO SUPPORT THE ACTIVITIES REQUIRED IN THIS SECTION THE COMMISSIONER SHALL ASSESS EACH CARRIER IN THE INDIVIDUAL HEALTH INSURANCE MARKET ACCORDING TO EACH CARRIERS' MARKET SHARE FOR THE ACTUAL COSTS OF ADMINISTERING THIS SECTION, NOT TO EXCEED \$250,000 ANNUALLY.

House Bill 5284 as passed the House:

Amend page 6, line 1, following "DISCOUNT" by inserting a "TO THE INSURER." and striking the balance of the sentence.