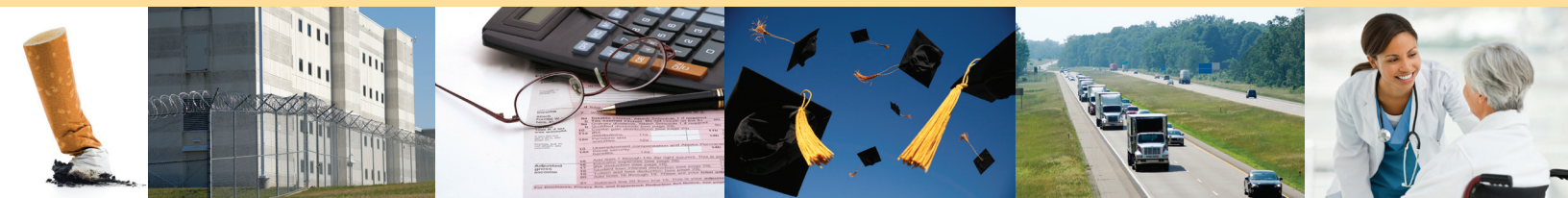


# Michigan Research Briefs:

*A Series on Key Policy Issues*  
Summer 2009



## *Regulation of the Individual Health Insurance Market*



**The Center for Local, State, and Urban Policy (CLOSUP)**, housed at the University of Michigan's Gerald R. Ford School of Public Policy, conducts and supports applied policy research designed to inform state, local, and urban policy issues. Through integrated research, teaching, and outreach involving academic researchers, students, policymakers and practitioners, CLOSUP seeks to foster understanding of today's state and local policy problems, and to find effective solutions to those problems.

## GLOSSARY

### Accident Fund

An independent, for-profit subsidiary of Blue Cross Blue Shield of Michigan that offers workers' compensation to employers.

### Area Rating

A system of calculating premiums based on the average cost of medical care in a geographic area. Under area rating, individuals are charged different premiums based on geography.

### Community Rating

A system of calculating premiums based on the average cost of medical care without adjusting for characteristics such as an individual's health status or history. Under community rating, all individuals in a group or area pay the same premium.

### Experience Rating

A system of determining premium rates based on a group's claims experience. Under experience rating, characteristics such as demographics or medical status or history are taken into consideration when setting premiums.

### Evidence of Insurability

A procedure used to review factors concerning a person's physical condition and medical history. From this information, the plan or insurance company evaluates whether the risk of the individual will be accepted and if they will offer coverage.

# Regulation of the Individual Health Insurance Market

## EXECUTIVE SUMMARY

Health insurance is currently an important issue in Michigan, with four bills recently under consideration in the legislature that would affect the individual insurance market and Blue Cross Blue Shield of Michigan (BCBSM). The current structure of the market allows for-profit insurance companies to reject older or sicker customers. BCBSM is the insurer of last resort, which means that BCBSM must currently provide insurance to all Michigan residents seeking coverage regardless of health status in return for a general exemption from state and local taxation.

These bills would give BCBSM more flexibility in the individual market and allow it to enter markets for other types of insurance. BCBSM claims that the bills are necessary for their financial security because BCBSM says the individual market is the fastest growing part of its business, but also the market in which they accrue the greatest losses (in 2008, \$133.2 million of their total \$144.9 million losses were in the individual insurance market).<sup>1</sup> BCBSM argues that recent financial difficulties will force them to lay off as many as 1,000 workers this year and to seek rate increases of 55 percent for customers purchasing individual health plans.<sup>2</sup>

Opponents of the legislation claim that the bills will allow BCBSM to use their non-profit status to strengthen their position in the individual insurance market, which could ultimately reduce access to and increase the cost of health insurance for individuals. In particular, they argue that the legislation will make it more difficult for high-risk individuals (i.e., older and sicker individuals) to obtain health insurance at a reasonable cost.<sup>3</sup> They fear that BCBSM will be able to raise rates more easily and pass their public obligation onto all insurers in Michigan while retaining their tax-exempt status.<sup>4</sup>

## BACKGROUND

### Health Insurance Trends

Sixty-one percent of all non-elderly (0–64 years of age) Americans receive health insurance through an employer (see Table 1). Sixty-seven percent of non-elderly Michigan residents are similarly insured. Alternatively, 5 percent of all non-elderly Americans purchase their own individual health insurance, as do 4 percent of Michigan non-elderly residents.<sup>5</sup> Seventeen percent of non-elderly Americans are uninsured altogether. Michigan has

### Guaranteed Issue

The applicant is guaranteed coverage up to an agreed amount or level without evidence of insurability.

### Guaranteed Renewable

The insured's right to continue an in-force policy by the timely payment of premiums. The insurance company cannot change the coverage or refuse to renew the coverage for other than non-payment of premiums (includes health conditions and/or marital or employment status).

### Group Conversion

The process through which individuals who are no longer part of a group obtain individual insurance coverage.

### Group Market

A market segment that includes groups of two or more people who enter into a group contract with a health insurance provider.

### Index Rate

The arithmetic average of the highest and lowest premium charged to an individual of an insurance plan.

### Individual Market

A market segment composed of customers not eligible for Medicare or Medicaid who are covered under an individual contract for health coverage.

### Insurer of Last Resort

An insurer of last resort must provide coverage to everyone who seeks it, regardless of their health status.

### Mandated Benefits

Health care coverage required by state and federal law to be included in health insurance contracts.

**Table 1.**

Health Insurance Coverage of the Population, Non-Elderly (0-64 years old)

Type of Coverage	Michigan <sup>1</sup>		United States <sup>2</sup>	
	Number	Percent	Number	Percent
Employer	5,785,860	67%	159,106,557	61%
Individual	377,104	4%	14,347,160	5%
Medicaid	1,226,710	14%	36,359,407	14%
Other Public	169,944	2%	6,642,562	3%
Uninsured	1,073,871	12%	44,970,781	17%
Total	8,633,489	100%	261,426,467	100%

Notes:

1: 2006–2007

2: 2007

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured. Michigan: *Health Insurance Coverage of the Total Population, states (2006–2007), U.S. (2007)*. <http://www.statehealthfacts.org/profileind.jsp?ind=126&cat=3&rgn=24>

a smaller proportion of uninsured individuals than the United States as a whole (12 percent of Michigan's non-elderly population is uninsured). However, Michigan still faces the same challenge faced by many other states: helping residents acquire and retain insurance in the individual market.

Historically, the percentage of Michigan residents insured through an employer has been higher than the nation as a whole, due to the importance of manufacturing and the strong union presence in the state. As the manufacturing industry declines and workers are laid off, the individual market has become more important as workers lose their employer-sponsored insurance and must turn to the individual market for coverage. The group market is defined as a market segment that includes groups of two or more people who enter into a group contract with a health insurance provider. The individual market is the market segment composed of customers not eligible for Medicare or Medicaid who are covered under an individual contract for health coverage.<sup>6</sup>

In 2008 premiums for employment-based benefits rose 5 percent in the U.S. This increase continued the trend of annual increases in employment-based health insurance premium prices, which has resulted in a 119 percent increase since 1999.<sup>7</sup> As the cost of health care and health insurance has risen, the number of uninsured individuals nationwide has risen as well. As the share of uninsured individuals without access to employer-based insurance grows, the individual health insurance market becomes more important.

## Blue Cross Blue Shield of Michigan

BCBSM is the largest health insurer in Michigan. In 2006, over 70 percent of Michigan residents with commercial insurance (including individual health insurance) were insured by BCBSM or by one of its subsidiaries. The proposed policy changes would only affect BCBSM's individual market, which is a small share of its business; only 5 percent (or 124,071 individu-



als) of BCBSM's total insured enrollment and 4 percent (equal to \$261 million) of its premiums were for individual insurance products.<sup>8</sup>

BCBSM is a not-for-profit company that acts as the insurer of last resort in Michigan in exchange for favorable tax treatment. The goal of the preferential tax treatment was to ensure access to health care services at reasonable prices for all people of Michigan. Legislation enacted in 1980 placed certain restrictions on all of BCBSM, not just its individual market, in exchange for tax benefits. Originally, BCBSM had to provide insurance to all Michigan residents seeking coverage regardless of health status (making BCBSM the insurer of last resort in both the individual and group markets), set rates at the same level for all individuals insured in a certain group, and develop a provider network in all areas of the state. In return, BCBSM had a general exemption from state and local taxation and a federal tax exemption.

These restrictions on BCBSM have since weakened. Currently, BCBSM is the insurer of last resort only in the individual market. BCBSM can now charge different premiums within a group based upon an individual's health status or medical history; that is, community rating restrictions have weakened. Now that BCBSM is not the insurer of last resort in the group market, BCBSM may experience rate groups of over 100 people, use geographical differences in pricing policies for groups with less than 100 employees, use age and geography to set rates for groups of two to 50 employees, and apply experience rating to new groups of 51 to 99 employees. In the individual market, BCBSM can use age to set premiums for individuals when a prescription drug benefit is offered. The ability to experience rate and use geographical differences in setting premiums for certain groups benefits BCBSM as they are able to minimize their exposure to risk when insuring certain groups.

Other restrictions on BCBSM (in both the individual and group markets) include that they must seek prior approval of rates and can only deny covering pre-existing conditions for six months after the effective date of the plan.<sup>9</sup> The Michigan Office of Financial and Insurance Regulation (OFIR) must approve rate changes before BCBSM can raise rates.

Meanwhile, other commercial insurers can change rates without obtaining prior approval and can limit coverage based upon pre-existing conditions for 12 months.

BCBSM continues to receive an exemption from most state and local taxes, but no longer has a federal tax exemption following a change in the federal tax code in 1986.

## PROPOSED LEGISLATION

### HB 5282 and HB 5283<sup>10</sup>

The Michigan legislature considered two bills in 2007 that would change the regulations regarding individual health care plans. House bills 5282 and 5283 passed in the Michigan House of Representatives on October 24, 2007 and were considered in the Senate.<sup>11</sup> While these bills have not been reintroduced this session, it is likely that the issues raised regarding the regulation of BCBSM will remain important.

HB 5282 would amend the Insurance Code to create a new chapter, Chapter 37A, to regulate individual plans, while HB 5283 would amend the Nonprofit Health Care Corporation Reform Act to specify that BCBSM is subject to this new chapter. BCBSM would still remain subject to the Nonprofit Health Care Corporation Reform Act, except as modified by Chapter 37A.

Under HB 5282 (as passed by the House), BCBSM would have more flexibility in the individual market while maintaining its tax-exempt status. Although it would remain the insurer of last resort, BCBSM could provide coverage for high-risk individuals (i.e., older and sicker individuals) under a guaranteed-access health benefit plan, meaning that BCBSM sets the amount or level of coverage an individual receives without taking into account their physical condition or medical history. Under the bill, BCBSM must offer four guaranteed-access health benefit plans, each with different levels of premiums and coverage, to individuals with serious medical conditions, and there are no requirements as to what services must be covered.<sup>12</sup> BCBSM could also limit or exclude coverage for a pre-existing condition if it was related to a condition for which med-





ical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation did not extend for more than 12 months after the effective date of the policy (currently, this exclusion allowance is for 6 months). The extension of the exclusionary period would minimize BCBSM's risk when taking on new individuals.

BCBSM would also have more flexibility to adjust premiums under the new legislation. It could establish up to ten geographic areas in the state, setting different policy rates and premiums by area. BCBSM could charge different rates to individuals based on age and initial health condition if these rate differentials were supported by sound actuarial principles. However, premiums could not vary from the index rate (the arithmetic average of the highest and lowest premium charged to an individual for a health benefit plan) for the plan by more than 80 percent, limiting BCBSM's ability to set different rates.

In summary, HB 5282 would give BCBSM more flexibility in the individual market than it has today. Specifically, it would have more flexibility in providing coverage for high-risk individuals, in setting premiums for individuals, and in excluding and limiting coverage for pre-existing conditions.

HB 5283 would create the "Charitable and Social Mission Fund," which would be used by the state to subsidize the cost of individual health coverage and require a one-time deposit of BCBSM's surplus to the fund. It would require BCBSM to issue an annual report describing its fulfillment of its charitable and social obligations, and would require the appointment of two additional public members to BCBSM's board of directors. One would be appointed by the Senate Majority Leader and one by the Speaker of the House. The bill would also permit BCBSM to allow rates charged for nongroup, group conversion, and Medicare supplemental coverage to include rate differentials based on the subscriber's health-related choices, such as tobacco use and participation in health screenings or wellness programs.<sup>13</sup>

In addition, this bill would shorten timelines in the rate approval process for BCBSM. Currently, BCBSM must file information related to its proposed rate changes with the OFIR commissioner at

least 120 days before the changes could take effect. This period would be shortened to 60 days. The bill would shorten the period the OFIR commissioner has to respond from 30 to 15 days. The bill would also shorten the time that the commissioner has to respond to requests for hearings and to make decisions.

In effect, HB 5283 would restrict BCBSM by requiring it to issue an annual report on its obligations, appoint two additional public members to its board, and make a one-time surplus deposit of \$100 million to the Charitable and Social Mission Fund. In return, BCBSM would benefit from shorter timelines in the rate approval process (allowing them to raise rates more quickly and easily) and would be able to charge individuals different rates based on their health choices.

### HB 5284 and HB 5285<sup>14</sup>

Two additional bills, also passed by the House on October 24, 2007, would allow BCBSM to enter other insurance industries. These bills expired at the end of the last legislative session and have not been reintroduced. HB 5284 was tie-barred to HB 5283 and HB 5285, and HB 5285 was tie-barred to HB 5284. If two bills are tie-barred to each other, it means that they both must be enacted for either to take effect.

HB 5284 would amend the Nonprofit Health Care Corporation Reform Act to specify that a subsidiary of BCBSM could market or transact any type of insurance if authorized by the OFIR commissioner. BCBSM could also own a subsidiary that is organized under another act and is not in the insurance business. In exchange, BCBSM would be required to deposit a one-time sum of \$100 million into the Charitable and Social Mission Fund created by HB 5283. HB 5285 amends the Insurance Code to allow the Accident Fund to transact types of insurance other than workers' compensation. BCBSM purchased the Accident Fund in 1994, which it operates as a for-profit subsidiary in the workers' compensation market. Currently, the Nonprofit Health Care Corporation Reform Act prohibits BCBSM from marketing or transacting other types of insurance, such as life, disability, or property insurance, and it limits the insurance activities of the Accident Fund to workers' compensation insurance.



## STATE AND LOCAL FISCAL IMPACTS

The Michigan House and Senate Fiscal Agencies have analyzed the potential costs of these four bills to the state and local governments in Michigan, and found that none of the bills would have substantial fiscal impacts. The Senate Fiscal Agency found that HB 5282 will not have a direct fiscal impact on health care costs for state or local government. It may have an impact on OFIR, which would have oversight responsibilities for the new regulations. HB 5283 would impose negligible costs to the OFIR Commissioner and could lead to reductions in overall health care costs if the use of differential rates based on tobacco use and health screenings lead to positive changes in health behaviors.<sup>15</sup>

The House Fiscal Agency found that HB 5284 and HB 5285 would not have a significant fiscal impact on state and local governments. The Senate Fiscal Agency found that HB 5284 could reduce costs for government-owned hospitals because the \$100 million BCBSM would deposit into the Charitable and Social Mission Fund could reduce the amount of uncompensated care currently experienced by these hospitals.<sup>16</sup>

## ARGUMENTS FOR AND AGAINST THE PROPOSED LEGISLATION

The main proponent of the legislation described above is BCBSM, which claims that the bills are necessary for its financial security.<sup>17</sup> BCBSM claims that having to insure older and sicker customers as the insurer of last resort is causing financial difficulties that will force it to lay off as many as 1,000 workers this year and to seek rate increases of 55 percent for customers purchasing individual health plans.<sup>18</sup> BCBSM lost \$144.9 million in 2008, mostly due to losses in its individual insurance business, which accounted for \$133.2 million of the losses.<sup>19</sup>

Opponents of the legislation claim that the bills will allow BCBSM to create a monopoly in the individual insurance market.<sup>20</sup> Opponents include Attorney General Mike Cox and groups such as *Put Michigan People First* and *Health Care for Health Care Workers*. *Put Michigan People First* is a coalition of Michigan groups dedicated to affordable and acces-

sible health care.<sup>21</sup> *Health Care for Health Care Workers* is an organization that represents and advocates for health insurance coverage of direct-care workers such as nursing aides, orderlies, and attendants. These groups are concerned that these bills would reduce access to and increase the cost of health insurance for individuals, and undermine BCBSM's mission as insurer of last resort. They fear that BCBSM will be able to raise rates more easily and pass their public obligation to make health insurance available to all Michigan residents onto all insurers in the state while retaining their tax-exempt status.<sup>22</sup>

*Put Michigan People First* claims that the legislation would force everyone in Michigan to pay more for health insurance, while an *Anderson Economic Group* (AEG) report commissioned by the *Coalition for Access and Affordability in Michigan* claims that the new rating policies would lead to higher premiums for the riskiest customers and lower premiums for low-risk customers.<sup>23</sup> Because the legislation would allow BCBSM more flexibility in setting different rates based on individual characteristics and allow it to raise rates more freely, it seems likely that high-risk customers will end up facing higher premiums. *Michigan Health Care for Health Care Workers* looked at whether the bills would make insurance more affordable or accessible for direct-care workers, and is concerned that the legislation would reduce access and increase the cost of insurance as the legislation alters BCBSM's role as insurer of last resort. Again, with greater ability to set different rates based on characteristics such as age and initial health condition, there is concern that the cost of individual health insurance would rise, effectively reducing access. It is important to note that while their concerns may be valid, analyses by these groups are unlikely to be objective.

With regard to BCBSM's layoffs, critics note that many insurance companies are being forced to lay off workers and restructure due to the current recession.<sup>24</sup> *Put Michigan People First* claims that if the bills passed, there would be more layoffs because BCBSM would now have a share of the for-profit industry, causing for-profit companies to cut jobs and raise rates. However, BCBSM may avoid layoffs because of the legislation, which could offset at least some of the potential layoffs at for-profit companies.



The AEG report claims that the proposed bills would reduce the burdens placed on BCBSM while allowing it to retain its tax benefits. AEG estimates that the state mandated restrictions put on BCBSM currently cost them \$7.7 million, while their tax exemption will be worth an estimated \$112 million in 2008. They also note that BCBSM's reserves (surplus) have grown from \$1.3 billion in 2001 to \$2.8 billion in 2006 and that the bills would not require BCBSM to use its reserves to lower premium rates or further its social mission.<sup>25</sup>

An analysis of HB 5284 and HB 5285 done by an economist, Gary Wolfram, of the Hillsdale Policy Group found that these bills would lead to economic distortions in the insurance market due to BCBSM's special tax status. Wolfram notes that the bills would allow BCBSM to expand into other insurance markets, but because BCBSM has a tax exemption that other firms do not have, this would give it an unfair advantage in the other markets. This tax advantage, combined with the financial reserves of BCBSM, and the Accident Fund would allow BCBSM to set lower rates and operate with lower profits than other companies, leading to distortions in consumer choice. That is, if BCBSM and the Accident Fund did not have an advantage enabling them to set lower rates, customers would be less likely to purchase insurance from them. Wolfram also notes that the legislation would give BCBSM and its subsidiaries an unfair advantage not only in the health insurance market but in other markets too, and would also increase government intervention in the insurance market due to the nonprofit status of BCBSM.<sup>26</sup>

In conclusion, the main beneficiary of this legislation will be BCBSM, which will have more flexibility in the individual insurance market. This may harm its competitors and consumers, especially high-risk individuals who may face higher premiums, but may help BCBSM avoid layoffs and rate increases.

### **BCBS IN OTHER STATE HEALTH INSURANCE MARKETS**

Because health insurance must be issued by carriers in the state in which an individual works or lives, each state has its own health insurance market. Within each state, insurers compete to secure

a greater share of the health insurance market.<sup>27</sup> As they gain greater shares of the market, the average cost to insure the marginal individual decreases; making it less costly to insure individuals as the size of the insurer's market share grows. Additionally, this process often allows the largest insurers to dominate certain portions of a state's health insurance market.

While state subsidiaries of Blue Cross Blue Shield, commonly called the Blues, have traditionally been not-for-profit health insurance carriers, they have experienced continual growth and have secured a large share of many state health insurance markets.<sup>28</sup> The Robert Wood Johnson Foundation's State Coverage Initiative (SCI) reports that in 2001 Blue Cross Blue Shield plans dominated the individual health insurance market in 39 states.<sup>29</sup> In some states, dominance of the Blues in the individual health insurance market has resulted in the presence of fewer insurance carriers. This reduces competition and further increases the relative dominance of BCBS subsidiaries.<sup>30</sup> Some contend that the presence of only a few carriers has caused rising costs of health insurance. In response to these rising costs, many states have developed regulatory policies such as community rating, guaranteed issue of individual health insurance, and mandated benefits that minimize costs to individuals and thereby allow more to be insured.

In order for states like Michigan to increase competition, they must offer health insurance market conditions that attract providers to offer insurance within the state. Providers are looking for state markets that allow them to lower their costs. States that regulate who providers must insure, what benefits they provide, or the price of coverage may have a difficult time attracting new providers and creating competition. Evidently, the push to increase competition may inherently conflict with a state's goal of providing affordable insurance for all individuals.

To attract more carriers into the health insurance market and to drive down prices through increased competition, states may reduce regulations.<sup>31</sup> Theoretically, relaxing state laws could decrease costs and potentially encourage some employers who do not currently offer health insurance to their employees to begin doing so. For example, currently BCBSM





passes the cost of insuring high-risk individuals onto employers who purchase BCBSM plans for relatively large groups. If Michigan relaxed regulations that restrain BCBSM from denying coverage to high-risk individuals or that constrain pricing, BCBSM might in turn reduce the price of group insurance sold to employers. However, studies suggest that easing state regulatory requirements and reducing state mandated insurance may lower the premiums for some, but that this small effect may not attract new employers to offer insurance to employees, removing the true benefits of increased competition.<sup>32</sup> Additionally, such deregulation may increase insurance prices for small groups of older and sicker employees, leading to market segmentation characterized by widely disparate individual insurance prices.

Moreover, in states where the BCBS subsidiary is a not-for-profit insurance provider, relaxing health insurance regulation would not necessarily result in a level playing field for insurance carrier competition. The not-for-profit BCBS subsidiaries have benefited from a great deal of federal, state, and local tax exemptions. In the case of BCBSM, the estimated savings resulting from exemption on three state taxes in 2008 (business tax, real and personal property tax, sales and use tax) is \$112 million.<sup>33</sup> Such savings often result in large profits, which are required to be further invested in that particular BCBS subsidiary's activities, as opposed to being divided among shareholders.

The fact that not-for-profit status mandates that profits are utilized for BCBS activities and not divided between shareholders seems to have induced BCBS subsidiaries to convert to a for-profit insurer in several states, such as California, New York, and Wisconsin. Typically, when a BCBS subsidiary converts from a not-for-profit insurance provider to a for-profit provider, they must compensate the state in some way for the tax exemption from which they have greatly benefited. In 1996, Blue Cross of California (BCC) transferred its accrued assets, (valued at \$3 billion), to two endowments—the California Endowment and the California Health Care Foundation—which were designed to expand access of affordable health care to the underserved population.<sup>34</sup> In 1999, Wisconsin Blue Cross

Blue Shield (WBCBS) gave 77% of its shares (valued at \$250 million) to the Wisconsin United Health Foundation. This contribution endowed public health grant-making entities at the University of Wisconsin Medical School and the Medical School of Wisconsin.<sup>35</sup> In 2002 Empire Blue Cross (EBC) of New York endowed two foundations designed to fund health initiatives in New York, which would otherwise be funded by the state.<sup>36</sup> These are only a few examples of the way that BCBS subsidiaries have agreed to compensate taxpayers for their share in not-for-profit BCBS carriers, in order for BCBS to end their contract with the taxpayer.

### **BCBS AS A STATE'S INSURER OF LAST RESORT**

Michigan can learn from states that have regulated the dominant health insurance provider, increased competition by relaxing regulations, and mitigated the costs of providing healthcare to uninsured and under-insured individuals. Michigan is one of four states, in addition to the District of Columbia, where Blue Cross Blue Shield is considered an insurer of last resort.<sup>37</sup> Michigan has regulated BCBSM more than North Carolina, Pennsylvania, Virginia, or the District of Columbia have regulated their BCBS subsidiaries. Michigan is the only one of these states that requires BCBS to guarantee all products to all individuals. Additionally, Michigan is the only state that restrains the pricing of BCBS individual insurance to a community rate; the other states do not restrain pricing of BCBS' individual insurance plans. Finally, of these states Michigan allows BCBS the shortest time period in which it can identify pre-existing health conditions. Michigan state law mandates that BCBSM may “look back” only six months into an individual's previous health history to identify pre-existing health conditions. Additionally, BCBSM is allowed to refuse to cover services related to a pre-existing condition for only six months after coverage begins, referred to as an “exclusionary period.”<sup>38</sup> However, it should be noted that in these other states BCBS does not receive full tax-exempt status and therefore does not command the fiscal benefits of BCBSM. Thus, it seems that BCBSM's tax-benefits come at a regulatory price.



Michigan's proposed legislation would closely align BCBSM with the regulations imposed on BCBS by District of Columbia, North Carolina, Pennsylvania, and Virginia. Instead of guaranteeing all products to all individuals, the proposed legislation would guarantee only certain products to individuals in Michigan. Additionally, the proposed legislation would deregulate their pricing of individual plans, by scaling back their required community rating to allow for increased price discretion based on individuals' pre-existence health conditions. Finally, the proposed legislation would expand BCBSM's look back and exclusionary periods from 6 months before and after insurance issuance to resemble that of North Carolina, which allows for 12 month look back and exclusionary periods. This would afford BCBSM a total of 24 months within which pre-existing conditions could be identified and refused coverage.

Clearly, state regulations in the District of Columbia, North Carolina, Pennsylvania, and Virginia are more generous to BCBS than are insurance regulations in Michigan. However, each state has also developed a plan to meet needs for individual insurance that are not being met by the insurer of last resort (primarily BCBS).

### **POLICY OPTIONS TO PROVIDE INSURANCE TO ALL INDIVIDUALS**

Outlined below are policy options that the state of Michigan could pursue in conjunction with the passage of legislation increasing the flexibility of BCBSM in the individual insurance market. These policy options may allow the state of Michigan to minimize potential consequences associated with passage of such legislation, such as an increased number of uninsured individuals and higher premiums for certain groups.

#### **State-Funded Programs to Fill the Uninsured Gap**

A consequence of limited regulation of the health insurance provider of last resort is a greater number of uninsured and under-insured individuals. Several states with BCBS subsidiaries as their insurer of last resort, including Michigan, have developed

programs to insure individuals who are not formally insured by providers (like BCBS) because of serious medical conditions or poverty status. These programs are designed to pay for uncompensated costs (often accruing to hospitals as a result of uncompensated emergency room visits) to prevent the passing on of uncompensated costs to the insured population, further increasing the cost of health care. Reviewing state plans developed to mitigate the cost of uninsured and under-insured individuals in the District of Columbia, North Carolina, Pennsylvania, Virginia, and Michigan, reveals that Michigan's plan is the least comprehensive of the five.

Virginia has two funds, the Indigent Health Care Trust Fund and the State and Local Hospitalization Program, to help to offset the cost of charity care provided by Virginia hospitals to indigent residents.<sup>39</sup> In the District of Columbia, the D.C. Health Alliance provides coverage through a network of primary care "medical homes" with both specialty and hospital services from participating providers. The D.C. Health Alliance is funded solely by the District, costing approximately \$130 million annually, and (as of December, 2008) has enrolled approximately 50,000 individuals.<sup>40</sup>

Pennsylvania created the Adult Basic Program in 2001, which is administered by the Pennsylvania Insurance Department and provides health insurance and basic benefits for adults, including preventative care, physician services, diagnosis and treatment of illness and injury, in-patient and outpatient hospitalization services, as well as emergency accident and medical care. This program charges enrollees a \$35 per month premium, plus \$5, \$10, and \$25 co-pays for doctor, specialist, and emergency room visits, respectively. Between 2001 and 2003 there was a tremendous response to the program, which outspent the years' allocations, making it necessary to create a waiting list. By 2005, nearly 38,000 Pennsylvania residents were enrolled in Adult Basic, which carried a waiting list of 110,000 people. In February of 2005, Pennsylvania's governor announced that an agreement had been made with four Pennsylvania not-for-profit BCBS plans to commit 1.6 percent of their annual health care premiums in addition to 1 percent of their Medicare and Med-



icaid premiums to support community health programs.<sup>41</sup> The contributions (also known as a community benefit obligation) will support the Adult Basic program, among others. It is estimated that BCBS plans will contribute nearly \$1 billion dollars to the Annual Community Health Reinvestment over its lifetime.<sup>42</sup> The voluntary establishment of the BCBS plans' community benefit obligation was given in exchange for the state Insurance Commissioner deciding that the BCBS plans did not have excessive surpluses.<sup>43</sup> Researchers from the Robert Wood Johnson State Coverage Initiative believe this agreement will set the stage for voluntary funding of state-funded health programs without not-for-profit insurers converting to for-profit status.

Michigan has relied primarily upon BCBSM to insure individuals who cannot ordinarily afford to purchase health insurance from a for-profit provider. Yet, Michigan has more generous eligibility requirements for Medicaid than some of the comparison states, particularly Virginia, and also has the Adult Benefit Waiver to cover the uninsured. The Adult Benefit Waiver uses State Children's Health Insurance Program (SCHIP) funds to provide health insurance coverage to childless adults with incomes at or below 35 percent of the federal poverty level. The benefit plans provided through the waiver are less broad than Medicaid or SCHIP coverage. However, the waiver also provides a voucher for qualifying adults to purchase private health insurance through their employers.<sup>44</sup> Also, Michigan has pioneered the Three-Share program, which shares the cost of health insurance premiums between employers, the employee, and the community. This program is designed to provide low-cost health insurance to small employers.<sup>45</sup>

There is a stark difference between the plans developed by Virginia, District of Columbia, Pennsylvania, and Michigan and the populations that they are designed to insure. Each of the first three plans is designed to offset the costs of insuring the uninsured or to actually insure the uninsured. However, Michigan's Three-Share program is designed to lower the cost of insurance to those individuals who receive insurance through an employer, and the Adult Benefit Waiver only provide minimal benefits to those living in extreme poverty. These plans

do not fully address the problem of uninsurance and mostly assume BCBSM to be an adequate safety net for individuals who are not otherwise insured. The lack of a comprehensive state plan to insure the uninsured may be the result of Michigan's relatively small uninsured population. As the uninsured population grows, Michigan may need to develop new programs and policies to better address this population's needs.

## Community Rating

Instead of creating state-funded programs to provide access to insurance to all state residents and to reduce the costs of health care, states can manipulate the type of community rating permitted. States can mandate individual health insurance be provided via a pure community rating or a modified community rating. Pure community rating means that there is a single premium for a community based on the average characteristics and claims experience of the entire community. However, age, gender, lifestyle, employment type, and health facts are not used to determine the rate. A modified community rating system determines rates for communities by dividing the community into groups based on characteristics such as age or gender. There are advantages and disadvantages to both policy options.

### *Pure Community Rating.*

Some economists assert that pure community rating will introduce an "adverse selection death spiral," thereby reducing insurance coverage. This view assumes that by charging all individuals the same premium price, despite the varying costs to the provider of insuring them, the premiums of relatively young and healthy individuals will rise in order to subsidize those of relatively older and sicker individuals. In response, the younger and healthier individuals will opt out of coverage. If enough individuals drop out of the market for insurance, prices can be expected to further rise for those who continue to purchase insurance.<sup>46</sup>

In April of 1993, comprehensive individual health insurance reforms were enacted in the state of New York requiring all individual insurance carriers (both for-profit and not-for-profit insurers) to offer their products on a guaranteed-issue basis and



to use pure community rating. Because BCBS was shouldering a great deal of the individual insurance burden in New York State at the time, a 1996 law was passed requiring all HMOs to offer individual insurance according to the 1993 law, even if they had not done so in the past.<sup>47</sup> To evaluate the potential negative effect of pure community rating, two economists compared New York, Pennsylvania, and Connecticut health insurance data. They found that the number of insured in New York, where pure community rating was imposed, did not fall in comparison to Pennsylvania or Connecticut, where pure community rating was not imposed, calling into question the validity of the “death spiral” argument.<sup>48</sup>

### *Modified Community Rating.*

In contrast to pure community rating, modified community rating allows insurers to determine rates based on both the average community rate and on the age and/or gender of the individual. In 1993, the state of New Jersey implemented the Individual Health Coverage Program (IHCP), which introduced a number of innovative reforms to encourage insurance carriers to participate in the individual insurance market and share in the cost of market losses through a “pay or play” system. If an insurer chose not to participate in the individual market, they had to contribute financially to the losses incurred by participating insurers. One component of the IHCP is the introduction of pure community rating.<sup>49</sup>

After the implementation of the IHCP, New Jersey saw drastic decline in enrollment in individual health insurance, a price increase, and enrollment shifts. One response to these changes was the 2005 Rutgers Center for State Health Policy’s examination of possible modifications to New Jersey’s community ratings. Three modifications to the pure community determined rate were simulated, two of which adjust rate groups based on age and gender, and a third that adjusts rate groups on age alone. Each of the simulations illustrated that community ratings modified for the age and/or gender of the individual seeking coverage would lead to significant premium price changes for some groups, increased enrollment, and a shift in the composition

of enrollment.<sup>50</sup> The researchers found that modified community ratings can generally be expected to increase the cost of premiums somewhat for older enrollees (by 13 percent to 15 percent) in comparison to a pure community rating.<sup>51</sup> Yet, insurance premiums for young adults could decrease dramatically (by 66 percent to 77 percent). These premium price adjustments could be expected to more than double enrollment. The proportion of enrollees between the ages of 21 and 40 years old would increase from 16 percent (under pure community rating) to as much as 66 percent (under modified community rating). An increased number of relatively moderate income individuals could be expected to enroll under modified community rating, illustrated by the fact that the median annual enrollee income would be expected to drop from approximately \$57,000 to \$40,000.<sup>52</sup>

These simulations illustrate that state regulatory changes can significantly influence premium prices and significantly shift the age, income, and health characteristics of those individuals that are likely to be uninsured. While significant numbers of relatively young and healthy individuals would be able to afford health insurance, some individuals who are relatively older and sicker may be unable to do so.

Such a shift has been seen in Michigan since 2004, when Michigan changed its regulation of BCBSM from pure community rating to allow age rating of certain insurance products. The change allowed BCBSM to age rate insurance products, which has shifted more than half of BCBSM’s business from pure community rated products to age rated products, typically sold to individuals under the age of 30 years old. This shift may have, in part, been a response to the growing numbers of young uninsured individuals. However, it is also important for states to recognize the potential large costs associated with uncompensated care resulting from uninsured older and sicker individuals.

## **CONCLUSION**

Four bills recently under consideration in the Michigan legislature would change the regulations for the individual insurance market. The bills would give BCBSM greater flexibility to set premiums,





extend the exclusion period for pre-existing conditions, and allow BCBSM to enter into additional insurance markets, among other changes. BCBSM claims that the proposed legislation is critical to its financial stability—that it is currently unable to compete with for-profit insurance companies—and that failure to pass the legislation will force it to lay off employees and raise rates. Opponents of the bills fear that they will alter BCBSM’s mission as insurer of last resort, making it harder for high-risk individuals to obtain health insurance, while allowing BCBSM to retain its tax exemptions.

Michigan may be able to learn important lessons about how to alter the regulations imposed on BCBSM from other states that have established benefit obligations for BCBS subsidiaries and implemented modified and pure community rating regulations on BCBS. While these policy options are not currently part of Michigan’s proposed legislation, they might assist in limiting negative consequences, which may possibly result from the passing of such legislation. All such states have developed plans to meet the need of individuals who can no longer afford individual health insurance, many of whom are likely relatively higher risk individuals. Without such a plan in place, Michigan runs the risk of amassing an increasing amount of uncompensated care. This uncompensated care will result from high-risk individuals joining the ranks of the uninsured. It is important that Michigan policy makers carefully consider the method by which they address Michigan’s problems of rising health insurance costs and rising numbers of uninsured, whether it be by regulation, deregulation, or some combination thereof.

## Notes

1. Anstett, P. (2009, March 3). Blue Cross Loses \$144.9 Million in 2008. *Detroit Free Press*; Blue Cross Blue Shield of Michigan. (2009, March 2). *Blue Cross Blue Shield of Michigan Reports Negative Earnings for 2008 Driven Mostly By Significant Losses on Individual Policies*. Retrieved March 28, 2009 from [http://www.bcbsm.com/pr/pr\\_03-02-2009\\_64617.html](http://www.bcbsm.com/pr/pr_03-02-2009_64617.html); Gongwer News Service. (2008, December 18). *Blues Bill Falls By the Wayside as Senate G.O.P. Holds Off*.  
2. Gongwer News Service. (2009, January 16). *Blues Blame Layoffs on “Broken” Insurance System; Critics Say It Is Part of Reality*.

3. Gongwer News Service, 2008.

4. Put Michigan People First. (n.d.) Retrieved February 9, 2009 from <http://putmichiganpeoplefirst.com/index.html>; Health Care for Health Care Workers. (2008, May 29). *HCHCW Joins Individual Market Reform Debate in Michigan*. Retrieved February 9, 2009 from <http://hchcw.org/archives/hchcw-joins-individual-market-reform-debate-in-michigan>.

5. The Kaiser Family Foundation. (n.d.) *Michigan: Health Insurance Coverage of the Total Population, states (2006-2007), US (2007)*. Retrieved February 9, 2009, from <http://statehealthfacts.org/profileind.jsp?ind=125&cat=3&rgn=24>.

6. Blue Cross Blue Shield Association. (n.d.). *Health-care Coverage Glossary*. Retrieved April 19, 2009 from <http://www.bcbs.com/coverage/glossary/index.html>.

7. The Kaiser Family Foundation and Health Research and Educational Trust (HRET). (2008). *Employer Health Benefits 2008 Annual Survey*. Menlo Park, CA: Author.

8. Anderson Economic Group. (2007). *Role of Blue Cross in Michigan’s Health Insurance Market*. East Lansing, MI: Author, Table 10.

9. In certain cases where an individual moves from group coverage to individual coverage, BCBSM is required to waive the pre-existing condition exclusion.

10. The information in this section is from House Fiscal Agency. (2008). *A Preliminary Summary of House Bills 5282 & 5283 as Passed by the House*. Lansing, MI: Author and Senate Fiscal Agency. (2008). *Individual Insurance/BCBSM Summary as Passed by the Senate*. Lansing, MI: Author unless otherwise noted.

11. These bills were tie-barred to each other, meaning that they both must be enacted for either of them to take effect.

12. Anderson Economic Group, 2007.

13. Group conversion is the process through which individuals no longer part of a group can obtain individual coverage.

14. The information in this section is from House Fiscal Agency. (2007). *A Summary of House Bills 5284 and 5285 as Introduced 10-11-07*. Lansing, MI: Author and Senate Fiscal Agency. (2008). *BCBSM Subsidiary Committee Summary*. Lansing, MI: Author.

15. Senate Fiscal Agency, 2008.

16. House Fiscal Agency, 2007; Senate Fiscal Agency, 2007.





17. Gongwer News Service, 2008.
18. Gongwer News Service, 2009.
19. Anstett, 2009; Blue Cross Blue Shield of Michigan, 2009.
20. Gongwer News Service, 2008.
21. The coalition includes: Area Agencies on Aging Association in Michigan (AAAAM), Michigan Association of Health Plans (MAHP), Michigan Disability Rights Coalition, The Arc Michigan, Capital Area Center for Independent Living, Elder Law and Disability Rights Section of the State Bar of Michigan, Coalition for a Fair & Competitive Insurance Market, and the American Association of Retired Persons.
22. Put Michigan People First, n.d.; Health Care for Health Care Workers, 2008.
23. Anderson Economic Group, 2007. The *Coalition for Access and Affordability in Michigan* is a group of private insurers that formed in response to the BCBS legislation.
24. Gongwer News Service, 2009.
25. Anderson Economic Group, 2007.
26. Wolfram, G. (2008). The Unintended Effects of HB 5284 and HB 5285: Market Power and Politicization of the Michigan Economy. Hillsdale Policy Group.
27. State Coverage Initiatives, Academy Health. (2004). *State of the States: Cultivating Hope in Rough Terrain*. Washington, D.C.: Author.
28. The Blue Cross and Blue Shield System includes 39 independent, community-based, and locally operated Blue Cross and Blue Shield companies. One in three Americans is insured by a BCBS company.
29. Chollet, D., Smieliauskas, F., & Konig, M. (2003). *Mapping State Health Insurance Markets, 2001: Structure and Change*. Washington, D.C.: State Coverage Initiatives, Academy Health.
30. Chollet, Smieliauskas, & Konig, 2003.
31. State Coverage Initiatives, 2004.
32. Chollet, Smieliauskas, & Konig, 2003.
33. Anderson Economic Group, 2007.
34. Anderson Economic Group, 2007.
35. Anderson Economic Group, 2007.
36. Anderson Economic Group, 2007.
37. Because the health insurance market differs significantly between states, we caution that these four states are not directly comparable to Michigan, but instead they offer insight into other means to address some of the struggles Michigan encounters when developing policy to provide health insurance to its residents.
38. The 6-month “look-back” and exclusionary periods are also imposed on HMOs in Michigan.
39. Robert Wood Johnson Foundation (n.d.) State Specific Strategies. Retrieved March 19th, 2009 from State Coverage Initiatives: [www.statecoverage.org/node/50/cs\\_states](http://www.statecoverage.org/node/50/cs_states).
40. Robert Wood Johnson Foundation (n.d.)
41. Pryor, C., & Durham, C. (2006). *The Pennsylvania Community Health Reinvestment Agreement: Establishing Non-Profit Insurers Community Benefit Obligations*. Washington, D.C.: State Coverage Initiatives, Academy Health.
42. Robert Wood Johnson Foundation, n.d.
43. Pryor & Durham, 2006.
44. Robert Wood Johnson Foundation (n.d.) State Specific Strategies. Retrieved March 19th, 2009 from State Coverage Initiatives: [www.statecoverage.org/node/50/cs\\_states](http://www.statecoverage.org/node/50/cs_states).
45. Robert Wood Johnson Foundation (n.d.)
46. Buchmueller, T.C. & DiNardo, J.E. (1999). *Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut*. Cambridge, MA: National Bureau of Economic Research.
47. Hall, M.A. (2000). An Evaluation of New York’s Reform Law. *Journal of Health Politics, Policy, and Law*, 25(1), 71–99.
48. Buchmueller & DiNardo, 1999.
49. The IHCP also included guarantee issue and renewal of health insurance plan coverage and standardization of individual health plans. Guarantee issue allows individuals to be insured up to an agreed upon benefit level without providing evidence of their insurability. Guaranteed renewal gives insured the right to continue in-force policies as long as they continue to pay premiums in a timely fashion. Changes in Health Care, Financing and Organizing. (2008) *Policy Brief, The Individual Insurance Market: A Building Block for Health Care Reform?* Washington, D.C.: Author.
50. Monheit, A.C., Cantor, J.C. & Banerjee, P. (2005). *Assessing Policy Options for the Non-Group Health Insurance Market: Simulation of the Impact of Modified Community Rating in the New Jersey Individual Health Coverage Program*. New Brunswick, NJ: Rutgers Center for State Health Policy.
51. Monheit, Cantor, & Banerjee, 2005.
52. Monheit, Cantor, & Banerjee, 2005.

## *Acknowledgments*

---

CLOSUP appreciates the work of the project manager, Tamara Wilder, throughout all phases of this project. CLOSUP gives special thanks to Emily Roessel and Nicole Wagner for assistance in researching and writing early drafts of the brief. Brian Jacob and Tom Ivacko provided invaluable support during the revision of this brief. CLOSUP is grateful to the following reviewers for their time and expert advice: Thomas Buchmueller (Ross School of Business, University of Michigan), Matthew Davis (Medical School, University of Michigan), Richard Hirth (School of Public Health, University of Michigan), Helen Levy (Institute for Social Research, University of Michigan), Edward Norton (School of Public Health, University of Michigan), Christine Shearer (Michigan Association of Health Plans), and Dean Smith (School of Public Health, University of Michigan).

---

### **Regents of the University of Michigan**

Julia Donovan Darlow, Ann Arbor  
Laurence B. Deitch, Bingham Farms  
Denise Ilitch, Bingham Farms  
Olivia P. Maynard, Goodrich  
Andrea Fischer Newman, Ann Arbor  
Andrew C. Richner, Grosse Pointe Park  
S. Martin Taylor, Grosse Pointe Farms  
Katherine E. White, Ann Arbor  
Mary Sue Coleman (ex officio)

---

## MICHIGAN RESEARCH BRIEF SERIES

Business Taxes

Economic Revitalization through College Scholarships:  
The Kalamazoo Promise

Regulation of the Individual Health Insurance Market

The Prison Population and Corrections Expenditures

Smoke-Free Legislation

Transportation Funding: Highways, Roads, Bridges,  
and Public Transit



Gerald R. Ford School of Public Policy  
Joan and Sanford Weill Hall  
735 South State Street  
Ann Arbor, MI 48109-3091

[www.closup.umich.edu](http://www.closup.umich.edu)

734-647-4091

[closup@umich.edu](mailto:closup@umich.edu)