

The Healthy Michigan Plan
Public Act 107 of 2013 §105d (8), (9)
2015 Report on Uncompensated Care and Insurance Rates

December 31, 2016

Submitted to the Michigan Department of Health and Human Services
and the Michigan Department of Insurance and Financial Services

Prepared by the University of Michigan Institute for Healthcare Policy & Innovation
in collaboration with the University of Michigan School of Public Health

§105d (8) The program described in this section is created in part to extend health coverage to the state's low-income citizens and to provide health insurance cost relief to individuals and to the business community by reducing the cost shift attendant to uncompensated care. Uncompensated care does not include courtesy allowances or discounts given to patients. The Medicaid hospital cost report shall be part of the uncompensated care definition and calculation. In addition to the Medicaid hospital cost report, the department of community health shall collect and examine other relevant financial data for all hospitals and evaluate the impact that providing medical coverage to the expanded population of enrollees described in subsection (1)(a) has had on the actual cost of uncompensated care. This shall be reported for all hospitals in the state. By December 31, 2014, the department of community health shall make an initial baseline uncompensated care report containing at least the data described in this subsection to the legislature and each December 31 after that shall make a report regarding the preceding fiscal year's evidence of the reduction in the amount of the actual cost of uncompensated care compared to the initial baseline report. The baseline report shall use fiscal year 2012-2013 data. Based on the evidence of the reduction in the amount of the actual cost of uncompensated care borne by the hospitals in this state, beginning April 1, 2015, the department of community health shall proportionally reduce the disproportionate share payments to all hospitals and hospital systems for the purpose of producing general fund savings. The department of community health shall recognize any savings from this reduction by September 30, 2016. All the reports required under this subsection shall be made available to the legislature and shall be easily accessible on the department of community health's website.

§105d (9) The department of insurance and financial services shall examine the financial reports of health insurers and evaluate the impact that providing medical coverage to the expanded population of enrollees described in subsection (1)(a) has had on the cost of uncompensated care as it relates to insurance rates and insurance rate change filings, as well as its resulting net effect on rates overall. The department of insurance and financial services shall consider the evaluation described in this subsection in the annual approval of rates. By December 31, 2014, the department of insurance and financial services shall make an initial baseline report to the legislature regarding rates and each December 31 after that shall make a report regarding the evidence of the change in rates compared to the initial baseline report. All the reports required under this subsection shall be made available to the legislature and shall be made available and easily accessible on the department of community health's website.

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Executive Summary

This report, pursuant to §105d (8) and (9) of Public Act 107 of 2013, provides the annual update to the baseline estimate of uncompensated care borne by Michigan hospitals as it relates to insurance rates and rate setting.

The main source of data for the uncompensated care portion is cost reports that hospitals submit annually to the Michigan Department of Health and Human Services (MDHHS). The initial report, submitted in December 2014, provided baseline data on hospital uncompensated care from 2013, i.e., prior to the implementation of the Healthy Michigan Plan (HMP). The December 2015 report presented data from 2014. Because of reporting lags and the timing of hospital fiscal years, these data represented post-HMP experience for only a subset of hospitals, and even in those cases the most recent data represented a mix of pre- and post-HMP data. The most recent data used in this report were submitted in 2015. For most hospitals, these data pertain to fiscal year 2015 and represent a full 12 months of post-HMP experience. For a subset of hospitals, the most recent data available are for fiscal year 2014 and therefore represent a mix of pre- and post-HMP data. We present results for 2013, 2014 and 2015, though for the purposes of evaluating the effect of the HMP on hospital uncompensated care, the cleanest comparisons are between 2013 and 2015.

Two main sources of data, key informant interviews and Michigan DIFS rate filings, provide information on the contribution of uncompensated care to premium rates, rate change filings, and the net effect on rates overall, in the year before and each of the two years following implementation of the Healthy Michigan Plan.

Key findings: §105d (8) Uncompensated Care

The cost report data indicate that the cost of uncompensated care provided by Michigan hospitals fell dramatically after the implementation of the Healthy Michigan Plan. Comparing data from 2013 and 2015 for a consistent set of hospitals, uncompensated care costs decreased by almost 50 percent. For the average hospital, annual uncompensated care expenses fell from \$7.21 million to \$3.77 million. Expressed as a percentage of total hospital expenses, uncompensated care decreased from 5.2 percent to 2.9 percent. Over 90 percent of hospitals submitting data for both FY 2013 and FY 2015 saw a decline in uncompensated care between those two years.

Key findings: §105d (9) Insurance Premium Rates

There was no evidence from the interviews and rate filings that the Healthy Michigan Plan affected health plan premium rates. Review and analysis of DIFS rate filings showed changes in the increases requested in premium rates by year and by product and market. The average weighted premium rate increase requested in filings declined from 2013-2015: 7.55% in 2013, 5.77% in 2014, and 5.20% in 2015. While the requested rate increase varied by products and markets, reasons given in the filings for the rate requests were related most often to increasing medical and pharmaceutical costs.

Interviews with key stakeholders revealed concerns with increasing medical and pharmacy costs. Some respondents expressed concerns about future premium changes as a result of changes in the methodology for determining risk adjustment or expiration in 2016 of the Federal reinsurance program. With the reinsurance program, all individual, small group, and large group market issuers of fully-insured major medical products, as well as self-funded plans, contributed funds to the reinsurance program since 2014, with proceeds distributed to insurers who had enrollees with high medical expenses. For 2016, these reinsurance payments reduced individual market premiums by an estimated 4 to 6 percent. Without the reinsurance program, some insurers will need to raise their premiums in 2017 by a comparable percentage to make up for the loss of the reinsurance funds.¹

The report details the decrease in uncompensated care costs since the Medicaid expansion; however, there was no evidence from the interviews and rate filings that the Healthy Michigan Plan affected health plan premium negotiations or premium rates.

Challenges in Quantifying the Impact of Uncompensated Care Costs and the Healthy Michigan Plan on Premium Rates

Developing health insurance premium rates involves numerous stakeholders, such as insurers, hospitals, employers, physicians, pharmacy benefit managers, pharmaceutical and medical device manufacturers, to name a few. There are also complex rate setting methodologies, and proprietary information, overlaid on continually changing medical and insurance markets. In addition, not all plans and policies offered in a state are subject to regulation, review, and approval by the state. There is no single source of data that provides all necessary elements for analysis. These and other factors make it difficult to attribute observed premium rate changes to the Healthy Michigan Plan.

The academic literature in health economics and health policy does not provide direct theoretical or empirical support for a transfer of the costs of uncompensated care or of shortfalls in Medicare and Medicaid payments to private payers, despite perceptions of the existence of cost shift.² Cost shifting has been defined as “the phenomenon in which changes in administered prices of one payer lead to compensating changes in prices charged to other payers.”³ Prior research demonstrates that uncompensated care as a share of overall health care costs has remained relatively flat while the private payment to cost ratio has increased, suggesting that factors other than changes in uncompensated care explain changes in private insurance premiums.⁴

¹<http://kff.org/private-insurance/perspective/what-to-look-for-in-2017-aca-marketplace-premium-changes/>

² Coughlin TA, Holahan, J, Caswell, K, McGrath, M. Uncompensated care for the uninsured: A detailed examination. Kaiser Family Foundation report. May 30, 2013. Available from: <http://kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-cost-shifting-and-remaining-uncompensated-care-costs-8596/>

³ Ginsburg P. Can hospitals and physicians shift the effects of cuts in Medicare reimbursement to private payers? Health Aff [Internet]. 2003;(Web Exclusive):W3–472 to W3–479. Available from: <http://content.healthaffairs.org/content/early/2003/10/08/hlthaff.w3.472.full.pdf>

⁴ Forslund TO. Cost shifting and the impact of new hospitals on existing markets. Wyoming Department of Health. 2014.

A number of factors contribute to changes in private insurance premiums, with changes in public payer rates and in uncompensated care being just two of these factors. Even in situations where a hospital has a large share of market power, hospitals may employ other strategies rather than increase prices when faced with revenue shortfalls, including cost cutting and “volume shifting,” and lowering private prices to attract more private volume.⁵ Even if cost shifting does occur at its maximum, the amount that would potentially be shifted to employers is less than 3% of private insurance premiums.⁶ The complex interplay of factors that explain changes in private insurance rates, as also noted in the literature, makes it very difficult to attribute changes in insurance premiums to the reductions in uncompensated care resulting from the Healthy Michigan Plan.

Conclusion

Based on hospital cost reports submitted to MDHHS, Michigan hospitals experienced a substantial decline in the costs of uncompensated care in FY 2015 compared to FY 2013. Yet rate filings and interviews with key stakeholders do not demonstrate a connection between reductions in uncompensated care and premium rates.

⁵ Frakt A. How much do hospitals cost shift? A review of the evidence. *Milbank Q.* 2011;89(1):90–130.

⁶ Coughlin TA, Holahan, J, Caswell, K, McGrath, M. Uncompensated care for the uninsured: A detailed examination. Kaiser Family Foundation report. May 30, 2013. Available from: <http://kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-cost-shifting-and-remaining-uncompensated-care-costs-8596/>

§105d (8): Uncompensated Care

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Introduction

In order to measure the effect of the Healthy Michigan Plan, §105(d)(8) of Public Act 107 requires the Department of Community Health (DCH), now the Department of Health and Human Services (DHHS), to publish annual reports on uncompensated care in Michigan. This section of the report, *The Healthy Michigan Plan: Uncompensated Care*, fulfills the requirement of §105(d)(8). The analysis is based on data from Medicaid cost reports submitted to the state annually from 2013 to 2015.

Background

The 2015 PA 107 report presented quarterly state-level data on inpatient hospital discharges from 2003 to the third quarter of 2014. These data revealed immediate changes in payer mix in Michigan after the implementation of the Healthy Michigan Plan. The Medicaid share of hospital discharges rose from 17 percent in the 1st quarter of 2014 – before HMP – to 20 percent in the 3rd quarter of 2014. At the same time the uninsured share of discharges also fell by three percentage points, from 4 percent to 1 percent. These sharp changes, which followed a decade in which payer mix shifted very gradually, suggested a significant effect of the Healthy Michigan Plan. Other published research using data from Michigan⁷ and comparing a greater number of states that implemented the ACA Medicaid expansion also indicate a significant reduction in uninsured discharges and an increase in Medicaid discharges after Medicaid expansion.⁸

Data: Medicaid cost reports

Each year, Michigan hospitals submit cost reports to the State Medicaid program. Based on several data elements contained in these reports, it is possible to calculate the cost of uncompensated care provided by each hospital.

Uncompensated care is the sum of two different types of costs: charity care and bad debt. **Charity care** is the cost of medical care for which there was no expectation of payment because the patient has been deemed unable to pay. **Bad debt** is the cost of medical care for which there was an expectation of payment because the patient was deemed to be able to pay for care, but ultimately payment was not received. Both types of uncompensated care may arise from patients

⁷ Davis MA, Gebremariam A, Ayanian JZ. Changes in insurance coverage among hospitalized non-elderly adults after Medicaid expansion in Michigan. *JAMA* 2016; 315:2617-8.

⁸ Hempstead K, Cantor JC. State Medicaid expansion and changes in hospital volume according to payer. *New England Journal of Medicine* 2016; 374(2): 196-198. Nikpay S, Buchmueller T, Levy HG. 2016. Affordable Care Act Medicaid expansion reduced uninsured hospital stays in 2014. *Health Affairs* 2016; 35 (1):106-110.

who are uninsured or from those who are under-insured and unable to afford deductibles or other cost-sharing required by their insurance plans when they receive hospital care. Changes in Disproportionate Share Hospital (DSH) payments do not have a direct impact on uncompensated care. For more information on the definition of uncompensated care, please see Appendix A.

The cost reports for state fiscal year (FY) 2015 include data on 142 hospitals. Hospitals vary in the timing of their fiscal years and this variation affects the timing of when data is reported to the state. Table 1 summarizes the timing of hospital fiscal years and indicates how this timing affects our ability to measure changes in uncompensated care before and after the implementation of the Healthy Michigan Plan (HMP).

For hospitals with fiscal years ending in the first three quarters of the calendar year (i.e., before September 30) the most recent submission pertains to their 2015 fiscal year. Regardless of the exact timing, FY 2015 started after April 1, 2014. Thus, all data from FY 2015 represents 12 months of post-HMP experience. There is variation, however, in how data for FY 2014 lines up with the start of the HMP. For hospitals with fiscal years ending in the first quarter, FY 2014 ended before the start of HMP enrollment, which means that FY 2014 represents 12 months of pre-HMP data. In contrast, for hospitals with fiscal years ending in the second or third quarter, FY 2014 started before and ended after the establishment of the program. Thus, for these hospitals FY 2014 represents a mix of pre- and post-HMP experience. Hospitals with fiscal years ending in the fourth quarter always submit their cost report data with a lag. For this group, the most recent (2015) submission contains data from FY 2014. For a large majority of these hospitals, the fiscal year ends on December 31, which means that 9 months of FY 2014 fell in the post-HMP period.

Uncompensated care, FY 2013 to FY 2015

Table 2 presents data on hospital uncompensated care for FY 2013, FY 2014 and FY 2015. Two sets of results are presented for FY 2013 and FY 2014. One pertains to all hospitals reporting data for those years—142 hospitals in 2013 and 141 hospitals in 2014. To facilitate comparisons with FY 2015, results for 2013 and 2014 are also reported for the subset of hospitals for which FY 2015 data are available. Results for each individual hospital are reported in Appendix C Table 1.

The data show that all Michigan hospitals provided approximately \$1.1 billion in uncompensated care in FY 2013, which represented 4.8 percent of total hospital expenses. This amount declined to \$913.5 million in FY 2014, representing 4.1 percent of total hospital expenses. As noted, only a fraction of FY 2014 fell after the start of the HMP.

FY 2015 is the first fiscal year that began after the HMP was in place. Thus, the impact of the HMP is more readily seen by focusing on the 88 hospitals that reported data for 2013 and 2015.⁹ In the baseline year, the average amount of uncompensated care for this subset of hospitals was lower than the average for all hospitals (\$7.2 million vs. 7.8 million) though uncompensated care as a percentage of total expenses was slightly higher (5.2 percent vs. 4.8 percent). For these

⁹ For one hospital that changed the timing of its fiscal year, no data from 2014 are available. This hospital is in the data set in both 2013 and 2015. Therefore, comparisons between those two years are for the same set of hospitals.

hospitals, the mean number of months of HMP exposure for this group in FY 2014 was 3.3 months. The results show that uncompensated care expenses fell 0.4 percentage points between FY 2013 and FY 2014, to an average of 4.8 percent. There was a further decline in FY 2015 to 2.9 percent of total expenses. For the 88 hospitals reporting 2015 data, the total amount of uncompensated care provided in 2015 was \$332.1 million, or 53 percent of the amount of uncompensated care provided by those same hospitals in 2013.

Figure 1 presents the results in graphical form, breaking out the results for FY 2014 in a slightly different way. For that year, hospitals are grouped according to HMP exposure, i.e., the number of months in FY 2014 that fell after April 1, 2014, when the HMP plan started. It is important to note that the separate categories for FY 2014 consist of different hospitals, and therefore comparisons among the different results for 2014 should be interpreted cautiously. With that caveat noted, the data suggest that uncompensated care fell shortly after the HMP went into effect. Among hospitals for which half of FY 2014 occurred after the HMP was in place, uncompensated care was 4.3 percent of total expenses, reduced from 4.8 percent for all hospitals in 2013. Among hospitals with 9 months of post-HMP experience in FY 2014, uncompensated care was 2.9 percent of total expenses, essentially the same as the rate in 2015.

Figure 2 presents the full distribution of the change between 2013 and 2015 in uncompensated care as a percentage of total expenses for the 89 hospitals submitting data for both years. Uncompensated care fell as a percentage of expenses for 94 percent of these hospitals (83 out of 88). The median change was 2.0 percentage points, just slightly below the mean difference of 2.3 percentage points shown in Table 2. Thirty percent of hospitals experienced a decline of 3 percentage points or more.

Conclusion

This is the third in a series of annual reports analyzing changes in uncompensated care following the implementation of the Healthy Michigan Plan. This year's report is the first to present data representing a full year of experience after the program was in place (for most, but not all, hospitals). The results indicate a substantial decline in uncompensated care. Over 90 percent of hospitals submitting data for FY 2015 saw a decline in uncompensated care measured as a percentage of total expenses between 2013 and 2015. For this group as a whole, uncompensated care expenses fell nearly by half between 2013 and 2015.

Table 1. The Distribution of Michigan Hospitals by the Timing of their Fiscal Year and Availability of Medicaid Cost Report Data

FY ends in:		Data Available for Hospital Fiscal Year		
		2013	2014	2015
1st Quarter	number of hospitals	9	9	9
	months post-HMP	0	0	12
2nd Quarter	number of hospitals	61	60	60
	months post-HMP	0	3	12
3rd Quarter	number of hospitals	19	19	19
	months post-HMP	0	6	12
4th Quarter	number of hospitals	53	53	0
	months post-HMP	0	9	---

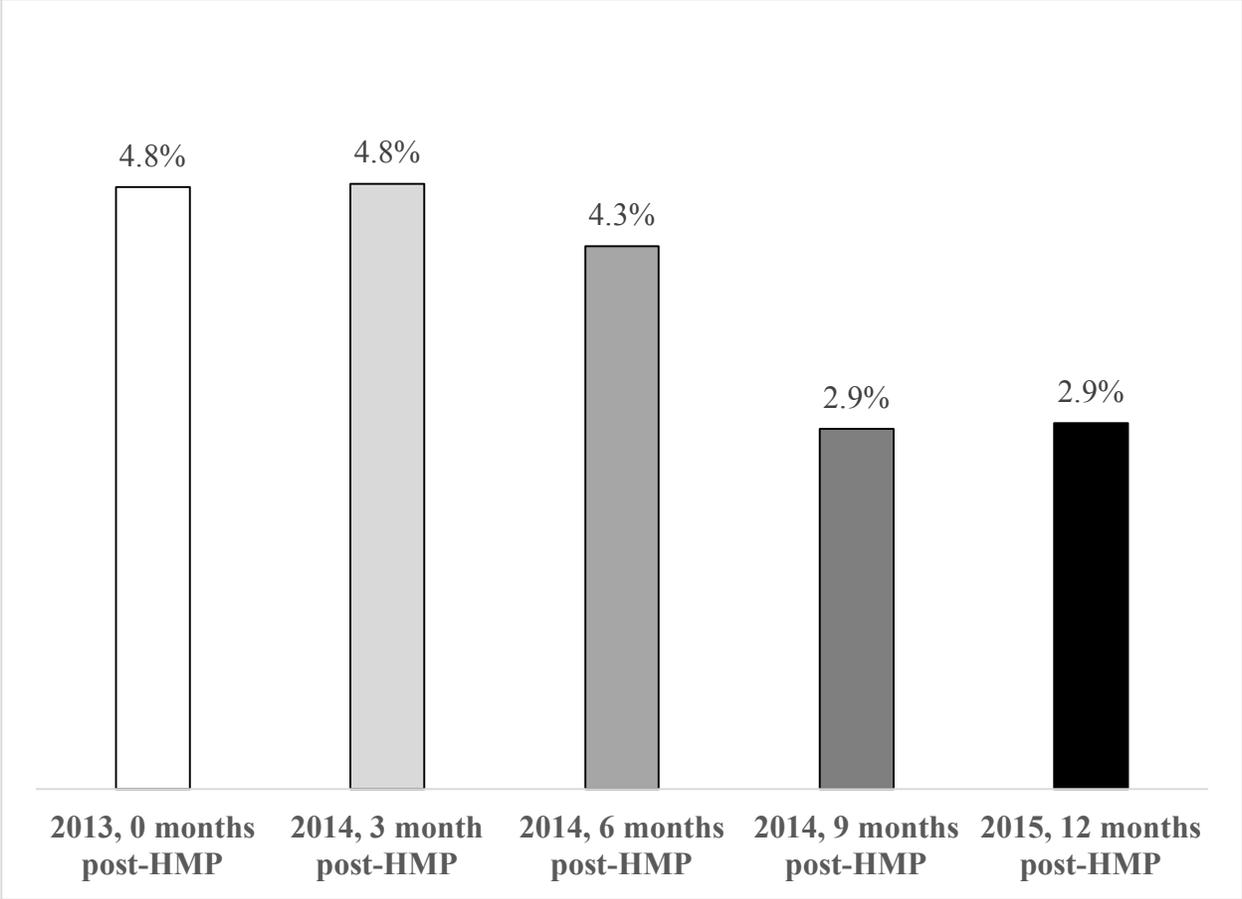
Notes: Hospitals are categorized according to the timing of the fiscal years. The first row in panel gives the number of hospitals in the category reporting data for each fiscal year. Because hospitals submit data with a lag, for hospitals with fiscal years ending in the fourth quarter, the 2015 submission pertains to their FY 2014. The second row in each panel gives the mean number of months in that fiscal year that fell after April 1, 2014.

Table 2. Uncompensated Care Costs, Hospital FY 2013, FY 2014 and FY 2015

	All Hospitals		Hospital FY Ends Q1 – Q3		
	2013	2014	2013	2014	2015
Number of Hospitals	142	141	88	87	88
Mean months post-HMP	0	5.4	0	3.3	12
Uncompensated Care Costs					
Total (millions)	\$1110.4	\$913.5	\$627.0	\$590.0	\$332.1
Mean (millions)	\$7.82	\$6.47	\$7.21	\$6.78	\$3.77
As a % of Total Costs	4.8%	4.1%	5.2%	4.8%	2.9%

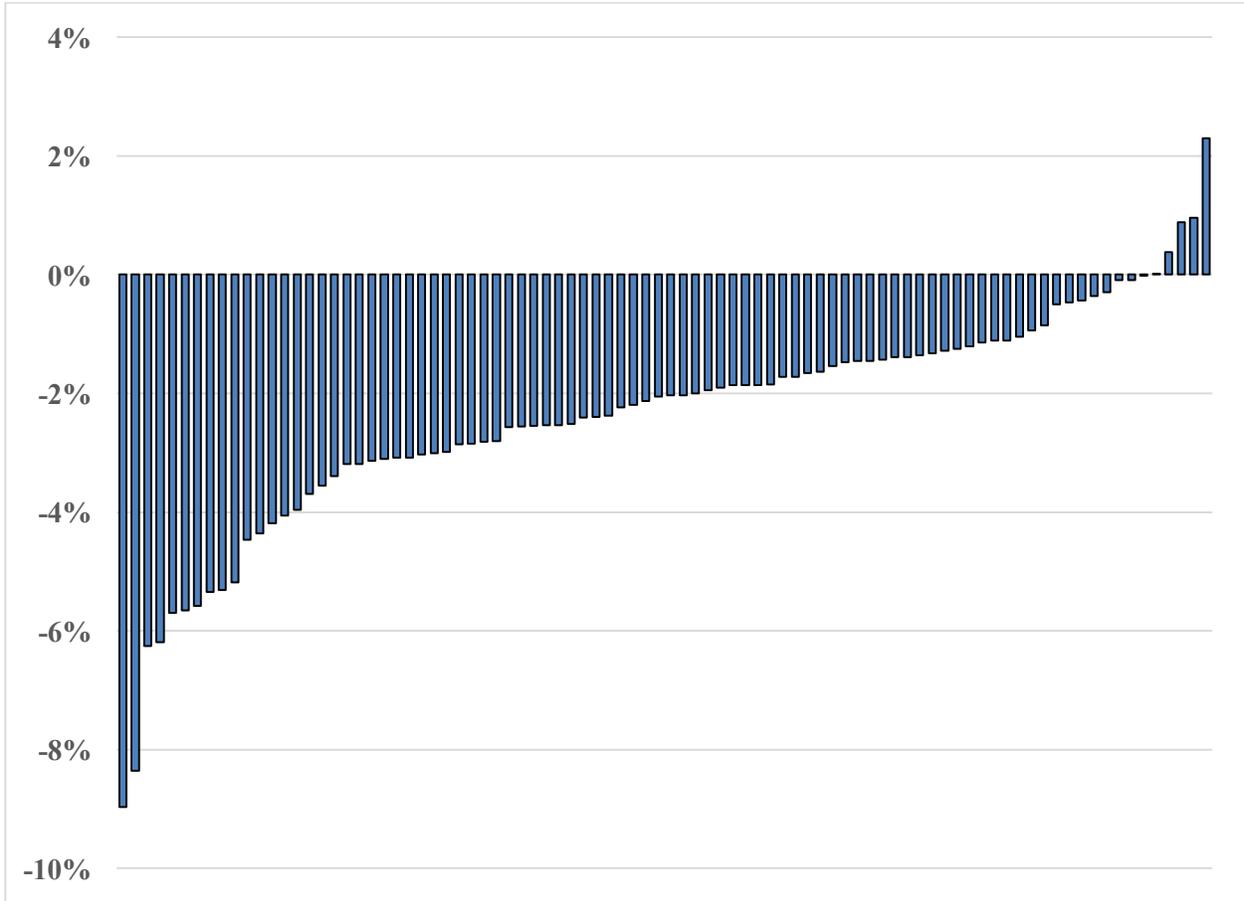
Notes: The figures for uncompensated care as a percentage of total hospital costs represent unweighted means.

Figure 1. Uncompensated Care as a Percentage of Total Expenses, by Exposure to the Healthy Michigan Plan, 2013 to 2015



Notes: The figures represent unweighted means for hospitals in each category. The first column presents data for all 142 hospitals that submitted data for FY 2013. This corresponds to column 1 of Table 2. The next 3 columns report FY 2014 results for hospitals with 3, 6 and 9 months of exposure to the HMP. The number of hospitals in these categories are 61, 19 and 53, respectively. Data are not reported for 9 hospitals for which FY 2014 ended before the HMP start date of April 1, 2014. FY 2015 data are for 88 hospitals that submitted data for that year. This figure corresponds to column 5 of Table 2.

Figure 2. Change in Uncompensated Care as a Percentage of Total Expenses Between 2013 and 2015 for Hospitals Reporting Data in Both Years



Notes: The sample consists of 88 hospitals for which FY 2015 data are available. Each bar represents the change for an individual hospital.

§105d (9): Insurance Premium Rates

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Introduction

To measure the effect the Healthy Michigan Plan “has had on the cost of uncompensated care as it relates to insurance rates and insurance rate change filings, as well as its resulting net effect on rates overall,” §105d (9) of Public Act 107 of 2013 requires the Department of Insurance and Financial Services (DIFS) to make an annual report each December 31 regarding the evidence of the change in rates compared to the initial baseline report in December 2014. This section of the report, *The Healthy Michigan Plan: Insurance Premium Rates*, fulfills the requirement of §105d (9) of 2013.

Two main sources of data, key informant interviews and Michigan DIFS rate filings, provide information on the contribution of uncompensated care to premium rates, rate change filings, and the net effect on rates overall, in the year before and each of the two years following implementation of the Healthy Michigan Plan.

To summarize the complex processes of premium rate setting and factors that affect changes in those rates, and to provide context for the analysis, the appendices to this report provide a synopsis of the methodology for premium setting, a table of factors that contribute to rate increases, and additional figures referenced in the report.

Background

Gathering all the necessary data to determine the cost of uncompensated care as it relates to insurance premiums is challenging and complex. Determining the reasons and mechanisms behind changes in premium rates by different types of plans and in different markets requires actuarial science, as well as knowledge of the local, state, and federal business, health, and political environments. Additionally, some ACA regulations and guidance affect individual markets differently from small and large group markets, including some ACA provisions that sunset. For instance, the Federal transitional reinsurance program ends in 2016.

Developing health insurance premium rates involves numerous stakeholders, such as insurers, hospitals, employers, physicians, pharmacy benefit managers, pharmaceutical and medical device manufacturers, to name a few. There are also complex rate setting methodologies, and proprietary information, overlaid on continually changing medical and insurance markets.

Additionally, not all plans offered in the state are subject to regulation, review, and approval by the state. More than half of Michigan employees of organizations offering health insurance are in self-insured plans; these employers are not subject to state plan rate review and approval, premium taxes, or mandated benefits. Rate filings do not include the detailed information required to determine the contribution of uncompensated care to rates, even for fully insured health plans that are subject to DIFS regulatory authority. In addition, contracts that might detail

the relationship between health care costs and insurance prices are often proprietary. Although DIFS and MDHHS collect data supporting their functions and mandates, they do not have access or authority to collect detailed data from those proprietary contracts.

There is no single source of data that provides all necessary elements for analysis. These and other factors make it difficult to attribute observed premium rate changes to the Healthy Michigan Plan.

To help inform understanding of insurance rates and rate changes in the year before and each of the two years following implementation of the Healthy Michigan Plan, the next sections of the report provides analysis of interviews with key informants and analysis of filings data available from DIFS.

Analysis of Key Informant Interviews

A stratified sampling approach used type and size of organization and region of the state to identify the interviewees.¹⁰ Semi-structured telephone interviews were conducted in each of the last three years with Michigan employers, healthcare insurers, and healthcare providers.¹¹ The interviews focused on the respondent's experiences with and impressions of the effects of the Healthy Michigan Plan on premium rates and the processes used to determine those rates. Respondents were specifically asked to comment on premium rate negotiations and rate setting, and the role of uncompensated care costs in those processes.

Thirty-one employers, health insurers and healthcare providers provided responses in the summer 2016. Characteristics of respondents appear in Appendix D. Interviewees were designated decision-makers or persons with appropriate expertise and experience in their organizations; these included benefits managers, senior-level financial officers, executives, and contract negotiators.¹²

Although a small sample of employers cannot be representative of the state's business types, locations, size, industry, or insurance behaviors, we sought to include comments from employers from across the state who could contribute unique and varying perspectives that might be associated with public and employer opinion on the impact of HMP on health coverage in Michigan.

Interview Responses

Respondents' reports of factors affecting premium rates, and excerpts from their interviews appear in Appendix F. This section provides a summary of these responses by category of respondent.

¹⁰ The Michigan Care Improvement Registry (MCIR) groups Michigan counties into six regions (<https://www.mcir.org/>). Key informant interviews for the three years used a convenience sample, loosely stratified by all six MCIR geographic regions with additional targeting in the southeast and southwest markets with the highest number of HMP enrollees, and a range of industry codes across the state.

¹¹ Given the Institutional Review Board (IRB) conditions of approval, no firms are identified by name in this report.

¹² The initial interviews for the 2013 baseline report were conducted with 29 Michigan-based employers. The 2014 report included completed interviews with 56 employers located in all MCIR sections of the state.

All Respondents

- Employers, health insurers, and healthcare providers did not identify the Healthy Michigan Plan or changes in uncompensated care as affecting insurance premium rates.

Employers

- Large employers were concerned about the current and future regulations on cost of benefits, risk pools, penalty payments, and special taxes.
- Large and small employers are seeking ways to reduce the costs of benefits through plan management and benefit design; large employers were using workplace wellness approaches to improve employee health and use of services.
- Large employers expressed concern about needing to offer less-competitive benefit packages in the future to avoid the Cadillac tax.
- Small employers expected instability in the individual and small group markets.
- Small employers noted their concern with their ability to offer health benefits to employees at an affordable price.

Hospitals and Healthcare Providers

- Healthcare providers noted fluctuations in patient volume related to changes in healthcare coverage. The changes in volume and patient insurance coverage affect operating margins that impact payment rates and negotiations.
- Hospitals noted concern with decreasing federal and nonfederal reimbursement rates relative to costs of providing services.
- Hospitals reported decreases in their bad debt post-ACA, market plans, and Medicaid expansion, but did not associate these policies with premium rate changes.
- Hospitals and hospital systems reported separately negotiated contracts with payers, but reported no detectible impact of uncompensated care or the Healthy Michigan Plan on those negotiations.
- Hospital uncompensated care costs have decreased since Medicaid expansion but it was unlikely that these decreases have a material impact on premium rates or are technically detectable in changes in premium rates.

Insurers and Health Plans

- Insurers were unable to negotiate for reductions in price increases as a result of the decrease in hospital uncompensated care costs.
- Insurers expressed concern over the increasing costs of pharmaceuticals and their impact on premiums.
- Insurers expressed concern about ending the federal transitional reinsurance program in 2017 and the effects on premiums.
- Insurers noted the impact on current and future revenues of the ACA regulations on risk adjustment and reinsurance.

Analysis of Department of Financial and Insurance Services (DIFS) Rate Filings

Each year, health plans are required to submit rates for review by DIFS. This requirement applies to health insurers selling individual plans, group conversion policies, Medicare supplemental

policies, small employer group plans, and plans sold by health maintenance organizations. DIFS does not set health insurance rates.¹³ DIFS does not review the rates for government entities, commercial large group plans (coverage through an employer with more than 50 employees), or self-insured employers (health benefits provided by an employer with its own funds). Approximately 54% of private sector enrollees in Michigan firms offering health insurance are in self-insured plans.^{14, 15}

In 2016, DIFS provided all health plan filings submitted and with dispositions in 2013, 2014, and 2015, with tracking codes to link individual filings for download from the public access System for Electronic Rate/Form Filing (SERFF) portal. Rate filings consist of multiple Federal and state-mandated forms, formats, and templates for each product.¹⁶ The list of abstracted elements from filings from 2013, 2014, and 2015, as well as inclusions and exclusions in selection of filings for analysis appear in Appendix E. There is no specific line item or cell in the filings forms or templates for the cost of “uncompensated care” or its contribution to rates. Filings analysis includes only those filings that noted a requested increase or decrease in premium rates. New products were excluded due to the absent experience period.

To provide context for the analysis, and to summarize the processes of premium rate setting and review, Appendices G and H provide definitions, a synopsis of the methodology for premium setting, and a table of factors that contribute to rate increases.

Findings from Rate Filings Analysis

Table 4 presents selected characteristics of the filings by year. Appendix E supplements this table with additional analysis of market, product, reasons for increase/decrease, and trend rates presented in tables and charts.

¹³ DIFS Health Coverage Rates and Rate Reviews: http://www.michigan.gov/difs/0,5269,7-303-12902_35510-113481--,00.html

¹⁴ Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2013, 2014, 2015 Medical Expenditure Panel Survey-Insurance Component.

¹⁵ Self-Insured Health Plans: Recent Trends by Firm Size, 1996–2015 By Paul Fronstin, Ph.D., Employee Benefit Research Institute “examines recent trends in self-insured health plans among private-sector establishments and workers based on data from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC). Data are presented in the aggregate and by establishment size.” 2016, Employee Benefit Research Institute–Education and Research Fund.

¹⁶ These may include but are not limited to written (free form text) description of methodology for determination of premium rates, medical rates forms, network data, rates tables with free text annotations, actuarial memorandum, unified rate review template (URRT), justifications and attestations, summary of benefits and coverage and associated rates, evidence of accreditation, SERFF tracking numbers of any document that is amended from its original version, filing notes, correspondence, disposition.

Table 4: Selected Characteristics of DIFS Rate Filings Analyzed by Year ¹⁷

	2015	2014	2013
Percent premium rate change requested (Average Weighted)	5.22	5.77	7.55
Health plan filings for premium rate changes	59	44	54
Number of filings requesting a decrease in premium rates	7	8	4
Number (Percent) of filings, by market	N (%)	N (%)	N (%)
Individual	19 (32)	7 (16)	10 (19)
Small Group	19 (32)	18 (41)	2 (4)
Large Group	21 (36)	19 (43)	42 (78)
Number (Percent) of filings, by product	N (%)	N (%)	N (%)
HMO	31 (53)	22 (50)	36 (67)
PPO	14 (24)	12 (27)	7 (13)
MM	11 (19)	8 (18)	10 (19)
POS	3 (5)	2 (5)	1 (2)
Percent rate change requested, by product	Ave %	Ave %	Ave %
HMO	3.4	2.4	6.2
PPO	6.5	7.8	8.7
MM	8.6	12.0	11.7
POS	5.7	5.8	6.7
Reasons for premium rate change, by percent of filings	%	%	%
Medical costs	93	68	85
Use of services	88	64	52
Benefit changes	58	48	44
ACA non-benefit changes (Taxes, risk pools, provider networks)	58	55	37
Morbidity of enrollees	49	64	52
Medical Costs Trend Rate (Ave %) reported in Actuarial Memoranda, etc.	6.73%	8.70%	7.33 %

¹⁷Additional data tables and charts appear in Appendix E.

Summary Findings

- The filings do not indicate that the Healthy Michigan Plan affected the number, plan type, or market of premium rate change requests.
- Filings do not reveal an effect of changes in uncompensated care on premium rate changes.
- The number of rate filings submitted for premium rate change requests increased slightly in 2015. This likely reflects the transitions in plan design, addition of essential benefits, and ACA policies and formula for reinsurance and risk adjustment.
- The percent premium rate change requested (average weighted) per filing decreased each year of the study, to its lowest rate in 2015, 5.22%.
 - Percent premium rate change requested (“Average Weighted”): 2013: 7.55%; 2014: 5.77%; 2015: 5.22%
- There were fewer and a smaller proportions of filings with very high (above 10%) rate change requests in 2015 and 2014 than in 2013; there were more single outlier negative and positive rate requests in 2015.
- The individual market showed the most variation in premium rates requested. The outlier rates appear more often in the individual market, and in the HMO product, in every year.
- The smallest rate changes requested in each year were in HMO product filings; largest rate change requested were in filings for the Major Medical products in each year.
- In all product categories, the average rate change requested was lowest in 2015, compared with 2013 and 2014.
- Filings noted the following reasons for requesting a premium rate increase:
 - Medical costs: Changes in prices and costs of medical services were noted in 85% of filings in 2013; 68% of filings in 2014; and in 93% of filings in 2015.
 - Utilization of Services: Increases in use of medical and health services, and in intensity of services: 2013: 52%; 2014: 64%; 2015: 88%.
 - Benefits: Changes in benefit design, plan features, out of pocket costs, and provider networks: 2013: 44%; 2014: 48%; 2015: 58%.
 - ACA: Changes in required coverage, medical loss ratios, single risk pools, taxes, fees: 2013: 37%; 2014: 55%; 2015: 58%.
 - Morbidity: Changes in the extent and types of disease or illness within the intended pool of covered individuals: 2013: 52%; 2014: 64%; 2015: 49%.
- Increases in medical prices and costs was the most common reason for requesting a rate change by large group, small group, and individual plans; and for HMO, PPO, and Major Medical (MM) plans in each of the three years. There were too few Point of Service (POS) plans to note trends.

- Changes in plan benefits was noted as the reason for changes in rates by large group plans in 2013 and 2014; and in individual markets in 2015.
- An increasing proportion of all filings each year noted utilization of services as a reason for the rate change.
- Medical Cost Trend rate was at its lowest of the three years in 2015, at 6.73% (2013: 7.33%; 2014: 8.70%)
- The Medical Cost Trend rates tended to be higher in large and small groups filings, rather than in the individual market filings. The distribution of Medical Cost Trend rates reported by large groups was wider and more variable.
- HMO plan filings noted increases in premium rates due to increasing pharmacy costs and increasing outpatient visits and professional services. Inpatient hospital use remained stable over the three years.

Conclusion

Interview respondents and rate filings did not identify the Healthy Michigan Plan as a factor affecting changes in premiums in 2013, 2014, or 2015.

Overall Conclusion

Based on hospital cost reports submitted to MDHHS, Michigan hospitals experienced a substantial decline in the costs of uncompensated care in FY 2015 compared to FY 2013. Yet rate filings and interviews with key stakeholders do not offer a connection between reductions in uncompensated care and premium rates.

Appendix A: Literature Review on Cost Shifting

Governmental reports

1. Key issues in analyzing major health insurance proposals. [Internet]. Congress of the United States Congressional Budget Office. 2008 [cited 2014 Nov 21]. p. 112. Available from: <http://www.cbo.gov/sites/default/files/12-18-keyissues.pdf>

This CBO report notes that cost shifting can only occur under certain conditions. One example is limited competition in which an isolated community is served by a single hospital or in a competitive provider market to offset the costs of uncompensated care or to make up for low public payment rates. Uncompensated care and low payment rates from public programs may result in hospitals reducing their costs by providing care that is less intensive or of lower quality.

2. Forslund TO. Cost shifting and the impact of new hospitals on existing markets. Wyoming Department of Health. 2014.

In its analysis of cost shifting in Wyoming, the Wyoming Department of Health reached two conclusions: First, cost shifting is one of three potential strategies that hospitals can pursue in the face of revenue shortfalls. Two other strategies, including cost cutting and “volume shifting” or lowering private prices to attract more private volume, may also be used. Second, hospitals’ ability to cost shift depends on their market power. This analysis of Wyoming data supports the conclusion that hospital market concentration is one of the more significant factors driving prices paid by the private sector. Market power is more strongly associated with changes in private prices than uncompensated or unreimbursed care. However, the report notes that just because a hospital has more market power does not necessarily mean that they engage in cost shifting.

Reviews of the literature and observable trends

1. Frakt AB. How much do hospitals cost shift? A review of the evidence. *Millbank Q*; 2011; 89(1): 90-130.

In reviewing the evidence on cost shifting, Frakt notes that policymakers should view with skepticism hospital and insurance industry commentary on the existence of inevitable, visible, or large-scale cost shifting. Some cost shifting may be caused by changes in public payment policy, but this is one of many possible effects on private insurance prices. Rather the author cautions that changes in the balance of market power between hospitals and health insurers which result in consolidation can have a significant impact on private insurance rates.

2. Coughlin TA, Holahan, J, Caswell, K, McGrath, M. Uncompensated care for the uninsured: A detailed examination. Kaiser Family Foundation. May 30, 2013. Available from: <http://kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-cost-shifting-and-remaining-uncompensated-care-costs-8596/>

This Kaiser Family Foundation report notes that there is limited evidence to indicate that increases in uncompensated care have caused hospitals to increase their charges for those with private insurance. The report notes that even as the uninsured rate grew over the past two decades, hospitals’ uncompensated care as a share of overall cost has remained steady. Further,

the private payment to cost ratio has steadily increased since 2001, which suggests that the rise in private surpluses is related to other forces, not a result of the cost of care provided to the uninsured. The authors estimate that in 2013, \$21.1 billion in providers' uncompensated care costs could be financed by private insurance in the form of higher payments and ultimately higher insurance premiums. Total private health insurance expenditures in 2013 are estimated to be \$925.2 billion, so the amount potentially associated with uncompensated care cost shift would be 2.3% of private health insurance costs in 2013. The authors note that even if the \$21.1 billion estimate is an underestimate by a wide margin, the potential cost shift from uncompensated care would account for only 4.6% of private health insurance in 2013.

3. Lee J, Berenson R, Mayes R, Gauthier A. Medicare payment policy: Does cost shifting matter? *Heal Aff.* 2003;W3–480.

The authors examine cost shifting through the lens of Medicare payment policy and state that the extent to which cost shifting impacts private payers and hospitals is a result of their market power and the amount of revenue in the system. Medicare payment policy is based on responsibility to patients as well as supporting the public good. Payment rates are influenced by interest groups and budgetary considerations. The majority of the time Medicare payments cover their responsibilities to Medicare patients and the community. However, if providers' prices rise, and neither public nor private payers' compensation follows suit, consumers pay more. The result is that people lose coverage, which the authors note is the ultimate cost shift.

Theoretical understandings of cost shift

1. Dobson A, DaVanzo J, Sen N. The cost-shift payment “hydraulic”: Foundation, history, and implications. *Health Aff.* 2006;25(1):22-33.

This paper reviews empirical examples of cost shift that show a correlation between lower Medicaid reimbursements and higher private insurance premiums leading to the explanation of cost shift as a potential explanation for increase in private premiums. In reality, the authors note that the potential for cost shift varies greatly over time and across health care markets. Hospitals can absorb some degree of cost shifting pressure through increases in efficiency and decreases in service intensity.

2. Frakt A. The end of cost shifting and the quest for hospital productivity. *Health Serv Res.* 2014;49(1):1–10.

This article explores the ways hospitals may respond to reductions in Medicare payments. Frakt describes cost shifting as one hypothesis for the ways in which hospitals may attempt to gain revenue in the face of declining Medicare payments. However, hospitals can also raise private prices commensurate with their market power in the absence of a public payment shortfall. Frakt notes that although there are circumstances under which hospitals could and did cost shift at high rates, recent research suggests that it is a far less pervasive phenomenon today.

3. Ginsburg P. Can hospitals and physicians shift the effects of cuts in Medicare reimbursement to private payers? *Health Aff [Internet]*. 2003;(Web Exclusive):W3–472 to W3–479. Available from: <http://content.healthaffairs.org/content/early/2003/10/08/hlthaff.w3.472.full.pdf>

This paper attempts to reconcile the different thinking between health care executives and economists regarding cost shifting. The potential for cost shifting varies according to structural factors that in turn vary by time and geography, and while Ginsburg says there is a theoretical basis exists for cost shifting, he shows other models where hospitals have room to adjust before cost shifting occurs.

4. Santerre R. The welfare loss from hospital cost-shifting behavior: A partial equilibrium analysis. *Health Econ.* 2005;14(6):621–6.

Microeconomic theory suggests that cost shifting can take place under specific conditions, and empirical studies indicate that cost shifting may have occurred in certain instances. This study models potential welfare loss caused by hospital cost shifting under ideal yet possible conditions.

Empirical studies

1. Friesner D, Rosenman R. Cost shifting revisited: The case of service intensity. *Health Care Manag Sci.* 2002;5(1):15–24.

This research found support for cost shift in some nonprofit hospitals in California while no cost shift was observed in profit-maximizing hospitals. However, both types of hospitals respond to lower service intensity, thus supporting the theoretical conclusion that lower service intensity may be utilized as an alternative to cost shifting.

2. Garthwaite C, Gross T, Notowidigdo MJ. Hospitals as insurers of last resort [Internet]. NBER Working Paper. 2015. Available from: <http://www.nber.org/papers/w21290>

The authors used previously confidential hospital financial data obtained through a research partnership with the American Hospital Association from 1984 to 2011 to study uncompensated care provided by hospitals and found that the uncompensated care costs for hospitals increase in response to the size of the uninsured population. They found that each additional uninsured person costs local hospitals \$900 each year in uncompensated care. Nonprofit hospitals were found to be more exposed to changes in demand for uncompensated care. The closure of a nearby hospital increases the uncompensated care costs of remaining hospitals. Increases in the uninsured population were found to lower hospital profit margins, which suggests that hospitals cannot or do not pass along all increased costs onto patients with private insurance.

3. Showalter M. Physicians' cost shifting behavior: Medicaid versus other patients. *Contemp Econ Policy.* 1997;15(2):74–84.

This article examines whether physicians practice cost shifting. This study found, in contradiction to cost shift, that lower Medicaid reimbursement rates resulted in physicians charging lower fees to privately insured patients though evidence also suggests that lower Medicaid reimbursements tend to cause physicians to treat fewer Medicaid patients.

4. Wagner KL. Shock, but no shift: Hospitals' responses to changes in patient insurance mix. *J Health Econ.* 2016;49:46–58.

Wagner analyzes hospital cost-shifting in response to a change in patient insurance mix resulting from recent Medicaid expansions for individuals with disabilities. Wagner found that hospitals actually reduced charges for disabled patients with private insurance. While the ACA Medicaid expansions affect a broader population and the results of this study may not be generalizable, the findings do suggest that cost-shifting is not the only way in which hospitals respond to a revenue reduction.

5. White C. Contrary to cost-shift theory, lower Medicare hospital payment rates for inpatient care lead to lower private premium rates. *Health Aff.* 2013;32(5):935–43.

Policymakers believe when Medicare constrains its payment rates for hospital inpatient care, private insurers pay higher rates. This demonstrates that slow growth in Medicare inpatient hospital payment rates also results in slow growth in private hospital payment rates. Greater reductions in Medicare payment rates led to a reduction in private payment rates, reflecting hospitals' efforts to rein in operating costs at a time of lower Medicare payments. Hospitals facing cuts in Medicare payment rates may also reduce the payment rates they seek from private payers to attract more privately insured patients.

6. White C, Wu V. How Do Hospitals Cope with Sustained Slow Growth in Medicare Prices? *Health Serv Res.* 2013;49(1):11-31.

White and Wu analyze the effects of changes in Medicare inpatient hospital prices on hospitals' overall revenues, operating expenses, profits, assets, and staffing. The authors findings suggest that hospitals recoup Medicare cuts not through cost shifting, but instead they adjust their operating expenses over time.

7. Wu V. Hospital cost shifting revisited: new evidence from the Balanced Budget Act of 1997. *Int J Healthc Financ Econ.* 2010;10(1):61–83.

Wu analyzes hospital cost shifting using a natural experiment generated by the Balanced Budget Act of 1997. This study found that urban hospitals were able to shift part of the burden of Medicare payment reductions onto private payers, but the overall degree of cost shifting was very small, and changes were based on the hospital's share of privately insured patients.

8. Zwanziger J, Bamezai A. Evidence of cost shifting in California hospitals. *Health Aff.* 2006;25(1):197–203.

This study of California hospitals examines whether decreases in Medicare/Medicaid payments were associated with increases in private insurance payments. A 1% decrease in Medicare price was associated with a 0.17% increase in the price for privately insured patients. This suggests that cost shifting from public to private payers accounted for a small percentage of the total increase in private payer prices from 1997-2001 in California.

Appendix B: Data Elements for Calculating Uncompensated Care and Discharges

Data Elements and Methods for Calculating Uncompensated Care

1. Defining uncompensated care

Uncompensated care is defined as the cost of charity care plus the cost of bad debt.

Charity care is the cost of medical care for which there was no expectation of payment because the patient has been deemed unable to pay for care. Each hospital has its own criteria for identifying patients who are eligible for charity care. For example, hospitals in the Mercy Health system pay 100% of the charges for patients who are uninsured and have family income below 100% of the federal poverty level. The University of Michigan's charity care program pays 55% of total charges for uninsured patients that do not qualify for public insurance programs, have family income below 400% of the federal poverty level, and meet several other criteria. However, not all discounted medical care is charity care. Discounts provided for prompt payment or discounts negotiated between the patient and the provider to standard managed care rates do not represent charity care.

Bad debt is the cost of medical care for which there was an expectation of payment because the patient was deemed to be able to pay for care. For example, bad debt includes the unpaid medical bills of an uninsured patient who applied for charity care but did not meet the hospital's specific criteria. Insured patients who face deductibles and coinsurance payments for hospital care can also generate bad debt.

Hospitals report charity care and bad debt separately on the Michigan Medicaid Forms, though as just noted hospitals vary in the criteria they use to distinguish charity care from bad debt. Even within a particular hospital, rules governing eligibility for charity care are often not strictly applied and may take into account the judgment of individuals determining eligibility.

For purposes of this report, Medicaid and Medicare shortfalls — the difference between reimbursements by these programs and the cost of care— are not included in the estimate of uncompensated care. Similarly, expenditures for community health education, health screening or immunization, transportation services, or loss on health professions education or research are not considered uncompensated care. Although the hospital does not expect to receive reimbursement for these services, they do not represent medical care for an individual. These costs incurred by hospitals fall into the broader category of “community benefit,” a concept used by the Internal Revenue Service in assessing hospitals' non-profit status.

2. Measuring uncompensated care using Michigan Medicaid cost report data

The cost of charity care is measured as full charges for uninsured charity care patients minus patient payments toward partial charity discounts, multiplied by the cost-to-charge ratio. The cost of bad debt is measured as unpaid patient charges for which an effort was made to collect payment minus any recovered payments, multiplied by the cost-to-charge ratio. Bad debts

include charges for uninsured patients who did not qualify for a reduction in charges through a charity care program, and unpaid coinsurance, co-pays and deductibles for insured patients.

The cost-to-charge ratio is the ratio of the cost of providing medical care to what is charged for medical care, aggregated to the hospital-level. For example, a cost-to-charge ratio of 0.6 means that on average, 60 cents of every charged dollar covers the cost of care. Variation in cost-to-charge ratios among different payment source categories reflects differences in the mix of services received by patients in those categories. Charity care and bad debt charges for uninsured patients are translated to costs using the cost-to-charge ratio for uninsured patients. Bad debt charges for insured patients are translated to costs using the whole hospital cost-to-charge ratio.

The specific data elements from the Michigan Medicaid Forms (MMF) that are used for these calculations are as follows.

Measures of care for which payment was not received enter positively:

- Uninsured charity care charges (MMF line 6.00)
Full charge of care provided to patients who have no insurance and qualify for full or partial charity care. Payment is not expected.
- Uninsured patient-pay charges (MMF line 6.10)
Full charge of care provided to patients who have no insurance and do not qualify for full or partial charity care (self-pay). Payment is expected but hospital has not yet made a reasonable attempt to collect payment.
- Uninsured bad debts (MMF line 6.36)
Full charge of care provided to patients who have no insurance and do not qualify for charity care. Payment is expected and hospital has made a reasonable attempt to collect payment.
- Third party bad debts (MMF line 6.38)
Insured patients' unpaid coinsurance, co-pays or deductibles when there is an expectation of payment. This includes gross Medicare bad debts. Payment is expected and the hospital has made a reasonable attempt to collect the amount from the patient

These amounts are offset by payments that were received by patients who qualify for charity care as well as bad debt recoveries. These payments enter the calculation of uncompensated care negatively:

- Uninsured payments from charges (MMF line 6.60)
Total payments made by uninsured charity care patients and uninsured self-pay patients towards charges.
- Recoveries for uninsured bad debt (MMF line 10.96)

Recovered amounts for uninsured bad debts, which can include amounts that were collected from patients or amounts from community sources (such as an uncompensated care pool).

- Recoveries for third party bad debts and offsets (MMF line 10.98)
Recovered amounts for insured patients' co-pays, co-insurance and deductibles, including Medicare beneficiaries.

The cost-to-charge ratios used in the calculation are:

- Uninsured inpatient cost-to-charge ratio
Cost-to-charge ratio calculated by MDHHS for the purposes of determining Disproportionate Share Hospital (DSH) payments. It is used to convert charges for care provided to uninsured patients to costs.
- Whole hospital cost-to-charge ratio
Cost-to-charge ratio calculated by MDHHS and used to convert charges for care provided to insured patients to costs.

In addition to measuring the dollar amount of uncompensated care costs, we also measure these costs relative to total hospital costs (MMF line 11.30) as a percentage.

Appendix C: Uncompensated Care Data by Hospital

Table 1. Uncompensated Care Expenses by Individual Hospital, FY 2013, FY 2014 and FY 2015

Hospital Name	CMS ID	Qtr of FY end	FY 2013		FY 2014		FY 2015	
			Total UC	as a % of Cost	Total UC	as a % of Cost	Total UC	as a % of Cost
Allegan General Hospital	1328	4	1.73	4.5%	1.69	4.4%	----	----
Allegiance Health	92	2	35.39	9.8%	29.41	8.0%	15.50	4.2%
Alpena Regional Medical Center	36	2	2.53	2.9%	1.84	2.0%	0.94	1.0%
Aspirus Grand View Hospital	1333	2	1.98	5.1%	2.30	5.9%	0.59	1.6%
Aspirus Keweenaw Hospital	1319	2	1.34	4.5%	1.40	4.2%	0.90	2.5%
Aspirus Ontonagon Hospital	1309	2	0.16	1.7%	0.11	1.1%	0.42	4.0%
Baraga County Memorial Hospital	1307	3	0.99	6.7%	0.78	5.1%	0.47	3.0%
Barbara Ann Karmanos Cancer Hospital	297	3	2.11	1.0%	1.98	1.0%	1.41	0.6%
BCA StoneCrest Center	4038	4	0.13	0.8%	0.11	0.7%	----	----
Beaumont Hospital - Dearborn	20	4	17.82	3.5%	13.14	2.4%	----	----
Beaumont Hospital - Farmington Hills	151	4	16.42	6.9%	7.57	3.1%	----	----
Beaumont Hospital - Taylor	270	4	6.05	5.1%	3.50	2.8%	----	----
Beaumont Hospital - Trenton	176	4	3.44	2.8%	2.33	1.8%	----	----
Beaumont Hospital - Wayne	142	4	7.84	6.6%	5.10	4.1%	----	----
Beaumont Hospital, Grosse Pointe	89	4	9.01	5.4%	5.48	3.3%	----	----
Beaumont Hospital, Royal Oak	130	4	45.87	4.0%	22.50	2.0%	----	----
Beaumont Hospital, Troy	269	4	19.35	3.9%	12.35	2.3%	----	----
Bell Memorial Hospital	1321	2	3.18	8.7%	1.38	4.4%	0.33	1.1%
Borgess Hospital	117	2	27.17	7.6%	20.59	5.8%	12.92	3.6%
Borgess-Lee Memorial Hospital	1315	2	4.00	13.7%	3.70	12.7%	2.18	7.6%
Brighton Hospital	279	2	----	----	----	----	----	----
Bronson Battle Creek Hospital	75	4	15.34	8.5%	11.31	6.6%	----	----
Bronson Lake View Hospital	1332	4	2.76	6.2%	2.43	5.9%	----	----

Bronson Methodist Hospital	17	4	49.41	10.2%	30.27	6.4%	----	----
Caro Community Hospital	1329	4	0.47	4.8%	0.48	4.5%	----	----
Charlevoix Area Hospital	1322	1	0.87	3.1%	0.96	3.2%	0.45	1.4%
Children's Hospital of Michigan	3300	4	3.48	1.1%	3.56	1.1%	----	----
Chippewa War Memorial Hospital	239	4	2.35	3.3%	1.03	1.3%	----	----
Clinton Memorial Hospital	1326	4	0.62	2.6%	0.71	3.1%	----	----
Community Health Center, Branch County	22	4	5.55	9.2%	3.60	5.9%	----	----
Covenant Medical Center, Inc.	70	2	9.72	2.7%	8.08	2.3%	3.35	0.9%
Crittenton Hospital	254	4	5.26	2.6%	3.32	1.8%	----	----
Deckerville Community Hospital	1311	2	0.21	3.5%	0.41	6.0%	0.25	3.9%
Detroit Receiving Hospital	273	4	31.25	14.3%	14.65	6.7%	----	----
Dickinson County Memorial Hospital	55	4	1.57	2.2%	0.91	1.2%	----	----
Doctors' Hospital of Michigan	13	4	3.48	12.9%	1.62	7.0%	----	----
Eaton Rapids Medical Center	1324	2	1.55	9.9%	1.76	9.5%	1.25	7.1%
Edward W. Sparrow Hospital	230	4	21.31	3.1%	17.34	2.5%	----	----
Forest Health Medical Center, Inc.	144	4	0.40	1.2%	0.28	0.8%	----	----
Forest View Psychiatric Hospital	4030	4	0.19	1.4%	0.17	1.2%	----	----
Garden City Hospital	244	4	6.08	5.2%	5.24	4.4%	----	----
Garden City Hospital	244	4	6.08	5.2%	5.24	4.4%	----	----
Genesys Regional Medical Center	197	2	14.78	4.0%	14.46	3.8%	5.59	1.5%
Harbor Beach Community Hospital	1313	4	0.06	0.8%	0.14	1.6%	----	----
Harbor Oaks Hospital	4021	2	0.06	0.5%	0.15	1.3%	0.18	1.4%
Harper University Hospital	104	4	8.63	2.2%	6.90	1.6%	----	----
Havenwyck Hospital	4023	2	0.22	0.9%	0.32	1.1%	0.22	0.7%
Hayes Green Beach Memorial Hospital	1327	1	3.56	7.8%	4.23	9.8%	2.21	4.9%
Healthsource Saginaw	275	4	0.19	0.8%	0.29	1.1%	----	----
Helen Newberry Joy Hospital	1304	4	1.85	7.4%	1.21	4.8%	----	----
Henry Ford Hospital	53	4	96.32	8.5%	83.36	7.6%	----	----
Henry Ford Macomb Hospital	47	4	14.63	4.7%	12.39	4.1%	----	----

Henry Ford West Bloomfield Hospital	302	4	6.24	2.5%	6.91	2.8%	----	----
Henry Ford Wyandotte Hospital	146	4	21.43	9.1%	16.46	7.2%	----	----
Hills & Dales General Hospital	1316	3	0.61	3.2%	0.50	2.5%	0.45	2.2%
Hillsdale Community Health Center	37	2	2.65	5.6%	2.10	4.6%	1.86	4.1%
Holland Community Hospital	72	1	4.82	3.0%	5.50	3.3%	3.38	1.9%
Hurley Medical Center	132	2	27.29	9.4%	16.01	5.4%	10.04	3.2%
Huron Medical Center	118	3	0.80	2.9%	0.75	2.5%	0.40	1.3%
Huron Valley - Sinai Hospital	277	4	8.62	5.7%	3.35	2.0%	----	----
Ionia County Memorial Hospital	1331	4	1.39	5.4%	1.08	4.2%	----	----
Kalkaska Memorial Health Center	1301	2	1.90	8.9%	1.83	8.4%	0.70	3.6%
Kingswood Psychiatric Hospital	4011	4	0.20	1.0%	0.11	0.6%	----	----
Lakeland Community Hospital - Watervliet	78	3	2.04	9.2%	1.56	6.3%	0.38	1.5%
Lakeland Hospital - St. Joseph	21	3	13.91	5.3%	12.10	4.3%	7.20	2.5%
Mackinac Straits Hospital	1306	1	2.20	11.3%	2.03	9.2%	1.73	7.2%
Marlette Regional Hospital	1330	2	0.76	3.4%	0.85	4.0%	0.64	3.1%
Marquette General Hospital	54	2	3.95	2.0%	3.37	1.9%	0.76	0.4%
Mary Free Bed Hospital & Rehab. Center	3026	1	0.86	1.9%	1.48	3.0%	0.67	1.4%
McKenzie Memorial Hospital	1314	3	0.59	4.6%	0.42	3.3%	0.30	2.4%
McLaren - Central Michigan	80	3	2.23	2.9%	2.08	2.7%	1.19	1.6%
McLaren - Greater Lansing	167	3	7.52	2.7%	11.18	4.2%	6.52	2.2%
McLaren Bay Regional	41	3	6.79	2.9%	5.82	2.3%	4.01	1.5%
McLaren Flint	141	3	14.07	3.7%	12.86	3.3%	4.75	1.2%
McLaren Lapeer Region	193	3	5.64	5.6%	5.77	5.8%	3.25	3.2%
McLaren Oakland	207	3	5.87	5.0%	6.49	5.2%	3.65	2.9%
McLaren-Northern Michigan	105	3	5.05	2.9%	3.42	1.9%	1.75	0.9%
Memorial Healthcare	121	4	2.04	2.6%	1.21	1.6%	----	----
Memorial Medical Center of W. Michigan	110	2	2.25	4.1%	1.84	3.3%	1.63	2.8%
Mercy Health Partners - Hackley Campus	66	2	10.88	6.8%	6.80	4.2%	4.02	2.4%
Mercy Health Partners - Lakeshore Campus	1320	2	1.03	6.4%	0.81	4.0%	0.54	3.3%

Mercy Health Partners - Mercy Campus	4	2	8.79	6.2%	7.47	3.4%	4.17	1.8%
Metro Health Hospital	236	2	13.20	6.1%	11.79	4.9%	10.60	3.7%
Mid Michigan Medical Center - Gladwin	1325	2	0.87	4.4%	0.91	4.4%	0.72	3.2%
Mid Michigan Medical Center - Clare	180	2	1.62	5.3%	2.77	8.4%	0.94	2.7%
Mid Michigan Medical Center - Gratiot	30	2	3.06	3.8%	2.74	3.5%	1.59	2.0%
Mid Michigan Medical Center - Midland	222	2	7.50	3.1%	7.27	2.9%	5.32	1.9%
Mount Clemens Regional Medical Center	227	3	19.85	8.1%	18.17	6.9%	8.90	3.3%
Munising Memorial Hospital	1308	1	0.44	5.8%	0.55	7.6%	0.32	4.1%
Munson Healthcare Cadillac Hospital	81	2	2.73	4.5%	2.64	3.7%	1.76	2.6%
Munson Healthcare Grayling Hospital	58	2	2.48	4.2%	1.87	2.6%	1.57	2.6%
Munson Medical Center	97	2	22.54	5.0%	17.25	3.8%	8.12	1.8%
North Ottawa Community Hospital	174	2	2.03	4.7%	1.73	3.8%	1.15	2.2%
Oakland Regional Hospital	301	4	0.10	0.4%	0.11	0.5%	----	----
Oaklawn Hospital	217	1	4.35	5.1%	2.99	3.5%	1.62	1.9%
Otsego County Memorial Hospital	133	4	1.34	2.6%	0.97	1.8%	----	----
Paul Oliver Memorial Hospital	1300	2	1.09	8.2%	0.97	7.2%	0.72	5.2%
Pennock Hospital	40	3	2.23	4.7%	2.57	5.9%	2.07	4.6%
Pine Rest Christian Hospital	4006	2	0.53	1.0%	0.63	1.0%	0.61	0.9%
Port Huron Hospital	216	3	7.58	4.7%	7.10	4.3%	4.45	2.8%
Promedica Bixby Hospital	5	4	1.18	1.7%	1.33	1.9%	----	----
ProMedica Herrick Hospital	1334	4	0.58	1.9%	0.65	2.4%	----	----
ProMedica Monroe Regional Hospital	99	2	9.39	6.5%	9.08	6.9%	6.34	4.6%
Providence Hospital	19	2	0.00	0.0%	20.71	3.6%	14.43	2.4%
Rehabilitation Institute	3027	4	1.51	1.9%	0.93	1.2%	----	----
Saint Mary's Standish Community Hospital	1305	2	0.87	4.5%	0.84	4.6%	0.49	2.6%
Samaritan Behavioral Center	4040	4	0.08	1.0%	0.05	0.6%	----	----
Scheurer Hospital	1310	2	1.54	5.4%	1.38	4.5%	1.35	4.0%
Schoolcraft Memorial Hospital	1303	4	0.33	1.7%	0.28	1.4%	----	----
Sheridan Community Hospital	1312	1	1.02	8.1%	1.01	7.4%	1.28	9.1%

Sinai-Grace Hospital	24	4	27.02	8.7%	11.42	3.8%	----	----
South Haven Community Hospital	85	2	1.42	4.6%	0.95	2.9%	0.39	1.2%
Southeast Michigan Surgical Hospital	264	4	0.04	0.3%	0.11	0.9%	----	----
Southwest Regional Rehabilitation Hospital	3025	2	0.45	3.9%	0.32	3.3%	----	----
Sparrow Carson Hospital	208	4	1.37	3.2%	1.77	4.3%	----	----
Spectrum Health	38	2	32.61	2.9%	40.51	3.4%	20.39	1.6%
Spectrum Health - Reed City Campus	1323	2	2.87	6.8%	3.14	6.8%	1.72	3.6%
Spectrum Health Big Rapids	93	2	2.61	5.8%	2.06	4.3%	1.99	3.8%
Spectrum Health Gerber Memorial	106	2	2.92	5.0%	3.37	5.6%	2.51	4.1%
Spectrum Health United Memorial - Kelsey	1317	2	0.87	7.0%	1.22	9.4%	0.91	7.0%
Spectrum Health United Memorial - United	35	2	2.55	4.4%	0.00	0.0%	2.26	3.3%
Spectrum Health Zeeland Community	3	2	1.56	3.9%	2.35	5.3%	1.72	3.4%
St Joseph Mercy Chelsea	259	2	2.55	2.8%	2.72	2.9%	0.99	1.0%
St. Francis Hospital & Medical Group	1337	3	4.16	7.3%	3.24	6.0%	1.87	3.2%
St. John Hospital and Medical Center	165	2	35.80	5.5%	34.65	5.3%	19.52	2.9%
St. John Macomb-Oakland, Macomb	195	2	21.95	6.2%	20.03	5.9%	11.44	3.3%
St. John River District Hospital	241	2	1.17	2.7%	1.11	2.4%	0.63	1.5%
St. Joseph Mercy Hospital - Ann Arbor	156	2	29.89	4.5%	26.09	4.3%	11.34	1.9%
St. Joseph Mercy Livingston Hospital	69	2	8.23	8.9%	7.23	8.0%	2.51	3.4%
St. Joseph Mercy Oakland	29	2	13.68	4.8%	18.41	6.7%	5.27	1.8%
St. Joseph Mercy Port Huron	31	2	4.87	7.3%	3.66	5.8%	1.26	2.0%
St. Mary Mercy Hospital	2	2	10.55	5.3%	14.36	7.1%	6.04	2.9%
St. Mary's Health Care (Grand Rapids)	59	2	15.48	4.7%	12.72	3.6%	7.78	1.8%
St. Mary's of Michigan Medical Center	77	2	17.86	8.0%	13.69	6.5%	5.33	2.6%
Straith Memorial Hospital	71	4	0.03	0.3%	0.03	0.3%	----	----
Sturgis Memorial Hospital	96	3	2.29	7.0%	1.86	5.5%	1.33	3.9%
Tawas St. Joseph Hospital	100	2	2.17	5.3%	1.41	3.6%	1.21	3.0%
The Behavioral Center of Michigan	4042	4	0.08	0.9%	0.09	1.0%	----	----
Three Rivers Health	15	4	2.54	6.6%	1.68	4.4%	----	----

University of Michigan Health System	46	2	51.02	2.4%	54.64	2.4%	37.08	1.5%
UP Health System - Portage	108	4	1.09	1.9%	0.54	1.1%	----	----
West Branch Regional Medical Center	95	1	2.17	5.8%	2.02	5.3%	1.75	4.5%

Notes: Because hospitals submit their data with a lag, for hospitals with fiscal years ending in the fourth quarter the most recent data available are from hospital FY 2014.

Appendix D: Key Stakeholder Interviews: Respondent Characteristics

<i>Healthcare Providers</i>		<i>N=9</i>
Size	Small/Private Practice	2
	Medium/Hospital	1
	Large/Regional Hospital System	6
Payer Mix	Primarily Private	6
	Primarily Public	1
	Mixed	1
	Other	1
<i>Employers</i>		<i>N=17</i>
Size	Small Employer 50 or fewer Employees	9
	Medium Employer 51-499	4
	Large Employer 500+	4
Payer Mix	Self-Funded	4
	Mixed	2
	Fully Insured	9
	N/A	2
Economic Sector	Professional, Scientific and Technical Services	3
	Retail Trade	3
	Healthcare	1
	Accommodation and Food Service	3
	Construction	2
	Finance and Insurance	1
	Manufacturing	2
	Other Services	2
<i>Health Insurers</i>		<i>N=6</i>
Market	Public	2
	Private	4
Covered members	< 250,000	1
	500,000 -1 million	2
	>1 million	3

Appendix E: DIFS Filings Sampling Exclusions, Inclusions and Rationale

Filings Sampling Exclusions

- Filings without a requested premium rate change. We are interested in the causes of rate change; thus we are excluding from our sample filings that did not submit a rate increase or decrease.
- New products. New products are filings that are submitted to go on the market in the coming year. These filings do not have any prior experience or claims data to compare or predict change in premium rates.
- 2016 filing data. 2016 filing data are incomplete; not all of the filings have been submitted which will apply to 2017 premium rates.

Filings Sampling Inclusions

Insurance filings provide a multitude of data. The following elements were abstracted from each 2015 filing for which a change (negative or positive) in rates was requested.

- Descriptive Data:
 - Filing Number
 - Date
 - Company Name
- Market
 - Health Insurance Market (Individual, Small Group, Large Group, Other)
 - Product Type
- Reason(s) for Rate Change
 - Reason for Rate Change (direct quotes from filings if available)
 - Medical Costs (trend in cost of medical care, physician contracts, etc.)
 - Morbidity (change in morbidity level of risk pool)
 - Benefits (change in benefits offered)
 - ACA (i.e., taxes and fees, legislative compliance, essential health benefits)
 - Utilization of Services (increasing or decreasing)
 - Demographics (age, community rating)
 - Other (i.e., tobacco Status)

Experience [Experience period is a time period used to calculate the premium in order to evaluate risk and return] and Claims

- Affected Policy Holders
- Covered Lives Benefit Change
- Benefit Change
- % Change Approved – weighted average
- Percent Rate Change Requested – weighted average
- Requested Rate: Annual – weighted average

Total Annual Premium Rate

- Premium Rate Change
- Prior Rate: Annual – weighted average
- Projected Earned Premium
- Projected Incurred Claims (Annual Dollars)

Medical Costs

- Trend Factors %
- Medical Trend %
- MLR %
- Pharmacy Trend %

Administrative

- Administrative Fees (Dollars PMPM)
- Administrative Fees % of Premium
- Profit and Risk % of Premium
- Taxes and Fees
 - Taxes and Fees % of Premium
- Uniform Rate Review Template
 - Administrative Expenses % (projected experience)
 - Profit and Risk % (projected experience)
 - Taxes and Fees % (PMPM component of premium increase)
 - Taxes and Fees as a percentage % (projected experience)
 - Single Risk Pool Gross Premium Avg Rate (PMPM)
 - Inpatient (Component of Premium Increase Dollars PMPM)
 - Outpatient (Component of Premium Increase Dollars PMPM)
 - Professional (Component of Premium Increase Dollars PMPM)
 - Prescription (Component of Premium Increase Dollars PMPM)
 - Other (Component of Premium Increase Dollars PMPM)

Rationale for DIFS Filings Inclusions (Drivers of Premium Rates)

Health insurers include several factors in the creation of the premium rate. The state requires that filings include the actuarial methods and data used. Often, this section of the filings is noted as “Confidential/Proprietary/Trade Secret.” Many insurers contract with actuarial firms; these firms often use proprietary methods for estimating risk, based on data specific to a number of plan and population features, including the plan type, size, benefits, region, and estimated numbers and types of claims.

Proposed Rate Increases: When included, the filing sections enumerate the contributions of the following (as titled on the forms) to the rate:

- **Medical Loss Ratio (MLR):** The claims experience on Michigan policies in a specific block of business must be adequate to achieve an 80% Federal Medical Loss Ratio.

- **Allowed and Incurred Claims Incurred during the Experience Period:** Allowed Claims data are available to the company directly from company claims records, with some estimation due to timing issues.
- **Claim Liabilities for Medical Business** are often calculated using proprietary methods.
- **Benefit Categories:** Claims are assigned to each of the varying benefit category by place services were administered, and types of medical services rendered.
- **Projection Factors**
 - **Single Risk Pools**, for policy years beginning after 1/1/14.
 - **Changes in Morbidity of the Population Insured:** The assumptions used are from the experience period to the projection period.
 - **Trend Factors (cost/utilization):** The assumption for cost and utilization is often developed from nationwide claim trend studies, using experience from similar products that were marketed earlier.
 - **Changes in Benefits, Demographics, and other factors: Non-Benefit Expenses and Risk Margin Profit & Risk Margin:** Projected premiums include a percent of premium for risk, contingency, and profit margin. Assumptions are often derived from analysis of pre-tax underwriting gain, less income taxes payable on the underwriting gain, and on the insurer fee, which is not deductible for income tax purposes.
- **Taxes and Fees** include premium tax, insurer fees, risk adjustment fees, exchange fees, and federal income tax.
 - **Premium Tax:** The premium tax rate is 1.25% on Michigan gross direct premiums written in the state of Michigan.
 - **Insurer Fees:** This is a permanent fee that applies to fully insured coverage. This fee will fund tax credits for insurance coverage purchased on the exchanges. The total fee increases from \$8B in 2014 to \$14.3B in 2018 (indexed to premium for subsequent years). Each insurer's assessment will be based on earned health insurance premiums in the prior year, with certain exclusions.
 - **Risk Adjustment Fees:** The HHS Notice of Benefit and Payment Parameters includes a section on risk adjustment user fees and specifies a \$0.08 per member per month user fee for the benefit year 2014. For benefit year 2015, HHS imposes a per-enrollee-per-month risk adjustment fee of \$0.10, and for 2016 benefit year, \$0.15. (See Federal Register / Vol. 80, No. 39 / Friday, February 27, 2015 / Rules and Regulations 10759).
 - **Federal Income Tax:** Income tax is calculated as 35% * (Pre-Tax Income + Insurer Fees), since insurer fees are not tax deductible.
 - **Reinsurance Fees:** This is a temporary fee that applies to all commercial groups (both fully insured and self-funded) and individual business from 2014 to 2016 for the purpose of funding the reinsurance pool for high cost claimants in the individual market during this three-year transitional period. The total baseline amounts to be collected to fund this pool are \$12B in 2014, \$8B in 2015, and \$5B in 2016, and

individual states can add to this baseline. Each insurer is assessed on a per capita basis. This fee expires in 2017.

- **Changes in Medical Service Costs:** There are many different health care cost trends that contribute to increases in the overall U.S. health care spending each year. These trend factors affect health insurance premiums, which can mean a premium rate increase to cover costs. Some of the key health care cost trends that have affected this year's rate actions include:
 - **Coverage Mandates** – Estimated impacts of changes in benefit design and administration due to the Patient Protection and Affordable Care Act mandates. Direct impacts include the effects of specific changes made to comply with new Federal and State laws.
 - **Increasing Cost of Medical Services** – Annual increases in reimbursement rates to health care providers, such as hospitals, doctors and pharmaceutical companies. The price of care can be affected by the use of expensive procedures, such as surgery, as opposed to monitoring or certain medications.
 - **Increased Utilization** – Annual increases in the number of office visits and other services. In addition, total health care spending may vary by the intensity of care and/or use of different types of health services.
 - **Higher Costs from Deductible Leveraging** – Health care costs may rise every year, while deductibles and copayments may remain the same.
 - **Impact of New Technology** - Improvements to medical technology and clinical practice may require use of more expensive services, leading to increased health care spending and utilization.
 - **Underwriting Wear Off** – The variation by policy duration in individual medical insurance claims, where claims are higher at later policy durations as more time has elapsed since initial underwriting.

- **Administrative Costs:** Expected benefit and administrative costs.

Factors that determine premiums vary by type of plan *market* (individual plans, small group plans, and large group plans):

Individual Plans (for those who purchase their coverage directly from an insurer, not job-based coverage):

- Age (the premium rate cannot vary more than 3 to 1 for adults for all plans)
- Benefits and cost-sharing selected
- Number of family members on the plan
- Location of residence in Michigan
- Tobacco use (the premium rate cannot vary by more than 1.5 to 1)

Small Group Plans (for those who have coverage through an employer with 50 or fewer employees):

- Benefits the employer selects
- How much the employer contributes to the cost
- Family size

- Age (the premium rate cannot vary more than 3 to 1 for adults for all plans)
- Tobacco use (the premium rate cannot vary by more than 1.5 to 1)
- Location of employer in Michigan

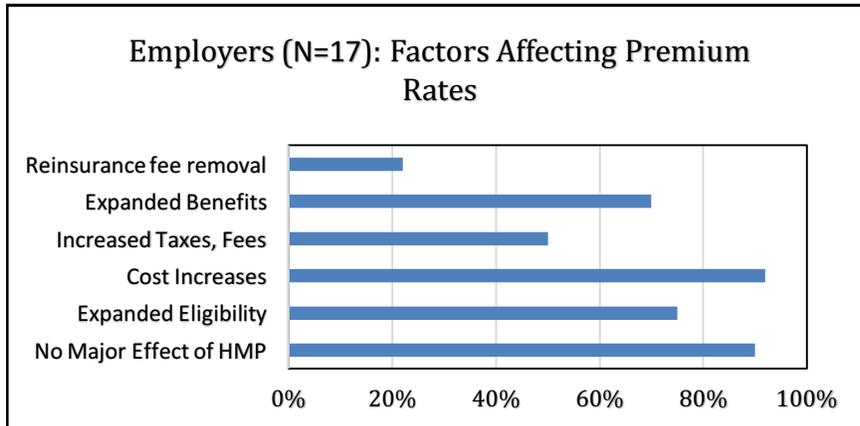
Large Group Plans (for those who have coverage through an employer with more than 50 employees):

- Benefits the employer selects
- Employee census information including age, gender, family status, health status and geographic location
- How much the employer contributes to the cost
- Industry
- Group size
- Wellness programs

Appendix F: Results from Stakeholder Interviews and DIFS Rate Filings Analysis

I. Interview Respondents' Reports on Factors Affecting Premium Rates

Employers:



“...yes, we are paying a lot more fees, we pay a lot of fees and don’t get more administrative effort to file reports for all folks ...”

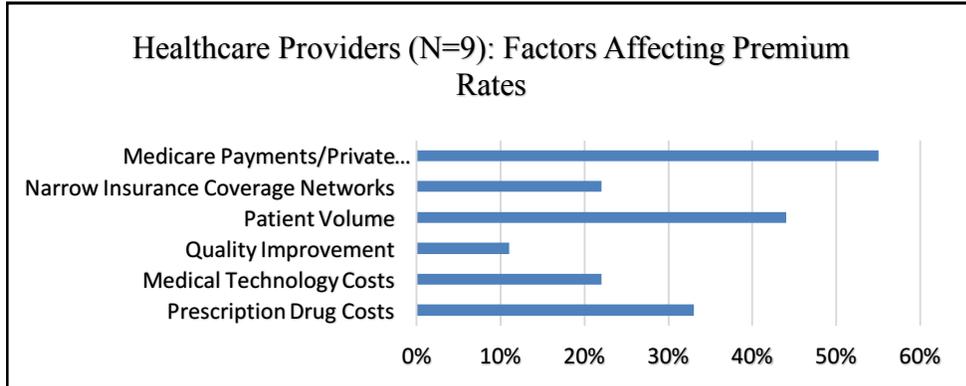
“Decision-making for benefits and ACA has seen the biggest changes...”

“It’s [the decision to offer health insurance] almost entirely based on cost; I don’t think changes to the Medicaid expansion have influenced it... it’s been pretty consistently cost-prohibitive... would like to be able to offer it, but it has just been so expensive that we haven’t been able to.”

“...Same portfolio as the previous year...Overall, we didn’t have to make the drastic adjustments that other employers or insurers did - our rates didn’t change much because we already offered pretty extensive coverage.”

“...Employees have a larger co-premium pay than before. That increased co-premium has been the biggest change this year. We pay more out of pocket.”

Hospitals and Healthcare Providers



“Medicare reimbursement definitely affects the payment rates, depending on if it changes.”

“If a major payer comes to us and says ‘your case costs are too high- we are excluding you from our network’ this has major implications for who we treat, our volumes, and all; if they include us in their narrow network, they have the bargaining power to keep their rates below our costs- this puts us in a financial bind...”

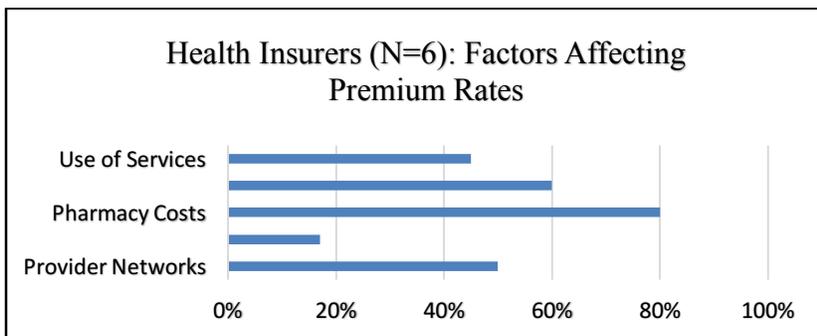
“Volume is critical, and so is the role of consumerism...the dynamics have changed where it is not just the payers making the payments, a key piece is coming from the patient ...”

“Patient safety and quality often increase costs in the short run, with reporting and payment tied to quality, but in the long run, quality and quality improvement are why we exist.”

“...we’ve actually thought of changes to charity care to include people who are underinsured because of the [now] significant contributions people have to make...”

“Technology and device costs and the prescription drug costs are the biggest concerns for our payment rates.”

Health Insurers



“In the individual market it becomes enrollee membership, a lot of selection issues, lots of healthy enrollees are not enrolling, so we are seeing issues of high use and cost with too many unhealthy persons in the market.”

“Then there is also the issue of more of a regulation in terms of the federal reinsurance is going away, so we are losing the protections there for the individual and small group markets.”

“As we are reflecting on changes in healthcare costs, pharmacy is becoming a big driver of it....”

“The biggest factors [affecting premium rates] are medical costs and pharmacy cost trends, medical inflation in general. Medical cost has been relatively low over the past year, and pharmacy has really been the biggest contributor.”

“Pharmaceutical absolutely, specialty especially... you need the tools and care coordination to handle it ... but pharmacy is so out of control, these single patent companies charging whatever they want....”

“I think [Healthy Michigan] has helped hospitals, but they definitely don’t say, ‘because we’ve got more money, because our uncompensated care has decreased, we’re going to give you a price discount’ ...and we can’t say the same thing in fairness, ‘we had a good operating margin, so we’ll pay you more,’ we don’t do it either, in all fairness. It just doesn’t work that way, in consideration of all of the other costs and factors affecting costs.”

“For the health insurance exchange we had to build our own premium – we based that on our hospital contracts, this is the number one factor, and it’s a new market, so that is difficult.”

“We are trying to keep premiums down and narrow our provider networks [to keep the costs down].”

II. DIFS Rate Analysis Tables and Charts

The findings from the rate filings analysis are organized into four sections:

- A. Number and type of filing
- B. Magnitude of the premium rate change requested
- C. Reasons for premium rate changes requested
- D. Medical cost trend rates noted in filings

All data are presented by year of filing (2013, 2014, and 2015).

A. Number and Type of Filing

Number of filings with rate change increase or decrease by market, by year

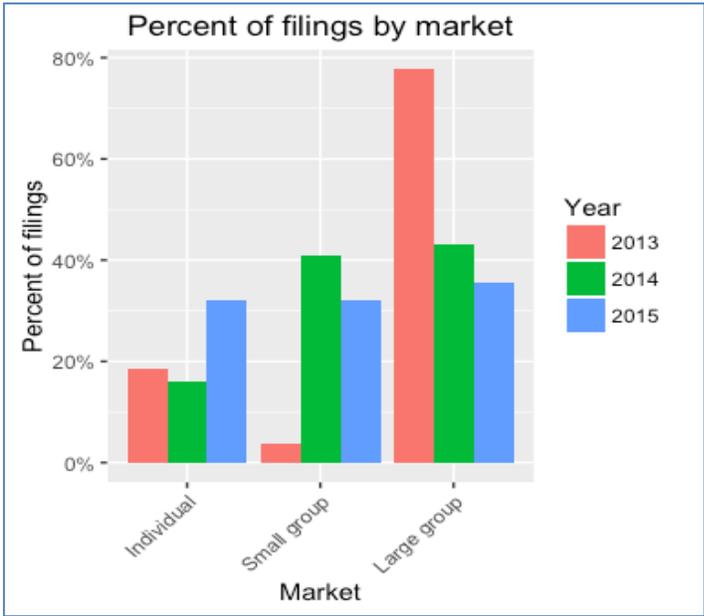
Year	Market	Decrease	Increase
2013	Individual	1	9
	Small group	0	2
	Large group	3	39
2014	Individual	1	6
	Small group	1	17
	Large group	6	13
2015	Individual	3	16
	Small group	4	15
	Large group	0	21

Number of filings with rate change increase or decrease by product, by year

Year	Product	Decrease	Increase
2013	HMO	4	32
	PPO	0	7
	MM	0	10
	POS	0	1
2014	HMO	8	14
	PPO	0	12
	MM	0	8
	POS	0	2
2015	HMO	6	25
	PPO	1	13
	MM	0	11
	POS	0	3

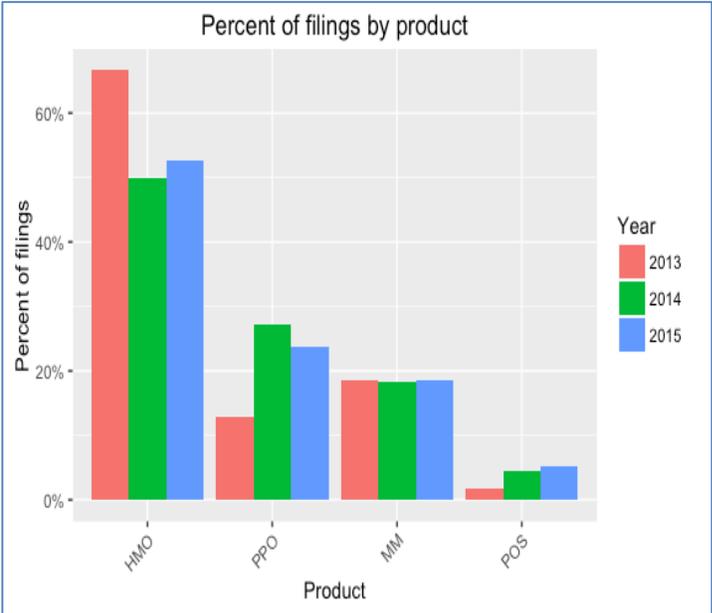
Percent of Filings Requesting Rate Change, by Market, by Year

Year	Individual	Small group	Large group
2013	18.5%	3.7%	77.8%
2014	15.9%	40.9%	43.2%
2015	32.2%	32.2%	35.6%



Percent of Filings Requesting Rate Change, by Product, by Year

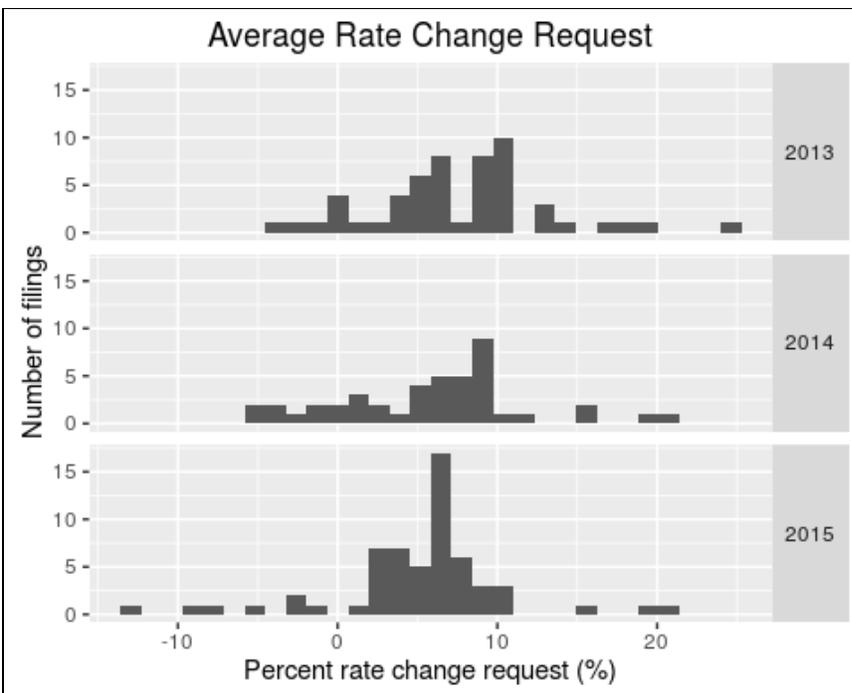
Year	HMO	PPO	MM	POS
2013	66.7%	13.0%	18.5%	1.9%
2014	50.0%	27.3%	18.2%	4.5%
2015	52.5%	23.7%	18.6%	5.1%



B. Magnitude of the Premium Rate Requested

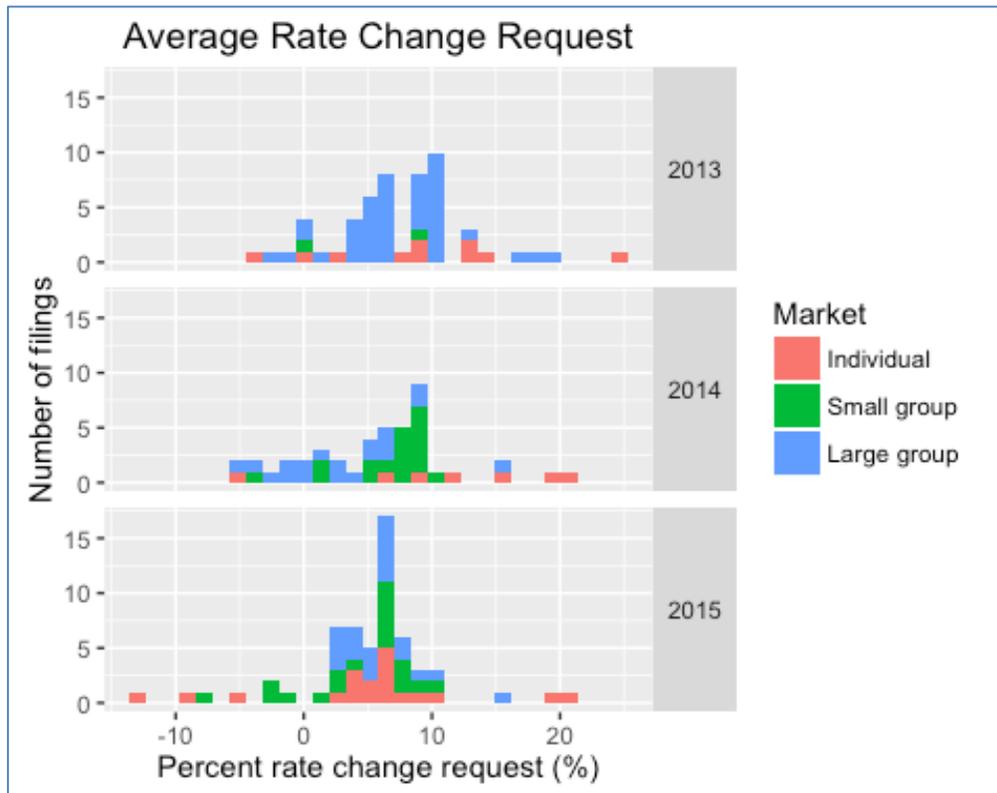
Percent Rate Change Request by Year (%)

Year	Filings	Average (%)	Min (%)	Max (%)
2013	54	7.55	-3.97	25.0
2014	44	5.77	-5.10	21.0
2015	59	5.22	-12.60	20.5



Percent Rate Change Request, by Market, by Year (%)

Year	Market	Filings	Average (%)	Min (%)	Max (%)
2013	Individual	10	8.87	-3.97	25.00
	Small group	2	4.68	0.50	8.86
	Large group	42	7.37	-3.19	19.80
2014	Individual	7	10.90	-4.90	21.00
	Small group	18	6.63	-3.70	9.90
	Large group	19	3.07	-5.10	15.00
2015	Individual	19	5.20	-12.60	20.50
	Small group	19	4.13	-8.30	9.90
	Large group	21	6.21	2.90	15.00



Percent Rate Change Request, by Product, by Year

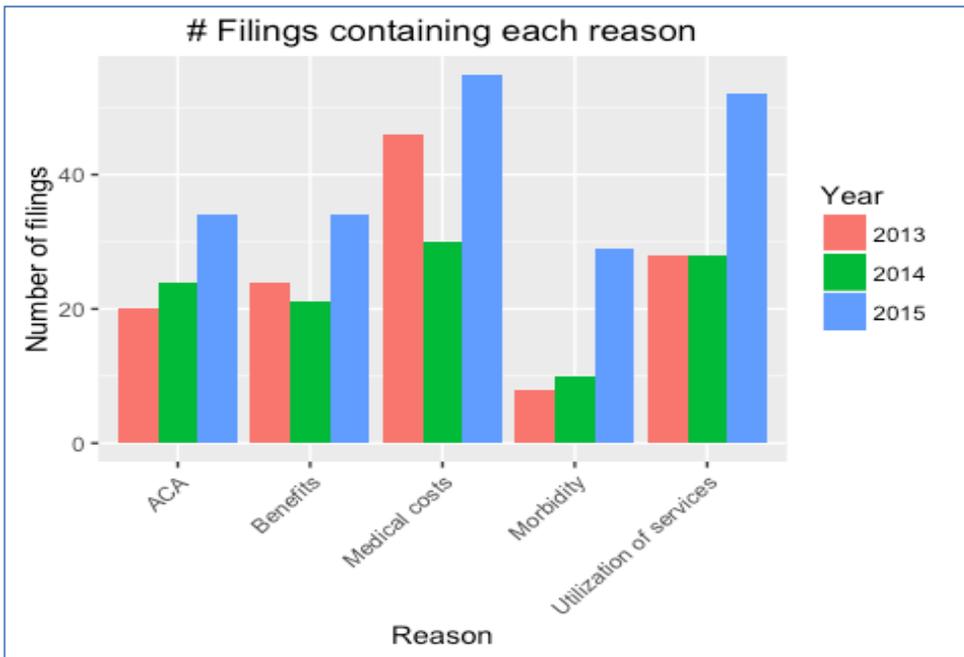
Year	Product	Filings	Average (%)	Min (%)	Max (%)
2013	HMO	36	6.20	-3.97	18.50
	PPO	7	8.67	0.50	14.60
	MM	10	11.69	5.48	25.00
	POS	1	6.73	6.73	6.73
2014	HMO	22	2.41	-5.10	9.50
	PPO	12	7.76	1.27	19.00
	MM	8	12.00	9.00	21.00
	POS	2	5.84	2.90	8.77
2015	HMO	31	3.40	-12.60	9.90
	PPO	14	6.48	-8.30	20.50
	MM	11	8.58	0.80	20.00
	POS	3	5.70	4.10	6.50



C. Reasons for Premium Rate Changes Requested

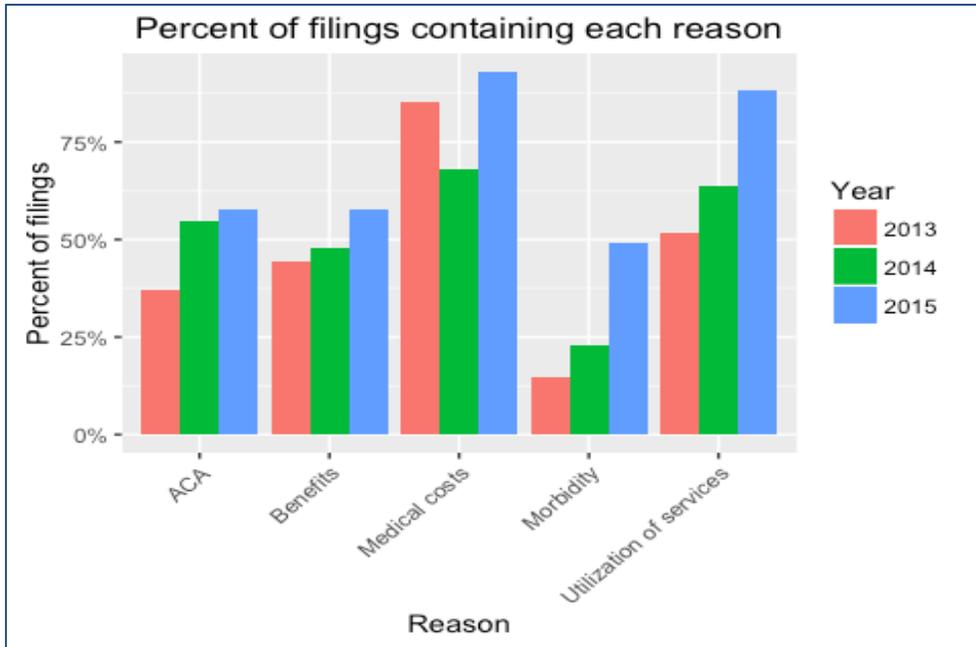
Number of Filings by Reasons for Rate Change Request, by Year

Year	ACA	Benefits	Medical costs	Morbidity	Utilization of services
2013	20	24	46	8	28
2014	24	21	30	10	28
2015	34	34	55	29	52



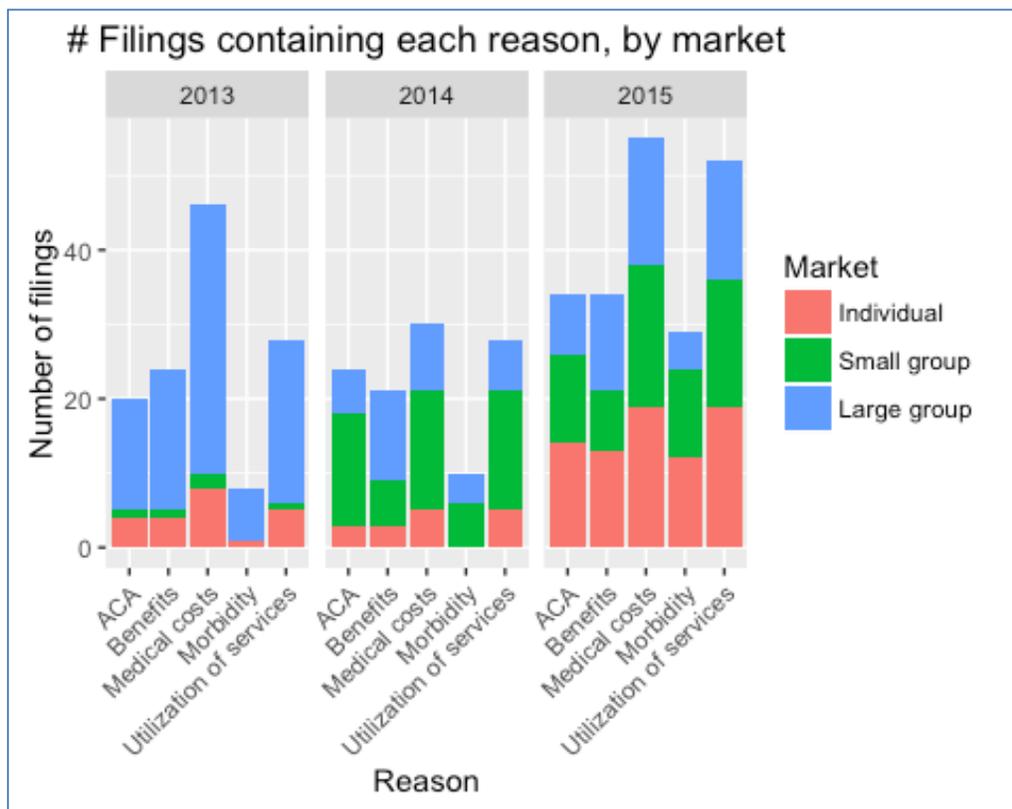
Percent of Filings by Reason for Rate Change Request, by Year

Year	ACA	Benefits	Medical costs	Morbidity	Utilization of services
2013	37.0%	44.4%	85.2%	14.8%	51.9%
2014	54.5%	47.7%	68.2%	22.7%	63.6%
2015	57.6%	57.6%	93.2%	49.2%	88.1%



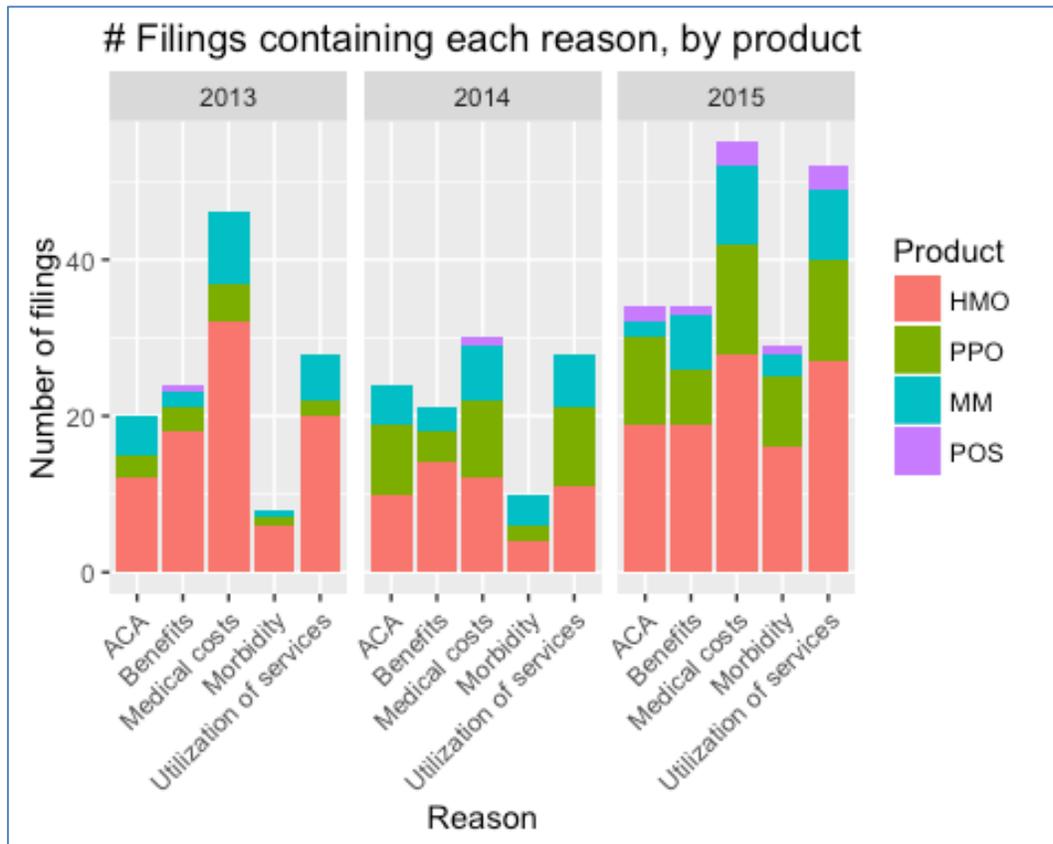
Number of Filings Noting Selected Reasons for Changes in Premium Rates, by Market, by Year

Year	Market	ACA	Benefits	Medical costs	Morbidity	Utilization of services
2013	Individual	4	4	8	1	5
	Small group	1	1	2	0	1
	Large group	15	19	36	7	22
2014	Individual	3	3	5	0	5
	Small group	15	6	16	6	16
	Large group	6	12	9	4	7
2015	Individual	14	13	19	12	19
	Small group	12	8	19	12	17
	Large group	8	13	17	5	16



Number of Filings Noting Selected Reasons for Changes in Premium Rates, by Product, by Year

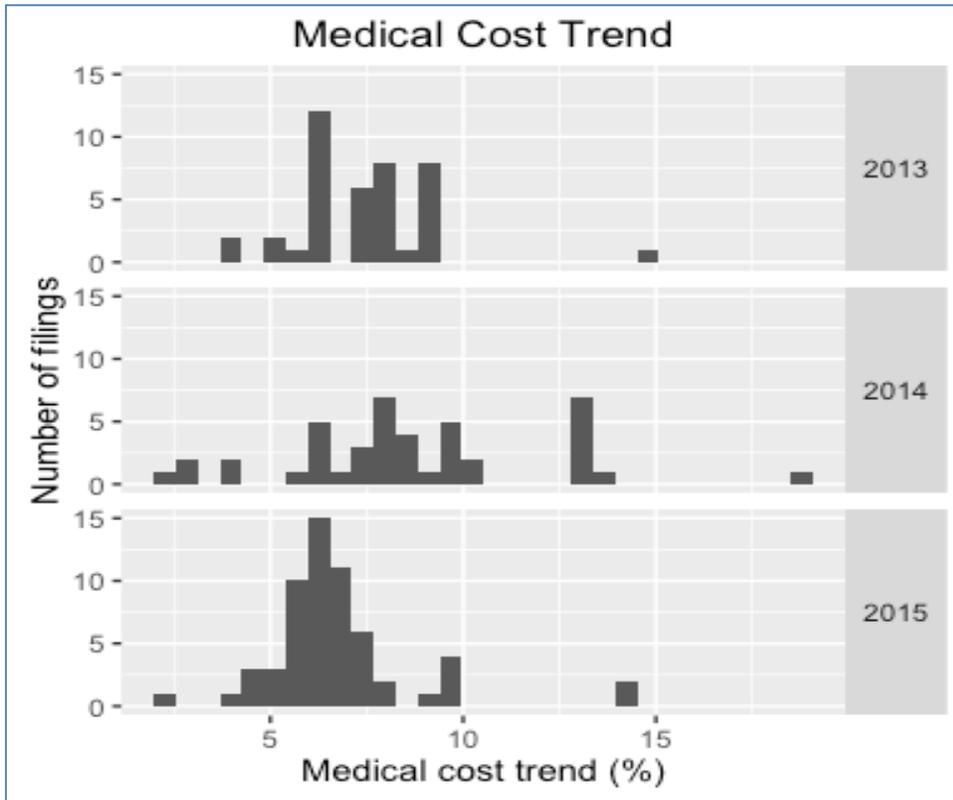
Year	Product	ACA	Benefits	Medical costs	Morbidity	Utilization of services
2013	HMO	12	18	32	6	20
	PPO	3	3	5	1	2
	MM	5	2	9	1	6
	POS	0	1	0	0	0
2014	HMO	10	14	12	4	11
	PPO	9	4	10	2	10
	MM	5	3	7	4	7
	POS	0	0	1	0	0
2015	HMO	19	19	28	16	27
	PPO	11	7	14	9	13
	MM	2	7	10	3	9
	POS	2	1	3	1	3



D. Medical/ RX Cost Trend Rates Noted in Filings (Actuarial memos)

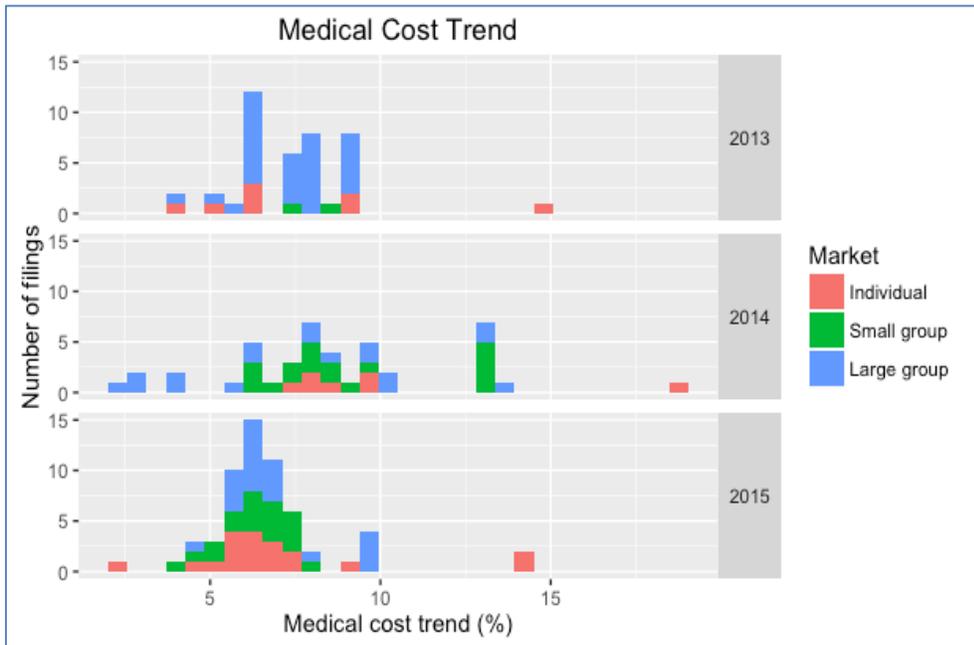
Medical/RX Cost Trend Rate, by Year

Year	Filings	Average (%)	Min (%)	Max (%)
2013	54	7.33	4.0	14.6
2014	44	8.70	2.5	19.0
2015	59	6.73	2.5	14.5



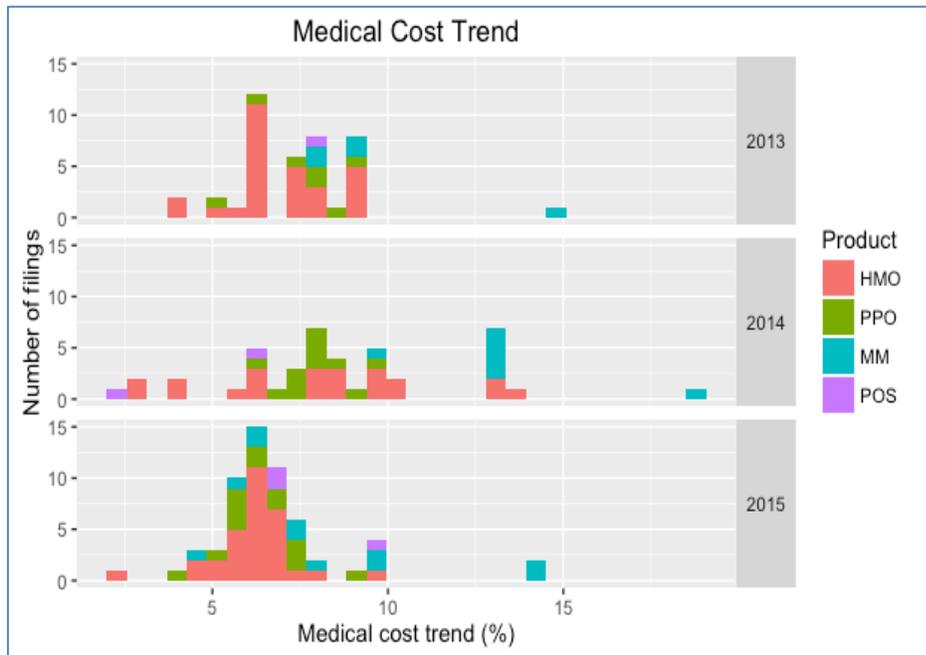
Medical/RX Cost Trend Rate, by Market, by Year

Year	Market	Filings	Average (%)	Min (%)	Max (%)
2013	Individual	10	7.60	4.0	14.60
	Small group	2	7.85	7.2	8.50
	Large group	42	7.22	4.2	8.84
2014	Individual	7	10.06	7.5	19.00
	Small group	18	9.16	6.0	13.00
	Large group	19	7.71	2.5	13.70
2015	Individual	19	6.98	2.5	14.50
	Small group	19	6.29	4.0	7.90
	Large group	21	6.89	4.6	9.60



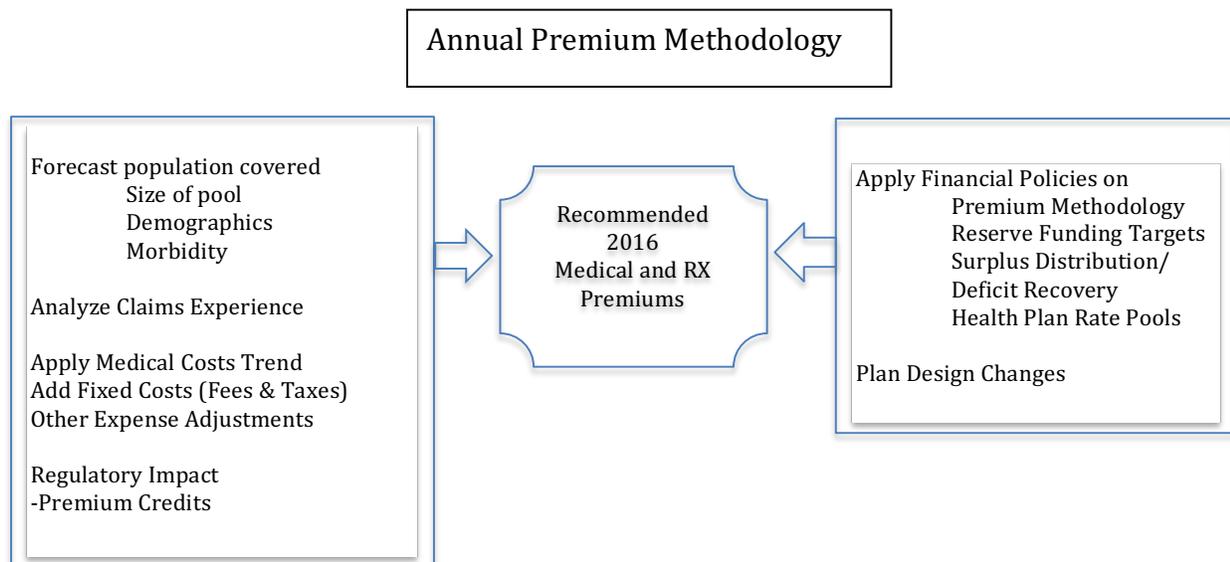
Medical/RX Cost Trend Rate, by Product, by Year

Year	Product	Filings	Average (%)	Min (%)	Max (%)
2013	HMO	36	6.88	4.0	8.9
	PPO	7	7.41	5.2	9.1
	MM	10	9.64	7.9	14.6
	POS	1	7.70	7.7	7.7
2014	HMO	22	8.05	2.9	13.7
	PPO	12	7.91	6.0	9.9
	MM	8	13.37	9.6	19.0
	POS	2	4.25	2.5	6.0
2015	HMO	31	6.16	2.5	9.5
	PPO	14	6.36	4.0	9.0
	MM	11	8.54	4.3	14.5
	POS	3	7.70	6.8	9.5



Appendix G: Overview of Process for Setting Health Insurance Premiums

Actuaries develop premiums based on projected medical claims and administrative costs for a pool of individuals or groups with insurance. Pooling risks allows the costs of the less healthy to be subsidized by the healthy. In general, the larger the risk pool, the more predictable and stable premiums can be. But, the composition of the risk pool is also important. Although the ACA prohibits insurers from charging different premiums to individuals based on their health status, premium levels reflect the health status of an insurer's risk pool as a whole. The majority of premium dollars goes to medical claims, which reflect unit costs (e.g., the price for a given health care service), utilization, the mix and intensity of services, and plan design. Premiums must cover administrative costs, including those related to product development, enrollment, claims processing, and regulatory compliance. They also must cover taxes, assessments and fees, as well as profit (or, for not-for-profit insurers, a contribution to surplus). Laws and regulations can affect the composition of risk pools, projected medical spending, and the amount of taxes, assessments and fees that need to be included in premiums.



Appendix H: Major Drivers of Premium Rate Changes Over Time

<i>FACTORS IN PREMIUM INCREASES</i>	
<i>Risk Pool Composition</i>	
Composition of the risk pool and How it compares to what was projected How it is expected to change	<p>CMS Proposed Standard Age Curve published in the Federal Register on November 26, 2012. This age curve has a 3:1 ratio for age rating. There is also a published factor for children.</p> <p>Insurer expectations regarding the composition of the enrollee risk pool, including the distribution of enrollees by age, gender, and health status.</p>
Single risk pool requirement	<p>The ACA requires that insurers use a single risk pool when developing rates. That is, experience inside and outside the health insurance marketplaces (exchanges) must be combined when determining premiums.</p> <p>Premiums for 2016 will reflect demographics and health status factors of enrollees both inside and outside of the marketplace, as was true for 2014 and 2015.</p>
Transitional policy for non-ACA-compliant plans	<p>For states that adopted the transitional policy that allowed non-ACA compliant plans to be renewed, the risk profile of 2014 ACA-compliant plans might be worse than insurers projected. This would occur if lower-cost individuals retain their prior coverage and higher-cost people move to new coverage. The transitional policy was instituted after 2014 premiums were finalized; meaning insurers were not able to incorporate this policy into their premiums.</p>
Regional, within-Michigan variations	<p>Premiums are set at the state level (with regional variations allowed within a state) and will reflect state- and insurer-specific experience. These factors are reflected in the trend factors reported by insurers.</p>
Reduction of reinsurance program funds	<p>The ACA transitional reinsurance program provides for payments to plans when they have enrollees with especially high claims, thereby offsetting a portion of the costs of higher-cost enrollees in the individual market. This reduces the risk to insurers, allowing them to offer premiums lower than they otherwise would be. Funding for the reinsurance program comes from contributions from all health plans; these contributions are then used to make payments to ACA-compliant plans in the individual market (For more information see: http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/).</p>

<i>Prices & use of services</i>	
Medical trend: Underlying growth in health care costs	The increase in medical trend reflects the increase in per-unit costs of services and increases in health care utilization and intensity
	<p>Short term National projection: National Health spending growth projected to rise 6.1% 2014-2015 (adjusted for inflation (CPI-U)).</p> <p>Long term projection: 2015-2022 national health spending projected to grow 6.2% annually.</p> <p>Health care reform impact on trend projected to be an average increase of 0.1% annually from 2012 to 2022 (CMS report on National Health Expenditure Projections 2012-2022).</p>
<i>Employer Plan Taxes & Fees</i>	
Temporary Reinsurance Fees (2014 thru 2016)	<p>Fees from self-insured plans will be used to make reinsurance payments to individual market insurers that cover high-cost individuals in each state.</p> <p>National fee rate of \$63 per (non-Medicare) member per year for 2014, \$44 PMPY for 2015, and \$31.50 PMPY for 2016.</p>
Temporary tax for PCORI fees (2012 thru 2018)	<p>Assessments will fund “patient centered outcomes research trust fund”</p> <p>Fees basis: \$1 per covered health plan member per year for CY 2012, \$2 per member per year for CY 2013, with PMPY amounts indexed to per capita increases in National Health Expenditures for years 2014-2018.</p>
Employer Shared Responsibility for Health Care, “Pay or Play”	<p>Requires large employers to “offer” medical coverage to employees averaging 30 or more hours of work per week</p> <p>Health care coverage will be offered to temporary employees</p> <p>Medical plans offered must satisfy mandated coverage levels; Employee premium must not exceed 9.5% of the employees pay rate</p> <p>Employers must successfully “offer” coverage to 70% of their qualified population beginning 2015, and 95% by 2016</p>

Health claims assessment tax of 1% of claims and/or premium	State of Michigan Public Act 142 of 2011: Effective Jan 2012, applies to medical, Rx and dental services delivered in Michigan to Michigan residents
<i>Plan Structure & Operations</i>	
Changes in provider networks	Mix of practitioner specialties; “narrowness” of network
Changes in provider reimbursement structures	Per service payment formulae; example: Inpatient stays paid on DRG, Percent of Charges, bundled rates
Benefit package changes	Changes to benefit packages (e.g., through changes in cost-sharing requirements or benefits covered) can affect claim costs and therefore premiums. This can occur even if a plan’s actuarial value level remains unchanged.
Risk margin changes	Insurers build risk margins into the premiums to reflect the level of uncertainty regarding the costs of providing coverage. These margins provide a cushion in case costs are greater than projected. Greater levels of uncertainty typically result in higher risk margins and higher premiums.
Changes in administrative costs	Wages, information technology, profit
Increase in the health insurer fee	In 2014, the ACA health insurer fee is scheduled to collect \$8 billion from health insurers. The fee will increase to \$11.3 billion in 2015 and gradually further to \$14.3 billion in 2018, after which it will be indexed to the rate of premium growth. The fee is allocated to insurers based on their prior year’s premium revenue as a share of total market premium revenue. In general, insurers pass along the fee to enrollees through an increase to the premium. The effect on premiums will depend on the number of enrollees over which the fee is spread—a greater number of enrollees will translate to the fee being a smaller addition to the premium. The increase in health insurer fee collections from 2014 to 2015 will, in most cases, lead to a small increase in 2015 premiums relative to 2014 (See Exchange and Insurance Market Standards for 2015 and Beyond (Final Rule), Federal Register: 79 (101), May 27, 2014. Available at: http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf .)

<p>Changes in geographic regions</p>	<p>Within a state, health insurance premiums are allowed to vary across geographic regions established by the state according to federal criteria.</p> <p>Changes in the number of geographic regions in the state or how those regions are defined could cause premium changes that would vary across areas. For instance, assuming no other changes, if a lower-cost region and a higher-cost region are combined into one region for premium rating purposes, individuals in the lower-cost area would see premium increases, and individuals in the higher-cost areas would see premium reductions.</p>
<p><i>Market Competition</i></p>	
<p>Market forces and product positioning</p>	<p>Insurers might withstand short-term losses in order to achieve long-term goals.</p> <p>Due to the ACA’s uniform rating rules and transparency requirements imposed by regulators, premiums are much easier to compare than before the ACA, and some insurers lowered their premiums after they were able to see competitors’ premiums.</p>