

**Press Crosswalk on Reform Legislation**

Strategic Issues	MAHP Recommendation	Put Michigan People First Recommendation	Senate Package Proposal (as Introduced)	House Package Proposal (as Introduced)	Key differences, House and Senate
<p><b>Benefit Design</b></p> <p><b>--Required Benefits</b></p> <p><b>--Incentives</b></p> <p><b>--HMO Flexibility</b></p>	<p>Standard Benefit would include inpatient, outpatient, drugs, physician and wellness services and limits on ER and urgent care, provisions for cost sharing. Inherent in this recommendation is support for flexibility to offer actuarial equivalents to an agreed upon standard benefit design in recognition of the need to offer beneficiaries choice. Benefit design would follow value based design principles.</p> <p>Revisions in the Insurance Code to provide consumers with more choice and affordable options— particularly in the individual market.</p>	<p>Adopt a standard benefit package that includes inpatient, outpatient, drugs, physician and wellness services, while encouraging limits on ER and urgent care. Along with the standard package, health plans should have the opportunity to offer actuarial equivalents to the standard benefit design to meet the needs of specific populations.</p> <p>Package needs to include all of the Consumer Protections agreed to in the debate last year and the flexibility for HMOs to be able to provide this product in the individual market</p>	<p>Most details left to a “Cover Michigan” board. See below.</p> <p>MI-Health benefit plans must include wellness, inpatient &amp; outpatient services, preventive care &amp; a value-based pharmaceutical benefit.</p> <p>Cover Michigan Board can waive benefit mandates now on certain insurers to allow them to participate on equal footing.</p>	<p>Most details left to the Insurance Commissioner, through rules process.</p> <p>Basic and basic enhanced benefit plans must be designed to minimize ER use, encourage wellness, &amp; include coverage for medically necessary &amp; appropriate inpatient and outpatient hospital services, medical &amp; surgical services and diagnostic services. HB 4934 pp 29-30 (Sec 3775)</p>	<p>Senate leaves details to a board; House to the Insurance Commissioner.</p> <p>Package design seems pretty similar.</p>

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<p><b>Rating Issues</b></p> <p><b>--Guaranteed Issue</b></p> <p><b>--Rate Bands</b></p> <p><b>--Other</b></p>	<p>Any reform discussion regarding a full guaranteed issue product must be strictly conditioned upon instituting an individual mandate for participation. MAHP believes that an individual mandate must include some combination of incentives and penalties to make an individual mandate effective. For example, it is possible to use an “opt out” method of participation as well as a state income tax return assessment (lien) against those who have tax refunds and have elected not to purchase coverage.</p> <p>However, there is consensus within the insurance industry and elsewhere that if full medical underwriting is not possible, using age as a rating factor becomes critical (with the possible additional consideration of using geography).</p>	<p>Modified guaranteed issue approach by health insurance carriers in Michigan, subject to market proportionality.</p> <p>Community rating except for the use of age as a rating factor, with possible use of feasible rate bands.</p> <p>All carriers would have to offer this to individuals proportional to their market share, meaning Blue Cross would no longer have the ability claim that they must take on people others don’t accept.</p> <p>This means Blue Cross would no longer be the insurer of last resort. There will be no health-related underwriting, but to provide a low-cost product that young people would be more likely to purchase, some age underwriting might be needed. However, to ensure that seniors are not priced out of the market, there is also a provision for subsidies for all based on income.</p>	<p>Guarantee issue in MI-Health to all eligible individuals.</p> <p>If eligibility is denied, insured has right to written explanation and right to appeal.</p> <p>MI-Health rates vary only on age, tobacco use, BMI, healthy behaviors</p> <p>Health condition rating prohibited except when MI-Health policy is first issued.</p> <p>Time frames for regulatory review of BCBSM nongroup, group conversion and Medigap rate filings shortened.</p>	<p>All insurers, HMOs and BCBSM required to offer a basic health benefit plan and a basic enhanced plan to individuals.</p> <p>All insurers, HMOs &amp; BCBSM must guarantee issue all health plans they offer in the individual market.</p> <p>Rates for individual policies can vary based on age, within a 5:1 rate band. Permits premium discounts of up to 50% based on healthy lifestyles.</p> <p>Changes the rate filing process for insurers and HMOs from prior approval to file &amp; use.</p> <p>Rates are presumed appropriate if they produce an anticipated loss ratio of 90% for Med Sup policies, 70% for policies issued by insurers and 80% for HMO coverage. The Commissioner must order refunds after 16 months</p>	<p>Senate requires guarantee issue to those eligible for Mi-Health program. Leaves rest of individual market alone. House requires guarantee issue to all in individual market.</p> <p>Senate allows several rate factors. House has large rate bands based on age.</p> <p>Senate retains most current regulatory oversight but shortens time for BCBSM review.</p> <p>House provides for presumption that rates are approved based on loss ratios.</p>

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				<p>if the actual loss ratio is less than the anticipated loss ratio.</p> <p>BCBSM non-group rates file and use rather than prior approval. It creates a presumption that non-group and group conversion rates are not excessive if they are based on an anticipated loss ratio of 80% (90% for Medigap rates.)</p>	
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<b>Provider Reimbursement (Parity)</b>	MAHP recommends that the Medicare reimbursement rate should be the basis for reimbursement under the targeted Michigan Program for the Uninsured.	<p>Rates for all providers in this targeted program for the uninsured should be based on prevailing Medicare rates.</p> <p>There will be no health-related underwriting, but to provide a low-cost product that young people would be more likely to purchase, some age underwriting might be needed. However, to ensure that seniors are not priced out of the market, there is also a provision for subsidies for all based on income.</p>	MI-Health policies must pay providers Medicare rates.	No provision	By setting reimbursement at Medicare rates, Senate provides for level playing field among providers. House allows those who can negotiate for lower provider reimbursement to do so.

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<p><b>Premium Subsidy and Sources</b></p>	<p>The proposed subsidy for the targeted Michigan Initiative for the Uninsured package, including funding for safety net expansion, would be from the following options:</p> <p>--BCBSM Annual Contribution at an amount equal to or near their tax benefit—coupled with redefinition of social mission obligation</p> <p>--Redirection of state funding for county health plans—since the proposed initiative for the uninsured would be targeted to same population—but with a broader benefit package.</p> <p>--Federal Stimulus Funding—to the extent this program can be incorporated under one time funding (to established the Subsidy)</p> <p>--Medicaid Support—to the extent Medicaid participation is part of the package—expansion of safety net recommendations</p> <p>Surcharge on Paid Claims</p>	<p>There should be a subsidy for low-income individuals, particularly older members. The age rating and subsidy for older individuals will produce a more affordable premium option for the younger population. Unless there is a subsidy, this concept will not get off the ground. The goal should be to keep premiums at 5-10 percent of income. Otherwise, low income and many seniors will be unable to afford it.</p> <p>The proposed sources of funding for the safety net expansion and subsidy for the targeted Michigan Initiative for the Uninsured package would be from the following options:</p> <p>--Medicaid Support—to the extent Medicaid participation is part of the package—expansion of safety net recommendations</p> <p>--Redirection of state funding for county health plans—since the targeted initiative for the uninsured would be targeted to same population—but with</p>	<p>MI-HEALTH sliding scale premium assistance. Funding would come from:</p> <p>A health access surcharge of up to 1.8% on claims paid under all non-retiree Michigan health coverage.</p> <p>An annual fee on BCBSM, to be determined by the Commissioner, not to exceed the amount of local tax and MBT that would have been due if BCBSM were subject to those taxes.</p> <p>Another possible funding source would be the quality assurance assessment for hospitals to the maximum allowable under federal matching requirements and allowing it to be used to subsidize Mi-Health.</p>	<p>Health Care Affordability Fund money must be spent to subsidize the cost of individual market health coverage as follows:</p> <p>1<sup>st</sup> to extend MiChild eligibility for households at or below 300% FPL</p> <p>2<sup>nd</sup> to subsidize individual coverage. Other than Med Sup, for households at or below 300% Federal Poverty Level (FPL)</p> <p>3<sup>rd</sup> to subsidize individual Med Sup premiums for households at or below 300% FPL.</p> <p>Funded by an annual assessment, set by the Commissioner, on nonprofit carriers, not to exceed the amount of local tax and MBT that would have been due if the nonprofit carriers were subject to those taxes.</p>	<p>Senate has a broad surcharge on all who provide insurance (including many self-insureds). Senate also would require BC to remit the value of its current tax exemption.</p> <p>House calls for a tax on nonprofit carriers, including Blue Cross, based on the value of their current tax exemption.</p> <p>Senate allocates funds to those under 300 percent FPL, based on sliding scale.</p> <p>House allocates funds first to MiChild, then to individual.</p> <p>Realistically, there is not enough money in the House plan to cover much more than MiChild.</p> <p>Senate adds a funding source by making full use of current hospital quality assessment</p>

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	<p>from Third Party Administrators and insurers.</p> <p>--Additional Provider taxes, or increases of existing provider tax, within the parameters of federal provider tax law</p> <p>--Other (e.g.)Managed Care use Tax</p>	<p>a broader benefit package.</p> <p>--Federal Stimulus Funding—to the extent this program can be incorporated under one time funding (e.g. to established the subsidy)</p> <p>--BCBSM Annual Contribution at an amount equal to or near their tax benefit—coupled with redefinition of social mission obligation</p> <p>--Surcharge on Paid Claims.</p> <p>--Additional Provider taxes, or increases of existing provider tax, within the parameters of federal provider tax law</p> <p>--Other</p>			<p>program (QAAP) to leverage more federal dollars.</p>
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<p><b>Reinsurance Mechanisms</b></p>	<p>MAHP recommends that a reinsurance mechanism be incorporated in the initiative for the Uninsured based on further consultation with experts in the area.</p> <p>A reinsurance mechanism will provide coverage for high cost cases---i.e., where the individual member exhausts the coverage limits and reaches the attachment point established for reinsurance. Several considerations remain under discussion, including a more limited reinsurance model covering a risk corridor of \$35,000 (annual) to \$200,000 (lifetime) limits.</p> <p>However other discussion is looking at a reinsurance model that triggers at a slightly higher attachment point with much higher limits, e.g., (\$50,000 and annual limit be increased to a \$1 Million level) with carriers having partial exposure, i.e., each carrier then retaining the final \$100,000 layer up to a \$1 million maximum coverage</p>	<p>Coalition appears to support use of a reinsurance mechanism that will provide coverage for high cost cases---i.e., where the individual member exhausts the coverage limits and reaches the attachment point. Coalition will explore this issue further and develop a more detailed recommendation.</p> <p>Reinsurance will be vital to provide care to the relatively few high cost individuals whose care would otherwise bankrupt the system</p>	<p>Michigan Claims Fund to reimburse carriers 90% of the amount between \$25,000 &amp; \$250,000 in paid claims for each individual health policy</p> <p>Funded by an annual assessment on each carrier writing individual health coverage.</p>	<p>MICAPP to reimburse carriers 100% of the amount above \$25,000 in paid claims for each individual health policy.</p> <p>Funded by annual participation contributions assessed on each carrier writing individual health coverage.</p>	<p>Both House and Senate set up a reinsurance mechanism funded by assessment on every carrier writing individual coverage.</p> <p>Senate limits exposure to 90 percent of claims between \$25,000 and \$250,000. No mention of what happens if run over \$250,000. House requires fund to pay for all claims more than \$25,000.</p> <p>House plan likely to be quite expensive to insurers, and therefore to those responsible for paying premiums (business, government, individuals).</p> <p>Senate could be very expensive, too, if fund pays for +\$250,000 claims.</p>

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<p><b>Expanding Safety Net Eligibility</b></p> <p><b>--Sources of financing</b></p>	<p>Through existing Medicaid State Plan amendments and potentially Medicaid waivers, Medicaid Eligibility should be expanded at least to 150% of the federal poverty level, FPL. The expansion of Medicaid should be seen as a first option for covering the uninsured.</p> <p>(Sources: Same as Premium Subsidy)</p>	<p>Increase Medicaid eligibility up to 200% of FPL to take advantage of federal dollars. This approach would reduce the target population that would be focus of uninsured initiative. This would also ensure Michigan gets the maximum federal funds for health care possible</p> <p>(Sources: Same as Premium Subsidy)</p>	<p>MI-HEALTH premium for eligibles at or below 200% FPL limited to 5% of income.</p> <p>Funding from Health Access surcharge and BCBSM fee.</p>	<p>Premium for guarantee issue policies to be subsidized for households up to 300% of poverty, with funds that remain after subsidizing MICHild. Funding source is BCBSM fee in lieu of taxes.</p>	<p>Senate says those under 200% FPL won't pay more than 5% of income for insurance. Surcharge on all plus BC fee makes this possible.</p> <p>House says those under 300%FPL will be subsidized; however, questionable if there will be money available for this subsidy.</p>

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<p><b>Consumer Protection Provisions</b></p>	<p>--Various Consumer Protection provisions, including standardizing pre-existing exclusions for all carriers and prohibiting underwriting for renewals;</p> <p>--Reasonable reforms regarding oversight by the Attorney General and Insurance Commissioner. This would require changes in both the Insurance Code— Chapters 34, 35, and 37 and PA 350</p> <p>--Revisions in the Insurance Code to provide consumers with more choice and affordable options— particularly in the individual market;</p> <p>--Reform regarding carrier rate filing and approvals and on issues on bringing products to market as quickly as possible.</p>	<p>Package needs to include all of the Consumer Protections agreed to in the debate last year and the flexibility for HMOs to be able to provide this product in the individual market.</p> <p>Among those Consumer protections agreed to:</p> <p>--Pre-existing condition limitations would be limited to 6 months.</p> <p>--Guaranteed renewal of the targeted product for Michigan’s uninsured.</p> <p>--Guaranteed issue of the targeted product for Michigan’s uninsured by all carriers subject to carrier proportional share of market.</p>	<p>All existing guarantee renewal requirements stay the same.</p> <p>All pre-ex provisions limited to 6 months</p> <p>No post-claims underwriting through rescission.</p> <p>No block closings without offering insureds the option to purchase other policies,</p> <p>Adds anti-steering provisions</p>	<p>All existing guarantee renewal requirements stay the same.</p> <p>All pre-ex provisions limited to 6 months.</p> <p>No post-claims underwriting through rescission.</p> <p>No block closings without offering insureds the option to purchase other policies,</p> <p>Adds anti-steering provisions</p>	<p>Both House and Senate have these consumer protection provisions.</p>

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<p><b>Eligibility Issues</b></p> <p><b>--Crowd out</b></p> <p><b>--HIPAA</b></p>	<p>“Eligible individual” means an individual who is a resident of the State of Michigan and meets all of the following requirements:</p> <p>(i) The individual has been a resident of the state for the previous 6 months;</p> <p>(ii) The individual is not eligible for coverage under any federal, state or county government program, including Medicare, Medicaid or the Children’s Health Insurance Program authorized under title XXXI of the Social Security Act, 42 USC 1397jj;</p> <p>(iii) The individual is not eligible (as a participant or beneficiary) for group health plan coverage, including group continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985;</p> <p>(iv) The individual has not had, during the previous 6 months, individual health insurance coverage, group health plan coverage or</p>	<p>Same as MAHP</p>	<p>An uninsured individual is eligible to participate in MI-Health if</p> <ol style="list-style-type: none"> <li>1. He or she has an annual income at or below 300% of FPL</li> <li>2. Is a MI resident for 6 months,</li> <li>3. Is not eligible for Medicaid, Medicare or MICHild,</li> <li>4. Has not had access to employer coverage for 6 months</li> <li>5. Hasn’t accepted an incentive to drop employer coverage.</li> </ol> <p>Prohibits a carrier from excluding or limiting coverage or imposing a waiting period for a pre-existing condition for HIPAA eligibles.</p>	<p>No crowd out provisions.</p> <p>All individuals are eligible for guarantee issue individual policies.</p> <p>Prohibits a carrier from excluding or limiting coverage or imposing a waiting period for a pre-existing condition for HIPAA eligibles.</p>	<p>Senate limits participation in its program to specific individuals generally regarded as the uninsured.</p> <p>House has no such limitation, since it says insurers must provide all products to all persons on guaranteed issue basis.</p> <p>Concern is that mandating guarantee issue for all products would drive up costs for the individual market as a whole.</p>

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	<p>coverage under a program established by any federal, state or county governmental entity;<sup>1</sup></p> <p><sup>1</sup> (This provision is intended to prevent “crowd-out” by requiring that the individual must have been uninsured for the prior six months. Individuals who move from the group market to the individual market (so-called HIPAA eligibles) are entitled to purchase coverage without a pre-existing condition exclusion from Blue Cross. In order to be a HIPAA eligible, there must not have been a break in coverage greater than 62 days. Since this bill would require an individual to have been uninsured for six months, the bill would not apply to HIPAA eligibles.)</p> <p>(v) The individual has not accepted a financial incentive from his or her employer to not enroll for coverage under his or her employer’s group health plan.</p>				
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<b>Oversight</b>  <b>--Regulatory Boards &amp; Composition</b>	No Recommendation on these topics from MAHP	No Recommendations on these topics from Consumer Coalition	<p>Creates MI-Health within DCH, with a 13 member governing board called the Cover Michigan Board.</p> <p>Creates the MI-Health fund within Treasury.</p> <p>Creates a 7 member Michigan Claims Board within OFIR.</p> <p>Creates the Michigan Claims Fund with the State Treasury, with the OFIR Commissioner as administrator of the fund for auditing purposes.</p>	<p>Creates a Health Care Affordability Fund as a charitable endowment fund in the State Treasury.</p> <p>Creates a Michigan Catastrophic Protection Plan Fund within the State Treasury, with the OFIR Commissioner as administrator of the fund for auditing purposes.</p>	<p>Senate relies on an appointed board for oversight.</p> <p>House puts oversight responsibility primarily on Insurance Commissioner.</p>

<b>Enrollment Capacity</b>	Target Population= Michigan's Uninsured Population	Target Population= Michigan's Uninsured Population	MI-Health target population is uninsured individuals at or below 300% of FPL. Cover Michigan Board must impose a cap on MI-Health enrollment if the amounts in the MI-Health fund are insufficient to meet the projected costs of enrolling new eligible individuals.	Target population is prioritized:  First, Children in households at or below 300%  Second, non-Medicare eligible adults  Third, Medicare eligible adults.	<p>Senate plan aims broadly at low income persons. Limits enrollment if funds not sufficient.</p> <p>House has limited funds for program, sets top priority for low income children, lowest for seniors.</p>
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