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The State's Implementation of Federal Health Care Reform

The Michigan Department of Community Health (MDCH) and the Office of Financial and Insurance Regulation (OFIR) have been working to launch the implementation of the Affordable Care Act (ACA—the Patient Protection and Affordable Care Act), commonly referred to as the "health reform bill," as signed by the President in March 2010. Following is a summary of the work that has been and must be done this year in Michigan to begin implementation of the new law.

Health Insurance Reform Coordinating Council

On March 31, 2010, Gov. Jennifer Granholm issued an Executive Order to create the Health Insurance Reform Coordinating Council. The Council includes the directors of the Michigan Department of Community Health, the Michigan Department of Human Services, and the Michigan Department of Technology, Management, and Budget, the state budget director, the state personnel director, the director of the Office of the State Employer, the commissioner of OFIR, and the director of Medical Services Administration (i.e., Medicaid) within the MDCH.

The Council's role includes engaging stakeholders to assist with the implementation of the law, facilitating collaboration with federal agencies, developing recommendations for health insurance exchange implementation, analyzing the law's impact on state departments and agencies, and identifying federal grants, pilot programs, and other funding opportunities to assist with the state's implementation of the law. The Council has also been charged to recommend any immediate executive or legislation action that will assist in implementation of the law; and to submit a strategic plan for implementation to the director of the MDCH and the governor. Other functions of the Council as requested by the governor or director of the MDCH related to the implementation of the law are yet to be determined.

The challenge for Michigan is that the makeup of the Council (i.e., the directors of the various state departments and agencies) will potentially be changing upon the new governor's assumption of office in early 2011. Some wonder whether the work of the current council will be continued and whether recommendations will be followed once new leadership is in place.

Medicaid Eligibility Processes

One of the largest pieces of the ACA law is the expansion of Medicaid eligibility to 133 percent of federal poverty ($29,327 for a family of four). The Department of Community Health is estimating up to 400,000 newly eligible for Medicaid through the expansion of the state program. There are a number of challenges that the State is currently attempting to resolve, including how to simplify the Medicaid enrollment process and how to determine whether an enrollee is eligible under the ACA law, or if that enrollee was eligible, but not enrolled, prior to the enactment of the law. The State must track these enrollees separately, as the 100 percent federal match available through the law applies only to the newly eligible beneficiaries from the coverage expansion.

The state has the option to expand Medicaid to cover parents and childless adults up to 133 percent of the federal poverty level now and receive current law matching federal rates until December 31, 2013. Michigan will most likely not expand Medicaid

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eligibility prior to the January 1, 2014 federally mandated start date due to the state's poor economic climate.

The state also needs to strategize how to simplify the enrollment process when implementing the new law. Medicaid enrollment is currently administered by the Department of Human Services. Under the new law, the state will need to make a number of outreach efforts to contact potentially eligible beneficiaries. In addition, there will need to be coordination with the newly developed health insurance exchanges to direct those not eligible for Medicaid under the expansion to the exchanges to purchase their health insurance as mandated by the federal law. This population, between 134 and 400 percent of the federal poverty level (up to $88,000 per year for a family of four), will be eligible for the federal subsidies offered through the insurance options on the exchange.

Maintenance of Effort

Upon enactment of the law, states are subject to a maintenance of effort (MOE) requirement for all eligibility categories included in Medicaid and the Children's Health Insurance Program (MIChild in Michigan) until September 30, 2019. States will maintain current rules, with the exception of income eligibility, and will receive a 23 percentage point increase in the federal match between Fiscal Years 2016-2019 for the Children's Health Insurance Program.

Health Insurance Exchange

In 2014, a health insurance exchange (HIE) will be implemented by the state (or a nonprofit organization as designated by the state) as a ''one-stop shop'' to enable consumers and small businesses to compare a variety of private insurance carriers for cost and coverage and purchase health care coverage. The state must decide which entity will manage the HIE and develop the various levels of coverage that will be available to consumers and small businesses. Each level of coverage will have to cover ''essential services'' as defined by the U.S. Department of Health and Human Services (DHHS) (e.g., doctor visits, hospitalization, prescription drugs).

High-Risk Pool

Prior to the implementation of the HIE and the Medicaid eligibility expansion, and within 90 days of enactment, the DHHS must establish a temporary high-risk health insurance pool or alternative program within each state. Michigan has chosen to implement its own high-risk pool. Individuals who will be considered for the high-risk pool must have a pre-existing condition, cannot have had insurance coverage for at least six months prior to the start of the high-risk pool, and must be a legal resident. OFIR Commissioner Kenneth Ross has indicated that limited federal funding means that Michigan's pool will not cover everyone who meets the three criteria above. The state has issued a Request for Proposals due July 7, 2010 to obtain bids from prospective administrators, with the State contracting with one or more administrators by July 26, 2010. Each administrator will be required to begin consumer enrollment no later than September 15, 2010; and will be required to begin coverage no later than October 1, 2010.

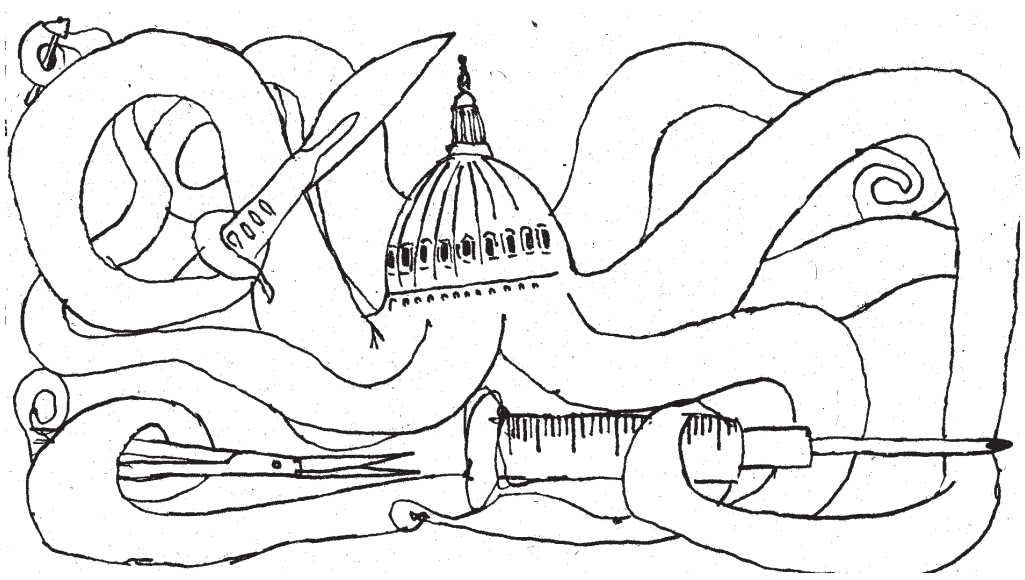
Each administrator will collect a monthly premium from subscribers and federal funding ($141 million) to cover payment of claims between October 1, 2010 and December 31, 2013. Limitations that have yet to be determined by the state will be imposed to ensure funding (federal and monthly premiums) will cover the costs of all claims through December 31, 2013.

Market Reforms

By September 23, 2010, the state is required by the ACA law to implement the following changes:

- Allow for continued coverage on parents' plans for young adults up to their 26th birthday
- Prohibit insurers from imposing a lifetime limit on a beneficiary's coverage
- Restrict insurers on the use of annual coverage limits
- Prohibit insurers from terminating coverage for beneficiaries if they become ill
- Require insurers to cover preventive health services and immunizations without an out-of-pocket cost to the consumer

Federal Health Care Reform



The New York Times, January 30, 1986 Cartoonist: Mark Podwal

Medical Loss Ratio Definition

The medical loss ratio is defined as the ratio of premiums that are used for medical care versus those used for administrative activities. New rules will require that more than the majority—85 percent for large group and 80 percent for small and individual group markets—of premiums be used for medical care, or the insurer will be required to offer refunds. It will be very important to monitor the definitions of medical care and administrative costs to ensure that the spirit of the law is complied with. The state is keeping a close eye on the work being done by the DHHS and the National Association of Insurance Commissioners as they work out clearer definitions of these terms.

State Implementation Work

There is much work ahead to prepare for those provisions of the law that will be implemented January 1, 2014. The National Academy of State Health Policy (NASHP) recommends that states take this opportunity to foster effective change in their health systems while developing the health insurance exchange, effectively regulating the health insurance market, simplifying Medicaid eligibility, using evidenced-based benefit designs, engaging the public in the development and implementation of policies, and collecting and using data to establish population health goals. NASHP also recommends that quality and efficiency be demanded from health systems, and that ways to build the capacity of health professions be pursued.[1]

The Center for Health Research & Transformation has recently released issue briefs—*The Patient Protection and Affordable Care Act at the State and Local Level and Impact of Health Reform on Coverage in Michigan*—available at www.chrt.org.

The Consumer Health Care Coalition will have opportunities to provide input to assist the MDCH and the OFIR throughout the implementation of the new law. Information about these opportunities will be provided as they arise.

From the Consumer Perspective

If the average consumer of health care services is wondering what the ''reform'' is in the ''health care reform bill,'' look no further than the requirements the state must meet in constructing the state's insurance exchange in these pages. The transparency, the options, the benefit packages—all will be available to the public.

It's been a long time coming, but maybe we are taking our first step in helping consumers understand health care services and their costs.

Could rational cost containment be far behind?

Beverley McDonald
Coalition Chairperson

[1] A. Weil, *State Policymakers' Priorities for Successful Implementation of Health Reform*, National Academy for State Health Policy, Washington, D.C., May 2010.

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HEALTH CARE BY THE NUMBERS

Notable Numbers of health care reform provisions to be implemented in 2010:

- **4 million**—the estimated number of Medicare Part D beneficiaries who will enter the coverage gap and receive a $250 payment; first payments issued in June;
- **26**—the age up to which parents can continue to insure their children on their policies without the children being IRS-defined dependents or in school;
- **35**—percentage of premiums that can be subsidized to help small businesses provide coverage to employees;
- **5 billion**—amount of funding allocated nationally to subsidized coverage in the high risk pools that will be implemented by September 2010 to cover uninsured persons with pre-existing conditions until January 2014;
- **0**—amount of copayment or deductible allowed in Medicare for preventive services;
- **25 million**—amount of funding included, beginning in 2010, for childhood obesity reduction demonstration grants.