



Michigan Association of Health Plans

November 6, 2008

The Honorable Marc Corriveau
State Representative
343 S. Rogers St.
Northville, MI 48167

Re: *Proposed Individual Market Reform Compromise Components* Document

Dear Representative Corriveau:

I wish to thank you for meeting with Paul Duguay and me on October 14, 2008 at your office in Northville. We appreciated your time and hearing about your plan for the pending individual market legislation. As you will also recall, we wanted to make you aware of our current position—as articulated in our Newsletter that I left with you following our meeting. Our substantive discussion centered on the House workgroup recommendation that was produced last June and entitled “*Proposed Individual Market Reform Compromise Components*”. That document contained various features, including provisions relating to:

- 6 month exclusion for pre-existing conditions
- BCBSM retaining their status as insurer of last resort
- BCBSM to report on their social mission spending
- Use of health condition upon initial application and use of rate bands
- BCBSM allowed to use rate-banded products
- File and use
- Rate approval subject to claim trend plus established incremental percentages
- Minimum loss ratios
- Penalty tax for percentage of declinations
- Use of a study of the individual market to assess possible need for a high-risk pool

You had indicated that, per request of the Speaker, you were pulling together a proposed conference report that would address the above elements but as of the date of our meeting there was no other document for review. As a result of our discussion, you asked MAHP to communicate to you by November 6 2008 what changes would be necessary to move MAHP from its current position to adopting a position of neutrality or perhaps approval. This letter provides that response.

I’ll discuss the MAHP position in four segments. The first segment is components of the proposed IMR reform that MAHP currently supports. The second are components MAHP could support with changes. The third are components MAHP cannot support under any variation. And the fourth are components that were not contained in the discussion proposal.

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1. Components MAHP currently supports:

- Recommendation to place a pre-existing condition exclusion to 6 months, rather than the 12 months stated in other versions of the legislation.
- Continuation of statutory requirement that BCBSM remain the “insurer of last resort,” but only if: BCBSM does not write underwritten products, does not benefit from a high-risk pool (or any such name), and is not a beneficiary of any penalty tax/assessment imposed on insurance product declinations. If BCBSM is allowed to benefit from these provisions, it would then essentially become an indemnity carrier (like the entities it continually criticizes) and will be “bailed out” financially while abdicating its responsibility as a benevolent, charitable trust.
- Conducting an unbiased, fully independent study of the individual health insurance market in Michigan. The study must go beyond the discussion of whether a high-risk pool is necessary. It should be a comprehensive analysis of the entire market and should recommend changes to assure greater competition, lower premiums, and greater access for all Michigan residents, including those currently without health insurance.

2. Components MAHP might support with changes:

- Use of health status upon application, but prohibited from use at renewal. This provision, of course, has been opposed by many consumer groups. They argue that BCBSM’s use of health status at any stage is antithetical to its favorable tax status and would give it even greater market advantages than it already enjoys and exploits. The use of health status by all carriers in the individual market (at time of application only), nevertheless, is a component MAHP can tolerate as long as it is used, applied and regulated consistently among all carriers in the individual market.
- Use of rate bands could be acceptable so long as the band widths are wide enough to adequately account for risk and if they are used, applied and regulated consistently among all carriers in the individual market.
- Use of “file and use” as a rate filing method, but it must be allowed for all carriers in the individual market (including HMOs) **and** the method must not be tied to a scheme to diminish the regulatory oversight and power of the Attorney General or OFIR in setting rates. We accept a “file and use” method if it allows carriers to get health coverage products to the market quickly, but it must not be done in a way that would circumvent the rate oversight structure currently in place.
- Filing of a report outlining BCBSMs social mission spending. MAHP might support such report so long as the report is conducted by an objective third party not associated in any way with BCBSM or its affiliated entities. The proposed legislation should also specify the subject matter to be reviewed and require an analysis of whether BCBSM, as a benevolent, charitable trust, has adequately upheld its duty under state law and whether

it should do other specific acts to assure the people of the state of Michigan are receiving benefits at least equal to the tax advantage it provides to BCBSM.

- Conducting a comprehensive study of the individual health insurance market in Michigan. As noted in part 1 above (last bullet point), MAHP supports a study, but unlike the proposed compromise document, it must go beyond the discussion of whether a high-risk pool is necessary. It should be an unbiased, comprehensive analysis of the entire individual market and should recommend changes to assure greater competition, lower premiums, and greater access for all Michigan residents.

3. Components MAHP cannot support:

- BCBSM being able to offer underwritten products in the individual market. Based on our review of this provision, BCBSM would have “two-tracked” individual products. The first is a continuation or “grandfathering” of its current community rated product (pool) and the second is an underwritten product. The two-tracked concept is understandably appealing to BCBSM because its community rated product (pool) over time will be intentionally “cannibalized” by BCBSM’s own underwritten products. These products will certainly be priced lower for younger and healthier individuals and they will be enticed to move from the community rated pool to the underwritten products. The claim experience of the community rated pool will gradually worsen and its premium rate will continually rise such that the pool will become a de facto high-risk pool and it will quickly be unaffordable for most of those remaining in the community rated product. This two-track scheme is absolutely antithetical to the notion of “insurer of last resort,” is an abdication of duty that was assumed in exchange for BCBSM’s favorable tax treatment, and is not contemplated within the original intent of PA 350.
- Implementation of file and use rate approval method that is tied to loss trend plus an incremental percentage. As stated in part 2 above (third bullet point) we accept a “file and use” method if it allows carriers to get health coverage products to the market quickly, but it must not be done in a way that would circumvent the rate oversight structure currently in place. The proposal eliminates Attorney General oversight for rate increase filings that are less than current loss trend plus a specified percentage. Assuming typical loss trends plus a percentage, one could expect BCBSM to institute 14% to 20% annual rate increases without scrutiny by the Attorney General. The cumulative effect would allow BCBSM to enjoy a 100% increase in just 5 years. Moreover, the proposal did not specify what could be considered in the definition of “trend.”
- Textured loss ratios. This component neither specifies exactly what the “textured loss ratios” are intended to do nor how the various loss ratios affect a carrier’s business. MAHP cannot support the component without a full explanation of its use and value. This component, in addition, interjects a concept absolutely foreign to health insurance underwriting. It builds in agent commissions as a part of the loss ratio. The loss ratio, like an underwriting term of art, has traditionally represented costs directly associated with payment of medical claims (costs for medical treatment). It has never, in our

experience, been used in any other manner. Adding agent commissions, which are undoubtedly administrative costs, to the loss ratio is an aberrant practice that has, to date, not been justified by any interested party.

- 90% loss ratio for Medigap coverage. It is not clear why this coverage has been added as a necessary reform within the individual market. Medigap coverage is clearly supplemental (not essential) and more importantly is a type of coverage that BCBSM already receives a subsidy to write. BCBSM can pass along a percentage surcharge to its subscriber groups to offset the expense of this typically high loss ratio product. We must not forget that BCBSM receives significant tax advantages in exchange for its duty to write Medigap coverage.
- As stated in the proposal, a “penalty” or “tax” assessed upon carriers that decline to write a certain percentage of applicants. MAHP has always opposed this type of penalty. This penalty assessment is undoubtedly a tax by any definition. The tax would be used to fund the de facto high-risk pool noted in part 3 above (first bullet point). The tax would inordinately benefit BCBSM (because they would be the only entity covered under the proposal’s definition of “community rated pool”) and the tax would come at the expense of BCBSM’s competitors. The tax would clearly be anti-competitive as it would certainly drive up competitor’s premium rates for individual insureds and businesses paying for group coverages. This component is obviously the funding mechanism for a BCBSM-managed community rated high-risk pool: only it goes by a different title.

4. Components not contained in the proposal that should be added to result in a more competitive environment:

- A requirement that there be a common benefit package. There should be at least one common (or creditable) basic coverage that would be the standard set of benefits each carrier must offer in the individual market. With at least one standard benefit package, consumers would be able to compare prices against identical products. This would allow consumers to compare “apples to apples” when it comes to deciding on which individual health product to choose at any given price. Health plans would be more competitive and would have to distinguish themselves based on better quality, customer service and outcomes. Consumers would greatly benefit from this type of product comparison.
- A requirement for an individual health insurance coverage mandate (standard creditable coverage as stated above in the first bullet point). Such a requirement would protect against adverse selection and would diversify the overall health insurance population in Michigan and would negate any need to create high risk pools or funding mechanisms.
- A requirement that OFIR reform and update its method of service area approvals for HMOs. The current system is outdated and leads to inconsistent determinations of service area coverage. A reformed and uniform method of service area approval would greatly help the residents of Michigan by expediting service area approval and thereby

more options and would make it easier for citizens to secure badly needed health care services.

- A requirement prohibiting the use of “most favored nation” clauses by any carrier with their hospital providers. These contract clauses lead to higher premium costs (due to increased health care payments) to be passed along to various insured populations and are by their nature anti-competitive.
- A requirement that BCBSM, because it stands alone in its status as a benevolent, charitable trust, and because of its clear dominance of the overall health care market in Michigan, should be subject to transparency regarding its administrative costs and the rates it pays to providers. Other states have instituted measures that protect citizens by bringing to light the amount of administrative expenses its Blue Cross plan pays and the amounts and details surrounding the amounts it pays to its contracting hospital and provider partners.

As we shared with you at our meeting, the current MAHP position is to defer all action on this legislation until the new legislative session and to regroup with a focus and objective on a broader health care reform legislation that will benefit Michigan citizens. We believe the most important issue is moving toward universal access and providing more affordable options for the uninsured in Michigan. We still believe that is the best policy at this time, particularly as a result of Tuesday’s election.

If a proposed conference report is prepared that incorporates the concerns we raised in this letter, we will revisit our current position—consistent with the request that you made of us to withhold any final position until we review the “conference report”. Again, thank you for meeting with Paul and me and we look forward to working with you in the future.

Sincerely,



Richard Murdock
Executive Director
Michigan Association of Health Plans

Cc: Members of House/Senate Conference Committee
MAHP Executive Committee