STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION

Bulletin 2012-13-INS

In the matter of

Premium Adjustment Factors in Health Plan Rate Filings

_____/

Issued and entered
this 29th day of August 2012
by R. Kevin Clinton
Commissioner

It has come to the Commissioner's attention that health plan issuers may be incorporating premium adjustment factors into their final rate development and not advising the Office of Financial and Insurance Regulation (OFIR) of these inclusions through their rate filings.

A premium adjustment factor is any factor that adjusts rates or premiums for subjective reasons, including but not limited to: underwriting judgment, competition, employer or agent price demands, rating or enrollment assumption error, unanticipated demographic changes, or any other subjective adjustment not expressly permitted under the Michigan Insurance Code (Code), MCL 500.100 *et seq.*

Premium adjustment factors are unfairly discriminatory in violation of the Code. In particular, Section 2020 of the Code, MCL 500.2020, prohibits making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, membership or policy fees, or rates charged for any policy or contract of accident or health insurance applicable to individual or family expense coverage or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

Similarly, Section 3519 of the Code, MCL 500.3519, provides that HMO rates must be "fair, sound, and reasonable in relation to the services provided …" Rating factors that are subjective and actuarially unsupportable are not "sound" or "reasonable in relation to the services provided" by an HMO. Additionally, Section 3521(2) of the Code provides that an HMO "shall submit supporting documentation used in the development of a prepayment rate or rating methodology." Any adjustment applied beyond rates and rating methodologies that have been filed and approved by OFIR is a violation of this section.

Sections 608(2) and 609 of the Nonprofit Health Care Corporation Reform Act (PA 350), MCL 550.1608(2) and 550.1609, require Blue Cross Blue Shield of Michigan's (BCBSM) rates to be equitable, adequate, and not excessive. To be equitable, rating differences must be supported by differences in anticipated benefit costs, administrative expense costs, differences in risk, or any identified cost transfer provisions. MCL 550.1609(3). To be adequate, a rate must not be unreasonably low relative to certain factors enumerated in Section 609(1) of PA 350 and must be based on reasonable evaluations of recent claim experience, projected trends in claim costs, the allocation of administrative expense budgets, and BCBSM's present and anticipated unimpaired surplus. MCL 550.1609(4). To avoid being excessive, a rate must not be unreasonably high relative to certain elements enumerated in Section 609(1) of PA 350. Premium adjustment factors do not comply with these sections of PA 350.

This bulletin applies to all issuers in Michigan, including commercial carriers, HMOs, and BCBSM. Market conduct examinations will take place on new and renewal business effective January 2, 2013 and later to verify compliance with this bulletin.

Any questions regarding this bulletin, including questions regarding compliance, should be directed to:

Karen Dennis, Departmental Manager
Insurance Rates and Forms Division
Office of Financial and Insurance Regulation
611 West Ottawa Street
P.O. Box 30220
Lansing, Michigan 48909-7720
dennisk1@michigan.gov

Toll Free: (866) 999-6442

R. Kevin Clinton
Commissioner