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Michigan's Exchange: A Fumbled Political Football

Michigan policymakers still have the opportunity to score a big win for Michigan consumers and small businesses by creating a state-operated health insurance exchange, which would specifically address Michigan's demographic, cultural, ethnic and regional needs as well as Michigan's insurance market. Gov. Snyder has supported a state-operated exchange and the Senate has passed enabling legislation; it is now up to the House to step up and close the deal. The state has until Nov. 16 to inform the federal government that it intends to develop a state-operated exchange, with details due on Dec. 14, 2012. Michigan also has the opportunity to try to retain nearly $10 million in federal funds to study the best way to proceed.

On Nov. 9, 2012, the Secretary of the federal Department of Health and Human Services granted a one-month extension to states planning to operate a state-based exchange to submit their detailed plans, called blueprints, for federal approval. In addition, she granted extensions until Feb. 15, 2013, to submit letters of intent and blueprints for state partnership exchanges.

The Secretary reiterated, however, that these extensions do not change the law and that exchanges will be operational in all 50 states by Jan. 1, 2014, as mandated in the law.

BACKGROUND

The Affordable Care Act, signed into law in March 2010, requires every state to have an operational health insurance exchange by Jan. 1, 2014, with initial enrollment beginning Oct. 1, 2013. An exchange is a regulated, consumer-friendly marketplace that offers quality, affordable healthcare coverage on a competitive basis. Individuals who do not have affordable coverage available through an employer and small businesses will be able to shop, readily compare health plans and enroll in coverage, both private and public (Medicaid or MIChild). States have the option of designing and operating their own exchanges or deferring to the federal government to design and operate all or most functions of the exchange.

In the governor's Health and Wellness Message in September 2011, he called for the establishment of a state-operated exchange, MI Health Marketplace, and urged lawmakers to pass enabling legislation by last Thanksgiving. He indicated his support for the concept regardless of the outcome efforts to repeal the law or the ruling by the Supreme Court.

> *"The Affordable Care Act (ACA) requires each of the states to establish a health insurance exchange by 2014. If Michigan does not establish its own exchange, then the federal government will step in to operate one for Michigan. While I recognize that all or a portion of the ACA may be repealed or found to be unconstitutional in lawsuits that are currently pending, Michigan must be prudent and plan to reach the best possible outcome under the existing law. Because Michigan needs a health insurance marketplace that best serves Michiganders, I am asking the Legislature to adopt legislation to create the MI Health Marketplace. This legislation should both satisfy the requirements of the ACA and improve the experience of purchasing health insurance coverage in Michigan."*
>
> *- Gov. Rick Snyder*

The Senate followed suit and passed legislation in November 2011. The House stalled waiting for hearings, waiting for the Supreme Court ruling, then waiting for the November 2012 election. Those events have all passed, and now the House has been given a new opportunity to step up and do what is right for Michigan's residents and small businesses – create a consumer-friendly exchange in Michigan.

WHAT IS AN EXCHANGE?

The word "exchange," means little to most people in the context of healthcare, but that is the name given in the law to the new competitive marketplace created in the Affordable Care Act. This marketplace will not require individuals "to give up or exchange"

their current healthcare coverage for something different or new, rather it will provide the opportunity for those who don't have employer coverage to shop for, compare, and purchase quality health insurance coverage. This new marketplace will provide new options for Americans to meet their specific health-care needs and achieve health security by obtaining quality, affordable coverage.

Each state has the option of developing and operating its own marketplace ("state-operated exchange"), partnering with the federal government on the implementation of limited components of the marketplace ("partnership exchange"), or deferring totally to the federal government to develop and operate the marketplace ("federally facilitated exchange").

This new marketplace, which must be available to customers online, by phone, or in person will provide a consumer-friendly setting where individuals and small businesses can compare health plans on an "apples to apples" basis without pressure or bias to purchase a particular product, and enroll in the plans that best meet their needs. To be sold on the exchange, health plans must be certified as meeting specifically defined standards to ensure high quality products are available. Plans will be required to provide benefit information in understandable language as well as in a format that provides easy comparison of multiple health plans.

In addition to purchasing health plans, individuals will also have the opportunity to apply for sliding-scale premium and cost-sharing subsidies available for those with incomes between 100% (or 133% if Medicaid is expanded) and 400% of the federal poverty level. The premium subsidies, which will be advancable tax credits, are intended to make the health plans more affordable and assist families and individuals in meeting the individual responsibility provision of the law which requires everyone to obtain coverage **if** it is affordable.

The sliding-scale premium subsidies will limit the cost of premiums to a percentage of income ranging from:

- 3% for those with incomes up to 133% of the federal poverty level or $25,390 for a family of three,
- to 6.3% for those with incomes at 200% FPL or $38,180 for a family of three,
- to 9.5% for those with incomes above 300% FPL or $57,270 for a family of three.

For example, a family of three with income of $38,180 would generally have to pay no more than $2,405 (6.3% of income) in premium costs. The balance would be subsidized by the federal government. Exchanges will classify plans into four tiers depending on the comprehensiveness of coverage and cost sharing. Federal subsidies will be based on a particular tier of plans. If a higher-tier plan is purchased, the consumer will be responsible for the extra cost. If a lower-tier plan is selected, the consumer will have to pay less as the subsidy will cover more of the premium cost.

The cost-sharing subsidies are intended to make it possible for people to use their benefits. Out-of-pocket spending limits for cost sharing are capped as follows:

- $3,967 for families with incomes between 100% and 200% FPL,
- $5,950 for families with incomes between 200% and 300% FPL,
- $7,933 for families with incomes between 300% and 400% FPL, and
- $11,500 for families above 400% FPL.

Direct consumer assistance will be provided through Navigator programs which must be established and funded by the exchange. Navigators' responsibilities are defined in the ACA and include: public education and outreach; providing information in a culturally and linguistically appropriate manner; providing impartial information about the plans available on the exchange as well as the federal subsidies; assistance with enrollment in a health plan; referrals to other consumer assistance programs to resolve questions or complaints related to coverage or billing or other issues. Certain entities, specified in the law, can be selected to become Navigators. They must have demonstrated experience in working with individuals or small businesses that are likely to purchase coverage through the exchange.

State-operated in-person assistance programs must be established in states that elect the partnership model with management of the consumer assistance function, and may be established in states that operate their own exchanges. Both programs will include trained individuals, meeting conflict of interest standards, who will be available to provide unbiased assistance and information and answer questions on available coverage options and enrollment. Assistance must be provided in a culturally and linguistically appropriate manner. Because Navigator programs are funded by the exchanges, it is possible that they may not be established until 2014. The federal government, however, recognizes the importance of public education and outreach, as well as consumer assistance for those selecting and enrolling in plans during the initial enrollment period, starting Oct. 1, 2013. Efforts are under way to secure funding to

enable programs in federally facilitated exchanges to be established by Oct. 1, 2013. Recent federal guidance also allows in-person assistance programs to be established and operated using federal exchange planning grants prior to Jan. 1, 2014.

Even though "apples-to-apples" comparisons will be available, consumer assistance will be essential because it may not be a simple process to choose the plan that best meets the needs of a family or individual. Out-of-pocket costs, including copays and deductibles, provider networks, and the specific benefits will vary by plan, making selection of the right combination of specific benefits, costs, and provider networks a challenge. While some have compared the exchange to a website such as Expedia, selecting healthcare coverage that meets one's needs is far more complicated that selecting an airline to fly from point A to point B.

To facilitate timely enrollment and provide the "1st class 21st century experience" required by the law, a simplified, streamlined application and enrollment process for both private coverage subsidies and public (Medicaid or MIChild) coverage must be developed. A state can design its own application, subject to federal approval, or it can use the application designed by the federal government. Individuals or families will be able to submit one application and be determined eligible for the premium and cost sharing subsidies or public programs. The application cannot be burdensome to the family or individual and, to the degree possible, eligibility for subsidies and Medicaid/MIChild will be determined through data matches with IRS and other federal or state data sources. Paper verification and documentation will be minimized, greatly simplifying the process.

WHY EXCHANGES ARE NEEDED

There are currently millions of Americans who are uninsured because they do not have access to affordable healthcare coverage through their employers, they have been denied coverage due to a pre-existing condition, their coverage has been terminated because their maximum benefit has been reached, or they have lost their jobs and their healthcare coverage.

The ACA addresses these issues by making affordable, quality coverage available to those who must purchase their own coverage through the new regulated, consumer-friendly marketplace. It is intended to both reduce the number of uninsured Americans and to ensure quality, affordable private coverage, on a competitive basis, is available.

Michigan continues to experience steep declines in employer-sponsored healthcare coverage with more than 1.25 million individuals losing coverage between 2000 and 2010, many of whom continue to be uninsured. For the period 2000-2001, the percentage of Michigan's population covered by employer-sponsored insurance was 77%; by 2010-2011, that percentage had declined to 61.5%. There are currently few, if any, affordable options for those who have lost their jobs and healthcare coverage or for those who do not have affordable coverage offered by their employers.

Currently there is no single place where consumers or small businesses can review and compare options and shop for healthcare coverage. There is little competition in the market to provide competitive prices while questionable practices (using fine print or confusing language to define benefits, recruiting healthy individuals while discouraging those less healthy from purchasing coverage) among companies are common. The new marketplace will provide a one-stop location for reviewing and shopping for health plans and a level playing field on which health plans will compete based on quality and price. Health plans will be required to follow a consistent format for specifying plan benefits and cost sharing and to use understandable language, rather than insurance jargon, so that consumers and small businesses can readily understand their benefits and exactly what they are purchasing. Consumer protections, a critical issue addressed in the law, will be a key function of the exchange.

The simplification of Medicaid eligibility determination for the majority of those eligible and the ability to apply for coverage through the exchange are key policy improvements included in the ACA. There are currently more than 40 ways to qualify for Medicaid or other public coverage in Michigan. The complexity is daunting for those who currently administer the program and for those who apply. The ACA simplified and collapsed most of the Medicaid categories and based the new structure simply on income and citizenship. For nonelderly and nondisabled applicants, eligibility will be determined on a new tax-related income basis, called modified adjusted gross income. Applicants will no longer have to be part of a federally-designated group to qualify. The law envisions eligibility determinations on a nearly immediate basis, but that is likely a goal for the future. It does not appear at this time that sufficient data match systems will initially be available to provide the "real time" determination through the exchange.

BENEFITS OF THE EXCHANGE

Effective Jan. 1, 2014, health plans will no longer be allowed to deny coverage or charge higher premiums for adults (these protections for children were implemented in 2010) with pre-existing conditions such as high blood pressure, diabetes, or cancer. In addition, lifetime limits can no longer be imposed by health plans and annual limits are phased out.

New health plans sold both on the exchange and outside the exchange must include a minimum set of benefits that cover the major categories specified in the law, which include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative

services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including vision and oral health). The exact benefits included in these categories will be defined by the state and are called the essential health benefits package. Health plans are expected to have some leeway in establishing their benefit packages, but must cover the essential health benefits package at a minimum. The ACA specifies that health plans must cover at least 60% of the cost of included services. Health plans sold on the exchange will be monitored to ensure they follow the provisions of the law and provide quality plans.

In a recent study, published in Health Affairs, researchers compared current individual and group health plans in Michigan and several other states and found that more than half of the plans did not meet the requirements to be sold on the exchange. Maternity care, one of the essential benefits that must be covered, is significantly lacking in the private market. The Department of Health and Human Services estimates that 62% of current enrollees in the individual market do not have that benefit.

Strong consumer protections will provide confidence and peace of mind to those shopping on the exchange. Health plan premium increases will be monitored by the exchange to ensure they are reasonable and justified. Marketing standards will be established to prohibit unethical advertising and provider network standards will be established to ensure the plans sold on the exchange have adequate doctors and other providers available in their plans. Health plans will be required to report quality and customer satisfaction ratings to help consumers make informed choices. They will also be required to meet quality standards and implement quality improvement strategies to ensure consumers receive good value for their healthcare dollars. Consumer assistance programs will be available to handle grievances or consumer concerns about health plan benefits or billings or claims.

Individuals and families will be able to apply for advance premium tax credits to reduce premium costs and cost-sharing subsidies as well as Medicaid and MIChild through the exchange. Small businesses will also be able to shop for and compare plans for their employees. In addition, small businesses that purchase coverage through the exchange may qualify for tax credits of up to 50% of the employers' cost of coverage.

The new marketplace will also provide affordable, quality options for those seeking to change jobs or establish a business on their own. Individuals will no longer have to feel trapped in a job because it offers healthcare coverage; other affordable options will be available.

MICHIGAN'S PROGRESS

Michigan's progress on developing a state-operated exchange stalled after the Senate passed S.B. 693 on Nov. 10, 2011. Numerous businesses, provider, and advocacy organizations testified in support of a state-operated exchange. However, House Republicans delayed action, first insisting on waiting for the Supreme Court ruling, then waiting for the outcome of the election in November 2012. In the meantime, they refused to appropriate the $9.8 million planning grant awarded to the state for initial research and planning. States that accepted planning grants were not obligated to establish a state-operated exchange. The planning grants were intended to allow states to perform the necessary research and evaluation so that they could make informed decisions on the best way to proceed. Michigan's funds are scheduled to be returned to the federal government on Nov. 28, 2012 because they have not been used during the one-year award period. Unless Michigan requests, and the Secretary of Health and Human Services approves an extension, and the state House appropriates those funds, Michigan will lose $9.8 million in economic activity as well as the extensive research and planning they could have supported.

Without legislation or other clear legal authority for establishing a state-operated exchange, the state is left with two options, both of which the federal government basically controls. The first option, a federally facilitated exchange, defers completely to the federal government to develop, establish and operate Michigan's exchange. The other option, a state-federal partnership exchange, allows the state to participate in a limited number of functions of the exchange; the federal government retains overall control and responsibility. Partnership exchanges were developed to provide the opportunity to states to transition to a state-operated exchange in the future if they could not be operational on Jan. 1, 2014. In August 2012, Gov. Snyder acknowledged that time was running out for Michigan to establish a state-operated exchange and expressed interest in pursuing a partnership exchange.

States that elect a partnership exchange have the option of conducting up to two of the 12 functions required by an exchange. Those functions include:

- health plan management (certification, monitoring, compliance with requirements) to ensure plans are qualified to be sold on the exchange, and/or
- operation of the in-person consumer assistance program and oversight and management of the Navigator program.

The state can elect to perform either or both functions.

WHAT'S NEXT

If Michigan intends to pursue a state-operated exchange, which the governor continues to encourage, the letter of intent must be submitted to the federal government by Friday, Nov. 16, 2012. The details must follow by Dec. 14, 2012. It is not clear if the federal extension provides sufficient time for the state to

successfully complete the necessary activities and pass authorizing legislation to receive federal approval by Jan. 1, 2013, to proceed with a state-operated exchange.

If the state is not able to make sufficient progress to be approved (or conditionally approved) to operate a state-based exchange, policymakers could elect a state partnership exchange for 2014 while working to transition to a state-operated exchange in 2015. States have until Feb. 15, 2013, to submit their letters of intent and blueprints for participation in partnership exchanges.

CONCLUSION

The Supreme Court has ruled and upheld the Affordable Care Act. The electorate has confirmed the ACA is here to stay. It's time to set-aside politics and come together to implement the Act in the best manner possible to improve the overall health and healthcare coverage of the people of Michigan.

Sources

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