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Jan Hudson, Senior Policy Analyst

Michigan's Health Insurance Marketplace Will Open for Business Oct. 1

Michigan's federally operated exchange, the new regulated, competitive, consumer-friendly Health Insurance Marketplace will open for business on Oct. 1, 2013. It is designed to help individuals without affordable employer coverage and small businesses compare options and purchase quality healthcare coverage. The **Health Insurance Marketplace website** and toll-free number (800-318-2596) are available to provide general information. Michigan-specific information will be available starting Oct. 1, 2013, when open enrollment begins.

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 open enrollment beginning in October. States have the option of designing and operating their own exchanges ("state-operated exchange"), or deferring to the federal government to design and operate all ("federally facilitated exchange"), or most ("partnership exchange") functions of the exchange. Michigan has deferred to the federal government to develop and operate its Marketplace.

Gov. Rick Snyder strongly supported the creation of a **state-operated marketplace** and urged lawmakers to pass enabling legislation. State lawmakers, however, refused and turned down federal funds for research and planning ($9.8 million). When the governor then proposed a federal-state partnership exchange, the Legislature refused to accept the federal dollars ($30.7 million) for implementation and consumer assistance. In total, the state has declined to accept more than $40 million in federal grants.

Because a state is not precluded from establishing a state-operated exchange after initial implementation in 2014, Michigan policymakers could develop a plan to transition to a state-operated exchange in 2015 or later. Federal grants for exchange development remain available through Dec. 31, 2014.

WHAT IS AN EXCHANGE?

The word "exchange," means little in the context of healthcare, but that is the name given in the law to the new competitive Health Insurance 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, compare and purchase quality health insurance coverage. This new, regulated marketplace will provide new options for Americans to meet their specific healthcare needs and achieve health security by obtaining quality, affordable coverage.

A key function of the Marketplace is consumer outreach, education and enrollment. Marketplaces must have a website that allows:

- consumers to obtain and view information on the qualified health plans, including a cost and subsidy calculator,
- applications for premium/cost sharing subsidies to be submitted, and
- enrollment in the plans that meet consumers' needs.

Marketplaces must also have a toll-free phone line to assist consumers and provide information, as well as in-person assistance to 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.

NAVIGATORS TO HELP

Direct consumer assistance will be available in the Marketplace through a variety of means to assist consumers through the process of:

- comparing plans,
- choosing the option that best meets their healthcare coverage needs and budgets, and
- applying for tax credits or Medicaid/MIChild.

Every marketplace will have a Navigator program 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. Navigator programs are funded by the exchanges, through state-based grants in state-run exchanges or through federal grants in partnership or federally run exchanges.

On April 9, 2013, the federal government released a funding opportunity announcement to the 34 states with federally facilitated or state-partnership exchanges to apply for grant funding for Navigator programs. Each state was guaranteed at least $600,000. The initial federal allocation, however, was only $54 million. **Final awards** announced on Aug. 15, 2013, totaled $67 million.

Michigan Organizations That Received Navigator Program Grants:

Michigan Consumers for Healthcare
$1,319,345

Community Bridges Management, Inc.
$896,366

Arab Community Center for Economic & Social Services
$276,593

American Indian Health & Family Services of Southeastern Michigan, Inc.
$49,583.50

The $2.5 million awarded to Michigan will likely be inadequate to educate and successfully enroll 1.2 million uninsured Michiganians in healthcare coverage. As a component of the federal-state partnership exchange grant award, Michigan could have received $19.3 million for consumer assistance programs. Those funds would have gone a long way to funding education, outreach, and enrollment efforts had the Legislature accepted the funds.

CERTIFIED APPLICATION COUNSELORS

Every marketplace must also have Certified Application Counselors who are trained to educate consumers and assist with the completion of applications for coverage. Their duties and training are far more limited than those of Navigators. Organizations must be certified to perform these duties and can designate or limit the populations they serve. Counselors are not subject to the same strict conflict of interest standards as Navigators (counselors must only disclose potential conflicts of interest), but must serve the consumer's best interest. While new funding was not included in the ACA for Certified Application Counselors, other grant or foundation funding can be used in addition to volunteers.

Even though "apples to apples" comparisons will be available, consumer assistance will be essential to families and individuals to help them find the plan that best meets their needs. Out-of-pocket costs, including copays and deductibles, provider networks, and the specific benefits will vary by plan, making selection of the right combination 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.

QUALIFIED HEALTH PLANS ON THE EXCHANGE

To be sold on the marketplace, 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.

PREMIUM AND COST-SHARING SUBSIDIES

In addition to purchasing and enrolling in health plans, individuals with incomes between 100% and 400% of the federal poverty level will be able to apply for sliding-scale premium and cost-sharing subsidies. The premium subsidies will be "advanceable tax credits" that are given in advance of filing tax returns. They are intended to make the health plans more affordable and assist families and individuals in meeting the requirement that everyone

Potential Qualified Health Plans in Michigan

Michigan's Department of Insurance and Financial Services has received and is reviewing the filing information from **14 insurance companies** seeking to be qualified to sell their products on the exchange. The plans will be reviewed by both the state and federal governments for compliance with state and federal laws. Filing and rate information are expected to be released on Oct. 1, 2013, the date open enrollment begins.

One of the companies seeking qualification to sell products on the exchange is **Consumers Mutual Insurance of Michigan**, Michigan's Consumer Oriented and Operated Plan, or CO-OP. Michigan was one of 24 states to receive a federal loan to develop and implement a CO-OP, a new type of nonprofit health insurer created by the ACA. Under this model, plans are designed to offer affordable, consumer-friendly and high quality health insurance options to individuals and small businesses, both on and off the exchange. Members will be owners of the company, and any excess premiums collected will be reinvested to improve the organization, keep future premiums low, reduce out-of-pocket costs or expand benefits. By the end of its second year of operation, the CO-OP must have 51% of its board composed of members.

obtain coverage if it is affordable. The Department of Health and Human Services has released a **video** explaining the application process.

The table below displays expected premium contributions at various income levels:

For example, a family of four with income of $47,100 would generally have to pay no more than $2,967 per year (6.3% of income) in premium costs. The premium balance would be subsidized by the federal government.

Exchanges will classify plans into four tiers depending on the comprehensiveness of coverage and the amount of cost-sharing. Because federal subsidies are based on income, the subsidies can be used to purchase whichever tier plan is desired. If a higher-tier plan is purchased, the consumer will be responsible for more of the premium 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 tiers of plans (bronze, silver, gold, platinum) do not indicate differences in quality of plans or benefits, rather they indicate differences in cost-sharing and premium costs. A bronze plan will have a lower premium, but higher cost-sharing than a platinum plan which will have a higher premium, but lower cost-sharing.

Premium Credits by Income Under the Affordable Care Act

Income		Expected Premium Contribution Remaining After Premium Credit	
Percentage of Poverty Line	Annual Dollar Amount (2013)	Premium Contribution as Percentage of Income	Monthly Premium Contribution
Family of Four			
100 - 133%	$23,550 - $31,322	2%	$39 - $52
133 - 150%	$31,322 - $35,325	3 - 4%	$78 - $118
150 - 200%	$35,325 - $47,100	4 - 6.3%	$118 - $247
200 - 250%	$47,100 - $58,875	6.3 - 8.1%	$247 - $395
250 - 300%	$58,875 - $70,650	8.1 - 9.5%	$395 - $559
300 - 350%	$70,650 - $82,425	9.5%	$559 - $652
350 - 400%	$82,425 - $94,200	9.5%	$652 - $745
Individual			
100 - 133%	$11,490 - $15,282	2%	$19 - $25
133 - 150%	$15,282 - $17,235	3 - 4%	$38 - $57
150 - 200%	$17,235 - $22,980	4 - 6.3%	$57 - $121
200 - 250%	$22,980 - $28,725	6.3 - 8.1%	$121 - $193
250 - 300%	$28,725 - $34,470	8.1 - 9.5%	$193 - $272
300 - 350%	$34,470 - $40,215	9.5%	$272 - $318
350 - 400%	$40,215 - $45,960	9.5%	$318 - $364

Source: Center on Budget and Policy Priorities

The cost-sharing subsidies, available to those with incomes up to 250% of the federal poverty level who purchase a silver-tier plan, reduce out-of-pocket spending and cost barriers making it possible for people to access needed care and services.

The ACA also caps out-of-pocket spending on a sliding scale for those with incomes below 400% of the federal poverty level, as demonstrated by the following table. Out-of-pocket limits will be updated each year, so the amounts in 2014 will be somewhat different from those shown below.

Percent of Federal Poverty Level Out-of-Pocket Maximum				
	100-200%	200-300%	300-400%	400%+
Individual	$2,017	$3,025	$4,033	$6,350
Family	$4,033	$6,050	$8,067	$12,700

The Kaiser Family Foundation has created a **subsidy calculator** that estimates the consumer's share of annual premiums, the amount of their federal subsidies, and cost-sharing limits based on income, household size, age, and tobacco usage.

APPLICATION PROCESS

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 assessment has been developed by the federal government. A state can design its own application, subject to federal approval, or it can use the federal application. Individuals or families will be able to submit one application and be determined eligible for the premium and cost-sharing subsidies or assessed/determined eligible for public programs. States have the option of allowing the exchange to determine Medicaid or Children's Health Insurance Program (MIChild in Michigan) eligibility, or the exchange can assess and transmit the application to the state for final eligibility determination. The application cannot be burdensome to the family or individual and, to the degree possible, eligibility for subsidies and Medicaid/CHIP will be determined through data matches with the IRS and other federal or state data sources. Paper verification and documentation must be minimized, greatly simplifying the process.

The simplification of Medicaid eligibility determination and the ability to apply for coverage through the exchange are key policy changes included in the ACA. Most Medicaid categories have been collapsed and the new structure is based simply on income and citizenship. Income eligibility will be determined on a new tax-related income basis, called modified adjusted gross income (MAGI) for those ages 19 – 64 who are not pregnant or Medicare eligible. Applicants will no longer have to be part of a federally designated group to qualify. Asset limits for most groups will be eliminated effective Jan. 1, 2014. The law envisions eligibility determinations on a nearly immediate basis, but it does not appear at this time that sufficient data match systems will initially be available to provide "real time" determinations.

> The state is expected to make final eligibility determinations for Medicaid and MIChild.
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> Applications submitted through the Health Insurance Marketplace that appear Medicaid or MIChild eligible will be transmitted to the state for final determination. An automated system, using the new MAGI eligibility rules, is under development.

The expansion of Medicaid eligibility to those with incomes up to 133% of the federal poverty level, included in the ACA, has been an extremely contentious issue in Michigan in spite of the governor's strong support and inclusion of the federal funds to expand Medicaid eligibility and the state savings in his FY 2014 budget recommendation. Both the House and Senate rejected the governor's recommendation. An alternate bill, H.B. 4714, was finally passed by both chambers in September. The **final bill** requires federal waivers and focuses on healthy behaviors, beneficiary cost-sharing and numerous program improvements. Due to the Senate's denial of immediate effect, the Medicaid expansion will be delayed from the Jan. 1, 2014 date included in the legislation, likely to April 1, 2014, leaving low-income, working residents uninsured for an extra three months. The Department of Community Health has estimated the state will lose $7 million per day in federal funding due to the delayed implementation.

WHY EXCHANGES ARE NEEDED

There are 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, they reached their maximum benefit level, or they have lost healthcare coverage along with their jobs.

Michigan continues to experience steep declines in employer-sponsored healthcare coverage with more than 1.6 million individuals losing coverage between 2000 and 2011, 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%. Over the same period, the number of workers ages 18-64 with employer-sponsored coverage fell by 1.2 million, from 4.2 million in 2000-2001 to 3 million in 2010-2011, by far the largest drop in the nation. There are 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 where 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 exactly what they are purchasing. Consumer protections, a critical issue addressed in the law, will be a key function of the Marketplace. Consumer information is available on the **federal Marketplace website**.

OTHER BENEFITS OF THE HEALTH INSURANCE MARKETPLACE

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. Surcharges on women will no longer be allowed, they will be charged the same rates as men for comparable coverage.

New health plans sold both on and off the Marketplace must include a minimum set of benefits that cover the categories specified in the law, including: out-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 state must select, from among federally specified options, the health plan that will be the basis for the state's essential health benefits package.

Michigan's Essential Health Benefit Plan
is based on Priority Health's HMO plan,
plus the addition of required benefits
not included in that plan.

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 the tiered health plans must cover at least 60% of the cost of included services. Health plans sold on the Marketplace will be monitored to ensure they follow the provisions of the law and provide quality plans.

Strong consumer protections will provide confidence and peace of mind to those shopping in the Marketplace. Health plan premium increases will be monitored by the Marketplace 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 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, billings, or claims.

Small businesses will also be able to shop for and compare plans for their employees in the Marketplace. In addition, small businesses that purchase coverage in the Marketplace may qualify for **tax credits** of up to 50% (35% for tax-exempt businesses) of the employers' costs of coverage.

SOURCES

Health Insurance Marketplace website:

https://www.healthcare.gov/

State-operated marketplace:

http://www.michigan.gov/snyder/0,4668,7-277--262254--,00.html

Final awards:

http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-8-15-2013.pdf

Fourteen insurance companies:

http://www.michigan.gov/difs/0,5269,7-303-13222_13250-305730--,00.html

Consumers Mutual Insurance of Michigan:

http://www.consumersmutual.org/

Video:

http://www.youtube.com/watch?v=l6KNt9Mf3GQ#at=12

Subsidy calculator:

http://kff.org/interactive/subsidy-calculator/

Application:

http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/marketplace-app-standard.pdf

Final bill:

http://www.legislature.mi.gov/documents/2013-2014/billconcurred/House/pdf/2013-HCB-4714.pdf

Federal Marketplace website:

https://www.healthcare.gov/what-is-the-health-insurance-marketplace/#state=michigan

Michigan's Essential Health Benefit Plan:

http://www.michigan.gov/difs/0,5269,7-303-13648-293672--,00.html

Tax credits:

https://www.healthcare.gov/will-i-qualify-for-small-business-health-care-tax-credits/