House
Legislative
Analysis
Section

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HEALTH INSURANCE:
SMALL GROUP MARKET

House Bill 4553 (Substitute H-3)
Sponsor: Rep. Stephen Ehardt
Committee: Health Policy

Complete to 5-27-03

A SUMMARY OF HOUSE BILL 4553 AS REPORTED BY THE HOUSE COMMITTEE ON HEALTH POLICY 5-22-03

House Bill 4553 would add a new chapter to the Insurance Code of 1956 to regulate health coverage made available to small employers by commercial insurers, Blue Cross and Blue Shield of Michigan, and health maintenance organizations (HMO's). The bill is tie-barred to House Bill 4279, which is the main bill in a package of bills that would amend the Nonprofit Health Care Corporation Act to provide a series of changes in the regulation of Blue Cross and Blue Shield of Michigan. (For a detailed summary of that package, see the summary by the House Legislative Analysis Section of House Bills 4279-4282 dated 5-27-03.) The provisions of House Bill 4553 would take effect six months after the bill was enacted.

House Bill 4553 would amend the Insurance Code of 1956 to add a new chapter (Chapter 37 – Small Employer Group Health Coverage) to do all of the following:

- allow small employer carriers to establish up to ten geographic areas in the state for use in establishing rates;

- specify which characteristics different types of carriers could use in determining rates;

- establish rate bands limiting the amount by which the premiums charged for a health benefit plan in a geographic area could deviate from the "index rate" for that plan, with the rate bands to be phased in for policies issued before the bill's effective date and later renewed, up until March 1, 2008, when the rate bands would apply equally to all plans;

- allow a carrier to charge a sole proprietor an additional premium of up to 25 percent;

- allow a carrier to charge a sole proprietor or small employer who had previously been self-insured an additional premium of up to 33 percent for two years;

- limit the percentage increase that could be charged to a small employer in a geographic area for a new rating period for plans issued on or after the bill's effective date and, after February 29, 2008, for renewals of plans originally issued before that date;

- allow carriers to establish premiums based on plan options, number of family members covered, and Medicare eligibility;

- require carriers to apply rating factors consistently to all small employers and sole proprietors in a geographic area;

- require small employer carriers to bill with a composite rate;

- require BCBSM to cover sole proprietors and require any other carrier offering coverage to sole proprietors to offer all sole proprietors in a geographic area the same plans;

- allow carriers to apply open enrollment periods for sole proprietors, require a carrier applying such a period to offer it annually, and require that the period be at least one month long;

- allow carriers to exclude or limit coverage to sole proprietors for pre-existing conditions, subject to certain constraints;

- require all small employer carriers to make available to all small employers all health benefit plans they market to small employers in the state;

- allow carriers to impose an "affiliation period" for new and late enrollees as long as the period is applied uniformly and without regard to health-status;

- prohibit carriers from offering or selling plans that contain "waiting periods" applicable to new or late enrollees;

- require carriers to accept late enrollees according to the provisions of Chapter 37;

- provide for special enrollment of employees and their dependents under certain conditions;

- require carriers to apply requirements uniformly when determining whether to provide coverage to a small employer;

- permit carriers to apply participation rules, which require a small employer to enroll a certain number or percentage of employees with the small employer carrier as a condition of coverage;

- require carriers to guarantee renewability for all small employer groups, with certain exceptions;

- establish a notification framework and restrict future activity of a carrier who ceases to renew all plans in a geographic area;

- require marketing disclosure notifications and maintenance of information on rating and renewal practices;

- require the commissioner to annually determine whether a reasonable degree of competition exists in the small employer health insurance market and to issue a report delineating his or her findings if there is not sufficient competition (and again if those findings are disputed); and

- authorize the commissioner to suspend rate bands based on the financial impact to the carrier or the overall impact the bands are having on the market.

The following is a more detailed summary of House Bill 4553.

Applicability. The bill would add a new chapter to the Insurance Code (Chapter 37: Small Employer Group Health Coverage) applying to "health benefit plans" that provided coverage to a "small employer" and that met one of the following two conditions:

- any portion of the premium or benefits was paid by or on behalf of the small employer or through salary deductions by the small employer;

- an eligible employee or dependent was reimbursed for any portion of the premium, through wage adjustments or otherwise, by or on behalf of the small employer.

Unless the policy met the above criteria, Chapter 37 would not apply to an individual health insurance policy that was subject to policy form and premium approval by the commissioner.

Chapter 37 would apply to each health benefit plan for a small employer or sole proprietor that was delivered, issued for delivery, renewed, or continued in Michigan on or after the (proposed) act's effective date. The continuation date of a health benefit plan would be the first rating period--presumably, the first date of the first rating period--that began on or after that date. (BCBSM would have to make a health benefit plan available to a sole proprietor upon request, and other carriers could do so.)

Definitions. "Health benefit plan" or "plan" would mean an expense-incurred hospital, medical, or surgical policy or certificate, BCBSM certificate, or HMO contract, and would not include any of the following: accident-only, credit, dental, or disability income insurance; long-term care insurance; coverage issued as a supplement to liability insurance; coverage only for a specified disease or illness; worker's compensation or similar insurance; or automobile medical-payment insurance.

"Small employer" would be defined as a person, firm, corporation, partnership, limited liability company, or association actively engaged in business who, on at least 50 percent of its working days during the preceding or current calendar year, employed at least two but not more than 50 "eligible employees". (Companies that were affiliated or eligible to file a combined state tax return would be considered one employer.)

"Eligible employee" would mean an employee who worked on a full-time basis with a normal workweek of 30 or more hours. Additionally, eligible employee could include an employee who worked on a full-time basis with a normal workweek of 20 to 30 hours, if an employer so chose and if the employer applied this eligibility criterion uniformly among all of the employer's employees, without regard to health status-related factors.

A "carrier" would be defined as a person that provided health benefits, coverage, or insurance in the state, including BCBSM, for-profit insurers, HMOs, and multiple employer welfare arrangements, as well as any other person providing a plan of health benefits, coverage, or insurance subject to insurance regulation in Michigan.

A "small employer carrier" would mean a carrier that offered health benefit plans covering employees of a small employer or a carrier that provided health benefit plans to sole proprietors. (As mentioned above, BCBSM would be required to provide a plan to a sole proprietor who requested coverage, and other carriers could provide a plan to a sole proprietor.)

Geographic areas, rating characteristics, and rate bands. A carrier could establish up to ten "geographic areas" in the state for the purpose of adjusting rates for health benefit plans subject to Chapter 37. A "geographic area" would have to include at least one entire county. If a geographic area included one entire county and additional counties or portions of counties, the counties or portions of counties would have to be contiguous with at least one other county or portion of another county in that geographic area. BCBSM would be required to establish geographic areas covering all counties in Michigan

The bill would allow different types of carriers to use different types of characteristics in determining premiums. In addition, the bill would establish rate bands for each type of carrier. In general, a rate band limits the spread between a carrier's highest and lowest premium rates due to characteristics within the band. Specifically, the bill would limit the amount that a carrier's rates could deviate from its "index rate" and would specify which characteristics fall within the band for each type of carrier.

"Index rate" would be defined as the average (during a rating period) of the base premium and the highest premium charged or that could be charged for each health benefit plan offered by each small employer carrier in a geographic area. "Base premium" would be defined as the lowest premium charged or that could be charged under a rating system by a small group carrier to small employers for a health benefit plan in a geographic area.

Different rate bands would be phased in between the date the (proposed) act took effect and February 29, 2008, after which date small employer carriers would be subject to final rate bands. The allowable characteristics, rate bands, and various phases of implementation are described below.

Different types of carriers could use the following characteristics for determining the premiums in a geographic area for sole employers and sole proprietors as follows:

- BCBSM could use only industry and age, both of which would fall within BCBSM's rate band.

- HMOs could use only industry, age, gender, group size, and duration of coverage, all of which would fall within an HMO's rate band.

- Small employer carriers other than BCBSM or an HMO—e.g., commercial insurers—could use three sets of characteristics: (1) industry, gender, and group size; (2) age; and (3) claims experience, health status, and duration of coverage. The third set of characteristics would be subject to a rate band. The first set of characteristics would fall outside of the rate band. The use of age would fall outside of the rate band initially but eventually would be subject to a maximum premium differential.

Rate bands. The following rate bands would apply to carriers for health benefit plans issued on or after the (proposed) act's effective date. These bands would also eventually apply to a health benefit plan issued before the (proposed) act's effective date, but not until the beginning of the next renewal period for the plan following February 29, 2008:

- for BCBSM, only industry and age could be used for determining the premiums charged during a rating period to small employers and sole proprietors in the same geographic area with the same or similar coverage, and the premiums could not vary from the index rate by more than 35 percent;

- for HMOs, only industry, age, gender, and group size could be used for determining the premiums charged during a rating period to small employers and sole proprietors in the same geographic area with the same or similar coverage, and the premiums could not vary from the index rate by more than 35 percent; and

- for other small employer carriers, industry, age, gender, and group size could be used for determining the premiums in a geographic area for a small employer or sole proprietor located in that area without rating band limitations. However, effective March 1, 2008, the maximum premium differential for age for a health benefit plan in a geographic area would be five to one. Further, claims experience, health status, and duration of coverage could also be used for determining the premiums in a geographic area, but the premiums charged during a rating period to small employers and sole proprietors located in that geographic area with the same or similar coverage for claims experience, health status, and duration of coverage characteristics could not vary from the index rate by more than 35 percent of the index rate.

BCBSM Renewal period ending before March 1, 2005. For a health benefit plan renewal period that ended before March 1, 2005, BCBSM could only use industry and age if the result was to lower the premium in a geographic area for a small employer or sole proprietor located in that geographic area.

Renewals of previously issued plans occurring March 1, 2005 through February 28, 2006. For a health benefit plan issued before the (proposed) act's effective date, the different types of small employer carriers would be subject to the following rate bands for renewals occurring on or after March 1, 2005 and through February 28, 2006:

- for BCBSM, premiums charged during a rating period to small employers and sole proprietors in a geographic area with the same or similar coverage could not be higher than 10 percent above the index rate nor lower than 20 percent below the index rate;

- for HMOs, premiums charged during a rating period to small employers and sole proprietors in a geographic area with the same or similar coverage could not vary from the index rate by more than 70 percent of the index rate; and

- for small employer carriers other than BCBSM and HMOs, premiums charged during a rating period to small employers and small proprietors with the same or similar coverage, for claims experience, health status, and duration of coverage characteristics, could not vary from the index rate by more than 70 percent of the index rate. (Industry, age, gender, and group size could be used for determining the premiums and would not be subject to the rate band.)

Renewals of previously issued plans occurring March 1, 2006 through February 28, 2007. For a health benefit plan issued before the (proposed) act's effective date, the different types of small employer carriers would be subject to the following rate bands for renewals occurring on or after March 1, 2006 and through February 28, 2007:

- for BCBSM, premiums charged during a rating period to small employers and sole proprietors in a geographic area with the same or similar coverage could not be higher than 20 percent above the index rate nor lower than 30 percent below the index rate;

- for HMOs, premiums charged during a rating period to small employers and sole proprietors in a geographic area with the same or similar coverage could not vary from the index rate by more than 60 percent of the index rate; and

- for small employer carriers other than BCBSM and HMOs, premiums charged during a rating period to small employers and small proprietors with the same or similar coverage, for claims experience, health status, and duration of coverage characteristics, could not vary from the index rate by more than 60 percent of the index rate. (Again, industry, age, gender, and group size could be used for determining the premiums and would not be subject to the rate band.)

Renewals of previously issued plans occurring March 1, 2007 through February 28, 2008. For a health benefit plan issued before the (proposed) act's effective date, the different types of small employer carriers would be subject to the following rate bands for renewals occurring on or after March 1, 2007 and through February 28, 2008:

- for BCBSM, premiums charged during a rating period to small employers and sole proprietors in a geographic area with the same or similar coverage could not be higher than 30 percent above the index rate nor lower than 35 percent below the index rate;

- for HMOs, premiums charged during a rating period to small employers and sole proprietors in a geographic area with the same or similar coverage could not vary from the index rate by more than 50 percent of the index rate; and

- for small employer carriers other than BCBSM and HMOs, premiums charged during a rating period to small employers and small proprietors with the same or similar coverage, for claims experience, health status, and duration of coverage characteristics, could not vary from the index rate by more than 50 percent of the index rate. (Again, industry, age, gender, and group size could be used for determining the premiums and would not be subject to the rate band.)

Exceptions to rate bands. For a sole proprietor, a small employer carrier could charge an additional amount of up to 25 percent above the otherwise allowed premium.

Beginning one year after the (proposed) act's effective date, if a small employer or sole proprietor had been self-insured for health benefits immediately before applying for a health benefit plan under Chapter 37, a carrier could charge an additional premium of up to 33 percent above the otherwise allowed premium for up to two years.

Increase in premium from one rating period to the next. The bill would limit the amount that a premium could increase from one rating period to the next both for health benefit plans issued on or after the (proposed) act's effective date, and after February 29, 2008, for renewals of health benefit plans issued before that date. The percentage increase in the premium charged to a small employer for a new rating period could not exceed the sum of the following: any adjustment due to change in coverage; the percentage change in the base premium for the health benefit plan; and any adjustment due to change in the characteristics of the group. Adjustments due to a change in the characteristics of the small employer or sole proprietor group would be subject to the following constraints:

- for BCBSM, up to 35 percent annually (and adjusted pro rata for rating periods of less than one year), due to industry and age of the group's members (i.e., the small employer's employees or employees' dependents or of the sole proprietor or the sole proprietor's dependents);

- for an HMO, up to 35 percent annually, due to industry, age, gender, group size and duration of coverage of the group's members;

- for any other small employer carrier, up to 15 percent annually, due to claims experience, health status, and duration of coverage of the group's members.

Rates - other. A small employer carrier would have to apply all rating factors consistently with respect to all small employers and sole proprietors in a geographic area. A small employer carrier could bill a small employer group only with a composite rate and could not bill so that one or more employees in a small employer group were charged a higher premium than another employee in that small employer group. However, health benefit plan options, number of family members, and Medicare eligibility could be used in establishing a small employer or sole proprietor's premium (notwithstanding the general limitations on the amount a carrier could charge different employers for the same coverage.)

Sole proprietors. A small employer carrier could offer an open enrollment period for sole proprietors, and if the carrier did so, the open enrollment period would have to be offered at least annually and would have to be at least one month long. Small employer carriers would not have to offer or provide to sole proprietors all plans available to non-sole proprietor small employers, but would have to offer to all sole proprietors in a geographic area all plans that are available to any sole proprietor in that area.

Small employer carriers could exclude or limit coverage for a sole proprietor for a condition only if the exclusion or limitation related to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months before enrollment, and the exclusion or limitation did not extend for more than six months after plan took effect.

A small employer carrier could not impose a preexisting condition exclusion for a sole proprietor that related to pregnancy as a preexisting condition or with regard to a child who was covered under any "creditable coverage" (see below) within 30 days of birth, adoption, or placement for adoption, as long as the child did not experience a significant break in coverage and the child was adopted or placed for adoption before attaining 18 years of age. The period of

creditable coverage could not be counted for enrollment of an individual under a health benefit plan if, after this period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage. For purposes of calculating periods of creditable coverage, a "waiting period" would not be considered a gap in coverage. (See below for the definition of "waiting period".)

"Creditable coverage" would be defined as health benefits, coverage, or insurance provided to an individual under any of the following: a "group health plan" (that is, an employee welfare benefit plan as defined in the federal Employee Retirement Income Security Act); a health benefit plan; Medicare (Parts A or B); Medicaid (with the exception of benefits provided under a section of the Social Security Act dealing with home and community care for functionally disabled elderly individuals); medical and dental plans for personnel of the U.S. Armed Forces, the commissioned corps of the National Oceanic and Atmospheric Administration, and the Public Health Service; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under the (federal government) Employees Health Benefits Program; a plan established or maintained by a state, county, or other political subdivision of a state providing health insurance coverage to individuals enrolled in the plan; and a health benefit plan for U.S. Peace Corps volunteers.

Offer to one, offer to all (or "guaranteed issue"). As a condition of doing business in Michigan with small employers, every small employer carrier would be required to make available to small employers all plans that it "marketed" to small employers in the state. A small employer carrier would be considered to be *marketing* a plan if it offered the plan to a small employer not currently receiving a plan from that small employer carrier. A small employer carrier would be required to issue any health benefit plan to any small employer that applied for the plan and agreed both to make the required premium payments and to satisfy any other provisions of the plan that were reasonable and consistent with Chapter 37.

Affiliation period/waiting period. In general, a small employer carrier could not offer or sell to small employers a health benefit plan that contained a "waiting period" applicable to new or late enrollees. "Waiting period" would mean, with respect to a health benefit plan and a potential enrollee in the plan, a period that must pass with respect to the individual before the individual was eligible to be covered for benefits under the terms of the plan.

However, a small employer carrier could offer or sell to small employers other than sole proprietors a health benefit plan that provided for an "affiliation period" that had to expire before coverage became effective for a new or late enrollee. "Affiliation period" would be defined as a period of time required by a small employer carrier that had to expire before health coverage became effective. A small employer carrier could only offer or sell a plan providing for an affiliation period if the following conditions were met:

- the affiliation period was applied uniformly to all new and late enrollees (and their dependents) of the small employer, without regard to any health status-related factor;

- the affiliation period did not exceed 60 days for new enrollees and did not exceed 90 days for late enrollees;

• the small employer carrier did not charge any premiums for the enrollee during the affiliation period; and

• the coverage issued was not effective for the enrollee during the affiliation period.

Late enrollees. A health benefit plan offered to a small employer by a small employer carrier would have to provide for the acceptance of late enrollees. A small employer carrier would have to permit an employee or a dependent of the employee, who was eligible but not enrolled, to enroll for coverage under the terms of the small employer health benefit plan during a special enrollment period if all of the following applied:

• the employee or dependent was covered under a group health plan or had coverage under a plan at the time coverage was previously offered to the employee or dependent;

• the employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other plan was the reason for declining enrollment (but only if the small employer or carrier required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time); and

• the employee or dependent's (other) coverage was either (a) under a COBRA (see below) continuation provision and that coverage had been exhausted or (b) was not under a COBRA continuation provision and that other coverage had been terminated as a result of loss of eligibility for coverage, for reasons that could include legal separation, divorce, death, termination of employment, reduction in the number of hours of employment or termination of employer contributions toward that other coverage. (Whether or not the employee or dependent's other coverage was under a COBRA continuation provision, the employee could not request enrollment later than 30 days after the date of exhaustion or termination of coverage or termination of employer contributions.)

"Dependent special enrollment period". A small employer carrier that made dependent coverage available under a plan would have to provide for a dependent special enrollment period during which a person could be enrolled under the plan as a dependent of the individual or, if not otherwise enrolled, the individual could be enrolled under the plan. For a child's birth or adoption, the spouse of the individual could be enrolled as a dependent of the individual if the spouse was otherwise eligible for coverage. To be eligible to enroll during this dependent special enrollment period both of the following criteria would have to be met:

• the individual was a participant under the plan or had met any affiliation period applicable to becoming a participant under the plan and was eligible to be enrolled under the plan (except for a failure to enroll during a previous enrollment period); and

• the person became a dependent of the individual through marriage, birth, or adoption or placement for adoption.

The dependent special enrollment period could not be less than 30 days long, beginning on the later of the date dependent coverage was made available or the date of the marriage, birth, or

adoption or placement for adoption. If an individual sought to enroll a dependent during the first 30 days of the period, the dependent's coverage would be effective as follows:

- for marriage, not later than the first day of the first month beginning after the date the completed request for enrollment was received;

- for a dependent's birth, as of the date of birth; and

- for a dependent's adoption or placement for adoption, the date of adoption or placement.

Uniform requirements and participation rules. Requirements used by a small employer carrier in determining whether to provide coverage to a small employer would have to be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier. However, a small employer carrier could deny coverage to a small employer if the small employer failed to enroll enough of its employees (either as a number or percentage) to meet the carrier's minimum participation rules. If a small employer carrier waived a minimum participation rule for a small employer, the carrier could not later enforce that minimum participation rule for that small employer.

Carriers would have to establish minimum participation rules according to sound underwriting requirements, and the rules would be subject to the following limitations:

- for a small employer of 10 or fewer eligible employees, a rule could require enrollment of up to 100 percent of the small employer's employees seeking health care coverage through the small employer;

- for a small employer of 11 to 25 eligible employees, a rule could require enrollment of up to 75 percent of the small employer's employees seeking health care coverage through the small employer;

- for a small employer of 26 to 40 eligible employees, a rule could require enrollment of up to 65 percent of the small employer's employees seeking health care coverage through the small employer; and

- for a small employer of 40 to 50 eligible employees, a rule could require enrollment of up to 50 percent of the small employer's employees seeking health care coverage through the small employer.

Guaranteed renewal. A small employer carrier that offered health coverage in the small employer group market in connection with a health benefit plan would have to renew the plan or continue the plan in force at the option of the small employer or sole proprietor, with certain exceptions. Specifically, guaranteed renewal would not be required in cases of fraud or intentional misrepresentation of the small employer or, for coverage of an insured individual, fraud or misrepresentation by an insured individual or his or her representative; lack of payment; or noncompliance with minimum participation or employer contribution requirements. Also, guaranteed renewal would not be required if the small employer carrier no longer offered that particular type of coverage in the market or if the sole proprietor or small employer moved outside the geographic area.

Discontinuation of plans in geographic area. BCBSM could not cease to renew all health benefit plans in a geographic area, but other carriers could. A small employer carrier that decided to discontinue offering all health benefit plans in a geographic area would have to do all of the following:

- provide notice of the discontinuation to the commissioner and to each small employer that it covered in the discontinued area at least 180 days before the discontinuation of coverage;

- discontinue all plans issued or delivered for issuance in the area and not renew any current health plan in the area;

- refrain from issuing or delivering for issuance any small employer health benefit plans in the area for a five-year period beginning on the date of the discontinuation of the last health coverage not renewed; and

- refrain for five years from issuing any health coverage in any area that was not one of its geographic areas on the date of the notice of the discontinuation of health coverage.

Information on premium rates/characteristics/renewability. Each small employer carrier would have to provide all of the following to a small employer upon request and upon entering into a contract with the small employer:

- the extent to which premium rates for a specific small employer were established or adjusted due to any permitted characteristic and rating factors of the employees of a small employer and dependents;

- the provisions concerning the carrier's right to change premiums, permitted characteristics, and any rating factors that would cause changes in premiums; and

- provisions relating to the renewability of coverage.

Actuarially sound methods and practices. Each small employer carrier would have to maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation demonstrating that its rating methods and practices were based on commonly accepted actuarial assumptions and were in accordance with sound actuarial principles. Small employer carriers would have to make this information and documentation available to the commissioner upon request, but it would not be subject to disclosure under the Freedom of Information Act to persons outside of OFIS, unless agreed to by the small employer carrier or ordered by a court of competent jurisdiction.

Further, on March 1 of each year, each small employer carrier would have to file with the commissioner an actuarial certification that the carrier was in compliance with these requirements and that the rating methods of the carrier were actuarially sound. A copy of this actuarial certification would also have to be retained by the carrier at its principal place of business. These requirements would not replace requirements of the applicable filing provision in the insurance code or in the BCBSM act.

Suspension of requirements by commissioner/attorney general. Upon a filing for suspension by the small employer carrier and a finding by the commissioner, after consulting with the attorney general, that either the suspension was reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency of the marketplace for small employer health insurance, the commissioner could suspend the following requirements: all or any part of the provisions governing rates; and the provisions requiring small employer carriers that discontinue all plans in a geographic area to refrain from issuing plans in either that area or any area that were not served by the carrier for a period of five years.

BCBSM. The bill would specify that BCBSM is subject to Section 619 of the Nonprofit Health Care Corporation Act, which deals with civil actions and relief. (While BCBSM is generally subject to all provisions of that act, House Bill 4279 proposes to add a provision stating that Chapter 37 supersedes the provisions of the Nonprofit Health Care Corporation Act in case of a conflict.)

Evaluation of market competitiveness. By March 1, 2006, and by each March 1 thereafter, the commissioner would have to determine whether a reasonable degree of competition in the small employer carrier health market existed on a statewide basis. If the commissioner determined that there was not sufficient competition, he or she would have to hold a public hearing and issue a report delineating specific classifications and kinds of types of insurance, if any, where competition did not exist, as well as any suggested statutory or other changes necessary to increase or encourage competition. The report would have to be based on relevant economic tests and would have to give appropriate weight to all measures of competition rather than focusing exclusively on a single measure.

If the results of the report were disputed or if the commissioner determined that relevant circumstances had changed, the commissioner would have to issue a supplemental report that included a certification of whether or not a reasonable degree of competition existed in the market. The supplemental report certification would have to be supported by substantial evidence and would have to be issued by the December 15 of the year the original report was issued.

These reports and certifications would have to be forwarded to the governor, the clerk of the House, the secretary of the Senate, and all the members of the Senate and House of Representatives' standing committees on insurance and health issues.

In making her or his determinations, the commissioner would have to consider all of the following:

- the extent to which any carrier controlled all or a portion of the small employer carrier health benefit plan market;

- whether there were enough small employer carriers writing small employer health benefit plan coverage in the state to provide multiple options to employers;

- the disparity among small employer health benefit plan rates and classifications to the extent that those classifications resulted in rate differentials;

• the availability of small employer health benefit plan coverage to employers in all geographic areas and all types of business;

• the overall rate level that was not excessive, inadequate, or unfairly discriminatory; and

• any other factors the commissioner considered relevant.

HMO contracts: "off-label" drug coverage. Public Act 538 of 2002 amended the Insurance Code to specify that policies and certificates that provide pharmaceutical coverage must cover "off-label" uses of FDA-approved drugs and the costs of supplies that are medically necessary to administer the drugs. The act imposed a similar requirement on HMO contracts, but did not restrict this requirement to HMO contracts that provide pharmaceutical coverage.

The bill would amend the HMO requirement so that only HMO contracts that provide pharmaceutical coverage would have to cover off-label uses of FDA-approved drugs and the costs of medically necessary supplies.

MCL 500.3406q et al.

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