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ACA IMPLEMENTATION RESEARCH NETWORK

MICHIGAN: BASELINE REPORT

**State-Level Field Network Study
of the Implementation of the
Affordable Care Act**

December 2014

**Rockefeller Institute of Government
State University of New York**

The Brookings Institution

**Fels Institute of Government
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MICHIGAN: BASELINE REPORT

State-Level Field Network Study of the Implementation of the Affordable Care Act

Part 1 – Setting the State Context

1.1. Decisions to Date

Michigan has taken a mixed approach to implementing the Patient Protection and Affordable Care Act (ACA). It very nearly became the first state led entirely by Republicans to create a health insurance exchange as part of the ACA. Instead, Michigan was one of the more than thirty states to default to a federally run exchange. The state decided to adopt the Medicaid expansion, but with a delayed start date of April 2014. This section outlines the process by which Michigan chose not to create an exchange but to expand Medicaid.

Insurance Exchange

In March 2010, when President Barack Obama signed the ACA into law, Michigan was led by Democratic Governor Jennifer Granholm. The state House was controlled by Democrats and the Senate by Republicans. The reaction to the ACA was sharply divided. Attorney General Mike Cox, a Republican, joined thirteen other states in a lawsuit challenging the law's constitutionality. On the other hand, Granholm took important steps to lay the foundation for the law's implementation. For example, she created the Health Insurance Reform Coordinating Council composed of cabinet-level officials and officers from throughout the executive branch (MI Executive Order No. 2010 – 4). The council solicited input from a variety of stakeholder groups and issued a report in December 2010 recommending the state administer its own exchange.

Meanwhile, the Department of Community Health applied for a planning grant from the federal government. The state was

awarded \$999,772 on September 30, 2010, to accomplish eight objectives: 1) conduct research to determine who is potentially eligible for the exchange and how the exchange will impact Medicaid, other state programs, and other state health plans; 2) determine how to best establish the individual and small business exchanges; 3) implement a plan for stakeholder involvement; 4) develop an initial plan for integrating the applications for state and federal programs; 5) develop a plan for determining the exchange's structure and governance; 6) develop an initial plan for reporting, accounting, and auditing; 7) review technical components and plan for the introduction of possible new systems; and 8) review and determine the necessary state statutory and regulatory changes needed to establish the exchange options.

The November 2010 elections were an important turning point in Michigan politics. Republicans retained control of the Senate while also gaining control of the House and the executive branch. Rick Snyder was elected governor as a moderate Republican with business experience, but he would be working with a very conservative legislature. In large part due to the growing tea party movement in parts of the state, Republicans won their largest majorities since the 1950s.¹ Because of term limits, the key health policy committees in each chamber would experience nearly 100 percent turnover between 2010 and 2011, with most members having very little experience in health policy.

After taking office in January 2011, the Snyder administration undertook an extensive process to get stakeholder input on the implementation of the Affordable Care Act and, in particular, the health insurance exchange. This effort was supported by the planning grant received by the state in 2010. Representatives from a wide variety of interest groups participated in five work groups: 1) governance; 2) finance, reporting, and evaluation; 3) technology; 4) business operations; and 5) regulatory and policy action. A report was issued in June 2011 calling for Michigan to develop its own exchange as a quasigovernmental organization and as a clearinghouse instead of an active purchaser.

In July 2011, committees in both chambers began holding hearings on the creation of an exchange in Michigan. A broad coalition of organizations testified in favor of creating an exchange, including groups typically aligned with Democrats such as the Michigan Consumers for Healthcare Advancement and the Michigan League for Human Services, alongside groups typically aligned with Republicans such as insurers, providers, hospitals, and most small business organizations. Opposition to a state exchange was led by the tea party, along with conservative think tank organizations such as the Mackinac Center for Public Policy and the Michigan chapter of Americans for Prosperity, as well as the National Federation of Independent Businesses.

Snyder released a "special message" in September 2011 calling for Michigan to create its own exchange. The Senate acted quickly to pass a bill on November 10, 2011. Two weeks later, the

Department of Licensing and Regulatory Affairs (LARA) was awarded a \$9.8 million Level One Establishment Grant “to conduct additional analysis on the impacts of the Exchange and the Affordable Care Act in Michigan,” including market analysis, technology planning, and education and outreach.² Before state agencies can spend federal grants, the money needs to be appropriated by the legislature. Republicans in the House successfully blocked the appropriation of this money, meaning that LARA was unable to use its Level One grant.

Four days later, the U.S. Supreme Court announced it would hear the cases challenging the constitutionality of the ACA. This decision was not a surprise, but cast a shadow over deliberations in the Michigan House that was difficult for supporters to overcome. House leaders indicated they would delay holding a vote until after the Supreme Court ruled. When the law was ruled constitutional, some House leaders initially said they would support a state exchange while others said they would still not. Ultimately, the House decided to wait until after the presidential election to take action on the state exchange proposal.

After Obama won reelection and it became less likely that the ACA would be repealed, leaders of the Michigan House moved forward with a legislative proposal. SB 693, the bill that had passed the Senate one year earlier, was defeated by the House Health Policy Committee on November 29, 2012, by a vote of nine to five. The vote was actually much closer than it appears at first glance. Two Democrats abstained after the bill was “tie-barred” to a bill banning abortion coverage;³ two Democrats did not show up for the meeting; and one Republican did not register a vote. This Republican, Wayne Schmidt of Traverse City, was under enormous pressure from conservative groups to oppose the ACA, but had indicated his support for an exchange. There was no reason to vote in favor of an exchange given that the bill would be defeated anyway. Had the bill not been tie-barred to abortion, it is possible that all the Democrats would have shown up and voted in favor, and Schmidt would have cast the deciding vote in favor of creating an exchange. Insiders say that had the bill made it through the committee, there were enough votes for it to pass the House floor and go to the governor’s desk.

When the bill to create an exchange died in the House, the Snyder administration shifted its focus to applying for a partnership exchange. The federal government awarded Michigan a second Level One grant on January 17, 2013, totaling \$30.7 million. Within a week, Snyder sent a letter to U.S. Health and Human Services (HHS) Secretary Kathleen Sebelius declaring his intent to create a partnership exchange.⁴ A blueprint was submitted shortly after that, with conditional approval given by HHS on March 5th. However, once again the legislature refused to appropriate the grant, effectively killing the prospect of a partnership exchange. Interestingly, this time the House approved the grant, but it was the Senate that blocked spending. The federal grant money was

returned on March 20th and Michigan effectively moved forward as a federally facilitated exchange state.

Although not officially partnering with the federal government, Governor Snyder's staff has worked behind the scenes to cooperate with HHS on the creation of the federally run Michigan exchange with a goal to have the exchange work as smoothly as possible for Michigan residents.

Medicaid Expansion

The Medicaid expansion was discussed very generally in Michigan starting in the late fall of 2012. At that time, Snyder was asked if he would support the expansion. He said he wanted more information, including if there was the provider capacity to serve the population so those covered simply didn't turn to the emergency room for their care. Several independent analyses were produced on the cost savings to the state of the Medicaid expansion. These included reports from the House and Senate fiscal agencies along with a report from the Center for Healthcare Research and Transformation (CHRT).

The CHRT report found that expanding Medicaid would result in a net savings of \$1.17 billion for Michigan through 2019, as well as cover 290,000 additional Michiganders by 2014 and 620,000 by 2020.⁵ This would reduce the number of Michigan nonelderly residents without insurance from 13.6 percent of the population in 2011 to 6.3 percent by 2019.⁶ CHRT had also done a survey of Michigan primary care physicians in the fall of 2012 that had an answer to the governor's question about capacity to serve the Medicaid population. That survey, published in January 2013, found that the overwhelming majority of primary care physicians had capacity and expected to serve patients who would newly enroll in Medicaid.⁷ The published results of this survey in January 2013 helped to address concerns about whether Michigan has sufficient capacity to serve the expansion population. As a result of these analyses and other analyses done by the governor's budget office and Department of Community Health, the governor in February 2013 included the Medicaid expansion in the budget he proposed to the state legislature.

The Michigan House passed a bill to expand Medicaid in June 2013, but the Senate adjourned for the summer without taking a vote. After a contentious summer in which supporters and opponents traveled the state and spent money advertising their arguments, the Senate met on August 27th to vote on the bill. The initial roll call was one person short of the twenty votes needed to pass a bill, with Republican Senator Patrick Colbeck of Canton not voting. Had he voted against the expansion, there would have been a nineteen to nineteen tie, and Lt. Governor Brian Calley would have cast the deciding vote in favor of the expansion. A second vote was held a few hours later, with Republican Senator Tom Casperson of Escanaba switching from no to yes. The second vote included an amendment to a provision in the expansion bill

that limits the prices that hospitals can charge uninsured patients. This gave supporters the required twentieth vote and the bill passed twenty to eighteen. However, the legislature did not pass the expansion with immediate effect, so the expansion could not begin until ninety days sine die, meaning April 2014.

1.2. Goal Alignment

Michigan's response can simultaneously be described as affirming, oppositional, and wait and see. Snyder has worked consistently for the creation of a Michigan-run exchange and has supported the expansion of Medicaid. Most Democrats in the legislature have been supportive of the ACA, whereas Republicans were more mixed. The Senate passed legislation to create an exchange as early as November 2011, with 50 percent of Republicans voting in favor. At that point, House leaders decided to wait and see if the U.S. Supreme Court would overturn or uphold the law, and whether Obama would be reelected. House leaders then supported creating an exchange but were unable to convince enough Republicans on the Health Policy Committee to approve the bill.

By contrast, legislative leaders were able to convince enough Republicans in both chambers to support Medicaid expansion. Leaders framed the legislation as "Medicaid reform" rather than Medicaid expansion and included the requirement of two federal waivers in the final bill.⁸ The first waiver, which was approved in December 2013, implements several policy changes for the newly eligible. One of these changes is the creation of prepaid accounts with private managed care organizations that collect contributions from any source and allow enrollees to use to pay for their cost-sharing expenses. Cost-sharing for those between 100 percent and 133 percent of the federal poverty level (FPL) is limited to 5 percent of family income, but can be decreased by engaging in healthy behaviors. In July of 2014, the Department of Community Health issued a draft rule to implement the prepaid accounts, since new enrollees do not have to make account contributions for the first six months. Other changes in the first waiver include advanced directive requirements, incentives to encourage the detection of fraud and abuse, and implementation of value-based benefit design.

Unlike the first waiver, the second waiver would not have to be approved until December 31, 2015. The second waiver would require that enrollees between 100 percent and 133 percent of the FPL with forty-eight months of cumulative enrollment either remain in Medicaid with a higher cost-sharing requirement (7 percent of family income) or forgo their Medicaid eligibility and enroll in private coverage via the health insurance exchange. Enrollees who chose to stay in Medicaid can have their cost-sharing lowered for healthy behaviors. The placement of time limits on Medicaid eligibility is not a standard practice, and it is not clear at this time that HHS will approve this second waiver.

Part 2 – Implementation Tasks

2.1. Exchange Priorities

Michigan's approach to its health insurance exchange has shifted considerably as the state moved from planning to create a state-based exchange, to supporting a partnership exchange, to ultimately becoming a federally facilitated exchange state with plan management responsibilities. However, its priorities have remained fairly consistent in supporting the basic functionality of efficient enrollment in Medicaid and private plans via the exchange.

In September 2011, Snyder endorsed the creation of a state-based exchange and supported SB 693, which would have established MiHealth Marketplace as Michigan's exchange. SB 693 called for the creation of a new nongovernmental nonprofit agency to operate MiHealth Marketplace, based on the clearing-house exchange model.⁹ In other words, Michigan's exchange was designed only to facilitate the purchase of qualified health plans (QHPs) and was restricted from negotiating rates, requiring competitive bidding, or engaging in other active purchaser activities. SB 693 would have also allowed Michigan to select its own navigator organizations to help facilitate enrollment on the exchange.

When SB 693 was passed by the Michigan Senate but failed in the House, the Snyder administration began to shift toward supporting a state-federal partnership as an alternative for its exchange. On January 17, 2013, Michigan was awarded its second federal Level One exchange grant (\$30.7 million) to support plan management and consumer assistance functions and help the state interface with the federal marketplace.¹⁰ Five days later, Snyder sent a letter to HHS, declaring the state's intention of supporting a partnership, with the state taking a lead role in these functions.¹¹ In March 2013, the Michigan Senate blocked the appropriation of the Level One grant funding, forcing the state to forgo the state-federal partnership and effectively have a federally facilitated exchange. While the state maintains plan management responsibilities, it plays no role in coordinating consumer assistance and cannot designate in-person assistors to supplement the assistance provided by federally approved navigators and certified application counselors. In-person assistors would have been an option under a partnership exchange.

For QHPs offered on the exchange for 2014, HHS provided states with some flexibility in implementing rating reforms in the individual and small group markets. Michigan adopted the federal default options in nearly all cases, such as using the age rating curve suggested by HHS. One exception is that Michigan's Department of Insurance and Financial Services (DIFS) designated sixteen county-based regions for the purposes of geographic rating. In addition, Michigan actively selected its essential health benefits benchmark plan, Priority Health HMO (the state's largest HMO), and supplemented its habilitative and pediatric dental and vision benefits to meet federal standards.¹²

DIFS served as the lead state agency for reviewing and approving qualified health plans submitted by Michigan insurers for the exchange. In late March 2013, insurers began submitting QHPs to DIFS for review. After being evaluated over the next four months, DIFS submitted its certification recommendations to HHS. At that time, insurers could make any necessary corrections to their plans. Unlike many other states, particularly those with state-based exchanges, Michigan chose to keep the QHP filings confidential until October 1, 2014, when open enrollment began and all QHP rates were announced.¹³

In addition to its work on QHP approval and development of the federal waiver for the Healthy Michigan Plan (Medicaid expansion), Michigan has also had to make significant changes to its existing Medicaid program. Beginning in 2014, most applicants for Medicaid have their eligibility assessed based on their Modified Adjusted Gross Income (MAGI) – the same formula that is used to determine premium tax credits on the exchange. The shift to MAGI is a major change for the existing Medicaid program, which previously asked questions about income, assets, and expenses when determining eligibility for one of Michigan's forty pre-2014 eligibility categories.¹⁴ In July 2013, the Michigan Department of Community Health submitted the results of consolidating several nondisability categories and determining the MAGI-equivalent eligibility threshold for each.¹⁵ In addition, Michigan created a simplified Medicaid application based on MAGI.

To support Medicaid enrollment from the federal exchange, Michigan has had to make significant investments to resolve information technology (IT) issues with the federal government and its own Medicaid enrollment system. In particular, the state has made multiple changes to its back-end functionality to support account transfers from the federal exchange. This work has faced delays from the federal government as it works out its own IT issues, but Michigan has been supportive in its goal of providing functionality and a quality customer service experience.

2.2. Leadership – Who Governs?

Leadership roles for Michigan's ACA implementation responsibilities are divided across a few key agencies in state government. For its plan management responsibilities with the federally facilitated exchange, the Department of Insurance and Financial Services is the lead regulator. From 2011 to November 2013, DIFS and its predecessor, OFIR, were directed by Kevin Clinton. In November 2013, Clinton was appointed by Snyder to be the new state treasurer. Prior to his recent work in state government, Clinton was president and CEO of a medical professional liability insurance company in Michigan.¹⁶ Snyder appointed Ann Flood, the chief deputy director at DIFS, to replace Clinton. Flood joined state government at the same time as Clinton, and they previously worked together in the private sector.¹⁷

For matters of Medicaid policy, the Department of Community Health (MDCH) is the lead agency for the Healthy Michigan Plan and other ACA reforms affecting the Medicaid program. In September 2012, Snyder appointed James Haveman to be director of the department. Haveman had a long career in public service and this was actually his second stint as the MDCH director. From 1996 to 2003, Haveman was the director under Governor John Engler. Within the Medical Services Administration of MDCH, Steve Fitton serves as the director of Michigan's Medicaid program. Fitton has held this position for four years, although he has worked on health policy in the Michigan state government for over forty years.

In 2011, when Michigan was planning for the implementation of its own state-based exchange, the Snyder administration assigned the Department of Licensing and Regulatory Affairs as the lead agency for exchange development. Snyder also appointed Chris Priest to be the project manager for MiHealth Marketplace. Priest had previously served as the director of the Bureau of Medicaid Policy and Health System Innovation at MDCH and as the director of the state of Michigan's Washington, DC, office. As Michigan shifted from developing a state-based exchange to supporting a federal one, Priest moved from his project manager role to his current position as senior strategy advisor for Snyder, where he coordinates ACA activities across state agencies.

In terms of the federal operations of the exchange for Michigan, federal employees are not colocated in Michigan or in other federally facilitated exchange states. Rather, federal operations are based primarily out of the Centers for Medicare & Medicaid Services' (CMS) offices in Washington, D.C.

2.3. Staffing

Since Michigan uses the federally facilitated exchange, it does not have any direct exchange staffing.

2.4. Outreach and Consumer Education

Following the Michigan legislature's refusal to appropriate its second Level One grant to support consumer assistance, the state has had a nominal role in coordinating outreach and education efforts for the exchange. Rather, Michigan has relied on nonprofit organizations to perform these tasks. Enroll America, a national effort to encourage the uninsured to enroll, has made Michigan one of its target states with its "Get Covered America" campaign.¹⁸ In addition, Michigan Consumers for Healthcare, one of the state's navigator organizations, has launched Enroll Michigan, a statewide network of nonprofit agencies to support services for health insurance consumers.¹⁹

While the state government has had a small role with exchange outreach, Michigan launched a media campaign to promote the Healthy Michigan Plan when it began on April 1, 2014. This campaign included public service announcements,

radio/television advertising, social media, and brochures to promote the program. In addition, the state worked with Medicaid providers and advocacy groups to solicit input for outreach and education activities.²⁰

2.5. Navigational Assistance

In August 2013, four Michigan organizations were awarded federal grant funding to serve as navigators. In total, these organizations received \$2.5 million of the \$67 million awarded nationwide.²¹ Of the four Michigan organizations, only one, Michigan Consumers for Healthcare, is working statewide through a network of local and regional organizations with experience in Medicaid and Children's Health Insurance Program (CHIP) outreach. The other organizations (Community Bridges Management; Arab Community Center for Economic & Social Services; and American Indian Health and Family Services of Southeastern Michigan) operate solely in southeast Michigan, including the Detroit metro area. All navigator organizations must provide enrollment support along with outreach and educational activities.

At this time, the only source of public funding for navigators is through these federal grants. This is a much lower level of financial support than what would have been available if the state utilized its second Level One exchange grant. According to Michigan Consumers for Healthcare, \$21 million of the \$30.7 million in that grant would have supported navigators and other in-person assistors.²² While the federal navigator awards provide necessary support for outreach and enrollment, it is a fraction of the funding the state could have had if it appropriated the Level One grant.

2.6. Interagency and Intergovernmental Relations

2.6(a) Interagency Relations. Interagency relations and responsibilities in Michigan have evolved over the last three years of the ACA's implementation. Originally, the state maintained a task force with representatives of major agencies (MDCH, LARA, DIFS, etc.) that met regularly to discuss strategic issues. However, over time, this task force became less necessary as the state's role and responsibilities became more defined. LARA's role in ACA implementation was reduced as state-based exchange planning stalled, and the responsibilities of MDCH (Medicaid issues), DIFS (plan management), and other agencies became more clearly defined by the tasks the state was accountable to complete. Currently, each of the lead agencies retains a point person, but the task force is no longer needed. The state has been able to maintain collaboration across agencies and reduce siloing, because personnel have a strong understanding of the ACA work being done in state government outside their particular agency. Snyder's office also provides some support in coordinating this work as necessary.

2.6(b) Intergovernmental Relations. For Michigan's plan management responsibilities with the federal exchange, the primary interaction with the federal government is between DIFS and the Center for Consumer Information and Insurance Oversight (CCIIO). Federal exchange states are assigned to a CCIIO project officer (often more than two states per officer) to address questions that states have with the federal exchange. While Michigan has a good relationship with CCIIO, it is not without some difficulties. From 2011 through 2013, Michigan had three different CCIIO project officers, and officers are occasionally not able to address all questions, leading some states to engage senior CMS officials directly in order to get adequate answers. In addition to federal interaction through DIFS, Michigan's Washington, DC, office also works with the federal government on ACA issues.

2.6(c) Federal Coordination. Unlike state-based exchange states, Michigan's ACA implementation tasks have not required working with several federal agencies. Most of interaction with the federal government has been within CMS: CCIIO for plan management and the Center for Medicaid for the Healthy Michigan Plan waiver. These two tasks are very interrelated for Michigan's exchange. However, while working with two parts of CMS on these tasks, it has not been clear to Michigan officials how well different parts of CMS communicate with each other.

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs). For the 2014 plan year, ten insurers in Michigan offered QHPs in the individual market. In total, sixty-three unique QHPs were available (not counting ten catastrophic plans that are only available to those who qualify). The number of plans available in each county varied dramatically. The three counties that comprise the Detroit metro area (Wayne, Oakland, and Macomb counties) each had nine insurers and fifty-five local QHPs, while rural areas had fewer options. For example, Delta County in the Upper Peninsula only had one insurer and five QHPs. Overall, Michigan counties averaged approximately four-and-a-half participating insurers and thirty-eight local QHPs.²³ For the 2015 plan year, four additional insurers have submitted QHP offerings to DIFS, but most are planning to offer plans only to certain counties, not statewide.²⁴

The only insurer in 2014 to offer QHPs in each county was Blue Cross Blue Shield of Michigan (BCBSM). BCBSM and its health maintenance organization (HMO), Blue Care Network (BCN), offered fourteen QHPs, including two multistate plans in conjunction with the Blue Cross Blue Shield Association. Prior to 2014, BCBSM held more than 50 percent of the enrollment in Michigan's individual market.

Of the ten participating insurers in Michigan in 2014, six offered only HMO products with limited networks. Some of these networks are more exclusive than others. In addition, only four platinum QHPs (the most expensive plans) were offered for 2014.

Overall, the prevalence of limited networks and lack of high-cost plans seem to signal the pressure on premium prices insurers are facing from competition in the new exchange market, as they try to enroll many who have been previously uninsured and gain market share.

2.7(b) Clearinghouse or Active Purchaser Exchange. Under a state-based exchange, Michigan would have adopted the clearinghouse exchange model. However, with a federally facilitated exchange, Michigan does not have this option and is following the parameters set by CMS.

2.7(c) Program Articulation. Michigan will rely on the federal exchange to make final premium tax credit determinations and initial assessments of Medicaid eligibility. Applicants with income changes during the year must contact the federal exchange for a redetermination. After an initial assessment by the federal exchange, MDCH will make final determinations for Medicaid eligibility.

2.7(d) States That Did Not Expand Medicaid. Although Michigan chose to expand Medicaid eligibility, the state had a temporary coverage gap from January 1, 2014, to April 1, 2014, when the Healthy Michigan Plan began. A related issue is that until April, those between 100 percent and 138 percent of the FPL were eligible for premium tax credits via the federal exchange. According to the Healthy Michigan Plan waiver application, the state intended to work with federal partners and transition this population from qualified health plans to Medicaid in April.²⁵

2.7(e) Government and Markets. At this time, it is not yet clear how the exchanges will affect the insurance market, particularly how employers will react to these changes. However, enrollment in the exchange and the Healthy Michigan Plan has been strong in 2014. Over 270,000 Michigan residents selected a plan through the exchange during the first open enrollment period. Michigan had one of the highest enrollment rates in the health insurance exchange, exceeding the Urban Institute's 2014 projections by 44 percent.²⁶ The state also reached its Healthy Michigan Plan enrollment target of 322,000 in less than four months. In the long run, analysis from CHRT has projected that exchange enrollment will grow to 554,000 by 2019, with employer-sponsored insurance still covering the majority of Michigan's nonelderly population.²⁷ No state action regarding additional regulation of stop-loss coverage for small self-insured businesses has been proposed.

2.8. Data Systems and Reporting

Like other states, Michigan has made a significant investment to upgrade its Medicaid IT infrastructure. In August 2013, Michigan announced a unique partnership with Illinois to share a cloud-based IT system.²⁸ Under this partnership, Illinois would avoid much of the cost of upgrading its own Medicaid management information system (MMIS) and instead use Michigan's

MMIS, which has already received CMS certification. Michigan is estimated to save approximately \$10 million over five years as result of the partnership, and maintenance costs are expected to be cut by 20 percent.

Several nonprofit organizations, including Enroll America, are using insurance coverage data to map the locations of the uninsured in Michigan. This type of work is being done by many of the same organizations directly involved in outreach and enrollment efforts. The state government is planning to conduct a variety of evaluations using data as part of the Healthy Michigan Plan. These evaluations include examining how expanded insurance coverage reduces hospital uncompensated care, reduces the number of uninsured, increases healthy behaviors, improves health outcomes, and enhances financial well-being.²⁹

Part 3 – Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

Like the individual exchange, Michigan's Small Business Health Options Program (SHOP) exchange will be operated by the federal government in 2014. However, on November 27, 2013, HHS announced that online enrollment in federal SHOP exchanges would be delayed until November 2014. Nonetheless, Michigan's small businesses can still purchase a SHOP plan through an agent or broker.³⁰ Unlike the individual market, agents and brokers are expected to maintain relationships with their current small business customers and provide most enrollment assistance.

In terms of setting policy for the SHOP exchange, Michigan, like nearly all other states, will require insurers to maintain separate risk pools for their individual and small group business. In addition, Michigan has adopted the standard definition of small employer as those with fifty or fewer employees for 2014 and 2015. In 2016, all states will recognize small groups as 100 or less.

Part 4 – Summary Analysis

4.1 Policy Implications

Most importantly, of course, the uninsured in the state who will obtain Medicaid and/or subsidized private insurance coverage are "winning." Two-thirds of those who are uninsured in Michigan are below 138 percent of the federal poverty level. The uninsured who are newly eligible for Medicaid in Michigan are somewhat younger, more likely to be male, and more likely to be single than those who are currently enrolled in Medicaid. The Center for Healthcare Research and Transformation projects that in 2014, Michigan will have approximately 864,000 uninsured, down from 1.14 million in 2011. This segment of the population is clearly benefitting from health reform.

In addition to the uninsured in Michigan, many small businesses (under fifty) will likely be able to help their employees find more cost-effective employee coverage on the health insurance exchange, because there is considerable competition in many parts of the state. Ten insurers are offering coverage on the individual exchange (eight on the SHOP exchange) with an average of forty-three plans to choose from, depending on geographic location of enrollees (a range of five to fifty-five plans). Many small employers who have been offering health coverage, especially those with low-wage workers, will be able to help their employees find coverage on the exchange with tax credits, increase wages, and reduce employer expenditures, at the same time.

Just about every organized group in Michigan supported the Medicaid expansion and lobbied heavily for its passage. Key supporters were: the Michigan Health & Hospital Association, the Michigan State Medical Society, the Small Business Association of Michigan, the Michigan Chamber of Commerce, many local and regional Chambers of Commerce, health plans, and consumer groups (Michigan Consumers for Health Care and its coalition partners). The Medicaid expansion was one of the few pieces of legislation in recent history that was strongly supported and actively lobbied by groups this diverse and across the political spectrum.

Finally, of course, the passage of the Medicaid legislation was a major win for Snyder, who had come out in support of the expansion in February of 2013 and who devoted considerable political capital to its passage.

On the other hand, failure to establish a state-based exchange or even a federal-state partnership exchange was a significant loss to the governor, who had also strongly advocated for moving forward on a state-based exchange, and when that did not pass the legislature, for a state-federal partnership exchange.

The failure of the state-based exchange was also a loss for the business community, health plans, providers, and consumer groups, all of whom had supported the state exchange. These groups were not as active in their lobbying for the exchange, however, as they were in their support of the Medicaid expansion.

Michigan citizens were also disadvantaged by not moving forward with the state-based exchange, because they were caught up in the problems of HealthCare.gov and because the governor's plan for a state-based exchange envisioned a nonprofit entity in Michigan providing key services. Snyder's plan would have enabled both customization of the exchange platform to work more seamlessly with other state programs and have enabled Michigan to provide exchange services at a lower fee than is included in the federal exchange. A state-based exchange also would have had a positive economic impact for Michigan since it would have been run through an entity that would have been located in the state.

The failure of the state-based health insurance exchange was, however, a win for the state's attorney general, Bill Schuette,

who had opposed the exchange, along with the Mackinac Center for Public Policy, a conservative think tank, and tea party legislators.

Some other groups that are perceived as losers with regard to overall health reform are insurance agents, whose fees have been limited and services reduced, and groups that lobbied against Medicaid expansion.

Finally, there are consumers and small businesses that are facing premium increases, sometimes significant, as a result of health care reform. While it is hard to get reliable trend information, health plans have added taxes and fees included in the ACA to premiums and have cancelled policies that enabled some individuals to have lower premiums than in the ACA-compliant plans. In addition, insurers have taken the opportunity provided by the ACA implementation to try to secure good risk business or reduce their risk exposure by offering early enrollment and/or shifting benefit designs and not extending certain policies when they had the opportunity to do so. As a result of these changes, some individuals and some businesses are facing higher premiums and less desirable benefit options than they had previously.

The perceived losers from health care reform have not, however, been able to create any substantive change in the political power alignment in the state. The groups that are perceived as losers are either disparate enough (e.g., small businesses and individuals negatively affected by premium and benefit changes), do not have enough allies (e.g., insurance agents) to create a political force, or were already allied prior to and independent of the health reform debate (e.g., the tea party and the Mackinac Center). Rather, the biggest political alignment change that has occurred in the state has been the favorable alignment of the groups around Medicaid expansion.

4.2. Possible Management Changes and Their Policy Consequences

The biggest challenges with implementing health reform continue to be technical, operational, and communications. There are many moving parts to the Affordable Care Act's implementation and the law is complicated and hard for consumers to understand. The failure to launch HealthCare.gov effectively could potentially open the door to another discussion about a state-based exchange since the governor would still prefer to have a state exchange. But, there could also be a sense from opponents of the Affordable Care Act that with public opinion about the ACA generally negative, there is no reason to move to a state-based exchange, because there is still hope among the opponents that the law will be fundamentally changed.

Operationally, health plans are still struggling with the back-end issues that are not resolved with the federal exchange. Since so many people were running into enrollment issues, some local health plans have directly enrolled individuals and sent bills

that consumers were not expecting. It is also not clear that the state is getting fully reliable eligibility information for Medicaid enrollments. These operational issues could take some time to sort out.

From a communications standpoint, there is still considerable confusion on the part of consumers about health plans that were cancelled; taxes and fees that are included in new health plans; and the complexity and design of health plans, including the balance between premiums, cost sharing, and provider networks. All these issues will take some time to sort out as well.

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