



# *Michigan Association of Health Plans*

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House Insurance Committee  
November 20, 2012

## Blue Cross Reform (Mutualization)

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**EXECUTIVE DIRECTOR**

Richard B. Murdock  
*Michigan Association of  
Health Plans*

My name is Rick Murdock and I am Executive Director of the Michigan Association of Health Plans. Our association represents 15 health plans serving over 2.5 Michigan citizens in Medicaid, Medicare and Commercial products and 55 business and limited members. Member health plans of MAHP employ nearly 4000 individuals throughout Michigan.

Michigan's health insurers strongly support the concept of creating a level playing field for all health insurers in Michigan – including Blue Cross Blue Shield of Michigan. Without question, the need for leveling that “playing field” can easily be seen.

There is no disputing the fact that Blue Cross Blue Shield has a 70 percent of Michigan's commercial insurance market – a monopoly by any measure. In fact, the American Medical Association has reported that Michigan has the **fourth worst competitive marketplace in the nation**, due to the Blue Cross monopoly dominance in every market region.

The MAHP vision is to strive toward making Michigan the most competitive market place for health insurance in the United States. I am confident that we can all agree that a more competitive marketplace will benefit Michigan insurance consumers, lowering prices for insurance premiums and increasing innovation and quality incentives. Unfortunately, SB 1293 and SB 1294, as passed by the Senate, does not improve competition or level the playing field and, in fact, ignore the realities of BCBSM's market dominance of over 70% of the commercial market share for health insurance in the state. Our current position of opposing the Senate passed version of SB 1293/1294 relates directly to this point.

Competition improves quality, lowers costs, and spurs innovation. I am sure that our mutual objective is to have Michigan residents benefit from a more competitive market. Our focus today is on the key issues we believe needs to be addressed in order to “tilt” the market place closer to the often stated objective of a “level playing field”.

#### Priority Issues for Change in SB 1293/1294

While there are many other issues that needs to be addressed in the Senate passed version of SB 1293 and SB 1294-- and you have heard many of those identified over the past several hearings (we have listed those in appendix to this testimony)--I want to emphasize that we have equal concern. However, we have gone through our internal process to arrive at our top two priority issues and recommended changes. Those priority issues are:

- 1. Immediate Ban on the use of Most Favored Nation Clauses; and*
- 2. Continued implementation of the Insurance Commissioners Order issued earlier this year requiring BCBSM to fairly compensate hospitals and no longer shift those costs to other carriers.*

#### Discussion

Why are these two issues so important at this time? BCBSM admits that approximately 70% of hospitals are under side agreements or Letters of Understanding, including the most favored nation clauses (that have not been reviewed by OFIR) thus preventing OFIR from reviewing and preventing violations of under PA 350. This is coupled with the payment model that explicitly refuses recognition of government program losses (even among the most efficient hospitals). The result is then two-fold: First, other health care purchasers have had to absorb more than their fair share contrary to the current provisions of PA 350—that are not carried into the “reform legislation”, and second, BCBSM has stifled competition, thus impeding the ability of competition to lower premiums.

The documents submitted by BCBSM to OFIR leading to the Commissioner’s order in July, disclose the enormous disparity in hospital payments between BCBSM and other commercial health plans: According to their own consultants—in documents submitted to OFIR, **BCBSM’s rates are 34% below market for inpatient services and 41% below market for outpatient services.**

In its response to OFIR's review questions on its Hospital Provider Class Plan, BCBSM admits that efficient hospitals have losses under Medicare and Medicaid, thus comprising a component of reasonable hospital financial requirements, but denies responsibility to pay its fair share. The only rationale offered by BCBSM for not paying government program losses for Peer Group 1-4 hospitals is **that those hospitals have the ability to shift government program losses to other health care purchasers**. It is hard to imagine a clearer violation of M.C.L. § 550.1516 which unequivocally states that "no portion of [BCBSM's] fair share of hospitals' reasonable financial requirements shall be borne by other health care purchasers." But that is looking backwards—what is most concerning is there is no such provision going forward in SB 1293/1294.

As you know, these issues have received considerable attention over the past year due to litigation and rulings/orders by the Insurance Commissioner. We were pleased by the action earlier this year by Commissioner Clinton regarding the use of "most favored nation" clauses and the need to prospectively seek approval of such contractual language beginning next year. Our amendment is to immediately ban the use of such provisions. Let's not forget that it was this "alleged" practice by BCBSM that led to the current litigation by the United States Department of Justice and Michigan Attorney General that will be heard next year in federal court.

Likewise, we were very pleased by the recognition by the Commissioner and his recommendation that BCBSM join other carriers in paying their fair share of the uncompensated costs resulting from reimbursement shortfalls by Medicare and Medicaid. Without these payments, a burden largely bourn by other insurance carriers, the viability of Michigan's hospitals are at risk. This issue of "cost shifting" has been a growing matter within our industry due to the continued growth in Medicaid and Medicare. Interestingly, as passed by the Senate, the obligation of BCBSM to comply with this order would be eliminated before it was implemented.

### **Summary/Recommendations**

So, if I were to summarize key points to remember, it would be these:

- Michigan is one of the worst competitive states for health insurance according to several reports, including that of the American Medical Association (4<sup>th</sup> worst).
- BCBSM has over 70% of the commercial market in Michigan and is the dominant carrier in every region of the state. Let's call it for what it is---a monopoly.

- We are in absolute agreement that reform is necessary—but not reform to only benefit one part of the Insurance industry—the most dominant carrier-- at the expense of others.

My starting point was that we want to make Michigan the most competitive state for health insurance. There clearly must be a transition period to reach that objective and simply and abruptly converting the most dominant carrier in our State to a non-profit mutual WITHOUT adopting any other change that affect the competitive environment maintains the current “monopoly status.” That is not leveling the playing field—that is tilting the field even more away from competition.

Our recommendation is this legislation must include provisions addressing the priority issues that I have identified in my testimony.

Thank you for your considerations.

## APPENDIX 1

### LISTING OF ISSUES/CONCERNS FROM SENATE PASSED SB 1293/1294

#### **Loss of Market Competition**

*BCBSM is estimated to have a 70% market share for health insurance in the state, providing coverage to nearly 5 million residents. Competition improves quality, lowers costs, and spurs innovation. Michigan residents will benefit from a more competitive market. The bills do not advance competition and, in fact, ignore the realities of BCBSM's market dominance.*

- a. ACA Does Not Require These Changes. BCBSM asserts that it needs to be regulated as an insurer in order to be successful under the Affordable Care Act ("ACA"). This is simply not true. The ACA forces other insurers to assume obligations that previously only BCBSM had, such as the guarantee issue obligation (no refusal of applicants based on health status). Similarly, other insurers today can use health status in setting premiums, while BCBSM cannot. Under the ACA, the use of health status in premium setting is prohibited. Thus, the ACA affects other insurers more than it affects BCBSM. The only change that is needed to PA 350 due to the ACA is the elimination of BCBSM's tax-exemption. The historical basis for the state tax-exemption has been that BCBSM is the insurer of last resort, but under the ACA all carriers are the insurers of last resort.
- b. Regulatory Consistency. The rationale for the bills is that it promotes a level playing field by making all carriers subject to the same regulatory standards. This has a surface appeal, but it misses the point that BCBSM has 70% of the market. Due to its market dominance, BCBSM should be subject to higher level of regulation. Moreover, since BCBSM has amassed considerable assets as a charitable, tax-exempt trust, it has a different set of duties to Michigan residents than other insurers have.
- c. Pro-Competitive Provisions Lost. PA 350 has numerous provisions to promote competition. If BCBSM becomes a mutual insurer, these provisions will no longer apply. Given its market size, the Legislature should be retaining provisions that keep BCBSM dominance in check. These provisions include:
  - Forbidding BCBSM from tying the sale of its products with the sale of other products by its subsidiaries, e.g., an employer cannot buy health insurance from BCBSM unless it also buys workers compensation insurance from the Accident Fund.

- Forbidding BCBSM from setting its premiums below cost in order to drive competing health plans from the market.
- Requiring BCBSM to pay hospitals fairly and covering its fair share of hospital losses under Medicare and Medicaid; if BCBSM underpays hospitals, it results in disproportionate cost shifting to other insurers and renders them less competitive.
- Requiring Attorney General approval of insurance company acquisitions and other out of state purchases since these transactions can increase BCBSM control over the health insurance market.
- Requiring BCBSM provider contracts and reimbursement arrangements be subject to Insurance Commissioner review and prior approval to ensure that BCBSM does not use its buying power to underpay providers or exclude providers from its products.

### **1.5 Billion Contribution to Foundation**

*Under the bills, if BCBSM converts to a nonprofit mutual insurer, it must pay \$1.5 billion to a newly created Foundation. The provisions in the bills regarding this contribution do not adequately protect the State.*

a. The obligation to make the contribution is weak. The bill provides that BCBSM will make “best efforts” to pay “up to” \$1.5 billion. The terms “best efforts” and “up to” are not commercially reasonable. How many people have mortgages where they only have to make “best efforts” to pay “up to” the amount borrowed? Does BCBSM allow policyholders to make “best efforts” to pay “up to” the premium charged?

b. The obligation to make the contribution over 18 years is unreasonably long. The Blue Cross Blue Shield Association requires a minimum level of surplus or a Blue Cross plan could lose the right to use the Blue Cross name and logo. The Association minimum is more conservative than the Michigan law minimum. Even at the more conservative level, at May 31, 2012, BCBSM had between \$1.4-\$1.8 billion of excess surplus. It could afford to pay all of the \$1.5 billion in one year or during a shorter number of years, e.g., 3 years.

c. No annual contributions are specified. While the contribution is to be paid over 18 years, the amount each year is not specified. There is risk, therefore, that BCBSM pays \$100 million over the first 17 years and \$1.4 billion in the last year.

d. Exceptions to contribution obligations are not transparent. It has been reported that the state is working on an agreement with BCBSM concerning exceptions to making the contribution requirement based on BCBSM solvency. This agreement has not been made public and according to published reports, it will be provided after the House votes. Legislators should not be voting without all necessary information being made available.

There is also not a credible reason for an exception. If the \$1.8 billion is paid annually over the 18 years, this represents \$83.3 million/year. At year-end 2011, BCBSM had over \$6.0 billion in invested assets. If its investments earn at least 1.4% per year, it can fully fund the \$83.3 million annual obligation

e. The Foundation purposes differ from BCBSM's purposes. Under PA 350, BCBSM exists to provide coverage to all residents at a reasonable price. The Foundation's purposes are broader than to provide coverage, but instead include promoting health and wellness. These are laudable goals, but the funds should be used to further the original purposes of BCBSM; namely, expand health insurance coverage. This is consistent with the law governing charitable trusts where the focus is matching the purposes "as close as possible."

### **3. Rationale for \$1.5 Billion Contribution and its "Fairness"**

*Either the \$1.5 billion contribution represents a down payment to allow a subsequent for-profit conversion or it represents a payment to have the right to unlimited premium rate increases. Either way, this is a bad deal.*

a. Down Payment for Subsequent Conversion. If the \$1.5 billion is viewed as a down payment to allow subsequent conversion, it is on its face inadequate. The fair market value of BCBSM is likely between \$6-10 billion if it were sold. The \$1.5 billion the Foundation payment is a fraction of the fair market value. Even in the absence of a sale, the balance sheet/book value of BCBSM was \$3.4 billion at May 31, 2012. All of the net assets of BCBSM are to be used for its charitable purposes. The conversion to a nonprofit mutual insurer allows BCBSM to use all of its charitable assets to advance non-charitable purposes. Moreover, BCBSM is given the opportunity to use on an unrestricted basis the charitable assets over the 18 year period during which Foundation contributions are to be made. Over that 18 year period, it will earn additional profits on the charitable assets.

b. Payment for the Right to Unlimited Premium Rate Increases. If the \$1.5 billion is not viewed as down payment to allow subsequent conversion, and BCBSM is taken at its word that it has no desire to convert, then what is the purpose of the payment? The bills allow BCBSM to avoid Attorney General review of its premium rate increases, and prevent the Attorney General, the Insurance Commissioner or a policyholder from seeking a hearing on whether the increase is excessive. Consequently, the \$1.5 billion payment should be viewed as representing the value to BCBSM of getting out of premium rate reviews. BCBSM must have concluded that whatever the “cost” is in terms of payment to the Foundation (\$1.5 billion), it is more than offset by additional premium revenue. In other words, the policyholders of BCBSM will be paying back to BCBSM via higher rates whatever BCBSM is paying to the Foundation.

c. Fairness Opinion. It has been reported that the state will receive a fairness opinion that reviews whether the state is getting a “fair deal” in terms of the \$1.5 billion contribution and other financial changes arising from BCBSM becoming a nonprofit mutual insurer. Fairness opinions are not the same as fair market value opinions, and it is well known in the industry that fairness opinions always conclude the transaction is fair. Typically the party requesting the fairness opinion wants to do the deal and is just looking for some external support that the deal it has made is “fair.” The fairness opinion has not been provided to Legislators; again lawmakers are expected to vote without all material facts.

d. Evaluating Fairness. In considering the fairness of the transaction, the state would need to weigh the \$1.5 billion against the loss of social mission benefits that BCBSM will no longer provide as a mutual insurer. In 2008, BCBSM released a report that concluded it provided \$391 million of social mission benefits in 2007 alone. Over 18 years, this represents \$7.0 billion, nearly five times the proposed \$1.5 billion contribution. Additionally, the bills allow the Accident Fund, an insurance subsidiary of BCBSM, to sell insurance other than workers compensation. The law today forbids Accident Fund from doing any other line of business. The state should receive value from BCBSM if the restrictions that currently apply to the Accident Fund are eliminated. The Accident Fund’s market value and enterprise opportunities will improve if it is no longer bound to only write one line of business.

#### **4. Premium Rating and Coverage--Keeping Dominance in Check**

*BCBSM today is subject to more regulation concerning its premium rates than other insurers. These regulations, however, exist to protect the large number of*

*BCBSM policyholders (nearly one out of every two residents). Loosening BCBSM premium rate regulation harms insurance buyers—whether individual or group. The harm to seniors is most significant.*

a. Rate Hearings. PA 350 permits the Attorney General, the Insurance Commissioner or a policyholder to request rate hearings. The only rate hearings that have occurred have been with respect to Medigap coverage (affecting fixed income seniors) and individual policies (affecting residents who do not have employer-provided coverage and have to buy coverage with after-tax dollars). While BCBSM complains of rate hearings and the delays, the reality is that each rate hearing has been exceptionally beneficial to protecting policyholders and mitigating otherwise large rate increases. For example, in 2007, BCBSM filed for a 50.3% increase in Medigap rates. Due to opposition by the Attorney General, BCBSM agreed to a reduced increase of 19%. This action saved Michigan seniors approximately \$70 million a year. As a matter of policy, do we want to protect fixed income seniors and individuals who buy insurance with after-tax dollars or do we want to make it easier for a carrier with 70% of the market to raise rates?

b. Rating Standards. PA 350 establishes specific rating standards that premiums not be excessive or inadequate. Consumers are harmed if rates are unreasonably high or if they are set unreasonably low to drive competition and choice from the market. As a mutual health insurer, the rating standards that apply under the Insurance Code are more relaxed. Consequently, the ability of the Insurance Commissioner to reject rates is not as strong. Additionally, the Affordable Care Act establishes additional burdens on carriers that raise rates by more than 10%; this only applies to individual and small employer group products and provides no protection relative to Medigap premium rating.

c. Medigap Coverage and Premium Rates. Currently, BCBSM provides Medigap coverage on a guaranteed issue basis to all eligible seniors. The coverage is community rated, so everyone pays the same rate regardless of age or health status. Under an agreement reached with the Attorney General's office in 2011, BCBSM agreed not to raise rates for five years. This five year period expires in July 2016. The bills continue this obligation until July 2016, but after that time, BCBSM will be able to use age in setting premium rates. Further as an insurer and not an entity burdened by Public Act 350, BCBSM will be able to underwrite the coverage (reject applicants based on health status except during limited open enrollment or guaranteed issue periods). The elimination of community rating and the risk of rejection due to underwriting are significant concerns to seniors.

d. Medigap subsidies. Medigap rates by BCBSM are very favorable in relation to the rates charged by other insurers. This is due to the fact that PA 350 allows BCBSM to collect a subsidy from other customers to reduce the premium rates. The subsidy value is currently estimated at \$200 million. Other than with respect to the continuation of the five year agreement with the Attorney General, BCBSM will no longer have the right to collect the subsidy from customers (this right appears in PA 350, not the Insurance Code); as a result, Medigap premiums are expected to rise substantially. More than 200,000 seniors will be affected by this change.

The bills provide that the Foundation may provide a subsidy to low income seniors. This subsidy will be less than the current subsidy. While the current subsidy is around \$200 million per year, the Foundation subsidy is expected to be more in the range of \$24 million per year. The Foundation subsidy also has a sunset. For fixed income seniors that are not determined to be “low income,” this Foundation subsidy is not of any help.

e. Exiting Medigap. BCBSM has historically had the duty to provide Medigap coverage as part of its social mission. Under the bills, it can choose to exit this line of business after July 2016. BCBSM may choose this path in order to drive business to more profitable products, such as Medicare Advantage. Seniors may do worse off under Medicare Advantage and should not be forced into an inferior product so BCBSM can generate more profits.

f. Group Conversion Subsidies. Under PA 350, BCBSM is entitled to collect a subsidy from employer group policyholders to reduce the premium rates for group conversion coverage. Group conversion is coverage issued to an individual who was formerly covered by a group plan and then loses that group coverage. Sometimes residents who have lost group coverage (and exhausted their COBRA continuation coverage benefits) purchase group conversion coverage. The BCBSM group conversion premium rates are lower due to the subsidy; these rates will rise significantly when BCBSM becomes regulated under the Insurance Code and will no longer collect the subsidy and reduce premium rates accordingly.

g. Loss of Community Rating and Product Termination. PA 350 provides that “it is the intent of the legislature to promote uniformity of rates among subscribers to the greatest extent practicable.” Accordingly, BCBSM is generally required to establish premiums on a community rated basis where there is not any variation due to geography, age, health status or smoking status. Over the years, the Legislature has narrowly tailored exceptions. For example, BCBSM was permitted to use age to vary rates for individual coverage, but only on products that provided a prescription drug benefit to insureds. The bills would expand the ability of

BCBSM to vary rates based on geography, age, and smoking status, and also permit premium rebates of up to 30% for healthy lifestyles. The bills also permit BCBSM to non-renew products that it wishes to discontinue, thus forcing insureds in those products to select other, more costly products. Together these clauses will likely eliminate all community rated products from the BCBSM portfolio. The loss of community rating harms the residents that are older and less healthy—the very ones that need the most protection.

h. Loss of Year-Round Open Enrollment. Under PA 350, BCBSM must accept applicants at any time during the year. Under the bills, BCBSM may establish open enrollment periods, e.g., the month of May. When individuals apply for coverage other than during the open enrollment period, BCBSM will be able to reject them. The need for open enrollment periods makes sense for other insurers; it does not make sense for BCBSM since it commands 70% of the market and has more than \$3.0 billion in surplus reserves. The ability of BCBSM to limit enrollment to a defined period will increase the number of uninsured in the state.

## 5. Protection of Charitable Assets

*The bills do not provide adequate protection of the billions of dollars in charitable assets, essentially permitting these assets to be used for any purpose by BCBSM.*

a. Nonprofit versus Charitable. Under PA 350, BCBSM is declared to be a “charitable and benevolent institution.” In 2002, the Attorney General opined that BCBSM is a charitable trust. Similarly, in the Governor’s special message on health and wellness (September 2011), he stated “Blue Cross belongs to you and me, as a charitable trust established for Michigan’s residents to deliver quality and affordable health care coverage.” Being “nonprofit” is not the same as being a charitable trust, and there is no language in the bills providing that, as a nonprofit mutual insurer, BCBSM will remain a “charitable and benevolent institution.” In other states where the Blue Cross plan converted to a nonprofit mutual, the Legislature specifically retained the charitable and benevolent language. For example, North Dakota’s law provides: “Every nonprofit mutual insurance company is a charitable and benevolent organization and the laws of this state relating to and affecting nonprofit charitable and benevolent corporations are applicable to all nonprofit mutual insurance companies.”

b. Stealth Conversion. Under the bills, BCBSM is not prohibited from forming a subsidiary and moving business to that subsidiary. BCBSM could take that action and then sell the subsidiary or take the subsidiary public without any corresponding obligation to pay those funds to the state. In 2002, the late Michigan Insurance

Commissioner, Frank Fitzgerald, noted that this is a common strategy for Blue Cross plans to convert:

“Another avenue to effectively turn BCBSM into a for-profit company would be the creation or acquisition of a subsidiary for-profit insurer.... The net effect could be the transfer of many or all of the company’s assets to this new for-profit entity, leaving the current BCBSM as nothing more than a shell and effectively creating a new company within the for-profit subsidiary. This scenario is more than idle speculation as this approach recently was pursued by Blues plans in Pennsylvania, Washington, Wisconsin, Utah, Oregon, and Idaho.”

Michigan Health Law Report, vol 1, #2 (Fall 2002), at pp. 9-10.

c. Attorney General Oversight. Under PA 350, the Attorney General has certain oversight of BCBSM. As noted above, this includes challenging excessive premium rate increases. This oversight also extends into reviewing BCBSM transactions with its affiliates and out of state purchases. This oversight will be eliminated under the bills. BCBSM asserts that it should only have to answer to the Insurance Commissioner, but the focus of Attorney General oversight is needed because the AG office brings a perspective that is usually not within the expertise of the Commissioner, such as whether an out of state acquisition furthers the charitable mission of BCBSM; whether an activity harms competition; and whether assets that are to be used to provide health coverage should be transferred to subsidiaries to make acquisitions of non-health businesses, such as workers compensation.

## 6. **Ability to Remain Tax-Exempt and Escape Burdens**

*The bills enable BCBSM to retain tax-exemption, enjoy premium rating flexibility and escape the obligation to make the \$1.5 billion contribution.*

a. BCBSM Does Not Convert. The bills do not require BCBSM to become a mutual insurer. BCBSM could choose to remain an entity under PA 350. Since PA 350 provides BCBSM complete exemption from state and local taxes, BCBSM could decide that it is better to remain under PA 350 than to convert to a mutual insurer and be taxed as other mutual insurers are taxed. The desire of BCBSM to become an insurer is to have greater premium rating and coverage flexibility. The bills amend PA 350 to eliminate rate hearings and the other protections noted above; in essence, BCBSM will be able to set premiums like an insurer while remaining under PA 350. The bills also expand the ability of the Accident Fund to write other lines of business. Consequently, BCBSM could conclude that if it remains under PA 350, it will (1) avoid taxes; (2) avoid making the \$1.5 billion

contribution to the Foundation; (3) avoid Attorney General review of premium rate increases; and (4) improve the market position of the Accident Fund. Simply put, the bills allow BCBSM the opportunity to “have its cake and eat it too.”

# MICHIGAN ASSOCIATION OF HEALTH PLANS

HOUSE INSURANCE COMMITTEE  
SENATE BILLS 1293 & 1294  
NOVEMBER 20, 2012

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## TODAY'S FOCUS

- ▶ Most favored nation clauses
- ▶ Cost shifting

## CONTEXT

- ▶ Market share
- ▶ ACA Changes

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## MARKET SHARE

- ▶ In a competitive market, health plans compete on **innovation, service and cost**
- ▶ When a health plan has dominant market share, it has the power to extract MFN clauses and force hospitals to accept unreasonably low payment
- ▶ In both cases, the market is harmed because the dominant carrier has jacked up the costs of its competitors
- ▶ BCBSM has dominant market share in Michigan

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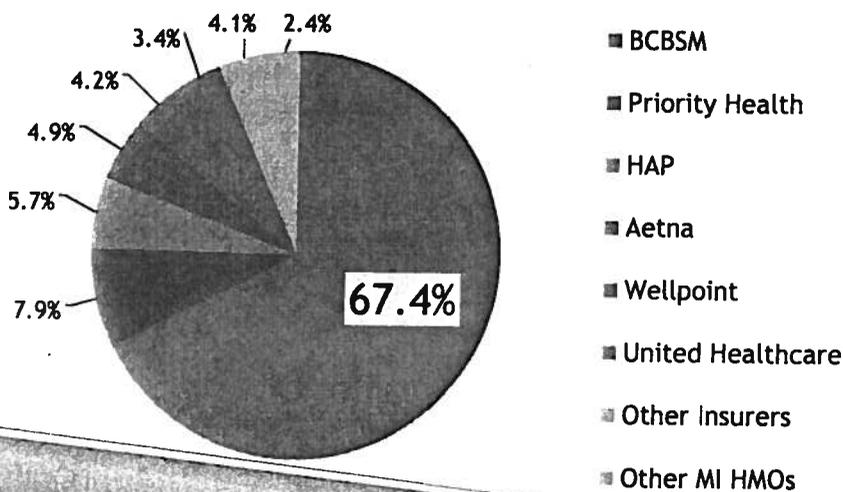
### AMERICAN MEDICAL ASSOCIATION STUDY: MICHIGAN IS 4<sup>TH</sup> WORST

	<u>BCBSM</u>	<u>Other</u>
<b>Ann Arbor</b>	80%	7% (HAP)
<b>Detroit-Livonia-Dearborn</b>	55%	26% (HAP)
<b>Flint</b>	68%	16% (HealthPlus)
<b>Grand Rapids-Wyoming</b>	65%	22% (Priority)
<b>Jackson</b>	85%	7% (Aetna)
<b>Kalamazoo-Portage</b>	74%	15% (United)
<b>Lansing-East Lansing</b>	67%	12% (PHP)/12% (Priority)

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### BLUE CROSS IS NEARLY 10 TIMES LARGER THAN ITS NEXT CLOSEST COMPETITOR



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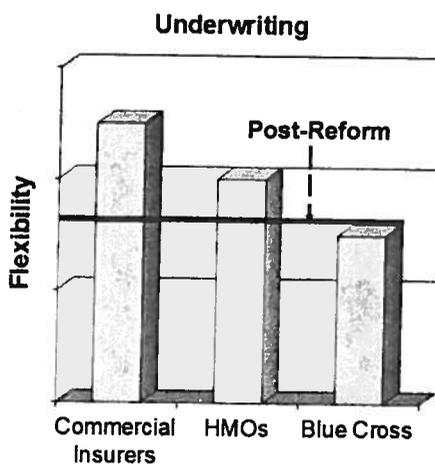
## ACA CHANGES

- ▶ BCBSM urges passage of SB 1293 and 1294 to “level the playing field” in preparation for the ACA
- ▶ The ACA affects more than BCBSM
- ▶ The proper inquiry is not “what can be done to help BCBSM position itself for the ACA?”
- ▶ The proper inquiry is “what can be done to help *all health plans* doing business in Michigan position themselves for the ACA?”
  - ▶ BCBSM is not the only health plan with Michigan employees

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## ACA CHANGES

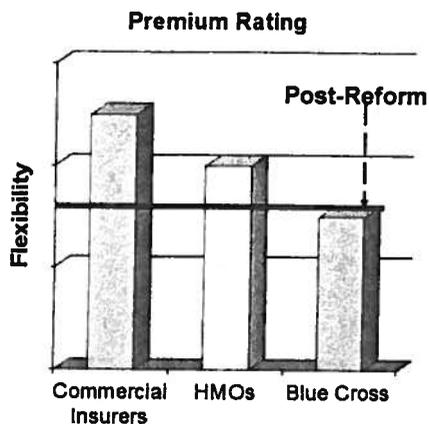


- ▶ Guaranteed issue (insurer of last resort)
- ▶ Guaranteed renewal
- ▶ Elimination of pre-existing conditions
- ▶ Restricts waiting periods for group coverage
- ▶ Prohibits discrimination based on health status
- ▶ Limits rescissions of coverage

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## ACA CHANGES

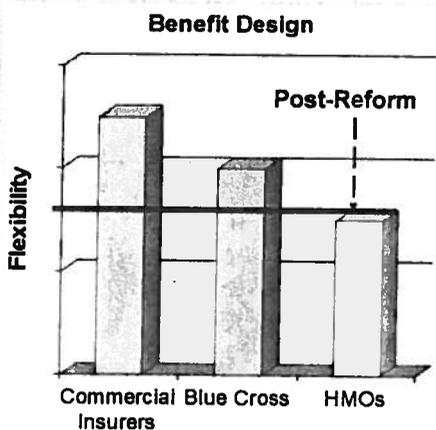


- ▶ Prohibits rating based on health status
- ▶ Only allows
  - ▶ Age rating, subject to a 3:1 band
  - ▶ Geographic adjustments
  - ▶ Tobacco surcharges (50%)
- ▶ Permits healthy lifestyle rebates
- ▶ Requires compliance with medical loss ratios

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## ACA CHANGES



- ▶ Every carrier must offer essential health benefits
- ▶ Limits on cost sharing
- ▶ Actuarial value:
  - ▶ 60%--Bronze
  - ▶ 70%--Silver
  - ▶ 80%--Gold
  - ▶ 90%--Platinum
- ▶ Duty to provide preventative health services

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## ACA CHANGES

- ▶ Because the requirements relating to **underwriting**, **premium rating** and **benefit design** are being standardized across all carriers, competition will occur most strongly in the areas of provider rates and the composition of provider networks
- ▶ The ACA does not address the issue of how health plans pay providers
- ▶ Some baseline standards regarding network adequacy are in the ACA (and SB 1293) to ensure reasonable access, but plans will be able to compete and distinguish themselves based on provider networks

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## EXCHANGE

## Expedia

	Detroit <b>DTW 5:15pm</b> →	Los Angeles <b>LAX 10:19pm</b>	Chicago <b>1 Stop</b>	<b>8h 4m</b>	Roundtrip from <b>\$592</b> per person includes tax and fees
<small>US Airways 1102 US Airways 1189</small>		<small>Show Flight Details</small>		<small>Baggage Fee Information</small>	<b>SELECT</b>
	Detroit <b>DTW 9:25pm</b> →	Los Angeles <b>LAX 12:30am +1 day</b>	Chicago <b>1 Stop</b>	<b>6h 5m</b>	Roundtrip from <b>\$702</b> per person includes tax and fees
<small>American Airlines 1235 operated by</small>		<small>Only 2 tickets left at this price!</small>			<b>SELECT</b>
	Detroit <b>DTW 4:30pm</b> →	Los Angeles <b>LAX 8:13pm</b>	Chicago <b>1 Stop</b>	<b>6h 43m</b>	Roundtrip from <b>\$719</b> per person includes tax and fees
<small>UNITED 1174 operated by MESA AIRLINES UNITED EXPRESS UNITED 123</small>		<small>Show Flight Details</small>		<small>Seat Preview</small>	<small>Baggage Fee Information</small>

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## BCBSM MFN PROVISIONS

- ▶ Two types:
  - ▶ **MFN Plus** - Appear in **side letters** with hospitals; not in Agreements filed with OFIR
  - ▶ **Standard MFN** - Appear in the **Participating Hospital Agreement** on file with OFIR
    - ▶ Only applies to Peer Group 5 Hospitals which are small rural hospitals

## BCBSM MFN PLUS

- ▶ In side letters with 22 hospitals/health systems
- ▶ These hospitals operate nearly half (45%) of the tertiary acute care beds in the state
- ▶ The side letters require hospitals to charge other commercial payors a substantial percentage above BCBSM rates
- ▶ Hospitals would incur financial penalties from BCBSM by setting prices to other payors at close to parity

## MFN PLUS - ILLUSTRATION

- ▶ The side letter contains a commitment by the hospital that it will not establish rates with other commercial payors unless those rates are 30% higher than the BCBSM rate
- ▶ If the BCBSM rate averages 60% of charges, the hospital is agreeing that other commercial payors will be required to pay at least 78% of charges (60% x 130%)
- ▶ Hospitals consequently will not contract with payors for less than 78% of charge. Even if a payor is willing to pay 110% of the BCBSM rate (66%), the hospital cannot agree to that rate without risk of substantial penalties from BCBSM

## MFN PLUS - MARKET HARM

- ▶ Hospital costs represent *about half* of medical costs for employer plan-sponsors
- ▶ Higher hospital charges result in higher medical costs, which are paid by employer plan-sponsors
- ▶ Employers typically absorb some of these higher costs, and pass through the remainder to their employees
- ▶ The result: Higher healthcare costs to Michigan employers and consumers, and BCBSM is shielded from competition

## **MFN PLUS - MARKET HARM**

- ▶ The only purpose of forcing competitors' hospital rates higher is to protect BCBSM from competition
  - ▶ If BCBSM is simply trying to assure that it has the best rate, why would it care if the hospital agreed to contract with another payor at 110% of the BCBSM rate?

## **MFN PLUS - MARKET HARM**

- ▶ By raising the cost of competitors' products, BCBSM avoids competing on innovation, service, and price
  - ▶ Michigan employers and consumers are denied access to competitors' superior products, which further increases medical costs and degrades healthcare outcomes
  - ▶ BCBSM takes advantage of the spread to charge higher fees to its customers, such as "access fees" that it tacks on to its customers' hospital charges

## BCBSM STANDARD MFN PROVISIONS

- ▶ In the Participating Hospital Agreement, BCBSM has a clause that applies to small rural (Peer Group 5) hospitals:
  - “Hospital will attest and commit that the payment rates which it has provided to BCBSM under this Agreement for non-Medicare members are at least as favorable as the rates which it has established with all other non-governmental PPOs, non-governmental HMOs or other non-governmental commercial insurers.”
- ▶ The Participating Hospital Agreement is developed by BCBSM in collaboration with Michigan hospitals, through the Michigan Hospital Association

## BCBSM STANDARD MFN PROVISIONS

- ▶ The fact that hospitals agreed to the MFN clause as part of the standard Participating Hospital Agreement is cause for concern
- ▶ Sometimes sellers (in this case hospitals) will agree to MFNs with buyers (in this case BCBSM) as means to protect market share
  - ▶ Knowing that competitor hospitals cannot discount below BCBSM rates to other insurers protects the other hospitals in the market from losing volume
  - ▶ If other insurers could secure more favorable rates from competitor hospitals, it may direct more volume to those hospitals

## BCBSM STANDARD MFN PROVISIONS

- ▶ MFN clauses actually impede the ability of market forces to lower costs
- ▶ Costs can be lowered in three respects:
  - ▶ **First**, as hospitals compete more vigorously to win market share, it will lower hospital costs for all payors
  - ▶ **Second**, as competing health plans secure lower hospital payment rates, they are able to offer lower premiums
  - ▶ **Third**, as BCBSM is facing more competitive pressure due to other insurers offering lower premiums, BCBSM will also lower premiums and become more efficient in order to retain business

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## BCBSM STANDARD MFNS HARM THE MARKET

- ▶ BCBSM MFNs serve no beneficial purpose
  - ▶ BCBSM MFNs do not allow hospitals to serve patients better or more efficiently
- ▶ BCBSM MFNs do not allow BCBSM to achieve lower rates: BCBSM already dictates its rates to hospitals.
- ▶ The only purpose of BCBSM MFNs is to prevent other health plans from competing with Blue Cross
  - ▶ Hospitals are basically prohibited from working with other health plans to grow hospital market share and diversify hospital revenues

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## BCBSM STANDARD MFN PROVISIONS

► Illustration

- Assume a hospital has \$50m in commercial health plan business with the following payors:

	Billed Charges	Payment Rate	Net Payment
BCBSM	\$ 35,000,000	60%	\$ 21,000,000
ABC Health Plan	\$ 4,000,000	80%	\$ 3,200,000
Other HMOs, PPOs combined	\$ 11,000,000	85%	\$ 9,350,000
	<b>\$ 50,000,000</b>		<b>\$ 33,550,000</b>

## BCBSM STANDARD MFN PROVISIONS

- Assume that ABC Health Plan is able to secure a new payment rate of 58% of charges and grows its business at the hospital

	Billed Charges	Payment Rate	Net Payment
BCBSM	\$ 35,000,000	60%	\$ 21,000,000
ABC Health Plan	\$ 9,000,000	58%	\$ 5,220,000
Other HMOs, PPOs combined	\$ 11,000,000	85%	\$ 9,350,000
	<b>\$ 55,000,000</b>		<b>\$ 35,570,000</b>

Hospital earns additional revenue by discounting below BCBSM rates

## BCBSM STANDARD MFN PROVISIONS

- ▶ In this case, the hospital's net payments increase more than \$2.0 million (from \$33.55m to \$35.57m)
  - ▶ If the marginal costs for treating the additional business were less than \$2.0 million, the hospital will find that it increased its net profits
  - ▶ If the additional volume came from re-directing business at competitor hospitals, the hospital also improved its market share
- ▶ Employers get the benefit of ABC Health Plan being a more effective competitor to BCBSM since ABC Health Plan has favorable payment rates

## BCBSM STANDARD MFN PROVISIONS

- ▶ The ACA expands coverage, so there will be a greater ability of carriers to "deliver" new volume to hospitals
- ▶ This, in turn, will increase the likelihood of hospitals willing to discount even greater to win their share of the new volume and, in the case of aggressive hospitals, win some of the shares that might otherwise go to their competitor hospitals
- ▶ MFN clauses will impede this development and stifle the ability of competition to drive down costs

## **SB 1293 AND 1294 AMENDMENT**

- ▶ The bills codify the Commissioner's July Order which requires prior approval before a carrier can use an MFN
- ▶ This approach lacks standards, thereby exposing the Commissioner to litigation alleging inconsistent treatment or claims of favoritism
- ▶ To assess the expected market impacts, the Commissioner would have to know each health plan's network composition and hospital rates in order to determine if the MFN would raise competitor costs; also need to know hospital capacity, marginal costs and referral patterns – all areas outside the Commissioner's expertise
- ▶ The better approach is a complete ban, just as numerous other states have done

## **BLUE CROSS HOSPITAL PAYMENT**

- ▶ Public Act 350 requirement
- ▶ PHA reimbursement models
- ▶ Payment in relation to costs
  - ▶ National averages
  - ▶ Dr. Cohen analysis
- ▶ Payment in relation to market

## BCBSM LEGAL OBLIGATION

► PA 350 provides:

“No portion of [BCBSM’s] fair share of hospitals’ reasonable financial requirements shall be borne by other health care purchasers.”

## BCBSM LEGAL OBLIGATION

► Federal Court ruling on BCBSM Motion to Dismiss made the following findings:

“[PA 350] states that no portion of Blue Cross’ fair share of the hospitals’ reasonable financial requirements shall be borne by other health care purchasers. M.C.L. §550.1516(2)(b). Although the Act allows Blue Cross to include reimbursement arrangements which include financial incentives and disincentives, **such arrangements cannot result in cost shifting to other health care purchasers.** The purpose of [PA 350] is to make certain that the people of Michigan are able to access health care services at a fair and reasonable price. **There is no provision in [PA 350] that allows Blue Cross to stifle competition.**”

## BCBSM STANDARD PAYMENT MODELS

- ▶ In July, the Commissioner ruled that BCBSM was not meeting this requirement in the **Participating Hospital Agreement**
- ▶ The Order requires that BCBSM develop a new model that explicitly takes into account government program losses (due in January)
- ▶ The Order applies to the reimbursement model for Peer Group 1-4 hospitals, not Peer Group 5
  - ▶ The Peer Group 5 Model explicitly recognizes Medicare and Medicaid losses

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## PHA REIMBURSEMENT MODELS

### BCBSM Peer 1-4 Model

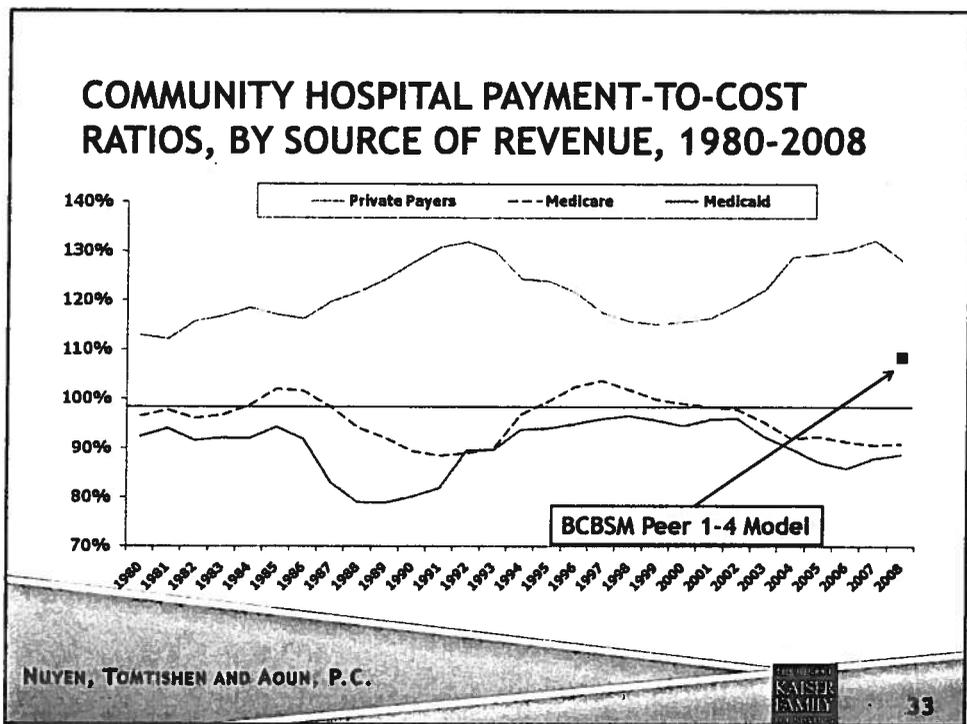
Hospital cost	100.0%
Margin	3.0%
Uncompensated Care	3.1%
Uncompensated Care gross-up	1.0%
Pay for performance	5.0%
<b>Sub Total</b>	112.1%
Other Operating Income offset	(3.0%)
<b>Total</b>	109.1%

### BCBSM Peer 5 Model

Full GAAP cost (net of bad debt)	100.0%
Margin	3.0%
Uncompensated Care	4.0%
Uncompensated Care gross-up	2.0%
Government Shortfall	7.0%
Governmental payor gross-up	8.0%
Pay for performance	6.0%
<b>Sub Total</b>	130.0%
Other Operating Income offset	(2.0%)
<b>Total</b>	128.0%

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### BCBSM PAYMENT IS BELOW HOSPITAL FINANCIAL REQUIREMENTS

- ▶ For Michigan hospitals, a majority of their business pays below cost
- ▶ Medicare Payment Assessment Commission most recent report concludes that, in 2010, Medicare paid on average **95.5% of cost**
  - ▶ In Michigan, Medicare represents 40% of a hospital cost
- ▶ Medicaid pays on average about **83% of cost**, with wide variation among hospitals (some as low as 52%)
  - ▶ In Michigan, Medicaid represents 13% of hospital cost
- ▶ Uncompensated care represents 4% of hospital cost

## **BCBSM PAYMENT IS BELOW HOSPITAL FINANCIAL REQUIREMENTS**

- ▶ Michigan Hospital Association estimates that in 2009:
  - ▶ Medicare shortfall: \$276 million
  - ▶ Medicaid shortfall: \$608 million
- ▶ Shortfalls under both programs are expected to grow due to ACA cuts

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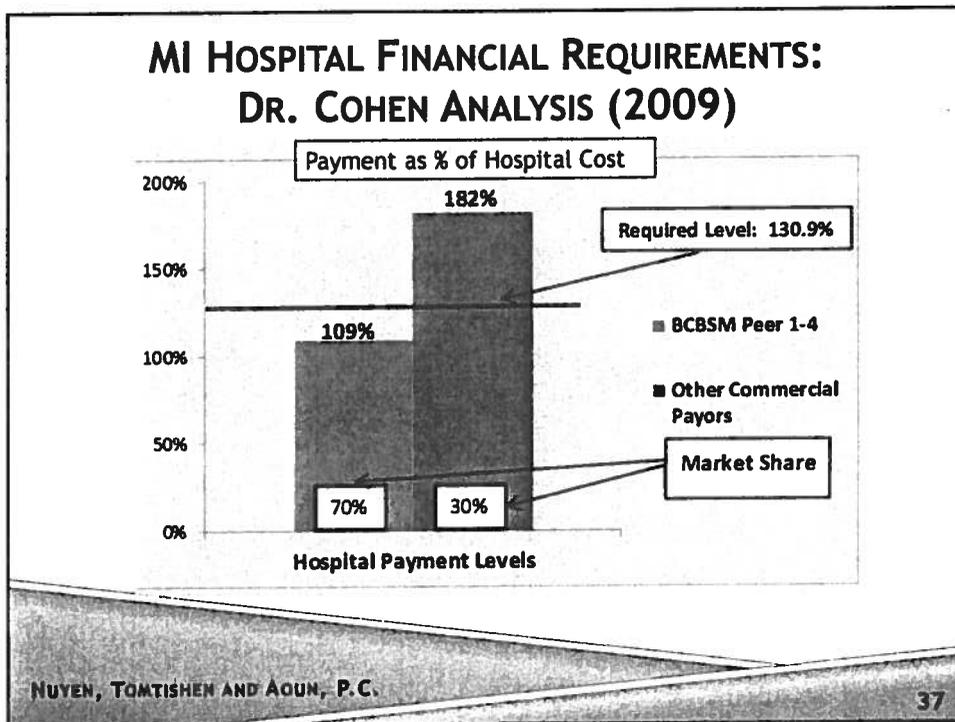
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## **BCBSM PAYMENT IS BELOW HOSPITAL FINANCIAL REQUIREMENTS**

- ▶ Dr. Cohen found that Michigan hospitals are more efficient than national and regional averages
  - ▶ Losses under government programs are being driven by payment policies and budget constraints, not hospital inefficiency
- ▶ Dr. Cohen estimated that hospitals need to recover 130.9% of cost given Michigan levels of uncompensated care, Medicare losses and Medicaid losses

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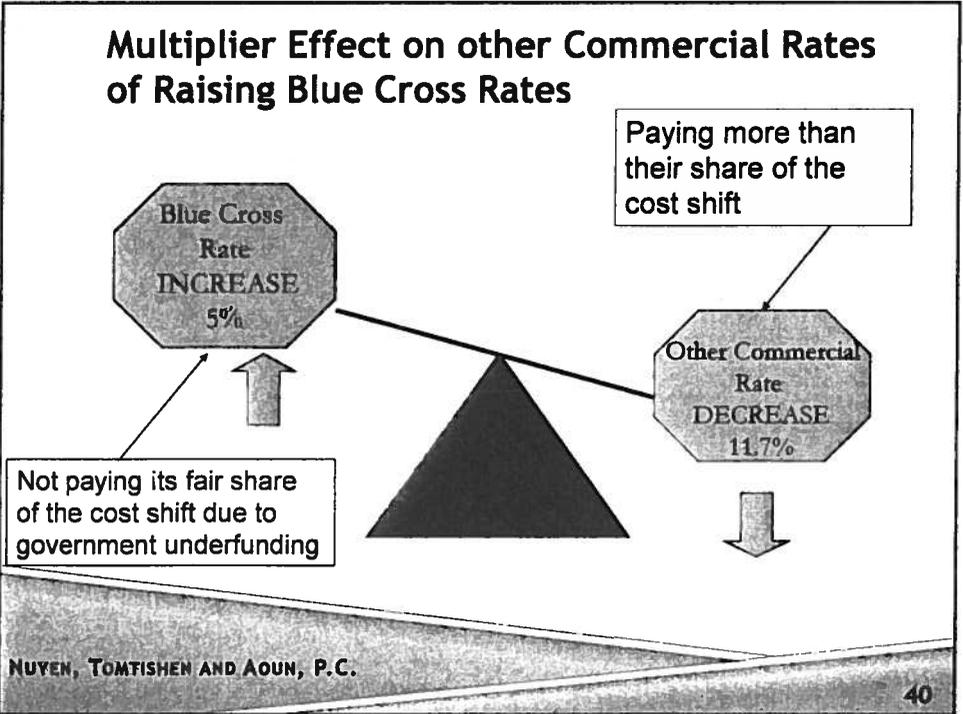
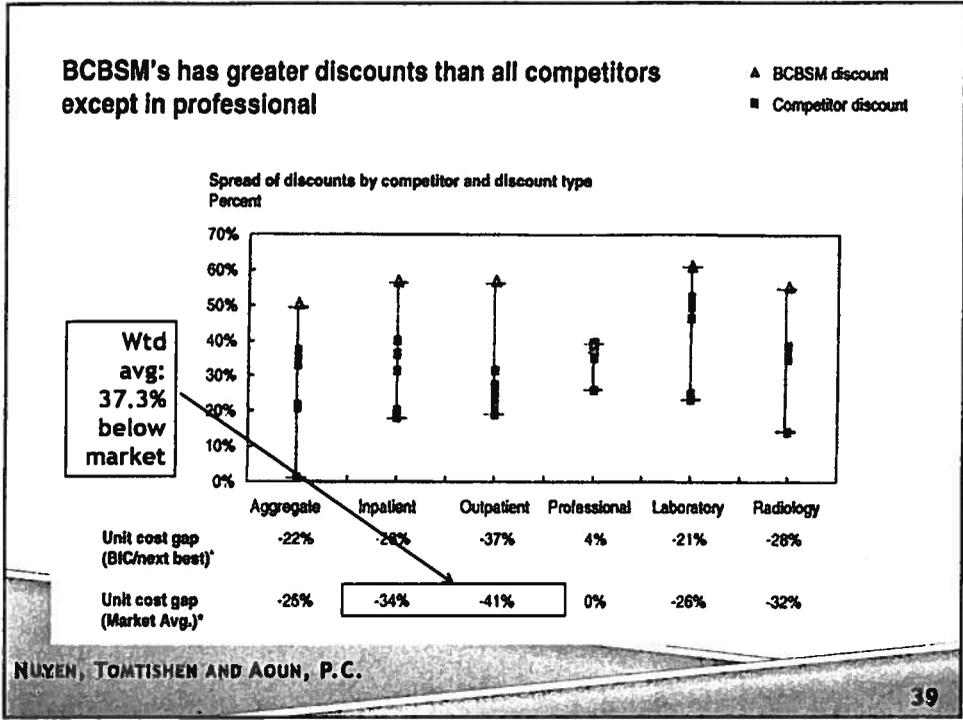
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## BCBSM PAYMENT IS BELOW MARKET

- ▶ BCBSM has internal data that show that it pays hospitals 37% below market

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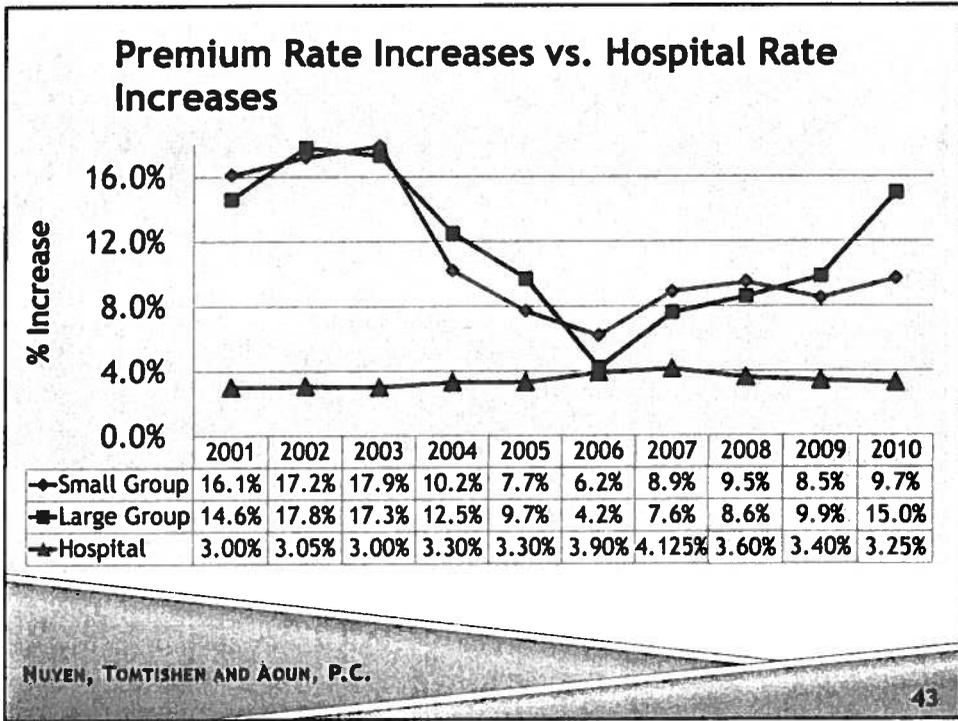


## **EFFECT ON PREMIUM RATES**

- ▶ BCBSM will assert that raising payment to hospitals will increase premiums
- ▶ Payment increases to hospitals can be offset by
  - ▶ BCBSM becoming more efficient (lowering administrative expenses)
  - ▶ BCBSM utilizing its excess surplus
  - ▶ BCBSM curtailing acquisition spending

## **EFFECT ON PREMIUM RATES**

- ▶ As Blue Cross pays hospitals more, the market will become more competitive and the new competition will improve control over premium rate increases
- ▶ There is not a strong correlation between BCBSM premium rate increases and hospital rate increases



## AMEND SB 1293

- ▶ To require that BCBSM pay its fair share of hospitals' reasonable financial requirements
  - ▶ Carry forward the provision from PA 350
- ▶ Define hospital financial requirements so that Medicare and Medicaid losses are explicitly recognized
  - ▶ Carry forward the Commissioner's Order
- ▶ Provide arbitration for disputes
  - ▶ Avoids Commissioner entanglement
  - ▶ Consistent with what the State requires of Medicaid HMOs
- ▶ Sunset after five years

## SOURCE MATERIAL

<u>Slide</u>	<u>Source</u>
5	AMA. Competition in Health Insurance: A comprehensive study of U.S. markets (2011 Update)
6	HealthLeaders InterStudy 2010 Michigan Health Plan Analysis
14	US v BCBSM, (E.D. Mich. Case No. 10-14155), Complaint, Par. 4(a) (Oct 18, 2010)
30	U.S. v. Blue Cross, (E.D. Mich. Case No. 10-14155), Memorandum Opinion and Order Denying Motion to Dismiss (August 12, 2011)
34	Medicare Payment Assessment Commission, Report to Congress (March 2012)
35	Michigan Hospital Association Report, Mission Critical: Michigan Hospitals Feb. 2011
36	Cohen, H., More Than a Decade of Quality, Efficiency and Value Improvements at Michigan Hospitals, January 2009, available at <a href="http://www.LowerHospitalCosts.org">www.LowerHospitalCosts.org</a> .
39	HVA Reimbursement Workshop Report of McKinsey & Company (2009), submitted by BCBSM to OFIR May 9, 2012
41	Rate Filings; BCBSM standard updates to hospitals

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