March 10, 2015
HOUSE HEALTH POLICY COMMITTEE PRESENTATION

Rick Murdock

Executive Director

Michigan Association of Health Plans

MAHP: Who We Are

- The Michigan Association of Health Plans is a nonprofit corporation established to promote the interests of member health plans.
- MAHP's mission is "to provide leadership for the promotion and advocacy of high quality, accessible health care for the citizens of Michigan."
- Represents 17 health plans covering all of Michigan and more than 45 related business and affiliated organizations. Our member health plans employ about 8,000 persons throughout the state.
- Member health plans provide coverage for more than 3 million Michigan citizens – nearly one in every three Michiganders.
- Member health plans collect and use health care data, support the use of "evidence based medicine", and facilitate disease management and care coordination in order to provide cost-effective care.

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Our members

Aetna Better Health of Michigan 1,2,3

Fidelis SecureCare 3

Harbor Health Plan 2

Health Alliance Plan 1,3

McLaren Health Plan 1,2

Molina Healthcare of Michigan 1,2,3

Physicians Health Plan 1,2

Total Health Care Plan 1,2,3

Upper Peninsula Health Plan 2,3

Consumers Mutual Insurance of Michigan 1

Grand Valley Health Plan 1

HAP/Midwest Health Plan 2,3

HealthPlus of Michigan, Inc. 1,2,3

Meridian Health Plan 1,2,3

Paramount Care of Michigan 1

Priority Health 1,2,3

United Healthcare Community Plan 1

1 = Commercial Health Plan
2 = Medicaid Health Plan
3 = Medicare Advantage or Medicare Special Needs Plan

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MAHP VISION

- ***By 2020, Michigan will provide health insurance coverage and options to more than 99% of the State's population.***

- ***By fostering competition, by 2020 Michigan will become one of the top 25 competitive states for health insurance. Today, we are third least competitive.***

- ***Michigan's Health Plans will work with partners in government, the provider community, community organizations, and business to improve the health status of Michigan residents.***

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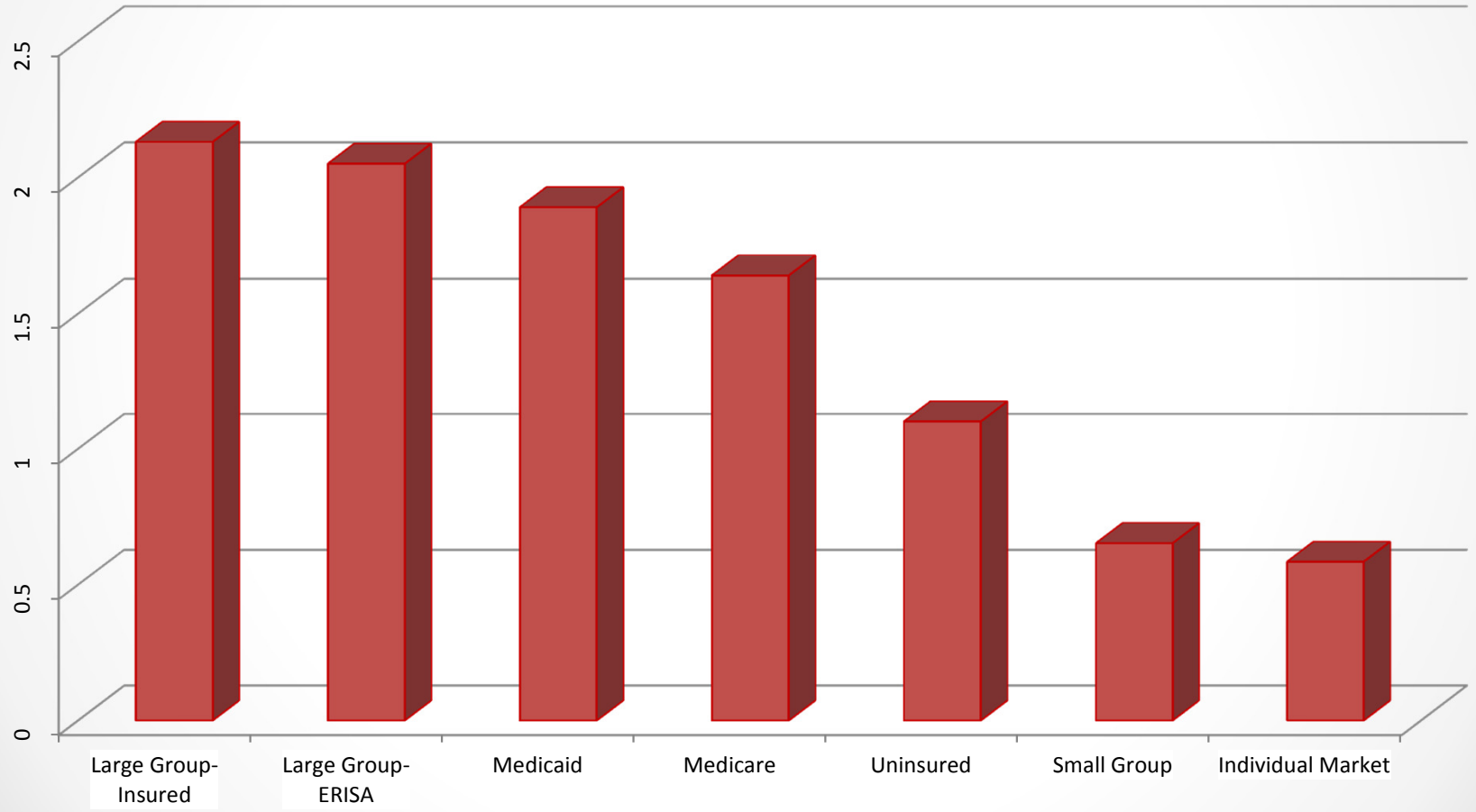
Coverage for Michigan Citizens Pre-HMP

(Millions)



Health Insurance in Michigan

Working Through the Maze of Insurance Coverage

- HMO – Health Maintenance Organization
- PPO – Preferred Provider Organization
- ASO – Administrative Services Only
- ACO – Accountable Care Organization
- ICO – Integrated Care Organization
- MCO – Managed Care Organization
- ASC – Accountable Systems of Care

- Individual Market – Exchange
- Small Group
- Large Group
- ERISA Exempt – Self-insured
- Medicaid
- Medicare

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What Health Plans Do

Under Full Risk Insured Products—Perform the following

- Claims Processing
- Eligibility Verification
- Authorizations and Referrals (standardization)
- Credentialing/Accreditation requirements
- Audits – Fraud, Waste, and Abuse

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What Health Plans Do -- Continued

Utilization Management:
- Techniques that provide safeguards against inappropriate care
- Prior authorization
- Claims review to identify inappropriate care

Disease & Case Management:
- Early identification of high-risk patients for early intervention
- Focus attention on individuals based on indicators (use of analytics)

Network Design:
- Carefully pooling providers who provide excellent care at lower costs
- Tiered networks

Benefit Design:
- Cost sharing through copays and deductibles
- Saving/spending accounts (HSAs, FSAs)

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Regulation of Health Insurance

Predominantly regulated by the Michigan Department of Insurance and Financial Services (DIFS) with authority derived from the Michigan Insurance Code (MCL 500.100 – 500.8302)

- Benefit Flexibility
- Commercial Rate Filing
- Rules and Standards for Rates
- Financial Solvency Standards
- Rule Promulgation by Director/Commissioner
- Network Adequacy
- Network Participation and Provider Contracts
- Required Benefit Plan Offerings (Mandates)
- Commercial Contract and Policy Form Filings
- Self-Funded/ASO Arrangements
- Geographic Limits on Product/Service Areas
- Guaranteed Issue
- Guaranteed Renewal
- Appeal of Benefit Denials

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Insurance Premiums

Underlying Cost Pressures for Health Insurance:

- Federal Insurance Premium tax (1.45% in 2014—expect about 2% in 2015 and will continue to increase rate until 2020.
- 2.3% Federal excise tax on manufacturers of medical devices
- 3.5% surcharge on premiums for Insurance Exchange
- Limits on Medical Underwriting (Age/Smoking/Geography). 20% population drives 80% cost because of chronic diseases and co-morbidities
- Benefit design changes forced on carriers (EHB/QHP)
- Minimum Medical Loss Rations – Large Group 85%, Small and Individual 80%
- Cost shifting concerns (Government payers, auto, uninsured)
- Pharmacy cost trends

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Health Care Reform

- Ushers in unprecedented change for health plans, affecting nearly all aspects of business operations.

- Increasing coverage to million will strain the delivery system, potentially resulting in access to care issues

<u>Keys Points:</u>

1. Insurance Reform
2. Health Insurance Exchange
3. Medicaid Expansion

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Michigan's Insurance Exchange

It's working

- Easier for consumers to shop: Promotes price competition in the individual and small group markets through greater transparency.
- Michigan one of 37 states using federal platform; our second year as a Partnership Exchange with federal government.
- Boosting competition! Insurers offering products up from 12 in 2014 to 16 in 2015; vastly increased selection of plans. According to an analysis by the Commonwealth Fund, the average premium for a silver plan sold on the Exchange decreased by 5%.

People are using it

- 311,000 individuals who selected a health plan using the Exchange (as of February 15, 2015). One third were new users of the Exchange.

The future is in question

- Subsidy is important: 88% of individuals in Michigan who selected a health plan using the Exchange qualified for financial assistance.
- SCOTUS decision on King V. Burwell could end credits – meaning healthy people could not afford insurance, only sick would buy, and leading to a death spiral (adverse selection).

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Qualified Health Plans

- Plans/Products divided into 5 categories based on actuarial value:
    1. Bronze – 60%
    2. Silver – 70%
    3. Gold – 80%
    4. Platinum – 90%
    5. Catastrophic plans

- All products must cover the "Essential Health Benefits" as selected by each State

- Consumer Protections:
    - Ban on annual and lifetime caps
    - Prohibit rescissions
    - Web-based portal
    - 1st Dollar coverage for prevention & wellness
    - Coverage of Emergency Services
    - Dependent Coverage (age 26)

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Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and Newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

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Employer Responsibility

- Must provide health insurance to full-time employees of large groups
  - "Employer Mandate – Play-or-Pay (delayed until 2015/16)
  - 50+ FTEs – must provide insurance to at least 95%
  - Minimum value – no less than 60% actuarial value
  - Affordable – cost to employee for self-only coverage cannot exceed 9.5% of household income
  - Minimum value calculator enables employers to test
  - Penalty if at least one employee receives tax credit via individual market
    - $2,000 per employee not covered (minus first 30 employees)
    - If not affordable, penalties would also apply

- Small Group Exchange – Small Business Health Options Program (SHOP)
  - Optional
  - 2-50 employees
  - Less than 25 employees making less than $25,000 average wage may be eligible for tax credits

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We Can Do Better Using Technology

- 20% of patient records not transferred in time for appointment
- 25% of patient tests to be re-ordered
- 1 in 3 hospitalized patients "harmed" during stay
- 1 in 5 Medicare Patients re-admitted within 30 days
- 63% of patients don't know their health care costs and 10% never find out
- 33% of health care expenditures don't improve health

(Source: Institute of Medicine/Best Care)

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Focus on Preventive Health

- Prevention involves a wide range of strategies from patient and provider education, to ensuring that appropriate health screenings take place, to community-wide efforts to help citizens choose healthier lifestyle behaviors

- Preventive health care services are one of our most effective tools for improving health outcomes and containing rising health care costs

- Health Plans have created and implemented a variety of initiatives to improve quality and access in internal administration, clinical disease management, delivery of services, and community outreach

- Partnerships between Health Plan, employer, and employee – internet based programs to use health risk appraisal tools blended with wellness programs with rewards for employees accepting more accountability.

- Growth of "Wellness Plans." Products that provide premium rebates based on members completing specific preventive programs.

Medicaid

- Michigan Medicaid program has chosen to use HMOs to deliver almost all of the Medicaid benefits
- 1.8 million traditional Medicaid beneficiaries (1.3 million in Managed Care)
- Mostly "moms and kids" (950,000) and disabled population (350,000)
- Healthy Michigan Program (Medicaid Expansion) with an additional 575,000 beneficiaries
- Expanding enrollment into managed care for Dual Eligible (Medicare/Medicaid)
- Expanding enrollment into managed care for Children's Special Health Care Services
- With HMP – one in four in Michigan is on Medicaid
- Over 50% of all births are paid for by Medicaid

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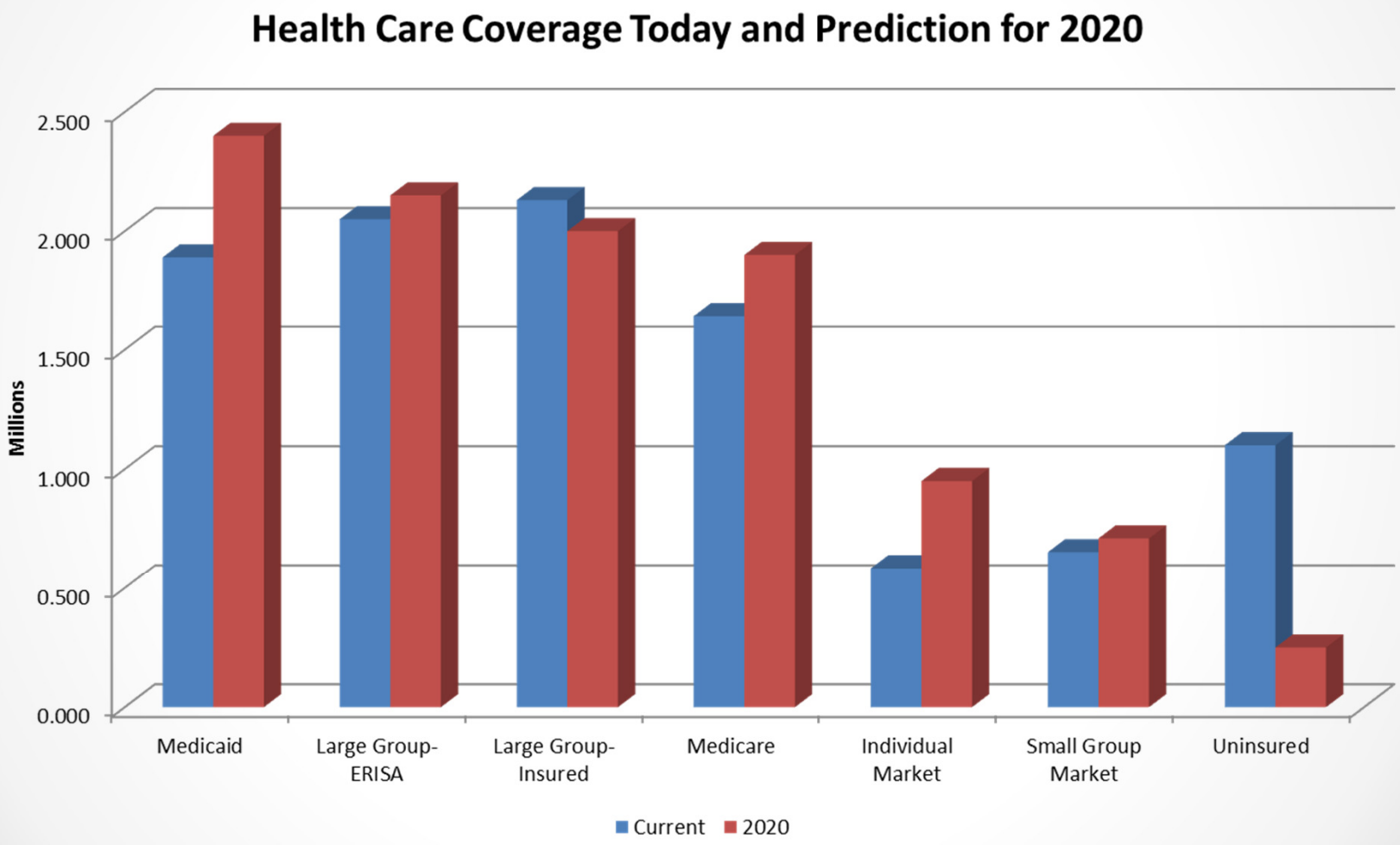
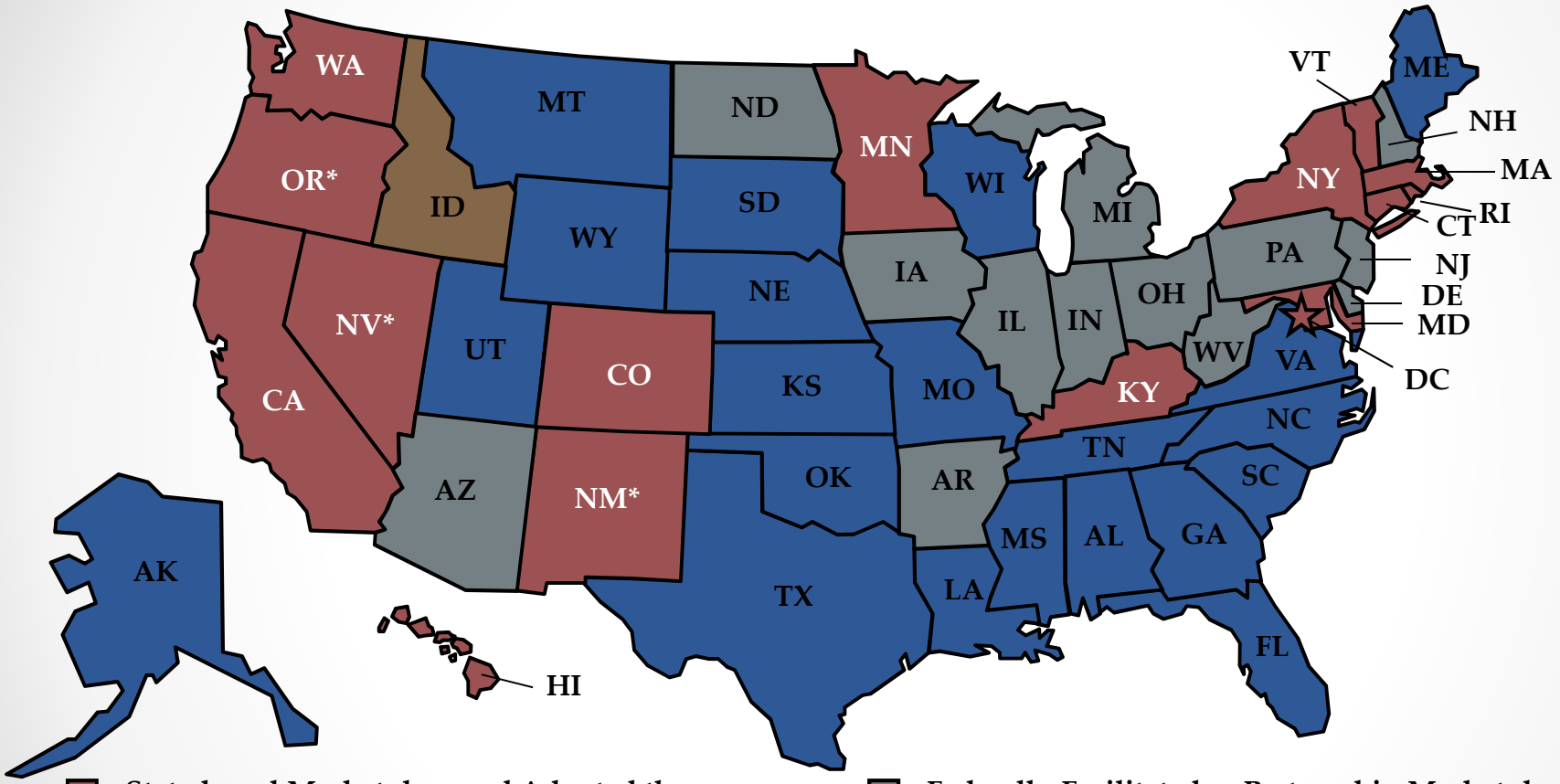
Coverage for Michigan Citizens and Prediction for 2020



Forces Impacting Continued ACA Implementation

- Republican Led Congress
- Supreme Court Case - King vs Burwell
- Low inflation in underlying health care costs may not be sustainable which would impact future premiums
- Effect of employer provisions only beginning to be felt because many have been able to avoid ACA requirements to date
- Medicaid Expansion states must begin to provide state matching dollars in 2017
- Public Opinion

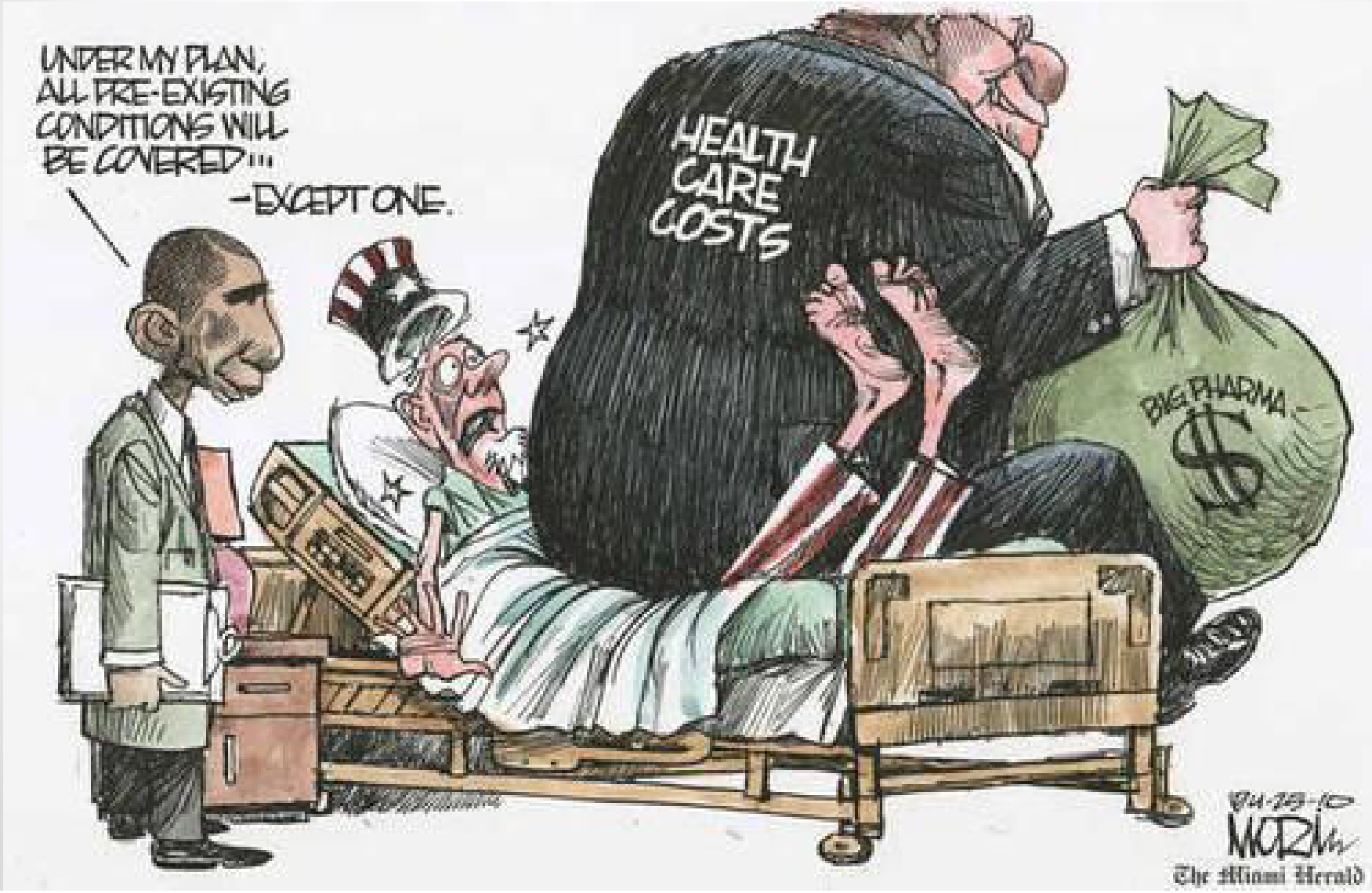
Current Status of State Individual Marketplace and Medicaid Expansion Decisions



- State-based Marketplace and Adopted the Medicaid expansion (16 States including DC)
- State-based Marketplace and Not Adopting the Medicaid expansion at this Time (1 State)
- Federally-Facilitated or Partnership Marketplace and Adopted the Medicaid Expansion (13 States)
- Federally-Facilitated or Partnership Marketplace and Not Adopting the Medicaid Expansion at this Time (21 States)

NOTES: *NM, NV, and OR are federally-supported state-based Marketplaces in 2015.
SOURCE: State Decisions on Health Insurance Marketplaces and the Medicaid Expansion, KFF State Health Facts, updated January 27, 2015. http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/.

What's Left to Do?



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