CHRT

ISSUE BRIEF

Issue Brief August 2014

Michigan Health Insurance Marketplace: Overview and Operations

On March 31, 2014, the Affordable Care Act's (ACA) Individual Marketplace officially closed for most people until open enrollment begins for 2015 health plans on November 15, 2014. By the end of the first open enrollment period, 272,539 Michigan residents had signed up for a plan through the marketplace.[1] Assuming that many of these residents complete the enrollment process, Michigan marketplace enrollment exceeded 2014 projections from CHRT,[2] the Department of Health and Human Services (HHS),[3] and the Urban Institute.[4] This issue brief summarizes the plans that have been offered on the individual marketplace, explains the financial assistance available through the marketplace, describes the operational challenges faced by the marketplace, and recaps Michigan's enrollment during the 2014 open enrollment period.

[1] U.S. Department of Health and Human Services. May 2014. *Profile of Affordable Care Act Coverage Expansion Enrollment in Medicaid/CHIP and the Health Insurance Marketplace, 10-1-2013 to 3-31-2014: Michigan.* **http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/pdf/mi.pdf** (accessed 7/1/14).

[2] Fangmeier, Joshua; Udow-Phillips, Marianne. July 2013. *The ACA's Coverage Expansion in Michigan: Demographic Characteristics and Coverage Projections. Cover Michigan 2013.* Center for Healthcare Research & Transformation. Ann Arbor, MI. **http://www.chrt.org/publications/cover-michigan/the-aca-s-coverage-expansion-in-michigan-demographic-characteristics-and-coverage-projections** (accessed 7/1/14).

[3] Tavenner, Marilyn; Mould, Don. September 2013. *Projected Monthly Enrollment Targets for Health Insurance Marketplaces in 2014 – Information.* U.S. Department of Health and Human Services. **http://waysandmeans.house.gov/uploadedfiles/enrolltargets_09052013_.pdf** (accessed 7/1/14).

[4] Blumberg, Linda; Holahan, John; Kenney, Genevieve; Buettgens, Matthew; Anderson, Nathaniel; Recht, Hannah; and Zuckerman, Stephen. May 2014. *Measuring Marketplace Enrollment Relative to Enrollment Projections: Update.* Urban Institute. **http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf** (accessed 7/1/14).

The Center for Healthcare Research & Transformation (CHRT) illuminates best practices and opportunities for improving health policy and practice. Based at the University of Michigan, CHRT is a non-profit partnership between U-M and Blue Cross Blue Shield of Michigan to promote evidence-based care delivery, improve population health, and expand access to care.

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The first marketplace open enrollment period began on October 1, 2013, and ended on March 31, 2014.[5] The marketplace offered consumers the opportunity to compare qualified health plans (QHPs) from multiple insurers. QHPs were required to comply with several newly effective ACA provisions which created minimum standards for coverage, regulated the design of plans, and allowed premiums to vary based on a limited set of factors unrelated to health status.[6] To make QHPs more affordable to consumers, the ACA provides tax credits and cost-sharing reductions to qualifying individuals to lower the premium and out-of-pocket costs.

Metal Levels

Insurers must meet several requirements to be certified to offer QHPs on the marketplace. Plans may impose cost-sharing for benefits, but cost-sharing levels for each plan must be assigned a standardized "metal level," which corresponds to the plan's actuarial value (AV). AV is the average share of cost of covered items and services that is paid for by the plan. The following are the metal levels available on the marketplace:

Bronze	60 percent AV
Silver	70 percent AV
Gold	80 percent AV
Platinum	90 percent AV

The remaining percentage of the cost of covered items and services is paid by consumers through out-of-pocket payments. The monthly premiums are generally lowest for bronze plans, and highest for platinum plans. For example, if a consumer chooses a bronze plan, the plan will cover an average of 60 percent of the cost of the individual's medical care, and the remaining 40 percent will be paid for out-of-pocket.[7] Some insurers also offer low-premium catastrophic plans on the marketplace, which cover a smaller share of expenses than bronze plans.[8] Only individuals under 30 years of age or those claiming a hardship or affordability exemption from the ACA's individual mandate are eligible to purchase catastrophic coverage.[9]

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[5] Consumers who tried to enroll in a plan during the open enrollment period, but did not finish by March 31, had until April 15 to complete the process. Those who submitted a paper application by April 7 were allowed to pick a plan through April 30.

[6] Fangmeier, Joshua; Udow-Phillips, Marianne. February 2014. *Premium Cost Changes Attributable to the Affordable Care Act*. Center for Healthcare Research & Transformation. Ann Arbor, MI.

[7] For each AV level, an insurer's responsibility for covered services will vary among enrolled individuals but should, on average, match the AV level across a standard population enrolled in the plan.

[8] Catastrophic plans typically do not cover any benefits until the plan's deductible is met, other than at least three primary care visits per year (generally with copay) and preventive services. The ACA requires coverage of certain preventive services with no cost sharing, including preventive services given an A or B rating by the United States Preventive Services Task Force.

[9] Individuals who received a notification from an insurer that their policy was not renewed are also eligible for a hardship exemption and may purchase catastrophic coverage.
Centers for Medicare and Medicaid Services. December 2013. *Options Available for Consumers with Cancelled Policies*. **http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-12-19-2013.pdf** (accessed 7/1/14).

Insurers and Offered Plans

In Michigan, 10 insurance issuers offered 63 non-catastrophic qualified health plans in the marketplace for 2014, but the degree of choice and competition diverged considerably by location, ranging from 55 plans in southeast Michigan (Macomb, Oakland and Wayne Counties) to five plans in Delta County. Premiums also varied considerably by region. The cost of the least expensive bronze premium was 64 percent greater in the Central Upper Peninsula ($199/month for a 21 year old) than in Kent, Muskegon and Oceana Counties ($121 per month for a 21 year old). FIGURE 1 summarizes the insurers and plans that were offered for 2014. Blue Cross Blue Shield of Michigan was the only insurer that offered QHPs statewide on the marketplace.

FIGURE: 1
2014 Michigan Marketplace, Insurer Participation and Plan Offerings[10]

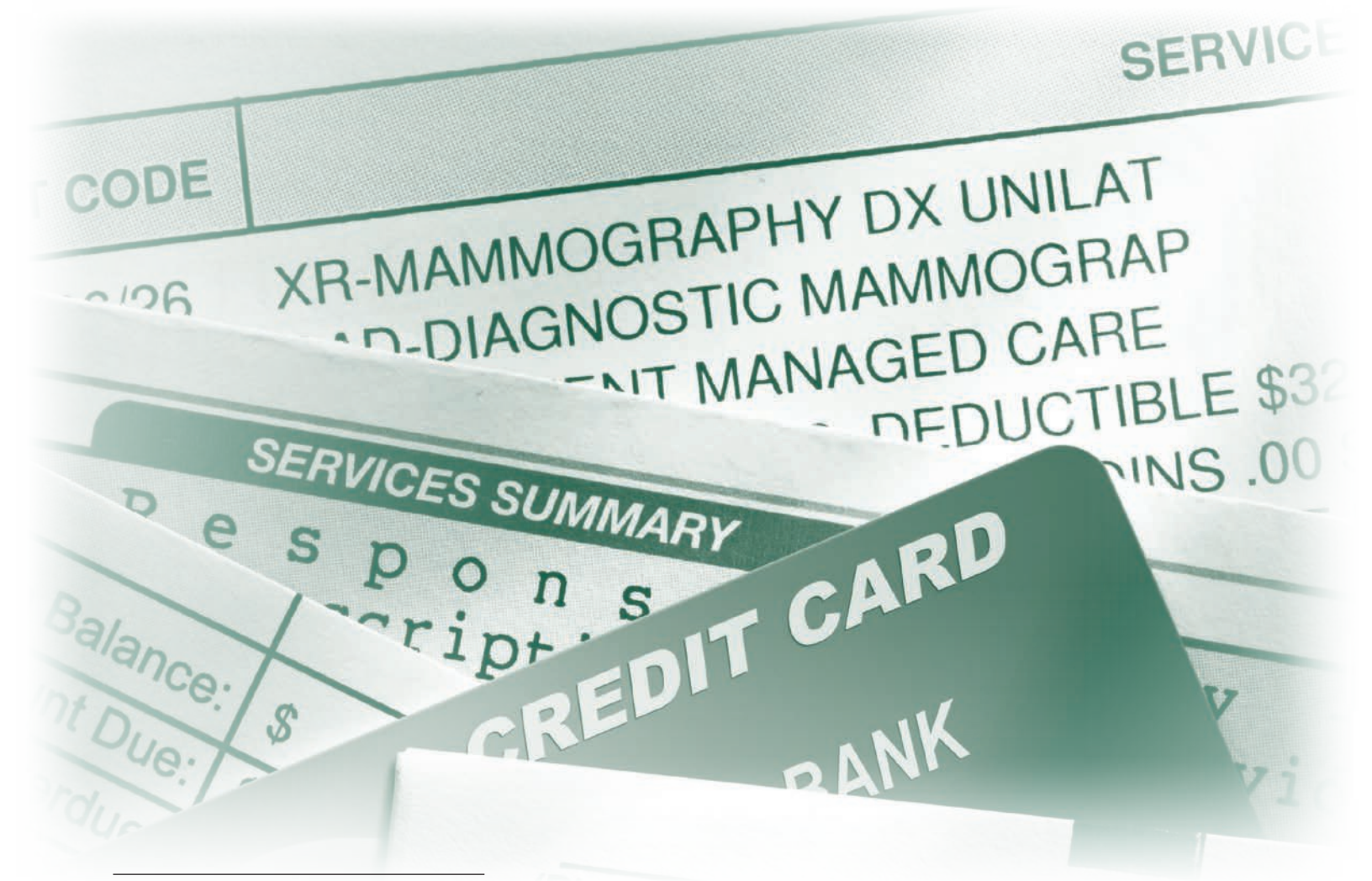
Insurance Company	Number of Counties Participating	Number of QHPs Offered[11]
Blue Care Network of Michigan	70	9
Blue Cross Blue Shield of Michigan	83	5
Consumers Mutual Insurance of Michigan	47	5
Health Alliance Plan (HAP)	23	7
Humana Medical Plan of Michigan Inc.	3	4
McLaren Health Plan, Inc.	28	6
Meridian Choice Health Plan of MI, Inc.	3	4
Molina Healthcare of Michigan, Inc.	3	3
Priority Health	70	18
Total Health Care USA, Inc.	4	2

[10] CHRT analysis of 2014 Michigan marketplace QHP data (retrieved from healthcare.gov).

[11] QHP totals include child-only QHPs but do not include catastrophic plans.

Cost to Consumers and Financial Assistance

During the first open enrollment period, 87 percent of those in Michigan who selected a plan were eligible for financial assistance in the form of premium tax credits and/or cost-sharing reductions to decrease their out-of-pocket costs.[12] This financial assistance is only available to those at certain income levels who are eligible to purchase coverage through the marketplace[13] and are not eligible for another form of minimum essential coverage, such as government-sponsored plans (i.e., Medicare and most forms of Medicaid[14]) and employer-sponsored insurance (ESI) that is adequate and affordable.[15]



[12] U.S. Department of Health and Human Services. May 2014.

[13] For example, unauthorized immigrants and incarcerated residents are ineligible to purchase coverage on the marketplace, regardless of income level or current coverage.

[14] Some Medicaid eligibility categories, such as certain "medically needy" programs and 1115 demonstration waivers, offer a narrow set of benefits and do not qualify as minimum essential coverage. According to proposed federal rules, eligibility for these programs would not preclude eligibility for ACA financial assistance.
Rosenbaum, Sara. February 2014. *When Does Medicaid Coverage Amount to Minimum Essential Coverage Under the Affordable Care Act? An Update on the Treasury/IRS Rules Defining Minimum Essential Coverage.* Health Reform GPS. **http://www.healthreformgps.org/wp-content/uploads/Rosenbaum-IRS-mec-2-10.pdf** (accessed 7/1/14).

[15] Under the ACA, ESI is considered affordable for an employee and his or her dependents if the employee's annual premium for self-only coverage is less than 9.5 percent of annual household income. ESI meets adequacy standards (minimum actuarial value) if the plan has an actuarial value of at least 60 percent.

Cost to Consumers and Financial Assistance *(continued)*

Advanced Premium Tax Credits (APTC)

Tax credits may be available for applicants whose household income is between 100-400 percent of the Federal Poverty Level (FPL), to help pay monthly premiums for non-catastrophic coverage on the marketplace. In order for low-income enrollees to avoid paying full premiums up front, the entire tax credit, or a portion, may be taken in advance.[16] In this case, the federal government sends the tax credit directly to the insurer each month, and the applicant pays the remaining portion of the premium. For the purposes of determining eligibility for financial assistance, household income is measured as modified adjusted gross income (MAGI).[17]

The tax credit amount varies based on two key factors: the applicant's household income and the cost of the benchmark (second lowest cost silver) plan in the applicant's region. The amount of the tax credit is generally calculated using the following formula:

Tax credit amount =

Age-adjusted premium for the benchmark plan in the applicant's region –

Applicant's maximum premium contribution based on their household income

An applicant's maximum premium contribution is the product of household income and the "applicable percentage"–a sliding scale that ranges from 2 to 9.5 percent of income between 100-400 percent of the federal poverty level. As a result, as an applicant's income increases, the amount of the tax credit decreases.

Premium tax credits can be applied to all non-catastrophic QHPs in the marketplace. If the premium of an applicant's selected QHP is less than the tax credit amount, the applicant will owe $0 in premium payments each month, but the applicant cannot keep leftover tax credit funds. CHRT has estimated that 79,000 uninsured Michigan residents could purchase their cheapest local bronze plan for $0 per person per month, and 199,000 could purchase it for less than $100 per person per month.[18] On the other hand, if an applicant's benchmark premium is less than their maximum premium contribution, the applicant will receive no tax credit at all, even if their income is below 400 percent FPL. In Michigan, an estimated 45,000 uninsured residents will not receive a tax credit due to this circumstance, which is most common among those with incomes between 300 and 400 percent FPL.[19]

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[16] Advanced credits must be reconciled when the household files taxes for that year. If household income is lower than projected, the applicant will receive the additional tax credit in the form of a tax refund. If income is greater than projected, the excess tax credits must be repaid to the federal government within certain limits.

[17] MAGI is a household's Adjusted Gross Income (AGI), plus certain deductions. The ACA defines a household as a taxpayer plus a spouse and any dependents, including children or other family members, who meet certain requirements.

[18] Fangmeier, Joshua. August 2014. *Effects of the ACA on Insurance Affordability for the Uninsured in Michigan.* Center for Healthcare Research & Transformation. Ann Arbor, MI.

[19] Ibid.

Cost to Consumers and Financial Assistance *(continued)*

FIGURE 2 illustrates premium tax credit amounts at different income levels for non-smoking 45-year-old individuals living in Wayne County and Ingham County, respectively. As these examples show, premium prices can vary across regions, even for individuals of the same age, because benchmark premiums are $50 per month more in Ingham County than Wayne County. However, maximum premium contribution amounts, which vary by income level, do not vary by region. Therefore, the tax credit amounts are actually higher in Ingham County than Wayne County.

FIGURE:2
Premium Costs and Tax Credit Amounts in 2014–45-year-old residents in Wayne County, MI, and Ingham County, MI

		Wayne County Lowest Cost Bronze Plan Premium: $189/month			Ingham County Lowest Cost Bronze Plan Premium: $214/month		
Household Income	Maximum Premium Contribution	Benchmark Premium	Tax Credit Amount	Personal Share of Premium	Benchmark Premium	Tax Credit Amount	Personal Share of Premium
$16,000/year (139% FPL)	$45/month (3.37% of income)	$253/ month	$189/month (full premium)	–	$303/ month	$214/ month (full premium)	–
$23,000/year (200% FPL)	$121/month (6.31% of income)	$253/ month	$132/month	$57/month	$303/ month	$183/ month	$31/ month
$34,500/year (300% FPL)	$273/month (9.5% of income)	$253/ month	–	$189/ month (full premium)	$303/ month	$31/month	$183/ month
$46,000/year (400% FPL)	$364/month (9.5% of income)	$253/ month	–	$189/ month (full premium)	$303/ month	–	$214/ month (full premium)

Cost to Consumers and Financial Assistance *(continued)*

Cost-Sharing Reductions

In addition to premium tax credits, individuals with household income between 100 and 250 percent FPL may be eligible for one of three levels of cost-sharing reductions if they enroll in a silver plan on the marketplace. Cost-sharing reductions (CSR) increase the actuarial value of a silver plan beyond 70 percent, reducing out-of-pocket costs. FIGURE 3 shows how CSR reduces these costs for a specific plan offered in Michigan (Blue Cross Premier Silver). In this example, the deductible at the lowest income level is $175 but increases to $300 and then $1,000 as income rises and the degree of CSR support declines.[20]

An estimated 223,000 of Michigan's uninsured population are estimated to qualify for some amount of CSR support. For those buying single-only coverage in Michigan, CSR reduces the average deductible for silver coverage by 46 percent. The federal government must make monthly advance payments to insurers to cover projected cost-sharing reductions, which are then reconciled with the actual cost-sharing amounts at the end of the benefit year. Unlike the premium tax credit, consumers do not have to reconcile CSR support payments when filing taxes for that year.

FIGURE:3
Illustrative Example of Cost-sharing Reductions (Blue Cross Premier Silver)

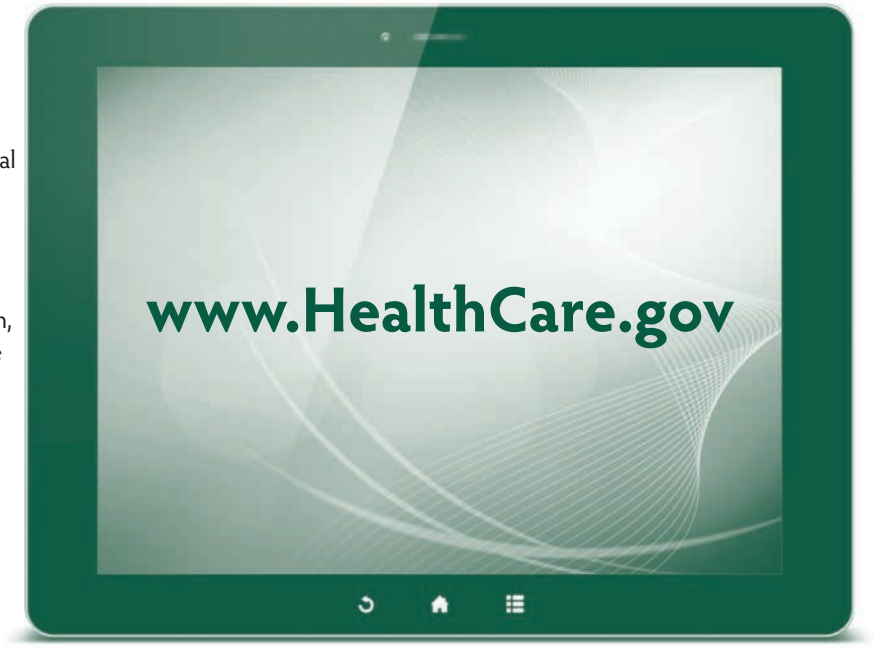
	Silver Plan with Cost-sharing Reductions			Silver Plan without Cost-sharing Reductions
Household Income (Individual)	≤150 percent FPL (≤$17,235)	151-200 percent FPL ($17,236 - $23,000)	201-250 percent FPL ($23,001 - $28,700)	>250 percent FPL (>$28,700)
Actuarial Value	94 percent	87 percent	73 percent	70 percent
Deductible (individual)	$175	$300	$1,000	$1,400
Out of pocket limit, medical (individual)	$500	$1,400	$4,500	$6,000
Primary care physician visit	$10 copay after deductible	$30 copay after deductible	$30 copay after deductible	$30 copay after deductible
Emergency room visit	$100 copay after deductible and 10 percent coinsurance after deductible	$250 copay after deductible and 10 percent coinsurance after deductible	$250 copay after deductible and 20 percent coinsurance after deductible	$250 copay after deductible and 20 percent coinsurance after deductible

[20] Insurers have some flexibility with the specifics of their benefit designs as long as they meet the actuarial values of each CSR level.

The health insurance marketplaces are often compared to other Internet commerce sites, but this discounts the degree of complexity in the enrollment process–both for the applicant and the back-end functions of the marketplace. This complexity presents several challenges to make the marketplaces operate effectively for consumers and participating insurers. These challenges include offering a functional application process, accurately verifying applicant information, transferring enrollment data to insurers, and transmitting subsidies to insurers. Although the enrollment process can vary for individual applicants depending on their circumstances, it generally is composed of the key steps shown in APPENDIX *(page 11)*.

Application and Information Verification

Applicants interested in enrolling in coverage through the marketplace were first required to create an account (using healthcare.gov for Michigan residents) and then submit an application. However, consumers faced serious website errors and delays during the opening weeks of first open enrollment. According to the firm Millward Brown, only 27 percent of consumers who attempted to create an account and register with the marketplace website were successful during the first week.[21] While this registration issue and the rest of the front-end process gradually improved during the first two months, enrollment lagged as less than a third of expected enrollees had selected a plan through the marketplace by November 30.[22]



In addition to these technical issues, the application process was complex and asked several questions to determine marketplace eligibility[23] and eligibility for financial assistance (tax credits, cost-sharing reductions or Medicaid/CHIP). Applicants interested in financial assistance were required to complete a more detailed application, including questions about the household, income amounts, and current health insurance coverage (if any) for family members. FIGURE 4 *(page 9)* shows examples of information requested in the detailed application.

[21] Pace, Matt. October 2013. *Healthcare.gov Applications Increased 31% during ACA's 2nd Week.* Millward Brown Digital. **https://blog.compete.com/2013/10/18/healthcare-gov-applications-increased-31-acas-2nd-week/** (accessed 7/1/14).

[22] CHRT calculation of HHS target enrollment compared to actual enrollments through November 2013.

[23] Specifically, the marketplace asks questions to confirm that applicants are not incarcerated and are legal U.S. residents.

Application and Information Verification *(continued)*

FIGURE:4
Select Marketplace Application Information

Type of Information Necessary	Examples of Information	Reason for Providing this Information
Family & Household Information	Names and birthdates of family members	To verify marketplace eligibility and determine the size of the family for calculating eligibility for assistance programs. Disability information used to assess potential Medicaid eligibility.
	Social Security Numbers (or document numbers for legal immigrants)	
	Tax filing intentions for the plan year	
	Physical disabilities or mental conditions of family members	
Income Information	Income documentation for all family members (pay stubs, W-2 forms, etc.) for the plan year	To calculate the projected Modified Adjusted Gross Income (MAGI) of the family for calculating eligibility for assistance programs.
	Certain tax deductions (student loan interest, alimony, etc.) for the plan year	
Additional Information	Policy numbers for current plans covering family members	To determine if any family members have access to coverage that makes them ineligible for premium tax credits and/or cost-sharing reductions.
	Detailed information about every employer-based plan available to family members (Employer Coverage Tool)	

Marketplace applications were then processed and information was verified against other data sources. Specifically, the marketplace has access to the federal data services hub, which is able to transmit information from federal agencies, such as the Social Security Administration (SSA), the Internal Revenue Service (IRS), the Department of Homeland Security (DHS) and the Department of Health and Human Services (HHS). For example, the marketplace uses data from IRS tax filings and the SSA to verify household income.[24] Applicants with information discrepancies were often asked to provide supporting documentation. However, as of the first quarter of 2014, the federal eligibility system was unable to resolve 2.6 million application inconsistencies, even when applicants provided appropriate documentation.[25]

[24] Centers for Medicare and Medicaid Services. *Frequently Asked Questions on Health Insurance Marketplaces and Income Verification*. August 2013. **http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/income-verification-8-5-2013.pdf** (accessed 7/1/14).

[25] Department of Health and Human Services, Office of the Inspector General. June 2014. *Marketplace Faced Early Challenges Resolving Inconsistencies with Application Data.* **http://oig.hhs.gov/oei/reports/oei-01-14-00180.pdf** (accessed 7/1/14).

Coordinating Enrollment and Payments with Insurers

Once an applicant selected a QHP to enroll in, the marketplace electronically transmitted information about the applicant and any included family members to the new insurer. This process is also known as 834 EDI Transmission. Once the insurer receives their information, they then send a confirmation back to the marketplace. At the beginning of the first open enrollment, nearly one-third of these transmissions from the federal marketplace contained serious errors.[26] However, the error rate declined considerably after the first few months as improvements were made.[27]

Applicants that appeared eligible for Medicaid or CHIP due to their income or disability were intended to be redirected electronically to their state's Medicaid agency for enrollment, usually through that state's enrollment website (mibridges.michigan.gov for Michigan residents). The marketplace is supposed to transmit an electronic "flat file" to states with applicant information, so eligible consumers can enroll in Medicaid from the marketplace. However, state Medicaid agencies have faced technical challenges in getting usable flat files from the marketplace, leading to large backlogs in some states.[28]

After the plan selection process, insurers began contacting their new customer to begin the billing process and collect additional membership information. Marketplace coverage only becomes effective after the first monthly premium is paid,[29] but statements from insurers suggest that more than 80 percent of enrollees had paid their premium as of May 2014.[30] The federal government also began to make payments to insurers for advanced premium tax credits and cost-sharing reductions. However, the permanent payment system was not built before the beginning of the first open enrollment, and the federal government has relied on an interim payment process. While it is not clear if payments have been inaccurate, the federal government expects the interim process to continue through September 2014.[31]

[26] Goldstein, Amy; Eilperin, Juliet. December 2013. *Health-care enrollment on Web plagued by bugs*. Washington Post. **http://www.washingtonpost.com/national/health-science/health-care-enrollment-on-web-plagued-by-bugs/2013/12/02/e3021b86-5b79-11e3-a49b-90a0e156254b_story.html** (accessed 7/1/14).

[27] Cohn, Jonathan. December 2013. *Exclusive: The Obamacare Error Rate Has Fallen Dramatically.* The New Republic. **http://www.newrepublic.com/article/115837/obamacare-834-error-rate-falls-25-percent-10-percent** (accessed 7/1/14).

[28] Ornstein, Charles. April 2014. *Medicaid Programs Drowning in Backlog.* Pro Publica. **http://www.propublica.org/article/medicaid-programs-drowning-in-backlog** (accessed 7/1/14).

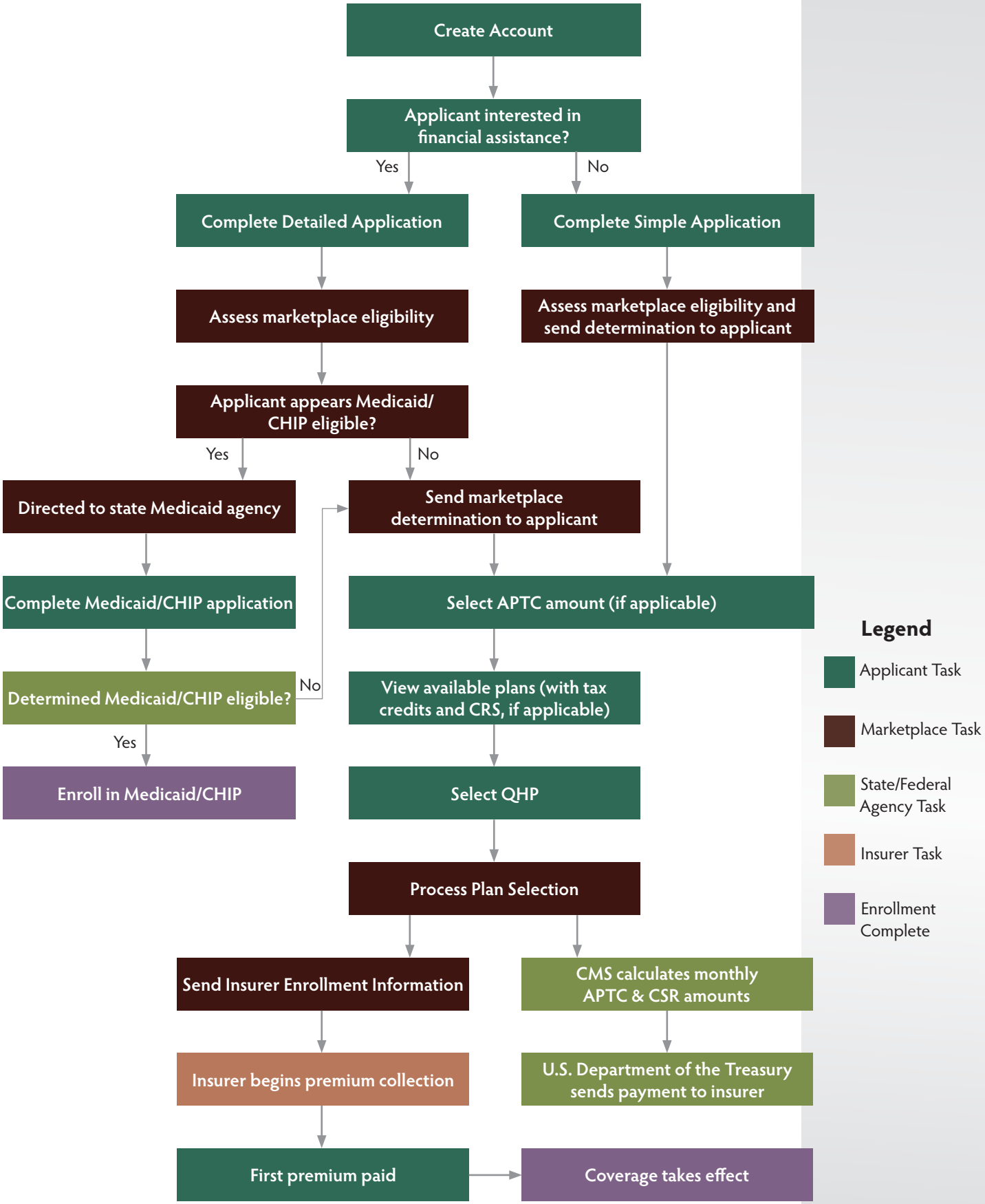
[29] Applicants that select a plan between the 1st and the 15th of the month can have effective coverage on the first day of the following month. Applicants who select a plan after the 15th generally have to wait until the first day of the second following month to begin using their new plan.

[30] Werner, Erica. May 2014. *Health insurers: Payment rates above 80 percent.* Associated Press. http://m.apnews.com/ap/db_268808/contentdetail.htm?contentguid=0A4ZRF2q (accessed 6/2/14).

[31] Centers for Medicare and Medicaid Services. April 2014. *Interim Payment Process Payment Timeline for May through September 2014.* https://www.politicopro.com/f/?f=25686&inb (accessed 7/1/14).

APPENDIX

Overview of Marketplace Enrollment Process



Conclusion

Michigan was able to mount robust enrollment in the marketplace during the first open enrollment period. Michigan ranks sixth among states in enrollment relative to 2014 projections, according to an analysis by Avalere Health.[32] While the technical challenges of the ACA are largely due to the complexity of the law and information that had to be integrated and coordinated, those issues did improve by the end of open enrollment and should improve further over future years. Overall, consumer experience with the marketplace will likely be driven by ease of use, plan choice and premium cost, which will all be important to monitor as this new insurance market matures over time.

[32] Avalere Health. May 2014. *Exchange Enrollment Outpaces Expectations in 22 States.* **http://avalerehealth.net/expertise/managed-care/insights/avalere-analysis-exchange-enrollment-outpaces-expectations-in-22-state** (accessed 7/1/14).

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