



# *Michigan Association of Health Plans*

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TESTIMONY BEFORE  
HOUSE COMMITTEE ON PUBLIC EMPLOYEE HEALTH CARE  
REFORM

November 5, 2009

Rick Murdock  
Executive Director  
Michigan Association of Health Plans

Good Afternoon Madam Chair and Committee members. Thank you for the opportunity to discuss with you our observations and recommendations regarding the overall issue of Public Employee Health Care Reform. My name is Rick Murdock and I am Executive Director of the Michigan Association of Health Plans. MAHP represents 19 health plan organizations that provide comprehensive health care benefits to over 2.3 million Michigan citizens from Commercial, Medicare and Medicaid products. Additionally, our members provide third party administration services for self-insured plans and county health plans services. We are proud of the quality and accountability of the services provided by our members that annually are ranked among the highest performing health plans in the United States. The most recently published rankings included five in the top 50 Commercial Plans; two in the top 25 Medicare Plans; and 11 in the top 50 Medicaid Plans. We expect this performance to again be recognized in the next ranking by the US News and World Report/NCQA report to be released shortly.

August 12, 2009 MAHP Letter

Soon after the release of the Draft Report on the Proposed Public Employee Health Care Reform, MAHP submitted a detailed letter with suggested areas of improvement. These areas included:

- Retaining Consumer Choice
- Equal Marketing Conditions and Assuring Competitive Process
- Migration of individuals from Small Group Customers
- Retention of Collective Bargaining

Our letter also addressed the purported savings from the proposal and the process to be pursued in further development. We continue to have many of the same concerns and due to other initiatives occurring at both the state and

federal level that argue for a need to proceed with prudence and caution.

While we believe that this proposal represents the “boldness” in looking at the core health care issues differently—a trait that other commentators have found refreshing, we do believe that much harm can occur without taking a prudent approach to enactment of any necessary legislation and its subsequent implementation. Therefore, we much appreciate the formation of this committee and look forward to the work that you ultimately will need to do to arrive at a sound conclusion and recommendations following the conclusion of all the hearings.

I would like to take the few moments today to address pertinent issues and concerns that we believe are critical to be resolved before finalization of this proposal and its companion legislation.

### **Current Concerns Regarding HB 5345**

1. **Consumer Choice.** As we noted in our August 12<sup>th</sup> letter MAHP fully supports the greatest degree of consumer choice in health plan carriers coupled with true competition in the marketplace. While limiting the number of offerings that all carriers might provide for public employees may be appropriate, limiting the choice of carriers will be anticompetitive. We believe a choice of health plan carriers for consumers leads to a greater amount of competition in the marketplace and creates downward pressure on health care premiums. This high level of market competition is consistent with the efficiencies sought by the proposal to reform public sector healthcare.

As a result, a threshold concern for MAHP is that any proposal affecting public sector employees should assure that all health plans be allowed to compete for the public sector business. **It would be virtually impossible for MAHP to support a proposal that designates or unfairly favors any single (or subsection of the entire health plan market) health plan or health insurance carrier.** MAHP would propose the insertion of clarifying language in HB 5345 to assure this competition and consumer choice.

2. **True Competition.** Consistent with this discussion regarding consumer choice, true competition in the marketplace can only happen when all carriers are subject to the same market conditions. Another way of characterizing “similar market conditions” is to assure that no single carrier (or segment of carriers) has an unfair advantage in the market. This is especially true as it relates to provider reimbursement rates. If one carrier has monopolistic control over the amounts paid to health care providers, then it may pay minimal reimbursements and realize savings that are not available to any other carrier. This presents an inherently unfair market advantage by one carrier being able to leverage its control over reimbursements and essentially “freeze out” competition.

One method to assure fair market competition is to establish a common reimbursement fee schedule for your proposal to reform public sector health care. If all carriers are subject to the same payment rates to providers, then vigorous competition will flourish and public sector employees participating in the reform program will greatly benefit by

plans striving to provide the greatest quality of care. In that way public sector employees will be served by competition that is based on performance, quality and customer service. If HB 5345 includes competitive bidding, likely significant premium savings will result from the inclusion of a common reimbursement schedule.

It is already well documented that the public sector payers (Medicare and Medicaid) do not pay the full cost of services. This underpayment—coupled with the uncompensated costs from services for the uninsured result in what is now referred to as a “hidden tax”. (I have included as an attachment, linkage to the most recent report documenting these costs). It is estimated that more than \$800 of the annual premium paid by individuals each year is related to this “tax”. In Michigan this will be exacerbated further due to the Medicaid budget that was enacted over the past week that contained 8% provider cuts. The entire provider base in Michigan is affected by these changes—not just the Medicaid or Medicare providers. Providers attempt to make up the difference through capturing higher reimbursement from commercial carriers including those who would be likely to be carriers for the public employee benefit proposal.

**Open and fair market competition is a principle that should be clearly set forth in any proposed legislation that may arise from this proposal and that provider reimbursement will be a prime focus of attention. MAHP urges lawmakers to add amendatory language to HB 5345 that will insure provider participation and create competition.**

3. Limiting Participation to Public Sector. Opening the public sector employee option to those in the private sector can create perverse and unintended consequences. A migration from those currently covered under private coverage to the public sector coverage would likely also cause an undue financial burden on the state. As a result, the more immediate goal of a public sector employee plan should be limited to qualifying public employees. This would minimize “crowd out” from the private market that might occur by opening up the program to those who currently have coverage. Reports from the Insurance Commissioner indicate that the small market reform is working in Michigan as intended by the legislature. MAHP believes that any participation under the proposed public employee plan for employees in the private sector will diminish the population served under the small market sector and drive premiums and employee cost higher.

**Therefore, we recommend that any discussion of inclusion of the private sector is premature and should not be pursued at this time. MAHP recommends that HB 5345 be amendment to delete the opt-in provision for private sector employers.**

4. Retention of Collective Bargaining. As we all know, collective bargaining has a long history in Michigan and it continues to play a large role in the purchasing of health care benefits in the group market, especially public sector groups. MAHP supports the retention of collective bargaining rights as a vital role for most local union representatives.

**While we know this point has been raised by many others, we hope that clearer provisions will be included in HB 5345 to assure that collective bargaining rights will be preserved and will not be limited.**

5. Cost Assumptions. MAHP has reservations about the total amount of saving estimates noted in that report and at what point in the process such savings might be realized. Regardless of actual savings realized, we caution that you should not assume that the projected savings will occur in time to be part of the FY 2011 budget deficit solution. Considering the time constraints in implementation of the program and working out of collective bargaining rights, it will be highly unlikely for the plan, even if launched in 2010, to have any appreciable downward pressure on short-run cost/savings.

Without repeating the analysis that was included in the Public Policy Associates, Inc. study that was released on October 19<sup>th</sup>, we share many of the conclusions from that assessment of cost savings. Further, as well documented in other testimonies that you have received, most of the public employee groups are already covered by Michigan's HMOs and PPOs that utilize various cost containment strategies and disease management/care coordination programs that are suggested in the proposal to create future savings. In other words—those savings estimated to occur have largely been realized.

One of the stated goals of the proposal is to “optimize the health of public sector employees, retirees and their families, by investing in prevention and wellness, rewarding healthy behaviors and encouraging individuals to actively participate in the management of their own health.” This goal accurately summarizes the core purpose of managed care plans and it is exactly what MAHP members perform on a daily basis. This experience of managing care makes MAHP member plans uniquely qualified to carry forward the purpose of the proposal for public sector health care and as I indicated at the outset, is what distinguishes the performance of our member health plans from others.

Further, the stated intent to “Establish a mechanism to ensure that the health care delivered in Michigan conforms to recognized best medical practices” is also an element in already underway. MAHP members have been in the forefront of promoting evidence based medicine. This is more than a concept, it is a practice to actively use those methods and procedures that have proven medical benefits and clinical effectiveness.

**While there may be other reasons to continue to pursue the public sector health benefit proposal—significant cost savings as outlined in the proposal are not a likely result and the exposure to additional costs as outlined in the Public Policy Associates analysis should be of concern to all.**

### **Concerns Related To Other State Initiative(s)**

1. Reform for Michigan Uninsured. This proposal also needs to be vetted in the context of other state initiatives and events. As many of you are very aware, MAHP and other

interested parties have worked with both the House Committee on Health Policy and the Senate Health Policy Committee to arrive at a consensus regarding affordable health care in Michigan. This was an outgrowth of the individual market reform debate from the prior legislative session. The emphasis is and continues to be on providing affordable coverage options for Michigan's uninsured population.

This point is important as the potential exists to implement "reform" through amendments to the state insurance code and Public Act 350 for assuring coverage for the uninsured that may be in conflict with potential amendments in legislation necessary for the public sector employee proposal. Further, the cost to carriers in implementing other reform may have a dampening effect on the ability to reach savings objectives—this would be in such undefined areas as reinsurance and premium subsidies that are under current review in the House and Senate Committees. Finally, there continue to be discussion regarding the establishment of various oversight committees, advisory boards, and other such mechanisms to provide future oversight of the reform initiatives.

**It is in all of our best interest to assure that any reform package in Michigan is well coordinated and in concert with other initiatives underway.**

2. Threat to Competition. Proposed Acquisition of Physicians Health Plan of Mid Michigan. Last month, the proposed acquisition of Physician's Health Plan of Mid Michigan by Blue Care Network was announced. This proposal is currently under review by the Insurance Commissioner. A public hearing on this acquisition will take place on November 23<sup>rd</sup> and we believe that information will be forthcoming to highlight the impact on competition that is likely to result if the purchase were to go forward. The impact on public sector employees, given the concentration of public employees in Mid-Michigan is significant.

**We believe that if other groups are interested in preserving competition and choice in the Mid-Michigan market to maintain high performing health plans and assure price competition then they should join MAHP and others at this public hearing to raise these concerns.**

3. Crains Detroit Business—Health Care Summit Solutions (Cost Containment)

One of the inherent flaws of HB 5345 is the absence of any significant cost containment initiatives. This concern has been raised about the other reforms proposals at the state and federal level. So it is timely that we are now seeing some conversation on this issue. Most notably, several weeks ago, attendees at *Crain's* Health Care Leadership Summit were organized into 50 roundtables for small-group discussions to develop and arrive at a consensus regarding initiatives to pursue for cost containment purposes. The intent of the consensus issues were to be those that did not require state or federal reform to occur but could begin with the leadership within the health care industry—and if necessary with supporting state legislation or administration.

It was understood by that audience that simply attempting to re-arrange or alter the delivery of benefits will have little impact on the overall cost of health care and that cost containment has to be system wide and cannot be focused on a single setting or population group. Without getting into the details of the roundtable discussions here are the overall ideas that have now been published in the Crains:

- **Idea 1:** Create an online health information exchange for Medicaid recipients that all doctors, hospitals, nursing homes, providers and insurers can access. Such a system could reduce duplicated tests and identify medical symptoms and diseases more quickly.
- **Idea 2:** Increase the number of primary-care providers, including physicians and such midlevel practitioners as physician assistants and nurse practitioners. Existing government programs to forgive student loans could be expanded and scholarships added.
- **Idea 3:** Expand wellness programs by providing financial incentives for employees to develop healthy lifestyles.
- **Idea 4:** Have the state of Michigan mandate health care price transparency as 40 other states have done. Armed with pricing and quality data, consumers would make better-informed decisions.
- **Idea 5:** Encourage doctors to adopt a “patient-centered medical home” approach by paying them more for electronic medical record systems, chronic disease registries and staff training.
- **Idea 6:** Use skills developed by auto industry engineers to improve efficiencies and streamline processes of hospitals and physician offices to improve quality and reduce costs.
- **Idea 7:** Mandate that all health plans reimburse hospitals and physicians at the same rates for the same services. Plans would compete on service and efficiency.
- **Idea 8:** Reduce overcapacity of acute-care hospitals, outpatient imaging and surgery centers. This could be done either by using a more aggressive Michigan certificate-of-need process, as New York State has done, or have each of the six hospital systems based in Southeast Michigan voluntarily close a hospital.

As an attachment to this testimony, I am including linkage to a report produced earlier this year for Americas Health Insurance Plans, AHIP, that highlights the impact of different cost drivers on the overall increase in health care premiums. **A key issue for this committee to address is the appropriate inclusion into HB 5345 of cost-containment initiatives that will provide the overall cost savings for this proposal.**

### **Concerns Related to Federal Reform Initiative**

It is difficult to discuss any change in health care without placing it in the context of federal health care reform. As we well know both the U.S. House of Representatives and Senate are nearing the final stages of debate on health care reform. It is clear that several key decisions have to be made and an overall Senate/House conference report to be attained. However, most observers agree that federal health reform is not only very likely

it is also apparent that the overall direction of the reform package will be established before the end of this year.

**It is recommended that this committee pause before taking final action in order to assure that all recommendations will not be contrary to the requirements under federal reform—or indeed be unnecessary due to the federal reform package.**

### **Recommendations For Public Employee Benefit Proposed Initiative:**

1. All Health Plans (carriers) are permitted to compete to provide public employee benefits.
2. The proposal must include a principle of “open and fair market competition” and provider reimbursement will be a prime focus of attention.
3. Any discussion of inclusion of the private sector is premature and should not be pursued at this time.
4. Clear provisions will be included to assure that collective bargaining rights will be preserved.
5. Assurance that any reform package for public employee benefit programs in Michigan is well coordinated and not in conflict with other state and federal initiatives underway.
6. In order to maintain high performing health plans and assure price competition for Mid Michigan, the Committee should join MAHP and others at the Insurance Commissioner’s November 23rd public hearing to raise these concerns.
7. The appropriate inclusion of cost-containment initiatives that will provide the overall cost savings for this proposal.

### **Attachments**

- MAHP August 12<sup>th</sup> Letter
- Summary of Federal Health Care Reform
- Linkage to:
  - USA Families—Hidden Tax
  - AHIP Report on Cost Driver



# Michigan Association of Health Plans

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August 12, 2009

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Hon. Andy Dillon  
Speaker of the House of Representatives  
P.O. Box 30014  
Lansing, MI 48909

Re: Public Sector Healthcare Reform

Dear Speaker Dillon:

The Michigan Association of Health Plans (MAHP) appreciates your efforts to reform public sector employee healthcare in the state of Michigan. A hallmark of our association is to promote managed care in a setting that achieves prudent efficiencies in the delivery of health care. It appears, based on our preliminary review, that your "Prescription for Public Sector Healthcare Reform" is generally consistent with the goals and mission of MAHP member plans. MAHP, however, has not received nor reviewed any of the vital details of the reform package or any associated legislation; and in the absence of such review, we are not able to indicate our formal position on the proposal. Any comments noted in this letter, therefore, are not intended to be statements endorsing or opposing any part of the Public Sector Healthcare Reform Proposal.

However in response to your request for comments and in light of our preliminary review, MAHP wishes to point out some key issues related to your proposal.

## **Key Concerns**

### **1. Retaining consumer choice**

MAHP fully supports the greatest degree of consumer choice in health plan providers. An expansive choice of health plans for consumers leads to a greater amount of competition in the marketplace and creates downward pressure on health care premiums. This high level of market competition is consistent with the efficiencies sought by your proposal to reform public sector healthcare.

As a result, a threshold concern for MAHP is that any proposal affecting public sector employees should assure that all health plans

with current enrollment be allowed to compete for the public sector business. It would be virtually impossible for MAHP to support a proposal that designates or unfairly favors any single (or subsection of the entire health plan market) health plan or health insurance carrier. We hope you share our belief that open and fair market competition is something that should be clearly set forth in any proposed legislation that may arise from your proposal.

## 2. **Equal market conditions and assuring competitive process**

Consistent with the preceding discussion regarding consumer choice, true competition in the marketplace can only happen when all carriers are subject to the same market conditions. Another way of characterizing “similar market conditions” is to assure that no single carrier (or segment of carriers) has an unfair advantage in the market. This is especially true as it relates to provider reimbursement rates. If one carrier has monopolistic control over the amounts paid to health care providers, then it may pay minimal reimbursements and realize savings that are not available to any other carrier. This presents an inherently unfair market advantage by one carrier being able to leverage its control over reimbursements and essentially “freeze out” competition.

One method to assure fair market competition is to establish a common reimbursement fee schedule for your proposal to reform public sector health care. If all carriers are subject to the same payment rates to providers, then vigorous competition will flourish and public sector employees participating in the reform program will greatly benefit by plans striving to provide the greatest quality of care. In that way public sector employees will be served by competition that is based on performance, quality and customer service. Indeed, we believe that public sector employees deserve the highest quality and service available and a common provider reimbursement schedule is the logical method for keeping quality care high and premiums low.

Another way to assure market integrity is to implement a competitive bidding process (based on a common reimbursement schedule discussed immediately above). If the public sector purchaser uses competitive bidding it will likely find significant premium savings.

## 3. **Migration of individuals and small group customers**

MAHP has been active in the current discussions regarding proposed reforms to the individual health insurance market. As you know, MAHP continues to participate in workgroup meetings held by Rep. Corriveau (regarding HB 4934 and its related bills) and Sen. Tom George (SB 579-582). We have consistently stated that Michigan needs comprehensive reform for the primary purpose of creating greater affordability and accessibility of health care coverage for all Michigan residents. The secondary purpose should be to reform the regulatory structure of health insurance.

What do we mean by “comprehensive reform to create greater affordability and accessibility?” This phrase means that more Michigan citizens should be converted from uninsured to insured. Those who currently have health coverage (especially employer-based coverage or through a federal health care program) should be encouraged to keep it, rather than migrate to a plan such as you proposed. A migration toward your proposal from those who already have coverage would likely cause an undue financial burden on the state. As a result, the more immediate goal of a public sector employee plan should be limited to qualifying public employees. This would minimize “crowd out” from the private market that might occur by opening up the program to those who currently have coverage.

4. **Retention of collective bargaining/local control of municipal employee coverage**

Collective bargaining has a long history in Michigan and it plays a large role in the purchasing of health care benefits in the group market, especially public sector groups. MAHP supports the retention of collective bargaining rights as a vital role for most local union representatives. We continue to study the proposal and as our analysis progresses, we hope to find clarification that collective bargaining rights will not be adversely affected.

MAHP also is sensitive to the concerns of local governments to retain their representative control over their business units. Of course a primary component of their respective business models is negotiation and purchase of health care coverage. And although economies of scale is logical over a wider range of governmental units, it might be advantageous for these affected governmental units to “opt in” to the proposed public sector plan. Such an “opt in” would be an especially good choice for those business units that can demonstrate a savings by joining forces with the state in the purchase of health insurance coverage.

5. **Realizing cost savings**

Page two of “The Dillon Prescription for Public Sector Healthcare Reform” states, “The State of Michigan faces a 2010 fiscal year deficit of more than \$1.7 billion. Structural changes in public sector active and retiree health care benefits provide an opportunity to help the state address this budget deficit by reducing costs by an estimated \$700 to \$900 million per year.” Although there is no doubt that the 2010 budget deficit will significant and a challenge for you and other policy makers to resolve, MAHP has reservations about the total amount of saving estimates noted in that report. Regardless of actual savings realized, we caution that you should not assume that the projected savings will occur in time to be part of the FY 2010 budget deficit solution. Considering the time constraints in implementation of the program and working out of collective bargaining rights, it will be highly unlikely for the plan, even if launched in 2010, to have any appreciable downward pressure on short-run cost/savings.

Further, while some savings will ultimately accrue due to the proposed pooling of public sector employees, we hope all observers understand that the vast majority of the proposed savings will come from the proposed re-alignment of benefit plans.

6. **Establishing workgroup and assuring procedural transparency**

The “The Dillon Prescription for Public Sector Healthcare Reform” is a wide ranging modification to a complex system of health benefit purchasing. Such a large scale proposal warrants a careful and deliberative review. Like most such reviews, it would be prudent to create a workgroup of all interested parties for a full and open exchange of opinions. MAHP stands ready to assist when and if a workgroup is convened.

The workgroup process, moreover, promotes transparency in the development of public policy. MAHP has advocated for this type of transparency, especially in the context of the current debate about individual market reform. Transparency, not only good for the development of the proposed public sector health care program, but it is also an important component of the day-to-day operation and the administration of the program. Additionally, transparency will provide interest groups with the assurance that key issues have been addressed in the development of the process and will be instrumental in the final implementation.

7. **Alignment of Goals with MAHP Mission**

Page three of “The Dillon Prescription for Public Sector Healthcare Reform” states several goals that are important to MAHP and fit squarely within mission of our member plans. One such goal is, “Aim to optimize the health of public sector employees, retirees and their families, by investing in prevention and wellness, rewarding healthy behaviors and encouraging individuals to actively participate in the management of their own health.” This goal accurately summarizes the core purpose of managed care plans and it is exactly what MAHP members perform on a daily basis. This experience of managing care makes MAHP member plans uniquely qualified to carry forward the purpose of your proposed plan for public sector health care.

Another very important goal noted on page 3 states, “Establish a mechanism to ensure that the health care delivered in Michigan conforms to recognized best medical practices.” MAHP has been in the forefront of promoting evidence based medicine. This is more than a concept, it is a practice to actively use those methods and procedures that have proven medical benefits and clinical effectiveness. Through the use of double-blind clinical trials and the use of cohorted studies, MAHP has been instrumental in providing information to members and associated medical providers on the most current treatments and those constituting best medical practices.

MAHP looks forward to receiving more detailed information regarding your proposal for public sector health care benefits. Once we have an opportunity to analyze draft legislation,

and obtain additional detail we will be better able to articulate a more definitive position.  
Again, thank you your for the opportunity to comment on the proposal.

Sincerely,

A handwritten signature in black ink that reads "Rick Murdock". The signature is written in a cursive style with a prominent initial "R".

Rick Murdock

Cc: MAHP Executive Committee

<b>REFORM</b>	<b>AMERICA'S HEALTHY FUTURE ACT OF 2009-SENATE FINANCE</b>	<b>AFFORDABLE HEALTH CARE FOR AMERICA ACT—HOUSE BILL</b>
Health Insurance Rescissions	Prohibits beginning in January 2013.	Prohibits beginning in 2010.
Limits on Pre-existing Conditions	Prohibition beginning in January 2013. Within a year of enactment creates a high risk pool for individuals with preexisting conditions.	Complete prohibition beginning in 2013. Beginning in 2010 reduces the window that plans can look back for pre-existing conditions from 6 months to 30 days and shortens the period that plans may exclude coverage of certain benefits.
Guarantee Issue	Requirement beginning in 2013.	Requirement beginning in 2013.
Individual Mandate	Establishes an individual mandate for health insurance beginning in 2013. Penalties are phased in according to the following schedule: \$0 in 2013; \$200 in 2014; \$400 in 2015; \$600 in 2016; and \$750 in 2017.	Beginning in 2013 requires individuals to obtain acceptable health insurance coverage or pay a penalty of 2.5% of their income that is capped at the cost off the average cost of qualified coverage.
Ban on Lifetime Limits	All plans operating in the Health Insurance Exchange are prohibited from placing lifetime caps on coverage.	Prohibits insurance companies from placing lifetime caps on coverage in 2010.
Employer Responsibility	Employers are not mandated to provide coverage but employers with more than 50 employees that do not provide coverage would be assessed a fee beginning in 2013.	Beginning in 2013 employers are required to offer coverage or pay a penalty of 8% of their payroll. Small businesses with annual payrolls below \$500,000 are exempt.
Health Insurance Exchange	State based health insurance exchanges will be established as early as 2010.	In 2013 health insurance exchanges would be open to individuals without other coverage and to small employers with 25 or fewer employees.
Medicaid Expansion	January 2014 up to 133% FPL	January 2013-up to 150% FPL
Public Health Insurance Option	N/A	Creates a new public health insurance option that is available within the Health Insurance Exchange in 2013.
Health Care Cooperative	The proposal authorizes federal funding for the Consumer Operated and Oriented Plan (CO-OP) program beginning in January 2012.	N/A
Increases Reimbursement for Primary Care in Medicaid		Phases in an increase in Medicaid reimbursement for primary care services beginning in 2010. Medicaid primary care services would be reimbursed at Medicare levels with 100% federal funding.
Enhanced FMAP for States with High Unemployment		Extend the current Recovery Act increase in federal Medicaid

		payments to states with high unemployment an extra 6 months thru June, 2011.
Premium Subsidies	Beginning in 2013 refundable tax credits would be available to individuals and families with incomes between 133 and 300% of the FPL who purchase insurance thru the exchange. Additional cost sharing subsidies would be available to individuals between 100-200% of the FPL.	Beginning in 2013 health insurance affordability credits will be available for people with incomes above Medicaid eligibility and below 400% of the FPL.
Small Business Tax Credits	Beginning in 2011, small employers with fewer than 25 employees and average wages of less than \$40,000 that offer health insurance would be eligible for a tax credit. In 2013 the credit would only be available to employers that purchase insurance coverage through the Exchange.	Beginning in 2013, tax credits will be available to small businesses that choose to provide health coverage. The credit could be worth up to 50% of the amount paid for employee health coverage.
Medicare Advantage	Beginning in 2014 MA benchmarks will be based on the weighted average of plan bids. The benchmarks will be transitioned in starting in 2011.	Beginning in 2011, reduces MA payments over 3 years to achieve parity with 100% FFS rates.
Excise Tax	The bill imposes an excise tax on high premium health plans for tax years after December 31, 2012.	N/A
Provider Taxes	The bill imposes taxes on the insurance industry (\$6.7 billion), manufacturers of prescription drugs (\$2.3 billion), manufacturers of medical devices (\$4 billion), and clinical laboratory services (\$750 million). These taxes would begin in January 2010.	A 2.5% tax on the sale price of all medical devices effective for the 2013 tax year.
Surcharge on High Income Tax Payers	N/A	The bill would impose a 5.4% surcharge on taxpayers with adjusted gross income in excess of \$1 million (married filing a joint return) and \$500,000 (single). Effective for all tax years ending after December 31, 2010.



## *Michigan Association of Health Plans*

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### WEB LINKAGE TO OTHER REPORTS REFERENCED IN MAHP TESTIMONY

**1. USA FAMILIES—HIDDEN TAX**

[www.familiesusa.org](http://www.familiesusa.org).

**2. AHIP—REPORT ON COST DRIVERS**

<http://www.ahip.org/content/default.aspx?docid=25127>