DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

December 16, 2011

The Honorable R. Kevin Clinton
Commissioner
Office of Financial and Insurance Regulation
State of Michigan
611 West Ottawa, 3rd Floor
Lansing, MI 48933

Re: State of Michigan's Request for Adjustment to Medical Loss Ratio Standard

Dear Commissioner Clinton:

This letter responds to the request of the Michigan Office of Financial and Insurance Regulation ("OFIR"), pursuant to section 2718 of the Public Health Service ("PHS") Act, 42 U.S.C. §300gg-18, for an adjustment to the 80 percent medical loss ratio ("MLR") standard applicable to the individual health insurance market in Michigan. OFIR has requested an adjustment of the MLR standard to 65 percent, 70 percent, and 75 percent for the reporting years 2011, 2012, and 2013, respectively.

Section 2718 was added to the PHS Act by Section 1001 of the Affordable Care Act and requires issuers in the individual market to spend at least 80 percent of premium dollars on reimbursement for clinical services and for activities that improve health care quality for enrollees. Beginning in 2011, if an issuer does not satisfy the MLR standard, it is required to provide rebates to enrollees.

Section 2718 permits an adjustment to the 80 percent MLR standard for a State's individual health insurance market if it is determined that applying this standard "may destabilize the individual market in such State." The regulation implementing section 2718, 45 CFR Part 158, provides that an adjustment should be granted "only if there is a reasonable likelihood" that application of the 80 percent MLR standard will destabilize the particular State's individual health insurance market. (45 CFR 158.301.) The regulation also provides the criteria the Secretary may consider "in assessing whether application of an 80 percent MLR . . . may destabilize the individual market in a State that has requested an adjustment." (45 CFR 158.330.) These criteria are discussed in Part III of this letter.

The Center for Consumer Information and Insurance Oversight ("CCIIO") within the Centers for Medicare and Medicaid Services ("CMS") has reviewed OFIR's application, as well as the supplemental information provided to us in response to questions raised by the application

and the public comments filed with regard to the application.[1] After a careful examination of these materials and consideration of the criteria set forth in the statute and implementing regulation, we have determined that the evidence presented does not establish a reasonable likelihood that the application of the 80 percent MLR standard will destabilize the Michigan individual market. Consequently, we have determined not to adjust the MLR standard in the Michigan individual market and, thereby, ensure that consumers receive the full benefit of this provision of the Affordable Care Act. This letter explains the basis of our decision.

I. Summary of the Michigan Application

CCIIO received OFIR's request for an adjustment to the MLR standard on July 28, 2011. Among the information OFIR included in support of its request were 2010 enrollment numbers, premium amounts, and market share for issuers in Michigan's individual market, as well as estimated MLRs and rebates for the largest issuers offering coverage in the Michigan individual market for each of the reporting years 2011, 2012, and 2013, under the 80 percent MLR standard and under OFIR's proposed adjustment.

On August 29, 2011, CCIIO requested from OFIR information needed in order for Michigan's application to be deemed complete and clarification regarding matters raised by OFIR's application. This letter requested that OFIR correct its MLR and rebate calculations, and that OFIR comment on matters including: comparability of products in the individual market, assumptions used in OFIR's calculations, and whether issuers have indicated that they plan to price their products to an 80 percent MLR. After OFIR responded to this request on October 4, 2011, OFIR's application was deemed complete on October 17, 2011, and the processing period provided for in 45 CFR 158.345 began.

In addition, CCIIO that same day posted notice on its website that any public comments regarding Michigan's application were due by October 27, 2011, as provided in 45 CFR 158.342. CCIIO received 13 public comments from stakeholder organizations, 100 public comments from consumers, as well as a petition signed by nearly 6,000 Michigan consumers, which we also address in this letter.

On November 16, 2011, CCIIO informed OFIR that it would extend the review period for up to an additional 30 days, as provided in 45 CFR 158.345(b).

II. Overview of the Michigan Individual Health Insurance Market

According to OFIR's application, over 340,000 residents obtain health insurance coverage from approximately 70 issuers on an individual basis in the Michigan individual health insurance market. Seventeen issuers have at least 1,000 life-years[2] each, and account for 97

[1] All of the documents and information described in this letter are posted on CCIIO's website at http://cciio.cms.gov/programs/marketreforms/mlr/mlr_michigan.html unless otherwise footnoted.

[2] Issuers with fewer than 1,000 life-years are not subject to rebate payments for the first reporting year. (45 CFR 158.230(d).) Life-years are the total number of months of coverage for enrollees during the year, divided by 12. (45 CFR 158.230(b).)

percent of the individual market. According to OFIR's application, the number of enrollees and market shares of these issuers as of December 31, 2010 are:

Table 1: Summary of MI's 2010 Individual Market[3]

	Issuer	Enrollees	Market Share
1.	BCBS	189,503	55.1%
2.	Golden Rule	40,104	11.7%
3.	Time	21,919	6.4%
4.	BCS	19,081	5.6%
5.	Aetna	15,409	4.5%
6.	Humana	12,631	3.7%
7.	World	6,356	1.8%
8.	Alliance	3,809	1.1%
9.	Celtic	3,794	1.1%
10.	Blue Care Network of MI	3,297	1.0%
11.	Health Alliance Plan	3,114	0.9%
12.	Priority Health	3,083	0.9%
13.	John Alden	2,995	0.9%
14.	MEGA	2,742	0.8%
15.	American Community	2,615	0.8%
16.	American Medical Security	2,457	0.7%
17.	Blue Care of MI	1,024	0.3%
	Rest of Market	9,852	2.9%
	TOTAL	343,785	100.0%

The data presented in Table 1 confirm the statement OFIR made in its transmittal letter that the Michigan individual health insurance market "is dominated by one issuer, Blue Cross Blue Shield of Michigan," and that the seven largest issuers (Blue Cross Blue Shield of Michigan, Golden Rule, Time, BCS, Aetna, Humana, and World) "account for nearly 90% of the state's individual market." OFIR explains that, as a result, in Michigan "[l]ike [in] many other states, most enrollees are covered by a limited number of issuers with the remaining issuers covering niche or regional markets."

According to OFIR's application, "[t]he current minimum MLR requirements in Michigan for individual policies are 65% for rated by age and optionally/collectively renewable policies, and 55% for all other policy types." While these minimum MLR requirements are not applicable to non-profit health care corporations like BCBS or to HMOs, OFIR's October 4 letter explains that "[t]he state MLR standards for HMOs and non-profit health care corporations in Michigan are equivalent to those in the commercial market." Unlike the Affordable Care Act's MLR standard that applies to each reporting year and is calculated based on data from up to three reporting years, Michigan's minimum loss ratio is an anticipated lifetime loss ratio standard.

[3] These numbers are based on Exhibit 1 to OFIR's initial application and data from the 2010 Supplemental Health Care Exhibits ("SHCE"s) that issuers file with the National Association of Insurance Commissioners ("NAIC") provided with OFIR's October 4 letter.

Furthermore, in contrast to the Affordable Care Act's MLR standard, Michigan's minimum MLR standard does not include adjustments for quality improving activities, taxes, or credibility.

Although Michigan does not have a guaranteed issue requirement or limits on health status rating, it does have, according to the application, "several options available to consumers in the event an insurer withdraws from the market." First, by statute BCBS "must provide health insurance coverage to any applicant who is a Michigan resident." Second, every HMOs after 24 months of operation "must have a 30 day enrollment period every 12 months during which time it offers individual policies on a guaranteed issue basis up to its capacity (as approved by the Commissioner)." Both BCBS and HMOs are allowed to impose six month pre-existing condition exclusions.

According to OFIR's application, "Michigan has no specific withdrawal requirements if an issuer chooses to leave the state." However, 45 CFR 148.122(f), a federal regulation promulgated to effectuate the Health Insurance Portability and Accountability Act of 1996, would require an issuer that leaves the Michigan individual market to provide a 180-day notice to OFIR and the issuer's policyholders prior to discontinuation of coverage, and would preclude such issuer from re-entering that market for five years.

III. Application of Regulatory Criteria to the Michigan Individual Market

Title 45 CFR 158.330 lists six criteria that the Secretary may consider "in assessing whether application of an 80 percent MLR … may destabilize the individual market in a State." They are:

a) The number of issuers reasonably likely to exit the State or to cease offering coverage in the State absent an adjustment to the 80 percent MLR and the resulting impact on competition in the State;

b) The number of individual market enrollees covered by issuers that are reasonably likely to exit the State absent an adjustment to the 80 percent MLR;

c) Whether absent an adjustment to the 80 percent MLR standard consumers may be unable to access agents and brokers;

d) The alternate coverage options within the State available to individual market enrollees in the event an issuer exits the market;

e) The impact on premiums charged, and on benefits and cost-sharing provided, to consumers by issuers remaining in the market in the event one or more issuers were to withdraw from the market; and

f) Any other relevant information submitted by the State's insurance commissioner, superintendent, or comparable official in the State's request.

The preamble to the regulation provides that 45 CFR 158.330 "does not set forth a single test" for determining whether application of an 80 percent MLR standard may destabilize the individual market in a State, but rather lists the "main criteria" to be considered in assessing such risk. (75 Fed. Reg. 74887 (Dec. 1, 2010).)

A. *Number of issuers reasonably likely to exit the State*

OFIR's application states that "no companies have expressed intent to exit the state or cease offering coverage in the individual health insurance market absent an adjustment to the 80% MLR." Nonetheless, OFIR expresses concern regarding "the impact that the potential rebates payable in the next several years will have on the Michigan market" given "the magnitude and number of potential rebates, relative to individual and company market profitability."

In its application, OFIR first observes in that regard that "[w]hile not specific to the MLR regulations, the state has lost two issuers from the individual health market in [the] last couple years." OFIR explains that American Community was placed into rehabilitation and subsequently withdrew from the individual and small group markets, and MEGA discontinued marketing in Michigan. Additionally, in its October 4 letter, OFIR notes that Unicare Life & Health has exited the individual market. OFIR next observes that "[t]wo other issuers have recently made decisions to exit or significantly scale back their presence in the small group market" (emphasis supplied). While conceding that "the decisions made by these two issuers may alone not destabilize the individual markets," OFIR states that the decisions of Aetna and Humana to withdraw from the small group market "signal potential concerns on their behalf with the health insurance market in Michigan."

We note that, as OFIR concedes, American Community's withdrawal was in consequence of an order of rehabilitation resulting from American Community's loss experience in its business, and was not related to the MLR provisions. Furthermore, pursuant to OFIR's Transition Plan Agreement, American Community's policyholders will receive an offer for replacement coverage from Golden Rule without underwriting and with no exclusions for pre-existing conditions.[4] Similarly, according to footnote 6 of revised Exhibit 2 to OFIR's application, all of Unicare's policies were transitioned to other issuers during 2010, subsequent to its withdrawal in 2009, which occurred prior to the passage of the Affordable Care Act. Likewise, according to footnote 3 of Exhibit 2 to OFIR's application, MEGA stopped issuing new health policies in Michigan beginning in 2008, two years before the passage of the Affordable Care Act. We further note that Aetna and Humana limited their withdrawals or scale-backs to the Michigan small-group market, not Michigan's individual market. The record with regard to Kentucky's and Indiana's requests for adjustment to the MLR standard demonstrates that Aetna has, in 2011, made business decisions to withdraw either from a State's individual, but not small group, market (in Indiana), or from both markets (in Kentucky).[5] However, Aetna has chosen not do so with regard to the Michigan individual market, suggesting that its concerns, if any, with the health insurance market in Michigan were limited to the small group market.

Indeed, the circumstances surrounding these issuers' actions suggest, if anything, that application of section 2718's 80 percent MLR standard will not destabilize the individual market

[4] OFIR's Petition for Approval of Golden Rule Transition Plan Agreement and the Ingham County Circuit Court's Order Approving Golden Rule Transition Plan Agreement are available at http://www.michigan.gov/documents/dleg/Golden_Rule_Transition__323755_7.pdf and http://www.michigan.gov/documents/dleg/Order_Approving_Golden_Rule_Transition_Plan_Agreement_6.9.10_324185_7.pdf.

[5] http://cciio.cms.gov/programs/marketreforms/mlr/states/Kentucky/ky_app_supplement_07082011.pdf; http://cciio.cms.gov/resources/files/Files%202/09262011/in_follow_up_response_07262011.pdf.pdf .

in Michigan. American Community, Unicare, and MEGA began their withdrawals in 2010, 2009, and 2008, respectively, with the Michigan individual market appearing to have incurred no catastrophic consequences. Furthermore, as one public commenter points out, it is not uncommon for there to be some volatility in a State's individual health insurance market even in the best of economic times. Issuers on a daily basis can, and do, leave particular lines of business or markets for a variety of reasons, including mismanagement and change in business focus or strategy.

On November 18, 2011, OFIR informed CCIIO that American Republic and World have notified OFIR of their intention to exit the Michigan individual market. Both issuers are part of the American Enterprise Group. However, we note that American Enterprise Group has announced the withdrawal of American Republic and World in all States, even though in most States neither company would be subject to rebates. According to Exhibit 1 to OFIR's application, in 2010 American Republic and World insured a combined total of 7,509 enrollees, or 2.2 percent of the Michigan individual market. As of October 2011, this number had declined to 3,238 enrollees. According to World's 2010 SHCE and information provided by OFIR, World had a credibility-adjusted 2010 MLR of 55.5 percent and estimated rebates of $2.9 million. American Republic had fewer than 1,000 life-years in the Michigan individual market, and consequently would not be subject to rebates. The fact that American Enterprise Group's decision to withdraw from the Michigan individual market was made without taking into account any adjustment to the MLR standard we might make, coupled with the fact that it is withdrawing from markets where it meets the MLR standard and would not be affected by the MLR provisions, suggests that its decision was not related to the risk of paying rebates in Michigan and elsewhere.

In sum, we do not believe that the actions taken by these seven issuers support OFIR's concern that immediate implementation of the 80 percent MLR standard could lead to market destabilization.

Under 45 CFR 158.321(d)(2)(iii), applicants requesting an adjustment to the MLR standard are asked to calculate the estimated MLR for issuers in the State using the methodology provided for in the Affordable Care Act and implementing regulation. OFIR's application calculates the estimated MLRs using data from calendar year 2010. The 2010 estimated MLRs are an imperfect proxy for the actual results issuers may generate if held to the 80 percent standard in 2011-2013. One reason for this is that the Affordable Care Act was enacted at the close of the first quarter of 2010, presumably after pricing and other business decisions affecting MLRs had largely been made and implemented. Another reason historical data may constitute an imperfect proxy is that there can be year-to-year variability in issuers' claims experience, financial performance, and reported MLRs. Notwithstanding these limitations, the historical data remain the best available basis upon which to estimate the impact of the 80 percent standard in 2011.

Seventeen issuers in the Michigan individual market are expected to have at least 1,000 life-years each in 2011 and thus to be at least partially credible (as defined in 45 CFR 158.230(c)).[6] Therefore, these issuers could be expected to be subject to rebate payments

[6] Experience of issuers with fewer than 1,000 life-years is considered to be non-credible and such issuers are not subject to rebate payments for the first reporting year. 45 CFR 158.230(d).

beginning in 2011 if their MLRs fall below the statutorily mandated 80 percent standard. The chart below shows, for each of these issuers, the estimated 2010 MLR, estimated rebate based on 2010 MLR, estimated 2010 pre-tax net gain in the individual market before payment of rebates, and estimated 2010 pre-tax net gain in the individual market if the issuer would have had to pay rebates in 2010.[7]

Table 2: Estimated 2010 MLRs, Rebates and Pre-Tax Net Gain ($ in millions)[8]

Issuer	Life Years	MLR After Credibility Adjustment[9]	Estimated Rebates	Pre-Tax Net Gain Before Rebates	Pre-Tax Net Gain After Rebates
BCBS	192,599	93.0%	$0.0	($54.6)	($54.6)
Golden Rule	33,372	61.0%	$10.0	$15.4	$5.5
Time	23,305	66.4%	$5.3	$2.8	($2.5)
BCS	19,081	86.1%	$0.0	$2.7	$2.7
Aetna	12,821	72.6%	$1.7	$5.8	$4.1
Humana	11,160	72.9%	$1.3	$0.3	($0.9)
World	6,451	55.5%	$2.9	$0.6	($2.3)
Alliance	2,577	72.0%	$0.3	$0.3	($0.0)
Celtic	3,058	80.2%	$0.0	($0.5)	($0.5)
Blue Care Network of MI	3,223	104.4%	$0.0	($1.1)	($1.1)
Health Alliance Plan	2,619	98.1%	$0.0	$0.0	$0.0
Priority Health	1,345	72.7%	$0.2	($0.9)	($1.1)
John Alden	3,115	67.5%	$0.7	$1.0	$0.4
MEGA	3,412	44.5%	$2.6	$4.1	$1.5
American Community[10]	2,615	61.6%	$4.7	$3.1	($1.5)
American Medical Security	2,874	79.9%	$0.0	$1.2	$1.2
Blue Care of MI	1,113	104.5%	$0.0	($0.3)	($0.3)

[7] "Pre-tax net gain" is the underwriting gain or loss as reported on the SHCE plus any Federal, State, or other taxes and fees paid. The net underwriting gain or loss reported on the SHCE is calculated by subtracting the following from net adjusted premiums earned after reinsurance: net incurred claims after reinsurance; expenses incurred for quality improving activities; claims adjustment expenses; and general and administrative expenses. Unlike the underwriting gain or loss reported on the SHCE, the pre-tax net gain is not reduced by taxes, and is thus consistent with the way underwriting gain is reported on the annual financial statements that issuers file with the NAIC.

OFIR's analysis relies on estimated after-tax net gain. However, for consistency purposes, and in order to avoid making assumptions regarding the impact of rebate payments on an issuer's tax liability, as well as assumptions regarding the allocation of Federal income taxes and investment income (which are reported by issuers at the national aggregate level across all lines of business, and not at the State and market level), we continue to use pre-tax net gain in our analysis, as we have done in our prior determinations. We note that, with regard to OFIR's application, the differences between the two approaches are not material to our determination, as both approaches result in a substantially similar impact of rebates on profitability.

[8] These numbers are from the revised Exhibit 2 to OFIR's October 4 letter and data from 2010 SHCEs provided with OFIR's October 4 letter.

[9] The credibility adjustments used to prepare the MLR estimates shown in Table 2 do not include deductible factors provided under 45 CFR 158.232(c); therefore, the credibility adjustments available to issuers are likely understated.

[10] Footnote 5 to the revised Exhibit 2 included with OFIR's October 4 letter notes that, because American Community did not report life-years on its SHCE, OFIR used the number of covered lives as a proxy. However, in place of the number of lives for American Community, OFIR input the number of lives for Unicare. Table 2 corrects for this error.

According to the 2010 MLR data shown above, it appears that six issuers in the Michigan individual market – BCBS, BCS, Celtic, Blue Care Network of MI, Health Alliance Plan, and Blue Care of MI – meet the 80 percent MLR standard. Additionally, at a credibility-adjusted MLR of 79.9%, American Medical Security is very close to meeting the 80 percent standard.

Nonetheless, there remain eight issuers with MLRs expected to be below the 80 percent standard in 2011: Golden Rule; Time; Aetna; Humana; Alliance; Priority Health; John Alden; and MEGA.[11] These issuers must adjust some combination of their operations and financial targets in order to satisfy an 80 percent MLR standard, assuming 2011 experience mirrors the 2010 experience. In its basic form under the Affordable Care Act and implementing regulation, the MLR is the ratio of monies spent on incurred claims and quality improving activities to premium revenue (adjusted for certain State and Federal taxes and fees). See 45 CFR 158.221. Therefore, all other things being equal, these eight issuers would either need to lower premiums or increase expenditures on claims or quality improving activities, or otherwise risk paying rebates to enrollees. Assuming that these issuers did not reduce their administrative costs, either of these actions could lead to a reduction in profitability, which may be a consideration for each company in assessing whether to remain in the Michigan individual market. In that regard, OFIR expresses concern that "[m]any … companies will be challenged to lower premiums or increase claims and claims related payments without sacrificing profitability below an acceptable level."

Of the eight issuers with MLRs considerably below 80 percent, four – Golden Rule, Aetna, John Alden, and MEGA – would retain a fair portion of their pre-tax net gains even after payment of rebates under an 80 percent MLR standard, and thus are also not reasonably likely to exit the State. Three issuers – Time, Humana, and Alliance – would appear to show a pre-tax loss after payment of rebates based on 2010 data. Priority Health, which was already unprofitable before payment of rebates, would be somewhat more unprofitable on a pre-tax basis. However, this analysis presumes certain facts, most notably the continuation of 2010 financial performance and no changes to 2010 business models that have likely changed in 2011.

Although OFIR states that all issuers with low MLRs, except Aetna and Humana, "have multi-year agency agreements and other business processes that make it difficult to price at the higher standard without incurring significant losses," OFIR's concern does not appear to reasonably extend to Time. In its 2011 third quarter report ("Form 10-Q") Assurant (Time's parent company) states that "Assurant Health Third Quarter 2011 results reflect progress as [Assurant and its subsidiaries] continue to adapt to the Affordable Care Act," and that "[s]elling, underwriting and general expenses decreased $79,084,000, or 18%" in the first nine months of 2011 versus the comparable period in 2010.[12] Time's parent company's statements suggest that Time has been able to successfully streamline its expense structure during 2011. If Time achieves an 18 percent reduction to selling and administrative expenses in the Michigan individual market by the end of 2011, as it appears to already have done at the national level, this would increase Time's pre-tax net gains such that it would be able to break even after payment of rebates under an 80 percent MLR standard in Michigan.

[11] As noted previously, American Community and World have already, or are in the process of, withdrawing from the Michigan individual market.

[12] Assurant, Inc., Quarterly Report (Form 10-Q), at 42 and 52 (Nov. 2, 2011).

Additionally, in its annual report to the shareholders, Humana states that "while [Humana] anticipates a challenging near-term profitability environment in the individual market, reform-related provisions are expected to increase the prospect pool by between 23 million and 40 million people in the next six years," and that Humana "expect[s] to be well-positioned to take advantage of this opportunity."[13] Humana's statements suggest that, notwithstanding the near-term impact of the Affordable Care Act's provisions on its profitability, Humana intends to stay in the individual market in order to benefit from the influx of new policyholders into the market in 2014.

With regard to Alliance, we note that based on its 2010 SHCE data, payment of rebates under an 80 percent MLR standard would lead Alliance to sustain a loss of only $22,723, or 0.5 percent of premium. An increase of only one percentage point to its MLR would permit Alliance to break even in the Michigan individual market in 2011 on a pre-tax basis. With regard to Priority Health, we note that, according to its 2010 SHCE, it experienced a pre-tax underwriting loss even before payment of rebates, in part due to non-claims expenses constituting 62 percent of premium. Given the unusually high level of non-claims expenses, Priority Health would sustain losses even under OFIR's proposed adjustment of the MLR standard.

We further note that, while OFIR expresses concern that many of the issuers it surveyed "have traditionally priced to a lifetime loss ratio at or above the stipulated minimums (55-60%)," OFIR's October 4 letter reports that "[a]ll issuers who responded indicated they have begun to adjust pricing in an attempt to meet the 80% MLR standard." This suggests that issuers with low MLRs intend to comply with the Affordable Care Act and remain in the market.

In sum, evidence presented in OFIR's application shows that all issuers in the Michigan individual market either already meet the 80 percent MLR standard or intend to meet that standard in the near future. Additionally, most issuers that are expected to owe rebates are either sufficiently profitable to absorb the impact of rebate payments under an 80 percent MLR standard, or are adapting their business models in order to continue to achieve sustainable financial performance in the individual market. Based on this, we do not expect any issuers to withdraw from the Michigan individual market and therefore could not conclude that it is "reasonably likely" that the market will be destabilized if the 80 percent standard is not adjusted.

B. *Number of enrollees covered by issuers that are reasonably likely to exit the State*

As stated previously, although, according to OFIR, no issuer has "expressed intent to exit the state or cease offering coverage in the individual health insurance market absent an adjustment," OFIR expresses concern that the impact of rebate payments on issuers' profitability may lead some to withdraw. As discussed in Part A above, seven of the seventeen issuers in the Michigan individual market that are at least partially credible, including the dominant issuer, either already meet, or are very close to the 80 percent MLR standard, and thus would not be likely to leave the market due to section 2718's MLR standard. Two other issuers are no longer in the market, while another four would remain profitable even after payment of rebates under an 80 percent MLR standard, and thus are also not reasonably likely to withdraw. Two issuers with

[13] Humana Inc., 2010 Annual Report, at 6, *available at* http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9ODQ2ODh8Q2hpbGRJRD0tMXxUeXBlPTM=&t=1.

MLRs below the 80 percent standard – Time and Humana – appear to be successfully changing their business models. One other issuer with a low MLR – Alliance – would be close to breaking even after payment of rebates under an 80 percent MLR standard, assuming it has not already adjusted its business model in 2011. According to OFIR's application, Alliance insures 3,809 enrollees, or 1.1 percent of the market. The remaining issuer with a low MLR – Priority Health – would have require significant changes to its business model to attain profitability in the Michigan individual market regardless of whether an adjustment is granted. Priority Health provides coverage to 3,083 enrollees, or 0.9 percent of the market. Again, we note that, according to OFIR's application, issuers with low MLRs have begun to adjust pricing to meet the 80 percent MLR standard.

C. *Consumers' ability to access agents and brokers*

OFIR asserts that "it is inevitable that agents' commissions will be reduced by issuers looking to lower non-claim related expenses to comply with the new MLR requirements" and concludes that "[t]his may lead to fewer qualified agents being available to consumers needing to purchase individual and small group health insurance." OFIR adds that "an adjustment will allow agents time to adjust their own business practices in recognition of the lower commission environment."

As discussed in Part A above, eight issuers had 2010 MLRs below the 80 percent standard and would be expected to pay rebates beginning in 2011. However, four of those – Golden Rule, Aetna, John Alden, and MEGA – would be able to achieve sustainable financial performance even after payment of rebates under an 80 percent MLR standard. Therefore, it is not clear that these issuers are likely to significantly reduce their commissions rates. Of the other four issuers that will require substantial adjustments to their business models in order to meet the 80 percent MLR standard, two – Humana and Alliance – paid commissions that averaged 3 and 1 percent of total earned premium in 2010, respectively. It is not clear that Humana or Alliance are likely to further reduce their level of agent compensation. The other two issuers likely to be significantly affected by the rebate requirement – Time and Priority Health – paid commissions that averaged 10 and 13 percent of total earned premium in 2010, respectively. However, while OFIR's October 4 letter states with regard to issuers included in its application that "[n]early all have lowered commissions on new business," OFIR does not provide any data on the magnitude of these reductions, nor on the magnitude of the resulting impact on agents and brokers.

CCIIO received public comments from three agent and broker organizations supporting OFIR's request. The Michigan Association of Health Underwriters ("MAHU") relates that many insurance agents have seen their income reduced by 30-50 percent as a result of the MLR requirements, and that this income reduction "has forced these small businesses to layoff their office staff and reduce the services that they once were able to provide their individual clients." The National Association Of Insurance and Financial Advisors-Michigan ("NAIFA-MI") argues that without an adjustment "smaller companies may go out of business and agents will see severe cuts in their compensation (possibly as high as 50%)," with the unintended consequences of "less competition and significantly reduced consumer service." The Michigan Association of Insurance Agents ("MAIA") states that "the dominant provider of health care insurance in Michigan with primary delivery of its products through agents, Blue Cross Blue Shield of Michigan, has dramatically reduced commissions to agents in response (in part) to PPACA's

provisions." MAIA adds that "[s]uch actions dictated by the need to meet the MLR standards will impact agents with lower income levels and higher workloads forcing many to discontinue offering their services when they are most needed." MAIA further asserts that this reduction "will mean that '**consumers may be unable to access agents**' as noted among the six criteria used by HHS to determine the risk of market destabilization" (bold in original). However, these organizations do not provide information on the number of agents or brokers who have or might leave the business, or on the number of Michigan consumers who could be affected.

The Michigan Legal Services ("MLS"), a consumer interest organization, argues that OFIR's concern that lower commissions will compromise consumers' access to agents and brokers is unsupported by evidence. MLS asserts that the evidence instead shows that in the Michigan individual market "[c]arriers are able to both pay brokers and have an 80% MLR." MLS adds that OFIR's "concern that brokers and agents will be harmed by the new standard is based on inflated and unfair commissions," arguing that "[t]he ACA was not enacted to protect exorbitant broker‟s fees, and granting OFIR‟s request allows this wasteful and harmful behavior to continue for that much longer."

In sum, notwithstanding the reductions in commissions that have already occurred, or may occur in the future, OFIR has not provided evidence that would lead us to conclude, according to the criterion established by CFR 158.330(c), that "absent an adjustment to the 80 percent MLR standard consumers may be unable to access agents and brokers."

D. *Alternate coverage options*

According to OFIR's application, "Michigan has several options available to consumers in the event an insurer withdraws from the market." OFIR explains that "BCBSM, HMOs, and the Health Insurance Program for Michigan all have guarantee[d] issue requirements assuming you meet certain requirements." In addition, as noted before, no issuer has "expressed intent to exit the state or cease offering coverage in the individual health insurance market absent an adjustment."

Nonetheless, OFIR expresses concern that the impact of rebate payments on issuers' profitability may lead some to exit the State, which would leave enrollees of such issuers in need of replacement coverage. OFIR states in its October 4 letter that "the size and complexity of the various benefit plans make it difficult to perform" a comparison regarding "whether products in the state are in general comparable in product design and cost." OFIR further states that it had recently surveyed the active issuers in the Michigan individual market with MLRs below 80 percent and that "six responded as having one or more products they felt were unique with respect to the benefits or cost sharing features that provide more affordable coverage."[14] OFIR notes that the unique coverage cited by the six issuers "ranged from child only policies to those with larger cost-sharing features and/or lower annual limits allowing more affordable coverage." OFIR observes that "[s]hould these issuers choose to cease offering these policy types or exit the market altogether due to the increased costs imposed by the higher MLR requirement, insureds will have difficulty securing comparable coverage from other issuers."

[14] OFIR's October 4 letter notes that remaining surveyed issuers "responded as either having no unique products or expressed uncertainty as to whether their product was unique."

As discussed in Parts A and B above, we do not expect any issuers to withdraw from the Michigan individual market as a result of implementation of the 80 percent MLR standard. However, even assuming that Alliance and/or Priority Health were to withdraw, according to OFIR's application, Michigan requires guaranteed issue by BCBS and HMOs. Therefore, if Alliance or Priority Health were to withdraw, their policyholders could obtain replacement coverage from BCBS and HMOs, and could not be denied coverage due to health status.

According to data submitted by OFIR and Alliance's website, Alliance offers PPO products, some of which are HSA-compatible, with deductibles ranging from $500 to $5,000, and coinsurance of 0% to 30% up to an out-of-pocket maximums of between $2,500 and $5,000.[15] According to data submitted by OFIR and Priority Health's website, Priority Health offers PPO products, some of which are HSA-compatible, with deductibles ranging from $1,000 to $10,000, coinsurance of 0% to 30% up to an out-of-pocket maximums of $2,000 to $6,000, and an annual limit of $2,000,000.[16] According to data submitted by OFIR and BCBS' website, BCBS, the largest issuer in the market, and subject to guaranteed issue requirement, offers HMO and PPO products, including HSA-compatible products, with deductibles ranging from $0 to $10,000, and coinsurance of 0% to 30% up to an out-of-pocket maximum of between $0 and $13,500.[17]

The following comparison displays the monthly premiums a single adult of various ages would pay for either a BCBS, an Alliance, or a Priority Health policy. This comparison is for policies with a deductible of $5,000 and coinsurance of 20 percent up to an out-of-pocket maximum of $5,000 (Alliance and Priority Health) and 30 percent up to an out-of-pocket maximum of $3,500 (BCBS). Although the BCBS policy has a higher coinsurance rate, it also has a lower out-of-pocket maximum. While the comparison is not exact, for an Alliance or Priority Health enrollee seeking alternative, comparable coverage, these may be the "most" comparable products based on premiums, benefits, and cost-sharing features. In these examples, the BCBS, Alliance, and Priority Health policies have approximately the same cost.

Comparison of the Monthly Rate to Insure a Single Adult[18]

		BCBS Policy	Alliance Policy	Priority Health Policy	BCBS Policy as a % of Alliance & PH Policy Cost
Age	24	$68	$60	$70	113% - 97%
	42	$125	$109	$124	115% - 101%
	52	$205	$211	$193	106% - 97%

[15] Alliance Health & Life Ins. Co., SOLO HAP: Flexible coverage for individuals and families, https://hap.inshealth.com/ehealthinsurance/benefits/ifp/MI/IFP-HAP-MI-5225R2-SOLO-eBrochure-10-01-10.PDF.

[16] Priority Health, MyPriority Plan Documents, https://www.priorityhealth.com/member/plans/mi-individual-health-insurance/mypriority/plan-documents.aspx (*last accessed* Dec. 6, 2011).

[17] BCBS Michigan, All Products, http://www.bcbsm.com/myblue/myblue_home.shtml (*last accessed* Dec. 6, 2011).

[18] Rates shown are for a single non-smoking male adult living in the Wayne county. Out-of-pocket maximums exclude the deductible. Alliance rates are for SOLO PPO 5000. Priority Health rates are for MyPriority. BCBS rates are for Keep Fit, which has the cost-sharing and benefit features most comparable to Alliance and Priority Health product features. Rates shown are as quoted on the issuers' websites. Rates for Alliance and Priority Health match the information provided by OFIR. Rates for BCBS' Keep Fit product were not provided by OFIR, but rates for BCBS' other products available on BCBS' website match the information provided by OFIR.

Based on our analysis of the publicly available premium and benefit level information, there is no indication that Alliance or Priority Health offer unique products, as their products are similar in cost and design to products offered by other issuers in the Michigan individual market. Therefore, even if one or both of these issuers were to withdraw, their enrollees should be able to obtain comparable coverage at comparable prices from other issuers in the market.

OFIR further notes that "as MCL 500.3406f allows issuers in the individual market to exclude coverage for pre-existing conditions for the first six months, we are concerned that individuals with pre-existing conditions will find it difficult to secure comparable coverage should their current issuer decide to exit the market or significantly reduce its writings as nearly all issuers have the six month limitation on new policies." OFIR adds that individuals "can purchase health insurance through the state's high risk pool but they must go without health insurance for six months." We also note that, while BCBS is the *de facto* issuer-of-last-resort in Michigan, and HMOs are generally subject to guaranteed issue requirements, both BCBS and HMOs are also allowed to impose six month pre-existing condition exclusions. Therefore, we agree with OFIR's assessment that potentially some consumers could be left with a temporary gap in coverage for some conditions if any issuers do exit the market. Nonetheless, as previously stated, we do not expect any issuers to withdraw as a result of implementation of the 80 percent MLR standard.

E. *Impact on premiums, benefits, and cost-sharing of remaining issuers*

OFIR's application notes that "[a]s it is difficult to identify which companies, if any, would choose to leave the market, evaluating the impact on premium costs and benefit features available on the remaining plans would be equally challenging." However, OFIR suggests that "[c]ertainly, if one of the larger issuers chooses to leave the market the number of coverage options available to individuals will decrease dramatically." OFIR otherwise does not address the impact on premiums, benefits or cost-sharing of issuers remaining in the Michigan individual health insurance market if application of the 80 percent MLR standard causes one or more issuers to leave the market. We note however that, according to OFIR's website, Michigan has "certain coverages that every traditional health insurance policy must include."[19] Such requirements tend to modulate any undesirable results that issuer exit may have upon the policy terms of remaining issuers.

F. *Other relevant information submitted by the State*

According to OFIR's October 4 letter, the total amount of rebates OFIR expects consumers to receive in 2011-2013 if the issuers offering coverage in the Michigan individual market had to meet an 80 percent MLR standard in each of those years is $89.1 million.[20] The total amount of rebates that consumers would receive under OFIR's proposed adjustment to the MLR standard is $38 million. This represents a $51.1 million reduction in payments to Michigan consumers and amounts to a 57 percent drop in rebates.

[19] Michigan Department of Licensing and Regulatory Affairs, Health Insurance Information: Health Coverage Basics, http://www.michigan.gov/lara/0,4601,7-154-10555_12902_35510-263908--,00.html.
[20] Assuming that World pays no rebates for 2012 and 2013.

IV. Summary of Public Comment

CCIIO received two letters from members of the U.S. House of Representatives, three comments from agent and broker organizations, 101 comments from Michigan consumers, ten public comments from consumer organizations, and a petition signed by nearly 6,000 Michigan consumers.

Representative Dave Camp, Chairman of the Committee on Ways and Means, and Representative Fred Upton, Chairman of the Committee on Energy and Commerce, on behalf of their Michigan constituents, wrote a letter to Secretary Sebelius in support of OFIR's application. The Chairmen state that it is "unreasonable to believe health plans will continue to offer health insurance in Michigan if this onerous regulation is implemented," and that "Michigan's individual health insurance market will quickly destabilize under this scenario." However, Representative Sander M. Levin, Ranking Member of the Committee on Ways and Means, and Representative John Dingell, in their letter to the Secretary opposing OFIR's application, assert that the Chairmen's letter "completely mischaracterizes the impact of the new health care legislation." Representatives Levin and Dingell state that in Michigan, "a few insurers with very small market shares … have low MLRs," and that absent evidence of market destabilization "it is imperative that the [MLR rebate] requirement go into effect on time so that Michigan consumers can benefit from higher value insurance plans and appropriate rebates."

The three agent and broker organizations support OFIR's request. These organizations assert that Michigan agents and brokers have, or are going to, experience dramatic reductions to their income resulting at least in part from the MLR provisions, and that this will result in fewer agents and brokers being available to consumers. These comments are addressed in greater detail in Part III.C, above.

Over 100 Michigan residents have sent brief e-mails urging the Secretary not to grant OFIR's request. The thrust of these comments was that granting an adjustment would be especially inappropriate given the hard economic times Michigan residents face and is in any event unjustified by the facts.

The ten consumer organizations oppose OFIR's request. Most of these commenters express concern that granting OFIR's request would eliminate an essential Affordable Care Act cost control measure, deny Michigan consumers more than $53 million in rebates, lead to higher premiums and more uninsured citizens, and begin to create an uneven playing field that will allow issuers to play one State off another. Many commenters point out that issuers are unlikely to leave the Michigan individual market because issuers would have to comply with the 80 percent MLR standard in any other State, except in those that have been granted an adjustment. Several commenters additionally argue that OFIR's request would unfairly deny individual consumers the rebate benefit available to small and large group consumers. Several commenters assert that granting OFIR's request will have a destabilizing impact on the Michigan insurance market.

Michigan Legal Services ("MLS") additionally expresses the view that OFIR's request "favors a small number of companies that are not performing well for their enrollees, at least in paying medical claims," which is "unfair to the carriers that actually provide medical care to

their clients." MLS observes that "even in the smaller carriers – the bottom 13 – four have at least an 80% MLR and one has 79.4% MLR." MLS concludes that "[t]his evidence demonstrates that it is possible for smaller insurance companies to meet the current MLR requirement and to stay viable, and weakens [OFIR's] central claim that implementing the MLR requirement as currently written threatens the vibrancy of Michigan's individual insurance market."

The Michigan League For Human Services ("MLHS") observes that "[w]hile the companies that do not currently meet the 80 percent MLR represent about one-third of the individual market, one carrier represents about one-third of that total." MLHS further "question[s] the value to consumers of policies in which the MLR is only 45 to 65 percent, the range for many of these companies."

The NorthWest Lansing Healthy Communities Initiative draws our attention to the fact that "the loss of the rebate would also disproportionately affect low-income workers."

Michigan Protect Your Care ("MPYC") claims that "the cost control measure that the ACA provides with the 20/80 Medical Loss Ratio rule" is needed because health insurance rates "have gone up dramatically in Michigan over the last several years." MPYC believes that it is an "empty threat" that issuers may leave the Michigan individual market if an MLR adjustment is not granted because "with over 1 million uninsured people currently in Michigan, it would not make good business sense to leave the Michigan market when the market is going to substantially expand [starting in 2014] for individuals buying health insurance."

Urban Neighborhood Initiatives ("UNI") asserts that the request will "encourag[e] continued wasteful behavior within the commercial insurance industry" and questions why "our state's long-suffering consumers [should] be denied $53 million in projected rebates simply so [that] uncompetitive companies … may continue on temporarily with what is clearly an unsustainable business model."

Both the Michigan Universal Health Care Access Network ("MichUHCAN") and the Michigan Council 25 of the American Federation of State, County, and Municipal Employees, AFL-CIO ("AFSCME") assert that granting OFIR's request would only "allow insurance companies to stick to their old ways for a few more years and to avoid making tough business decisions, all at the expense of struggling consumers." MichUHCAN and AFSCME argue that "the risk of poor performers leaving the state will exist as long as there is an insurance market" and that in Michigan the "small risk of insurers leaving the market is outweighed by the definite benefits to consumers that come with this MLR requirement." AFSCME adds that "the real danger is that the increased demand" arising from the Affordable Care Act "could, without the corresponding restraint of reasonable loss ratios result in higher costs pushing health care out of the reach of low and middle income citizens without costly federal subsidies."

Nearly 6,000 Michigan residents signed a petition requesting that the Secretary deny OFIR's request. The petition states that "Michigan consumers deserve the $53 million in rebates in their pockets, not in the pockets of insurance companies!" Many of the signers of the petition also included their own, separate comments.

We acknowledge the views and concerns expressed in these comments.

V. Conclusion

As described at the outset of this letter, section 2718 of the PHS Act permits the Secretary to adjust the 80 percent standard in the individual market if it is determined that applying this standard "may destabilize the individual market in [the] . . . State." The regulation implementing section 2718, 45 CFR Part 158, provides that an adjustment should be granted "only if there is a reasonable likelihood" that application of the 80 percent MLR standard will destabilize the particular State's individual health insurance market (45 CFR 158.301).

After applying the standards and criteria set out in section 2718 and 45 CFR Part 158 to the information submitted by OFIR, we conclude that the evidence presented does not establish a reasonable likelihood that implementation of an 80 percent MLR standard may destabilize the Michigan individual market. We reach this conclusion for the reasons outlined in the analysis under the criteria set out above, and based on the specific characteristics of the Michigan individual market addressed in that analysis.

As noted in Part III.A above, seven issuers that are at least partially credible, and would thus be expected to be subject to MLR rebate provisions in 2011 based on 2010 enrollment, would not owe rebates because they have MLRs of very close to 80 percent or higher. Additionally, six of the eight issuers remaining in the market that could be expected to owe rebates for 2011 based on 2010 performance are either sufficiently profitable or are adapting their business models, which should allow them to achieve sustainable financial performance in the individual market. As further discussed in Part III.A, one of the two remaining issuers with low MLRs – Alliance – should require only modest changes to its business model in order to avoid incurring losses at an 80 percent MLR standard. The other issuer – Priority Health – would sustain pre-tax losses even under OFIR's proposed adjustment. Thus, denying OFIR's requested adjustment to the MLR standard will not make a difference between Priority Health operating with a pre-tax gain vs. a pre-tax loss. We noted earlier that Priority Health's situation stems from unusually high administrative expenses. Furthermore, as previously stated, issuers in the Michigan individual market with MLRs below 80 percent have indicated that they are adjusting their pricing to meet the 80 percent standard. Therefore, there is no basis to conclude, based on these facts, that there is a reasonable likelihood that any of these issuers may leave the market as a result of implementation of the 80 percent MLR standard. As further discussed in Part III.D, even if Alliance and/or Priority Health were to withdraw, Michigan's competitive market and the guaranteed issue requirement for BCBS and HMOs would generally ensure that most of these two issuers' enrollees would be able to obtain alternate coverage at comparable prices from the remaining active issuers in the market.

As discussed in Part III.C above, although OFIR expresses concern that the 80 percent MLR standard could result in lower agent commissions and fewer agents servicing the individual market, OFIR does not provide specific data to support this concern. Additionally, as discussed in Part III.C, it is not immediately obvious that most issuers would need to reduce commissions in order to meet an 80 percent MLR standard and remain profitable. In sum, there is insufficient evidence to conclude that an 80 percent MLR standard would significantly reduce consumers' ability to access agents and brokers in Michigan.

For these reasons, we conclude that an adjustment to the 80 percent MLR standard in the Michigan individual market is not appropriate.

Pursuant to 45 CFR 158.346, OFIR may request reconsideration of the determination issued in this letter. A request for reconsideration must be submitted in writing within ten days of the date of this letter to MLRAdjustments@hhs.gov, and may include any additional information in support of such request. A determination on a request for reconsideration will be issued within 20 days of the receipt of the request.

Please contact me should you have any questions.

Sincerely,

/Signed, SBL, December 16, 2011/

Steven B. Larsen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight