

Key Consumer Protections

- Prohibits commercial insurers from using many of the most egregious practices in the marketplace by limiting their use of health as a rating factor; prohibiting re-underwriting at renewal, rescissions, closing blocks of business and narrowing the excessively high range of rates they offer by instituting rate bands
MAHU Concerns: If a carrier can only use a 2:1 rate band for health then how will this allow them to accept more applicants while maintaining a product that can be competitively priced? It could cause more rejections which in turn creates more cherry picking penalty to be paid. Not much protection for consumers from higher prices. We have taken a position since the beginning that not allowing carriers to close blocks of business to allow for new products to be brought to market is a problem in that a new carrier could come to the market and scoop up all of the good risks by undercutting the current carriers thus leaving all of the bad risks with the current carriers including BCBSM. The 7:1 rate banding for age isn't the problem here. However adding the 2:1 rating for health status and requiring that 2:1 to exist within the 7:1 age band will not allow any carrier, even BCBSM to effectively rate the applicant that is in an older age bracket that is close to or has hit the upper rates of the 7:1 age band. This would create a situation where no carrier could collect the premium it requires to effectively keep this person in a standard product. This will only cause those in the older and sicker population to continue to create losses for the carriers.
- Preserves a very key regulatory role for the Attorney General when rates are filed above the prescribed trend threshold – **MAHU can support this**
- For the first time ever, OFIR will have the ability to order refunds if rates are deemed excessive. And in the case of BCBSM, the AG will have the ability to enforce the order of the Commissioner to order refunds to consumers. – **MAHU can support this.**
- Ensures graduated rate filings; protects consumers from large annual spikes in rates and prescribes a slow transitional process where trend is phased in – **MAHU concerns: If the trend of a carrier is running higher than trend then how does that cost get passed on in rate increases if the increases are capped? Who provides the subsidies for these larger costs? A commercial carrier is likely to pull from the market and leave an entire block of customers holding the bag.**
- Community rating is preserved for the at-risk populations and seniors with consumers benefiting from BCBSM's ability to sell more affordable competitive products – **MAHU concerns: What is the definition of at-risk population. We still have seen no example of medical underwriting that will be done by BCBSM. Definition of "affordable" is very subjective.**

- Commercial carriers will bear some financial responsibility for risk for the portion of individuals they chose to reject, subjecting them to a cherry picking penalty – **MAHU concerns: A cherry picking penalty is essentially a premium tax that will be passed on to insured's thus raising the premiums even more. A high risk pool is a much better market alternative for spreading the risk equally. This is getting very close to creating a guarantee issue situation. If the objective is to attract younger healthier people to buy coverage then this will continue to increase cost for those people and even fewer of them will seek to purchase coverage.**
- Seniors will be protected with a higher loss ratio for all carriers who offer a Medigap product in the marketplace (not just BCBSM). A graduated, slow transitional rate filing process also ensures that they will not see large annual rate increases – **MAHU concerns: Once again, what happens if the trend in a block justifies a large rate increase, who subsidizes that requirement of a higher rate if the rate is capped?**
- Data will be required and a report will be issued as to the need for a high risk pool in the marketplace in the future; competition in the marketplace will be evaluated to ensure that reforms are sustainable – **MAHU could support this with clear language as to the timeframe involved and defining who would be performing the analysis and reporting.**

Proposed Individual Market Reform Compromise Components

- Reduced pre-existing condition clause to 6 months for all carriers ensuring enhanced consumer protections for individuals who have pre-existing health conditions. Current law allows commercial carriers to have a 12 month pre-existing condition clause – **MAHU can support this.**
- Blue Cross Blue Shield of MI is still required to maintain their insurer of last resort status accepting all applicants regardless of health status – **MAHU is concerned in that no example of health questions have been presented and if BCBSM can't use health status then why have a medical question application?**
- For the first time ever, BCBSM will be required to issue a report outlining their Social Mission spending and will have to ensure that their Social Mission spending exceeds their tax exempt value – **MAHU can support**
- Allows initial health condition to be used at application only and prohibits carriers from re-underwriting or jacking up rates upon renewal – **MAHU is concerned if BCBSM is allowed to rate based on health status and what does application look like?**
- For the first time ever limits commercial carriers' ability to rate based on age and health by instituting 7 to 1 rate bands with a 2 to 1 limitation on health status for commercial insurers helping to increase access to more affordable products – **MAHU has a concern that limiting a commercial carrier to a 2:1 rate band for health**

status is simply causing more rejections which then feeds more penalty into the cherry picking subsidy.

- This proposal would not include a high risk pool, but would require the Blues to maintain (keep open) their currently existing community rated products/pools – **MAHU could support this but would want to know if rate bands can be applied to this pool. If so then as the pool gets smaller then the premiums for this pool will increase tremendously.**
 - Current consumers in Blues community rated pool are grandfathered in to the current system – **MAHU is concerned about the same issue as the point above.**
 - Blues would be allowed to sell rate banded products under same regulatory structure as commercial insurers in addition to being required to offer non health underwritten community rated products – **MAHU could support this with clarification of impact of rate bands.**
 - Consumers would be allowed to choose either a Blues community rated (non-health underwritten) or underwritten product – **MAHU is concerned that this simply allows BCBSM to have the best of both worlds. With an appropriate rate difference, they could steer insureds into which ever pool they need the membership in.**
 - File and use for all commercial carrier rates – **MAHU can support this.**
 - BCBSM rates are file and use for all amounts below trend plus 8 and file and approve for rates above that limit after year 4. AG authority remains as it is today for all file and approve rates except with an expedited hearing process. More specifically for Blues' community rated plans (including Medigap) in years 1-4 there will be a graduated rating process. Anything above the prescribed graduated rate increases will be subject to current file and approve process with AG authority to intervene.
More specifically:
Year 1: trend +3
Year 2: trend +5
Year 3: trend +7
Year 4: trend +8
- Any increases above these prescribed amounts in years 1-4 will be subject to current file and approve process with expedited hearings – **MAHU can support this**
- Textured loss ratios with commercial carriers set at 70 percent and BCBSM at 85 percent (higher standard than commercials) of medical loss with a 5% percent commission allowance built in. Commissions above 5% would be allowable, but would have to be applied as an administrative cost. All carriers will be subject to new data reporting requirements to OFIR to obtain the information relative to loss ratios. – **MAHU maintained a position of support for inclusion of commissions in the medical loss ratio. Having a cap on the amount of commissions allowed in the**

MLR is problematic as it allows for commissions to be cut if they are higher than 5% in order for a carrier to reduce admin expenses. This was our point from the start.

- Institutes 90 percent loss ratio for all carriers who sell Medigap. – **MAHU could support a separate loss ratio for BCBSM –vs. - commercial carriers as outlined in the above point.**
- A cherry picking penalty will be applied to those carriers that reject individuals in the marketplace. Commercial carriers will be subject to new reporting requirements wherein they must report their rejection rates to OFIR. OFIR will then determine cherry picking penalties based on a percentage of individuals that are rejected by a carrier in a given year. Penalties will be applied as follows:
 - 1-5% rejection rate= A 1% penalty charge (of carrier premium volume in individual market)
 - 6-10% rejection rate= A 1.5% penalty charge (of carrier premium volume in individual market)
 - Anything above 10% = A 2% penalty charge (of carrier premium volume in individual market)

This penalty structure ties penalty directly to the percentage of individuals a carrier rejects. Therefore, there is a disincentive to reject more individuals.

Monies collected through this process will be deposited into a Treasury fund and Distributed to help mitigate future rate increases in the community pool

MAHU concerns: This approach is not a free market solution. A HRP would be a better solution. Imposing a penalty on carriers based upon their rejection rate is problematic when combined with tight rate bands of 2:1 for health status. In essence, this becomes an assessment that will be simply passed on to insureds in the form of higher premiums. This doesn't create stability in the rates for consumers. Assessing carriers into a HRP is a more equitable means to spread risk. Again this doesn't create a market in which younger healthier people are inclined to purchase coverage if the products that are being offered to that population is going to subsidize the older, sicker population that can't be charged an appropriate premium due to the rate band maximum being met.

- A study will be included using S-5 language, which is comprehensive and looks at the need for a high risk pool and competition in the marketplace. – **MAHU has maintained a position of being able to work with a HRP or without a HRP**