STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

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DIRECTOR

June 19, 2017

Jennifer Kostesich, Project Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Dear Ms. Kostesich,

Re: Project Number 11-W-00245/5 – Healthy Michigan Plan

Enclosed is the quarterly report for Healthy Michigan Plan. It covers the second quarter of federal fiscal year 2017. The report provides operational information, program enrollment, and policy changes related to the waiver as specified in the Special Terms and Conditions.

Should you have any questions related to the information contained in this report, please contact Jacqueline Coleman by phone at (517) 284-1190, or by e-mail at colemanj@michigan.gov.

Sincerely,

[redacted]

Penny Rutledge, Director
Actuarial Division

cc: Ruth Hughes
Angela Garner

Enclosure (6)

# Michigan Adult Coverage Demonstration
# Section 1115 Quarterly Report

## Demonstration Year: 8 (01/01/2017 – 12/31/2017)
## Federal Fiscal Quarter: 2 (01/01/2017 – 03/31/2017)

*Approval Period: December 30, 2013 through December 31, 2018*

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# Introduction

On April 1, 2014, Michigan expanded its Medicaid program to include adults with income up to 133 percent of the Federal Poverty Level (FPL). To accompany this expansion, the Michigan Adult Benefits Waiver (ABW) was amended and transformed to establish the Healthy Michigan Plan, through which the Michigan Department of Health & Human Services (MDHHS) will test innovative approaches to beneficiary cost sharing and financial responsibility for health care for the new adult eligibility group. Organized service delivery systems will be utilized to improve coherence and overall program efficiency. The overarching themes used in the benefit design are increasing access to quality health care, encouraging the utilization of high-value services, and promoting beneficiary adoption of healthy behaviors and using evidence-based practice initiatives. The Healthy Michigan Plan provides a full health care benefit package as required under the Affordable Care Act including all of the Essential Health Benefits as required by federal law and regulation. The new adult population with incomes above 100 percent of the FPL are required to make contributions toward the cost of their health care. In addition, all newly eligible adults from 0 to 133 percent of the FPL are subject to copayments consistent with federal regulations.

State law requires MDHHS to partner with the Michigan Department of Treasury to garnish state tax returns and lottery winnings for members consistently failing to meet payment obligations associated with the Healthy Michigan Plan. Prior to the initiation of the garnishment process, members are notified in writing of payment obligations and rights to a review. Debts associated with the MI Health Account are not reported to credit reporting agencies. Members non-compliant with cost-sharing requirements do not face loss of eligibility, denial of enrollment in a health plan, or denial of services.

On December 17, 2015, CMS approved the state's request to amend the Healthy Michigan Section 1115 Demonstration to implement requirements of state law (MCL 400.105d (20)). With this approval, non-medically frail individuals above 100 percent of the FPL with 48 cumulative months of Healthy Michigan Plan coverage will have the choice of one of two coverage options:

1. Select a Qualified Health Plan offered on the Federal Marketplace. These individuals will pay premiums but can enroll in the Healthy Michigan Plan when a healthy behavior requirement is met; or

2. Remain in the Healthy Michigan Plan with increased cost-sharing and contribution obligations. These individuals are also required to meet a healthy behavior requirement.

MDHHS's goals in the demonstration are to:

- Improve access to healthcare for uninsured or underinsured low-income Michigan citizens;
- Improve the quality of healthcare services delivered;
- Reduce uncompensated care;
- Encourage individuals to seek preventive care and encourage the adoption of healthy behaviors;
- Help uninsured or underinsured individuals manage their health care issues;
- Encourage quality, continuity, and appropriate medical care; and

- Study the effects of a demonstration model that infuses market-driven principles into a public healthcare insurance program by examining:
    - The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
    - The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
    - Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes; and
    - The extent to which beneficiaries feel that the Healthy Michigan Plan has a positive impact on personal health outcomes and financial well-being.

## Enrollment and Benefits Information

MDHHS began enrolling new beneficiaries into the program beginning April 1, 2014. Beneficiaries who were enrolled in the ABW were automatically transitioned into the Healthy Michigan Plan effective April 1, 2014. Potential enrollees can apply for the program via the MDHHS website, by calling a toll-free number or by visiting their local MDHHS office. At this time, MDHHS does not anticipate any changes in the population served or the benefits offered. The following tables display new enrollment and disenrollment by month:

| Table 1: Healthy Michigan Plan New Enrollments by Month | | | |
|---|---|---|---|
| January 2017 | February 2017 | March 2017 | Total |
| 41,686 | 28,795 | 28,104 | 98,585 |

| Table 2: Healthy Michigan Plan Disenrollments by Month | | | |
|---|---|---|---|
| January 2017 | February 2017 | March 2017 | Total |
| 28,428 | 26,467 | 27,284 | 82,179 |

Most Healthy Michigan Plan beneficiaries choose a health plan as opposed to automatic assignment to a health plan. As of March 15, 2017, 377,586 or, 71 percent, of the State's 527,707 Healthy Michigan Plan health plan enrollees selected a health plan. The remaining managed care enrolled beneficiaries were automatically assigned to a health plan. All Medicaid Health Plan members have an opportunity to change their plan within 90 days of enrollment into the plan. During this quarter, 7,052 of all Healthy Michigan Plan health plan enrollees changed health plans. This quarter, 3,483 or approximately 49 percent, of beneficiaries that changed plans were previously automatically assigned to a health plan. The remaining beneficiaries were those that changed plans after selecting a health plan.

Healthy Michigan Plan members have the opportunity to reduce cost-sharing requirements through the completion of Health Risk Assessments and engaging in healthy behaviors. MDHHS has developed a standard Health Risk Assessment form to be completed annually. Health Risk Assessment forms and reports are located on the MDHHS website. The Health Risk Assessment document is completed in two parts. The member typically completes the first

section of the form with the assistance of the Healthy Michigan Plan enrollment broker. Members that are automatically assigned to a health plan are not surveyed. The remainder of the form is completed at the member's initial primary care visit. Completion of the remaining Health Risk Assessment sections (beyond those completed through the State's enrollment broker) requires beneficiaries to schedule an annual appointment, select a Healthy Behavior, and have member results completed by their primary care provider. The primary care provider securely sends the completed Health Risk Assessment to the appropriate Medicaid Health Plan.

Healthy Michigan Plan members that successfully complete the Health Risk Assessment process and agree to address or maintain healthy behaviors may qualify for reduction in copayments and/or contributions and gift cards. The following opportunities are available to Healthy Michigan Plan beneficiaries:

- Reduction in copayments: A 50 percent reduction in copayments is available to members that have agreed to address or maintain healthy behaviors and have paid 2 percent of their income in copayments.
- Reduction in contributions: A 50 percent reduction in contributions can be earned by members that have agreed to address or maintain healthy behaviors and have completed a Health Risk Assessment with a Primary Care Practitioner attestation.
- Gift card incentives: A $50.00 gift card is available to beneficiaries at or below 100 percent FPL that have agreed to address or maintain healthy behaviors and have completed a Health Risk Assessment with a Primary Care Practitioner attestation.

The initial assessment questions section of the Health Risk Assessments completed through the MDHHS enrollment broker had a completion rate of 93 percent this quarter. MDHHS is encouraged by the high level of participation by beneficiaries at the initial point of contact. The details of Health Risk Assessment completion can be found in the enclosed March 2017 Health Risk Assessment Report. The following table details the Health Risk Assessment data collected by the enrollment broker for the quarter:

**Table 3: Health Risk Assessment Enrollment Broker Data**

| Month | Number of Completed HRAs | Percent of Total | Number of Refused HRAs | Percent of Total | Total Enrollment Calls |
|---|---|---|---|---|---|
| January 2017 | 3,002 | 92% | 259 | 8% | 3,261 |
| February 2017 | 4,296 | 93% | 335 | 7% | 4,631 |
| March 2017 | 5,247 | 92% | 462 | 8% | 5,709 |
| Total | 12,545 | 92% | 1,056 | 8% | 13,601 |

The following table details Health Risk Assessment data collected by the Medicaid Health Plans for the quarter:

**Table 4: Health Risk Assessment Health Plan Data**

| | January 2017 | February 2017 | March 2017 | Total |
|---|---|---|---|---|
| Health Risk Assessments Submitted | 2,042 | 2,583 | 2,958 | 7,583 |
| Gift Cards Earned | 1,680 | 2,067 | 2,388 | 6,135 |
| Reductions Earned | 357 | 510 | 562 | 1,429 |
| Reductions Applied | 746 | 782 | 692 | 2,220 |

## Enrollment Counts for Quarter and Year to Date

Healthy Michigan Plan enrollment in this quarter has remained consistent with previous quarters. In addition to stable Healthy Michigan Plan enrollment, MDHHS saw the typical number of disenrollments from the plan as reported in the Monthly Enrollment Reports to CMS. Healthy Michigan disenrollment reflects individuals who were disenrolled during a redetermination of eligibility or switched coverage due to eligibility for other Medicaid program benefits. In most cases beneficiaries disenrolled from the Healthy Michigan Plan due to eligibility for other Medicaid programs. Movement between Medicaid programs is not uncommon and MDHHS expects that beneficiaries will continue to shift between Healthy Michigan and other Medicaid programs as their eligibility changes. Enrollment counts in the table below are for unique members for identified time periods. The unique enrollee count will differ from the March 2017 count from the Beneficiary Month Reporting section as a result of disenrollment that occurred during the quarter.

**Table 5: Enrollment Counts for Quarter and Year to Date**

| Demonstration Population | Total Number of Demonstration Beneficiaries Quarter Ending – 03/2017 | Current Enrollees (year to date) | Disenrolled in Current Quarter |
|---|---|---|---|
| ABW Childless Adults | N/A | N/A | N/A |
| Healthy Michigan Adults | 682,224 | 682,224 | 82,179 |

## Outreach/Innovation Activities to Assure Access

MDHHS utilizes the Healthy Michigan Program website to provide information to both beneficiaries and providers. The Healthy Michigan Plan website contains information on eligibility, how to apply, services covered, cost sharing requirements, frequently asked questions, Health Risk Assessment completion, and provider information. The site also provides a link for members to make MI Health Account payments. MDHHS also has a mailbox, healthymichiganplan@michigan.gov, for questions or comments about the Healthy Michigan Plan.

MDHHS continues to work closely with provider groups through meetings, Medicaid provider policy bulletins, and various interactions with community partners and provider trade associations. Progress reports are provided by MDHHS to the Medical Care Advisory Council (MCAC) at regularly scheduled quarterly meetings. These meetings provide an opportunity for attendees to provide program comments or suggestions. The February 2017 MCAC meeting occurred during the quarter covered by this report. The minutes for this meeting have been attached as an enclosure. MCAC meeting agendas and minutes are also available on the MDHHS website.

## Collection and Verification of Encounter Data and Enrollment Data

As a mature managed care state, all Medicaid Health Plans submit encounter data to MDHHS for the services provided to Healthy Michigan Plan beneficiaries following the existing MDHHS data submission requirements. MDHHS continues to utilize encounter data to prepare MI Health Account statements with a low volume of adjustments. MDHHS works closely with the plans in reviewing, monitoring and investigating encounter data anomalies. MDHHS and the Medicaid

Health Plans work collaboratively to correct any issues discovered as part of the review process.

## Operational/Policy/Systems/Fiscal Developmental Issues

MDHHS regularly meets with the staff of Medicaid Health Plans to address operational issues, programmatic issues, and policy updates and clarifications. Updates and improvements to the Community Health Automated Medicaid Processing System (CHAMPS), the State's Medicaid Management Information System (MMIS) happen continually, and MDHHS strives to keep the health plans informed and functioning at the highest level. At these meetings, Medicaid policy bulletins and letters that impact the program are discussed, as are other operational issues. Additionally, these operational meetings include a segment of time dedicated to the oversight of the MI Health Account contactor. MDHHS and the health plans receive regular updates regarding MI Health Account activity and functionality. The following policies with Healthy Michigan Plan impact were issued by MDHHS during the quarter covered by this report:

**Table 6: Medicaid Policy Bulletins with Healthy Michigan Plan Impact**

| Issue Date | Subject | Link |
|---|---|---|
| 01/27/2017 | Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Code Updates | MSA 17-01 |
| 02/01/2017 | Healthy Michigan Plan Co-Pay Increases | MSA 17-02 |
| 02/01/2017 | Medicaid Provider Manual Chapter for Non-Emergency Medical Transportation (NEMT) | MSA 17-03 |
| 02/01/2017 | Claims for Non-Enrolled Providers | MSA 17-04 |
| 02/01/2017 | Lead Abatement Services | MSA 17-05 |
| 02/24/2017 | Pharmacy Claim Reimbursement Changes and Coverage of Medication Therapy Management Services | MSA 17-09 |
| 03/01/2017 | Early Refills for Prescription Drugs | MSA 17-06 |
| 03/01/2017 | Enhanced 340B Reporting Requirements | MSA 17-07 |
| 03/01/2017 | Updates to the Medicaid Provider Manual; Clarification to Bulletin MSA 17-05 | MSA 17-08 |
| 03/31/2017 | Coverage of Physician-Administered Injectable Drugs as Pharmacy Claims for Administration in Residential Treatment Centers | MSA 17-12 |
| 03/31/2017 | Clinic Billing Format Change to Institutional; FQHC Certification Update | MSA 17-10 |

## Financial/Budget Neutrality Development Issues

Healthy Michigan Plan expenditures for all plan eligible groups are included in the budget neutrality monitoring table below as reported in the CMS Medicaid and Children's Health Insurance Program Budget and Expenditure System. Expenditures include those that both occurred and were paid in the same quarter in addition to adjustments to expenditures paid in quarters after the quarter of service. The State will continue to update data for each demonstration quarter as it becomes available.

| Table 7: Healthy Michigan Plan Budget Neutrality Monitoring Table | | | | | |
|---|---|---|---|---|---|
| | DY 5 - PMPM | DY 6 - PMPM | DY 7 - PMPM | DY 8 - PMPM | DY 9 - PMPM |
| Approved HMP PMPM | $667.36 | $602.21 | $569.80 | $598.86 | $629.40 |
| Actual HMP PMPM (YTD) | $475.33 | $482.91 | $488.07 | $428.59 | - |
| Total Expenditures (YTD) | $1,775,497,936.00 | $3,510,168,651.00 | $3,783,622,317.00 | $874,405,701.00 | - |
| Total Member Months (YTD) | 3,735,293 | 7,268,850 | 7,752,190 | 2,040,172 | - |

## Beneficiary Month Reporting

The beneficiary counts below include information for each of the designated months during the quarter, and include retroactive eligibility through March 31, 2017.

| Table 8: Healthy Michigan Plan Beneficiary Month Reporting | | | | |
|---|---|---|---|---|
| Eligibility Group | January 2017 | February 2017 | March 2017 | Total for Quarter Ending 03/17 |
| Healthy Michigan Adults | 678,232 | 680,560 | 681,380 | 2,040,172 |

## Consumer Issues

This quarter, the total number of Healthy Michigan Plan complaints reported to MDHHS was 79. Complaints reported to MDHHS are detailed by category in the table below. Overall, with over 2 million member months during the quarter, MDHHS is encouraged by its low rate of contacts related to Healthy Michigan Plan complaints. MDHHS will continue to monitor calls to the Beneficiary Helpline to identify issues and improve member experiences.

| Table 9: Healthy Michigan Plan Complaints Reported to MDHHS<br>January 2017 – March 2017 | | | | |
|---|---|---|---|---|
| | Obtaining Prescriptions | Other Covered Services | Transportation | Total |
| Count | 58 | 11 | 10 | 79 |
| Percent | 73% | 14% | 13% | |

## Quality Assurance/Monitoring Activity

MDHHS completes Performance Monitoring Reports (PMR) specific to the Medicaid Health Plans that are licensed and approved to provide coverage to Michigan's Medicaid beneficiaries. These reports are based on data submitted by the health plans. Information specific to the Healthy Michigan Plan are included in these reports. The measures for the Healthy Michigan Plan population mirrors those used for the traditional Medicaid population. MDHHS continues to collect data and assist health plans with deliverables for the purpose of PMR completion. The most recently published Bureau of Medicaid Program Operations & Quality Assurance quarterly PMR with Healthy Michigan Plan specific measures was published in April 2017 and is included as an enclosure.

## Managed Care Reporting Requirements

MDHHS has established a variety of reporting requirements for the Medicaid Health Plans, many of which are compiled, analyzed and shared with the plans in the PMRs described in the Quality Assurance/Monitoring Activity section of this report. MDHHS and the Medicaid Health Plans continue to monitor MI Health Account call center and payment activity.

The MI Health Account Call Center handles questions regarding the MI Health Account welcome letters and MI Health Account quarterly statements. MDHHS' Beneficiary Help Line number is listed on all MI Health Account letters. Staff are cross trained to provide assistance on a variety of topics. Commonly asked questions by callers contacting the MI Health Account Call Center relate to general MI Health Account information and payment amounts. Members calling regarding the quarterly statements have asked about amounts owed, requested clarification on the contents of the statement, and reported an inability to pay amounts owed.

During this quarter, Healthy Michigan Plan members continued making payments for contributions and copays to the MI Health Account. Detailed MI Health Account activity is included in the attached April 2017 MI Health Account Executive Summary Report. Previous quarterly reports contained tables from the MI Health Account Executive Summary report formatted to reflect information specific to the quarter and information not available in previous quarterly reports. These tables have been removed from this quarterly report because the April 2017 MI Health Account Executive Summary Report aligns with previously unavailable information and information available for this quarter.

MDHHS has refined the Managed Care Organization grievance and appeal reporting process to collect Healthy Michigan Plan specific data. Grievances are defined in the MDHHS Medicaid Health Plan Grievance/Appeal Summary Reports as an expression of dissatisfaction about any matter other than an action subject to appeal. Appeals are defined as a request for review of the Health Plan's decision that results in any of the following actions:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of a payment for a properly authorized and covered service;
- The failure to provide services in a timely manner, as defined by the State; or
- The failure of the Health Plan to act within the established timeframes for grievance and appeal disposition.

From January 2017 to March 2017, there were 174 total appeals among all the Medicaid Health Plans. Medicaid Health Plan decisions were upheld in 46 percent of the appeals. From January 2017 to March 2017 there were a total of 831 grievances. The greatest number of grievances came from the Access category. Access grievances can include a primary care physician not accepting new patients, limited specialist availability, the refusal of a primary care physician to complete a referral or write a prescription, a lack of services provided by the primary care physician, long wait times for appointments and denied services. Transportation grievances relate to issues with the transportation benefit and often mirror the complaints members directly reported to MDHHS. Grievances related to quality of care pertain to the level of care issues experienced by beneficiaries. Administrative/Service grievances can range from issues with

claims, enrollment, eligibility, out-of-network providers and benefits not covered. Issues reported under the Billing category pertain to billing issues. MDHHS will continue to monitor the Medicaid Health Plans Grievance/Appeal Summary Reports to ensure levels of grievances remain low and resolution of grievances is completed in a timely manner. MDHHS has included grievance and appeals data reported by the Medicaid Health Plans from this quarter in the following tables:

| Table 10: Managed Care Organization Appeals<br>January 2017 – March 2017 | | | | |
|---|---|---|---|---|
| | Decision Upheld | Overturned | Undetermined/ Withdrawn | Total |
| Count | 80 | 78 | 16 | 174 |
| Percent | 46% | 45% | 9% | |

| Table 11: Managed Care Organization Grievances<br>January 2017 – March 2017 | | | | | | |
|---|---|---|---|---|---|---|
| | Access | Transportation | Administrative/ Service | Billing | Quality of Care | Total |
| Count | 285 | 240 | 178 | 81 | 47 | 831 |
| Percent | 34% | 29% | 21% | 10% | 6% | |

## Lessons Learned

MDHHS continues to learn from the experience of launching a program the size and scope of the Healthy Michigan Plan. This quarter, the University of Michigan issued several news articles and publications regarding their Healthy Michigan Plan findings. According to a University of Michigan study, the implementation of the Healthy Michigan Plan has made a positive impact on the State's economy and budget. Michigan's Medicaid expansion has benefited the state's population beyond those enrolled in the program through the creation of jobs and associated personal spending.[1] The University of Michigan has also published findings of substantial decreases in uncompensated care in Michigan after the implementation of the Healthy Michigan Plan. The full 2015 Report on Uncompensated Care and Insurance Rates with these findings has been included as an enclosure.

## Demonstration Evaluation

MDHHS has commissioned the University of Michigan's Institute for Healthcare Policy and Innovation (IHPI) to serve as the Healthy Michigan Plan independent evaluator. The IHPI has developed a comprehensive plan to address the needs of the State and CMS. Demonstration evaluation activities for the Healthy Michigan Plan are utilizing an interdisciplinary team of researchers from the IHPI. The activities of the evaluation will carry in seven domains over the course of the five year evaluation period:

[1] John Z. Ayanian, M.D., M.P.P., Gabriel M. Ehrlich, Ph.D., Donald R. Grimes, M.A., and Helen Levy, Ph.D. N Engl J Med 2017; 376:407-410 | February 2, 2017 | DOI: 10.1056/NEJMp1613981

I. An analysis of the impact the Healthy Michigan Plan on uncompensated care costs borne by Michigan hospitals;

II. An analysis of the effect of Healthy Michigan Plan on the number of uninsured in Michigan;

III. The impact of Healthy Michigan Plan on increasing healthy behaviors and improving health outcomes;

IV. The viewpoints of beneficiaries and providers of the impact of Healthy Michigan Plan;

V. The impact of Healthy Michigan Plan's contribution requirements on beneficiary utilization;

VI. The impact of the MI Health Accounts on beneficiary healthcare utilization, and;

VII. The cost effectiveness of the Healthy Michigan Marketplace Option.

Below is a summary of the key activities for the Fiscal Year (FY) 2017 second quarterly report:

**Domain I**
Domain I will examine the impact of reducing the number of uninsured individuals on uncompensated care costs of Michigan hospitals. Although the Interim Report for Domain I isn't due until FY 2018, IHPI has engaged in activities to find and compare baseline uncompensated care results from hospital cost reports and IRS filings to understand the distribution of uncompensated care in Michigan. This quarter, IHPI discovered a number of issues during its preliminary analysis of the Medicare cost data. As a result, IHPI is in the process of further examining and cleaning the data. Additionally, IHPI analyzed updates to baseline data from Michigan and other states to identify appropriate comparison groups for the cross-state components of the analysis. IHPI is investigating alternative approaches to identifying hospitals that prior to the passage of the Affordable Care Act had been providing a disproportionate share of uncompensated care. Once a strong set of criteria has been identified, IHPI will examine the extent to which the effect of the Affordable Care Act differed between these hospitals and others that provided less uncompensated care at baseline.

**Domain II**
Domain II will examine the hypothesis that, when affordable health insurance is available and the applicable for insurance is simplified, the uninsured population will decrease significantly. Similar to Domain I, the Interim Report for Domain II is not due until FY 2018. This quarter, IHPI Analyzed updated data to determine which states offer the most relevant comparison to Michigan's experience and to identify appropriate comparison groups for the cross-state components of the analysis. Also, IHPI continues to track the growing academic literature on the effects of the Affordable Care Act on health insurance status.

**Domain III**
Domain III will assess health behaviors, utilization and health outcomes for individuals enrolled in the Healthy Michigan Plan. This quarter, IHPI began processing measures for the Healthy Michigan Plan beneficiaries with initial Healthy Michigan Plan enrollment during April 1, 2014 – September 30, 2014. This includes processing of utilization measures related to their second year enrollment. This activity will continue in the next quarter.

**Domain IV**
Domain IV will examine beneficiary and provider viewpoints of the Healthy Michigan Plan through surveys. IHPI continued to analyze 2016 Healthy Michigan Voices survey of current enrollees. A report with subgroup analyses, analyses of relationships and multivariate analyses was submitted to MDHHS for review in February 2017. Additionally, in March 2017, data collection was completed of those beneficiaries from the 2016 Healthy Michigan Voices Survey who have been disenrolled. IHPI began reviewing the raw data for accuracy and initial coding of open-ended items. Lastly, the 2017 Healthy Michigan Voices Survey is in the field and a majority of data collection has been completed.

**Domains V/VI**
Domains V and VI entail analyzing data to assess the impact of contributions and the MI Health Account statements on beneficiary utilization of health care services, respectively. This quarter, IHPI completed analysis of MDHHS administrative data, including impact on cost-sharing requirements and the Healthy Michigan Voices survey data related specifically to Domain V/VI. Analyzing test samples from the claims data to assess its usefulness for their analyses continued. IHPI continued to work with Domain VI to plan analyses of survey data relevant to cost-sharing.

**Domain VII**
Domain VII will evaluate the cost effectiveness of the Healthy Michigan Marketplace Option. The Marketplace Option will not be implemented until April 2018. IHPI worked on the modifications to the proposed evaluation plan based on CMS feedback. Additionally, IHPI began preparations for the Secret Shopper Study and analyses of quality measures by examining trends in data. IHPI has been meeting with MDHHS staff regarding the implementation of the Marketplace Option and cost data that can be utilized for the purposes of this analysis.

## Enclosures/Attachments

1. March 2017 Health Risk Assessment Report
2. February 2017 MCAC Minutes
3. April 2017 Performance Monitoring Report
4. April 2017 MI Health Account Executive Summary
5. 2015 Report on Uncompensated Care and Insurance Rates

## State Contacts

If there are any questions about the contents of this report, please contact one of the following people listed below.

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## Date Submitted to CMS

June 19, 2017

Michigan Department of Health and Human Services

Medical Services Administration

Bureau of Medicaid Care Management and Quality Assurance

# *Healthy Michigan Plan - Health Risk Assessment Report*

March 2017

Produced by:

Quality Improvement and Program Development - Managed Care Plan Divison

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## Health Risk Assessment Part 1



## Health Risk Assessment Part 2

## Introduction

Pursuant to PA 107 of 2013, sections 105d(1)e and 105d(12), a Health Risk Assessment has been developed for the Healthy Michigan Plan (form DCH-1315). It is designed as a two part document, where the beneficiary completes the first three sections and the primary care provider completes the last section. It includes questions on a wide range of health issues, a readiness to change assessment, an annual physical exam and a discussion about behavior change with their primary care provider. The topics in the assessment cover all of the behaviors identified in PA 107 including alcohol use, substance use disorders, tobacco use, obesity and immunizations. It also includes the recommended healthy behaviors identified in the Michigan Health and Wellness 4X4 Plan, which are annual physicals, BMI, blood pressure, cholesterol and blood sugar monitoring, healthy diet, regular physical exercise and tobacco use.

# Health Risk Assessment Part 1

Health Risk Assessments completion through Michigan ENROLLS

In February 2014, the enrollment broker for the Michigan Department of Health and Human Services (Michigan ENROLLS) began administering the first section of the Health Risk Assessment to Healthy Michigan Plan beneficiaries who call to enroll in a health plan. In addition to asking new beneficiaries all of the questions in Section 1 of the Health Risk Assessment, call center staff inform beneficiaries that an annual preventive visit, including completion of the last three sections of the Health Risk Assessment, is a covered benefit of the Healthy Michigan Plan.

Completion of the Health Risk Assessment is voluntary; callers may refuse to answer some or all of the questions. Beneficiaries who are auto-assigned into a health plan are not surveyed. Survey results from Michigan ENROLLS are electronically transmitted to the appropriate health plan on a monthly basis to assist with outreach and care management.

The data displayed in Part 1 of this report reflect the responses to questions 1-9 of Section 1 of the Health Risk Assessment completed through Michigan ENROLLS. As shown in Table I, a total of 314,291 Health Risk Assessments were completed through Michigan ENROLLS as of March 2017. This represents a completion rate of 95.46%. Responses are reported in Tables 1 through 9. Beneficiaries who participated in the Health Risk Assessment but refused to answer specific questions are included in the total population and their answers are reported as “Refused”. Responses are also reported by age and gender.

# Health Risk Assessment Completion through Michigan ENROLLS

**Table I. Count of Health Risk Assessments (HRA) Questions 1-9 Completed with MI Enrolls**

| MONTH | COMPLETE | DECLINED |
|---|---|---|
| April 2016 | 279,562 | 12,476 (4.27%) |
| May 2016 | 282,318 | 12,620 (4.28%) |
| June 2016 | 284,785 | 12,745 (4.28%) |
| July 2016 | 287,641 | 12,896 (4.29%) |
| August 2016 | 289,929 | 13,019 (4.30%) |
| September 2016 | 292,862 | 13,187 (4.31%) |
| October 2016 | 295,511 | 13,314 (4.31%) |
| November 2016 | 298,264 | 13,575 (4.35%) |
| December 2016 | 301,746 | 13,879 (4.40%) |
| January 2017 | 304,748 | 14,138 (4.43%) |
| February 2017 | 309,044 | 14,473 (4.47%) |
| March 2017 | 314,291 | 14,935 (4.54%) |

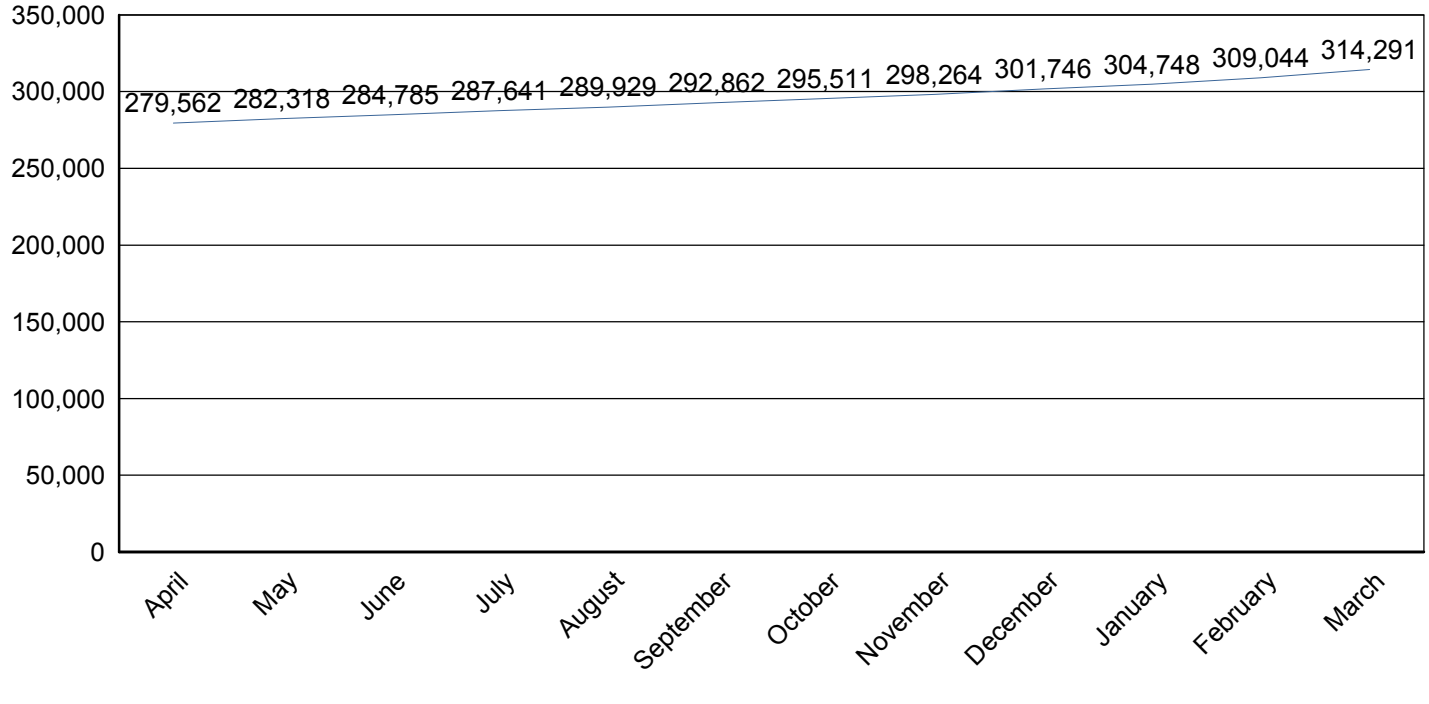
**Table 11. Demographics of Population that Completed HRA Questions 1-9 with MI ENROLLS**

**January 2014 - March 2017**

| AGE GROUP | COMPLETED HRA | |
|---|---|---|
| 19 - 29 | 73,801 | 23.48% |
| 30 - 39 | 67,276 | 21.41% |
| 40 - 49 | 63,708 | 20.27% |
| 50 - 59 | 75,975 | 24.17% |
| 60 + | 33,531 | 10.67% |
| **GENDER** | | |
| F | 169,060 | 53.79% |
| M | 145,231 | 46.21% |
| **FPL** | | |
| < 100% FPL | 260,926 | 83.02% |
| 100 - 133% FPL | 53,365 | 16.98% |
| **TOTAL** | **314,291** | **100.00%** |

**Figure I-1. Health Risk Assessments Completed with MI ENROLLS**

**March 2017**



# Question 1. General Health Rating

Question 1. In general, how would you rate your health? This question is used to assess self-reported health status. Healthy Michigan Plan enrollees were given the answer options of excellent, very good, good, fair or poor. Table 1 shows the overall answers to this question for March 2017. Among enrollees who completed the survey, this question had a 0.17% refusal rate. Figures 1-1 through 1-3 show the health rating reported for the total population, and by age and gender.

**Table 1. Health Rating for Total Population**

**March 2017**

| HEALTH RATING | TOTAL | PERCENT |
|---|---|---|
| Excellent | 35,783 | 11.39% |
| Very Good | 81,596 | 25.96% |
| Good | 112,374 | 35.76% |
| Fair | 63,446 | 20.19% |
| Poor | 20,573 | 6.55% |
| Refused | 519 | 0.17% |
| **TOTAL** | **314,291** | **100.00%** |

**Figure 1-1. Health Rating for Total Population**

**March 2017**

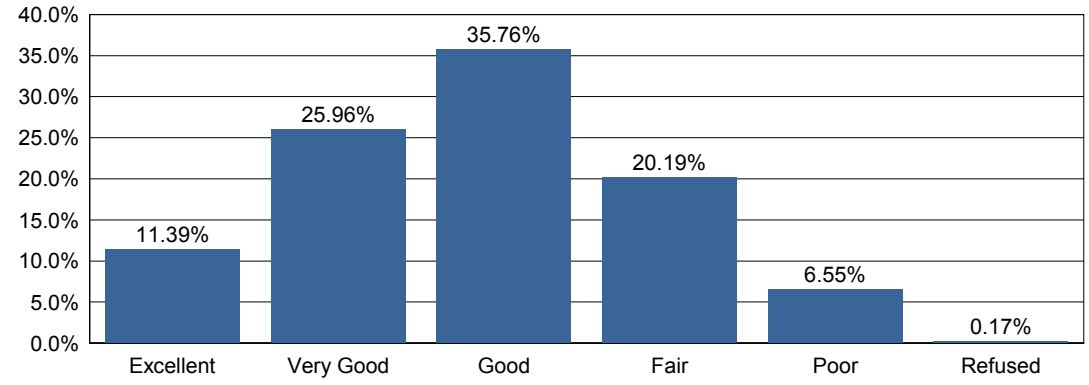



**Figure 1-2. Health Rating by Age**

**March 2017**

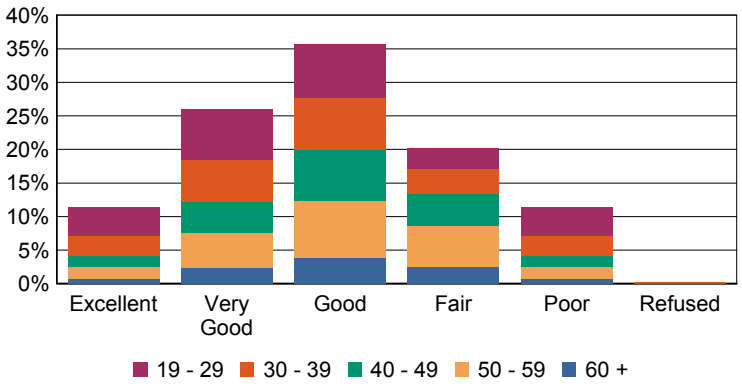
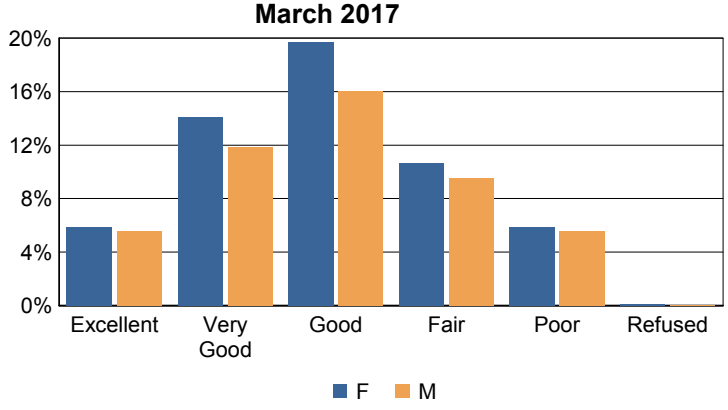



**Figure 1-3. Health Rating by Gender**

**March 2017**



# Question 2. Exercise

Question 2. In the last 7 days, how often did you exercise for at least 20 minutes a day? This question is used to assess selfreported exercise frequency as an important component of maintaining a healthy weight. Healthy Michigan Plan enrollees were given the answer options of every day, 3-6 days, 1-2 days or 0 days. Table 2 shows the overall answers to this question for March 2017. Among enrollees who participated in the survey, there was a 1.51% refusal rate for this question. Figures 2-1 through 2-3 show the exercise frequency reported for the total population, by age and gender.

**Table 2. Exercise Reported for Total Population**

**March 2017**

| EXERCISE | TOTAL | PERCENT |
|---|---|---|
| Every Day | 71,915 | 22.88% |
| 3-6 Days | 91,940 | 29.25% |
| 1-2 Days | 77,627 | 24.70% |
| No Days | 68,078 | 21.66% |
| Refused | 4,731 | 1.51% |
| **TOTAL** | **314,291** | **100.00%** |

**Figure 2-1. Exercise Reported for Total Population**

**March 2017**

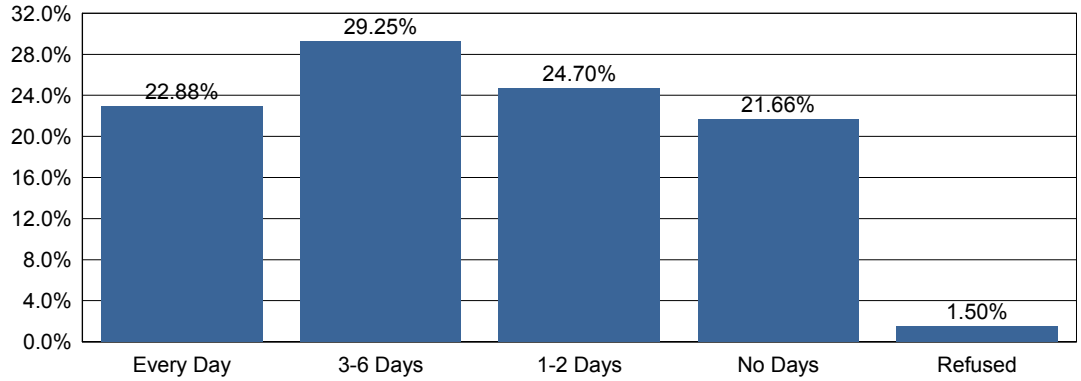



**Figure 2-2. Exercise Reported by Age**

**March 2017**

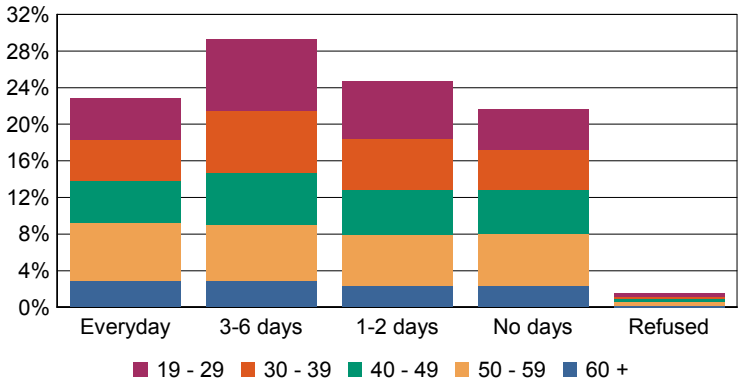
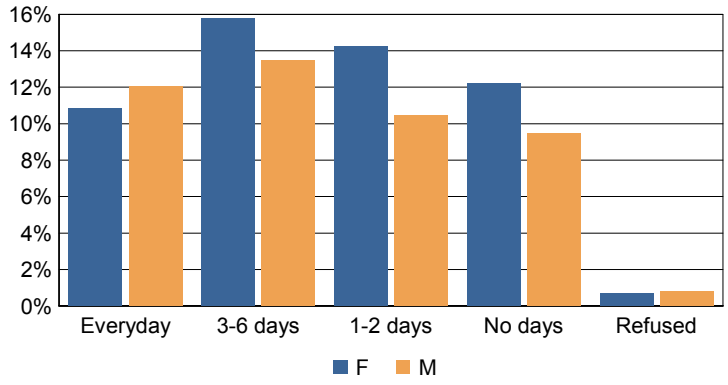



**Figure 2-3. Exercise by Gender**

**March 2017**



# Question 3. Nutrition (Fruits and Vegetables)

Question 3. In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day? This question is used to assess self-reported nutrition as an important component of maintaining a healthy weight. Healthy Michigan Plan enrollees were given the answer options of every day, 3-6 days, 1-2 days or 0 days. Table 3 shows the overall answers to this question for March 2017. Among enrollees who participated in the survey, there was a 1.86% refusal rate for this question. Figures 3-1 through 3-3 show the nutrition reported for the total population, and by age and gender.

**Table 3. Nutrition Reported for Total Population**

**March 2017**

| NUTRITION | TOTAL | PERCENT |
|---|---|---|
| Every Day | 106,367 | 33.84% |
| 3-6 Days | 109,111 | 34.72% |
| 1-2 Days | 71,625 | 22.79% |
| No Days | 21,358 | 6.80% |
| Refused | 5,830 | 1.86% |
| **TOTAL** | **314,291** | **100.00%** |

**Figure 3-1. Nutrition Reported for Total Population**
**March 2017**

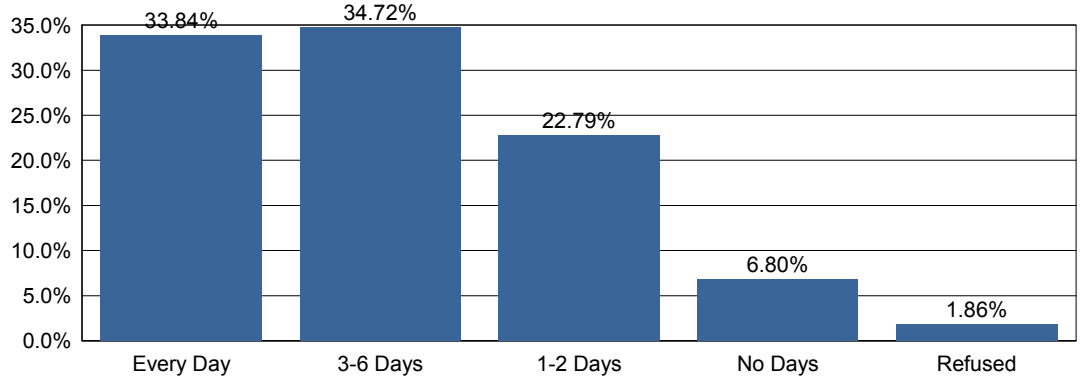



**Figure 3-2. Nutrition Reported by Age**
**March 2017**

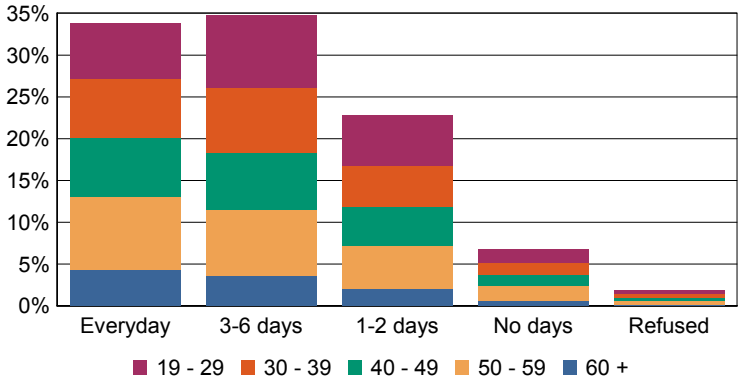
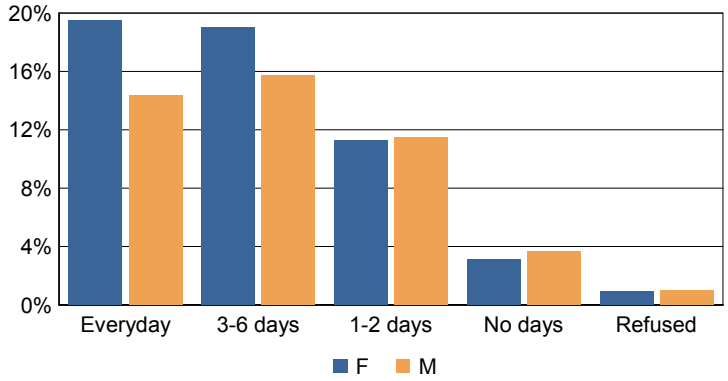



**Figure 3-3. Nutrition by Gender**
**March 2017**



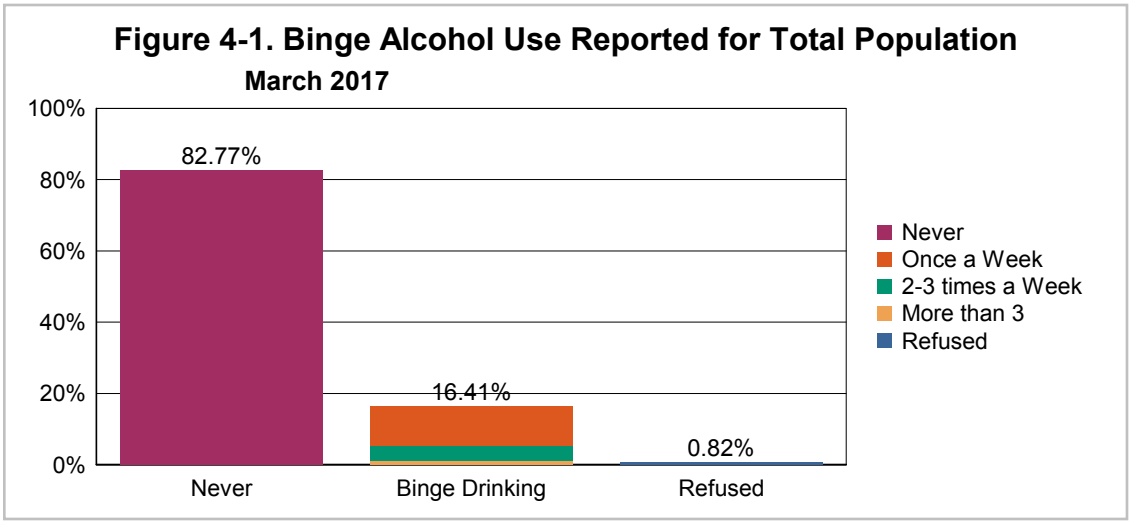
# Question 4. Binge Alcohol Use

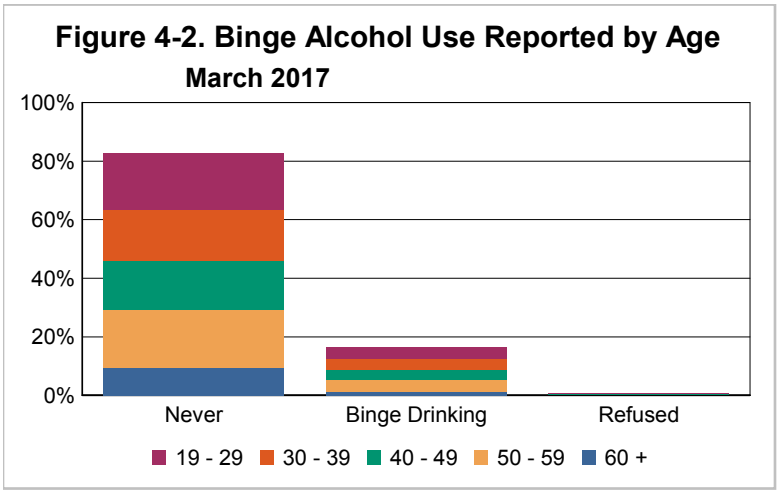
Question 4. In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time?
This question is used to assess self-reported binge alcohol use. Healthy Michigan Plan enrollees were given the answer options of never, once a week, 2-3 a week and more than 3 times during the week. Table 4 shows the combined overall answers to these questions for March 2017. Among enrollees who participated in the survey, there was a 0.82% refusal rate for this question. Figures 4-1 through 4-3 show binge alcohol use status reported for the total population, and by age and gender.

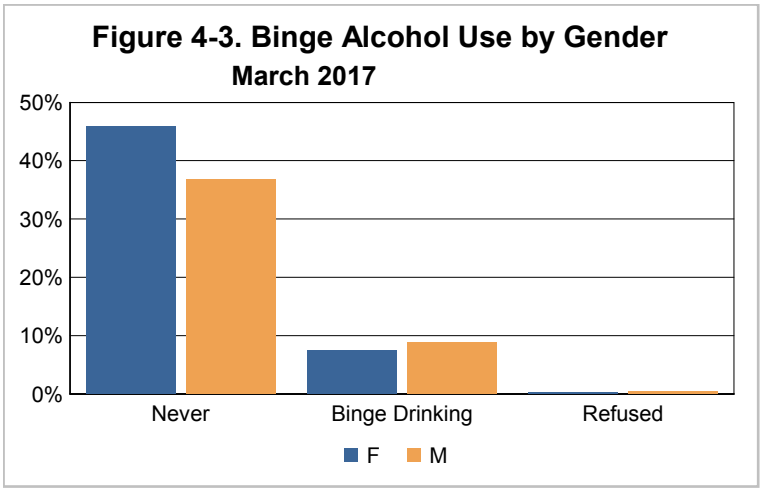
**Table 4. Binge Alcohol Use Reported for Total Population**

**March 2017**

| ALCOHOL | TOTAL | PERCENT |
|---|---|---|
| Never | 260,125 | 82.77% |
| Once a Week | 34,932 | 11.12% |
| 2-3 times a Week | 13,486 | 4.29% |
| More than 3 | 3,173 | 1.01% |
| Refused | 2,575 | 0.82% |
| **TOTAL** | **314,291** | **100.00%** |



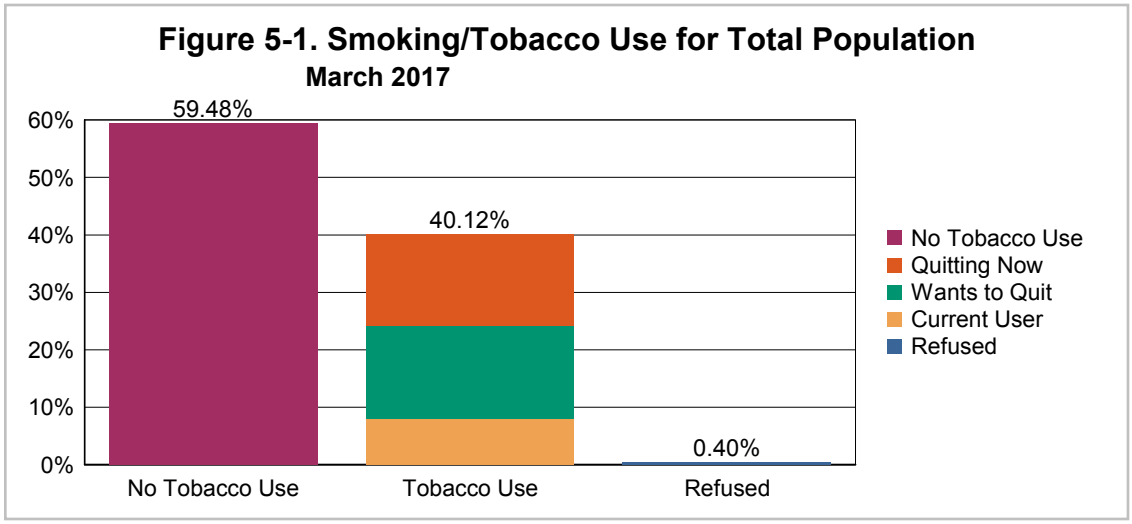
# Question 5. Smoking/Tobacco Use

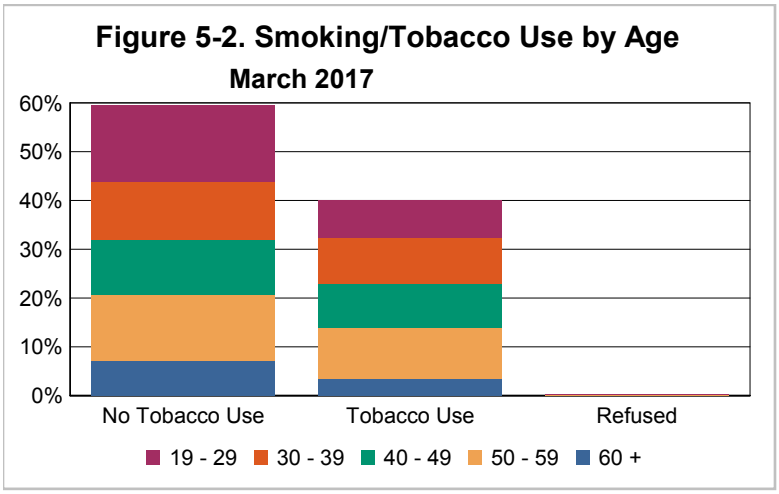
Question 5. In the last 30 days, have you smoked or used tobacco? This question is used to assess self-reported smoking/tobacco use. Healthy Michigan Plan enrollees were given the answer options of yes or no. Enrollees who answered yes, were asked a follow-up question: If YES, do you want to quit smoking or using tobacco? For this follow-up question, enrollees were given the answer options of yes, I am working on quitting or cutting back right now and no. Table 5 shows the combined overall answers to these questions for March 2017. Question 5 had a 0.40% refusal rate. Figures 5-1 through 5-3 show smoking/tobacco use reported for the total population, and by age and gender.

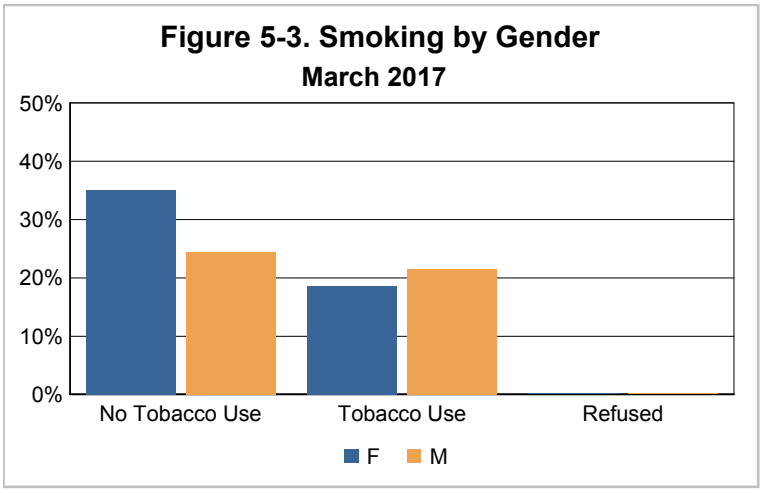
**Table 5. Smoking/Tobacco Use Reported for Total Population**

**March 2017**

| TOBACCO USE | TOTAL | PERCENT |
|---|---|---|
| No Tobacco Use | 186,946 | 59.48% |
| Quitting Now | 49,979 | 15.90% |
| Wants to Quit | 50,797 | 16.16% |
| Current User | 25,309 | 8.05% |
| Refused | 1,260 | 0.40% |
| **TOTAL** | **314,291** | **100.00%** |



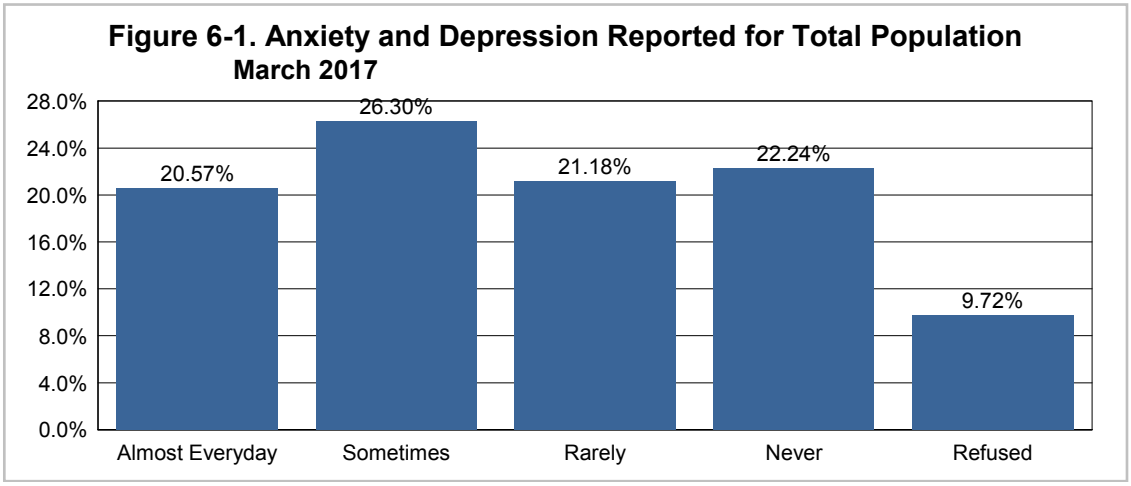
# Question 6. Anxiety and Depression

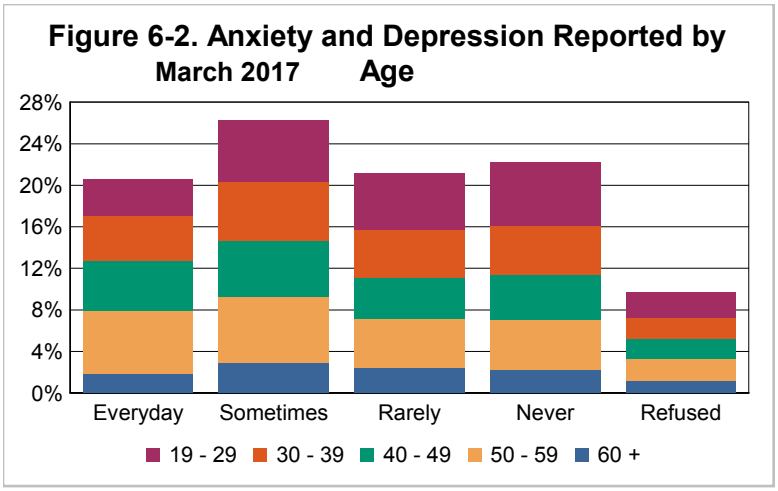
Question 6. In the last 30 days, how often have you felt tense, anxious or depressed? This question is used to assess selfreported mental health status. Healthy Michigan Plan enrollees were given the answer options of almost every day, sometimes, rarely and never. Table 6 shows the overall answers to this question for March 2017. Among enrollees who participated in the survey, there was a 9.72% refusal rate for this question. Figures 6-1 through 6-3 show anxiety and depression reported for the total population, and by age and gender.

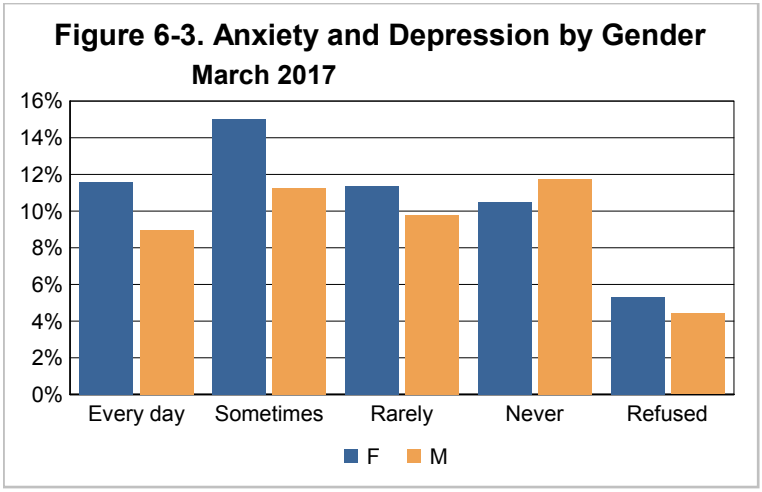
**Table 6. Anxiety and Depression Reported for Total Population**

**March 2017**

| DEPRESSION | TOTAL | PERCENT |
|---|---|---|
| Almost Every day | 64,634 | 20.57% |
| Sometimes | 82,651 | 26.30% |
| Rarely | 66,550 | 21.18% |
| Never | 69,893 | 22.24% |
| Refused | 30,563 | 9.72% |
| **TOTAL** | **314,291** | **100.00%** |



# Question 7. Drugs and Substance Use

Question 7. Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax? This question is used to assess self-reported substance use. Healthy Michigan Plan enrollees were given the answer options of almost every day, sometimes, rarely and never. Table 7 shows the overall answers to this question for March 2017. Among enrollees who participated in the survey, there was a 0.76% refusal rate for this question. Figures 7-1 through 7-3 show substance use reported for the total population, and by age and gender.

**Table 7. Substance Use Reported for Total Population**

**March 2017**

| SUBSTANCE USE | TOTAL | PERCENT |
|---|---|---|
| Almost Every Day | 6,060 | 1.93% |
| Sometimes | 8,136 | 2.59% |
| Rarely | 7,447 | 2.37% |
| Never | 290,269 | 92.36% |
| Refused | 2,379 | 0.76% |
| **TOTAL** | **314,291** | **100.00%** |

**Figure 7-1. Substance Use Reported for Total Population**

**March 2017**

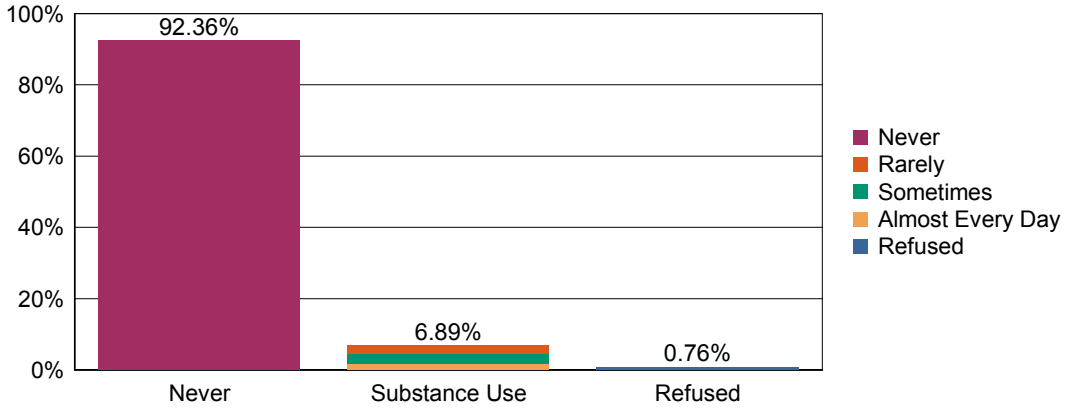



**Figure 7-2. Substance Use Reported by Age**

**March 2017**

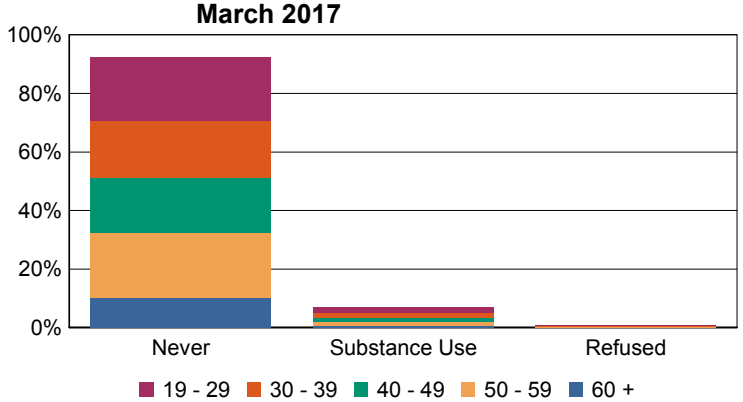
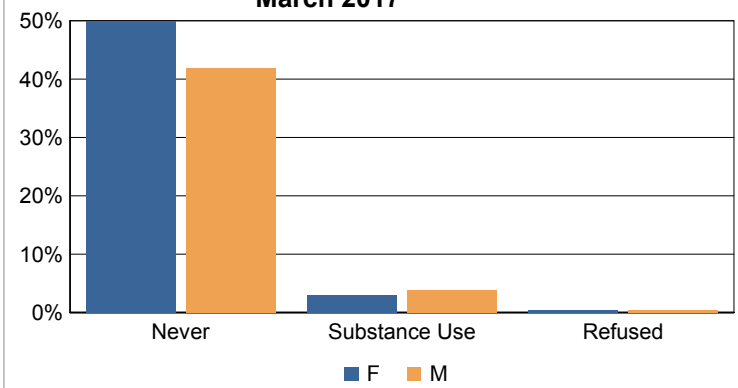



**Figure 7-3. Substance Use by Gender**

**March 2017**



# Question 8. Immunization Status (Annual Flu Vaccine)

Question 8. The flu vaccine can be a shot in the arm or a spray in the nose. Have you had a flu shot or flu spray in the last year? This question is used to assess self-reported annual flu vaccine as an indicator of immunization status. Healthy Michigan Plan enrollees were given the answer options of yes or no. Table 8 shows the overall answers to this question for March 2017. Among enrollees who participated in the survey, there was a 1.85% refusal rate for this question. Figures 8-1 through 8-3 show immunization status reported for the total population, and by age and gender.

**Table 8. Immunization Status Reported for Total Population**

**March 2017**

| IMMUNIZATION | TOTAL | PERCENT |
|---|---|---|
| Yes | 70,175 | 22.33% |
| No | 238,316 | 75.83% |
| Refused | 5,800 | 1.85% |
| **TOTAL** | **314,291** | **100.00%** |

**Figure 8-1. Immunization Status Reported for Total Population**

**March 2017**

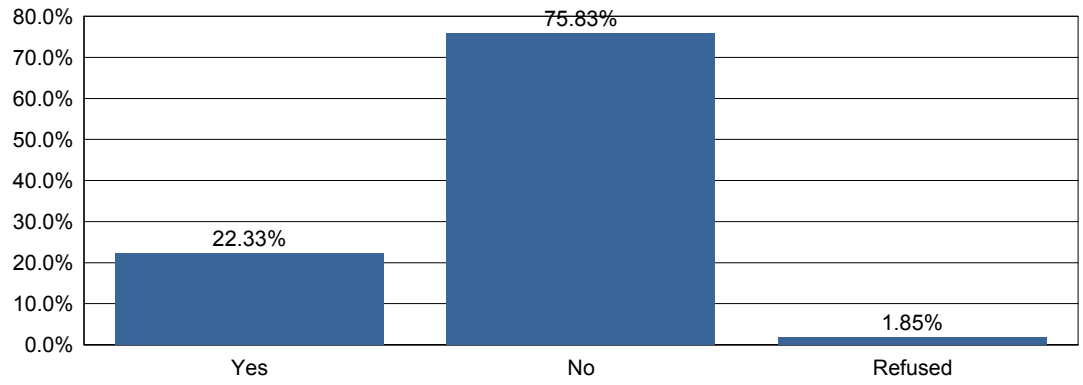



**Figure 8-2. Immunization Status Reported by Age**

**March 2017**

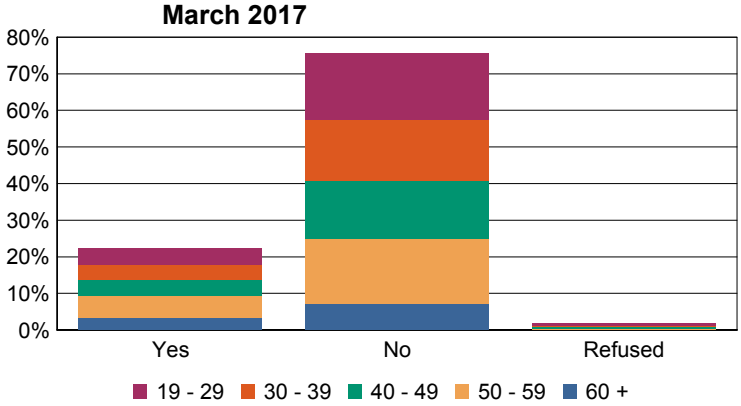
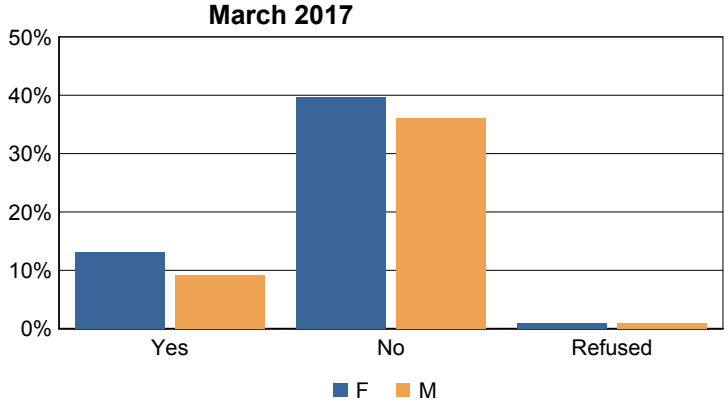



**Figure 8-3. Immunization Status by Gender**

**March 2017**



# Question 9. Well Check Visit

Question 9. A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last check-up? This question is used to assess self-reported well check visit. Healthy Michigan Plan enrollees were given the answer options of within the last year, between 1-3 years and more than 3 years. Table 9 shows the overall answers to this question for March 2017. Among enrollees who participated in the survey, there was a 3.12% refusal rate for this question. Figures 9-1 through 9-3 show well check visit reported for the total population, and by age and gender.

**Table 9. Well Check Visit Reported for Total Population**

**March 2017**

| CHECK-UP | TOTAL | PERCENT |
|---|---|---|
| Within the last year | 162,630 | 51.75% |
| Between 1 & 3 years | 78,055 | 24.84% |
| More than 3 years | 63,799 | 20.30% |
| Refused | 9,807 | 3.12% |
| **TOTAL** | **314,291** | **100.00%** |

**Figure 9-1. Well Check Visit Reported for Total Population**

**March 2017**

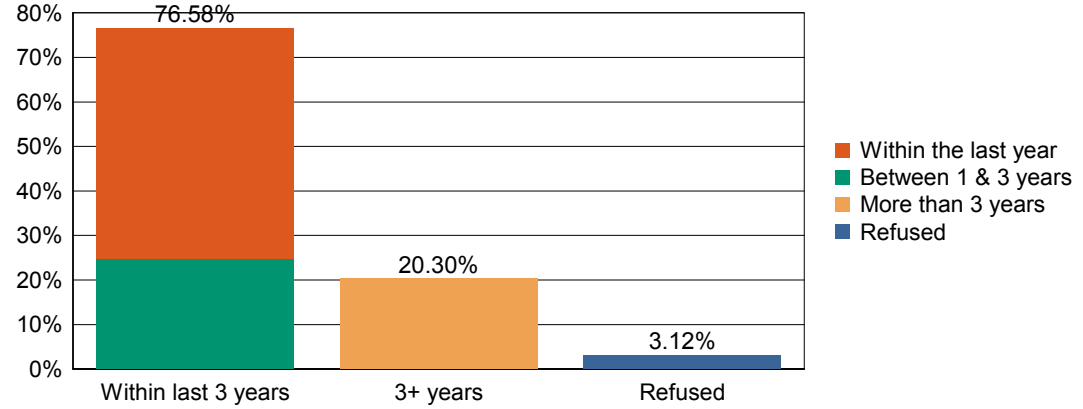



**Figure 9-2. Well Check Visit Reported by Age**

**March 2017**

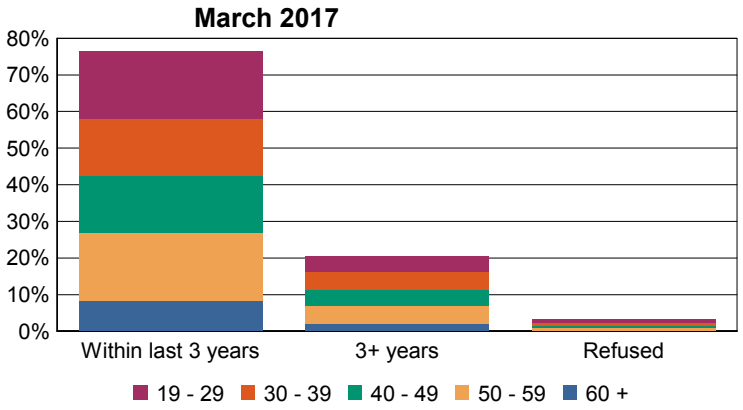
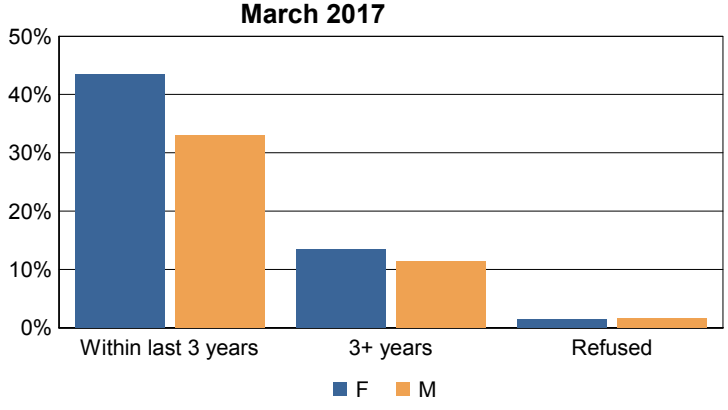



**Figure 9-3. Well Check Visit by Gender**

**March 2017**



# Health Risk Assessment Part 2

Health Risk Assessments completion with Primary Care Provider

In April 2014, the Healthy Michigan Plan was launched, and an initial preventive health visit to a primary care provider was promoted for all new beneficiaries. Beneficiaries were also encouraged to complete the last section of the Health Risk Assessment at this initial appointment. This final section of the Health Risk Assessment is completed jointly by beneficiaries and their primary care provider. It is designed as a tool for identifying annual health behavior goals.

Completion of this section of the Health Risk Assessment is also voluntary. Healthy Michigan Plan Beneficiaries who complete a Health Risk Assessment with a primary care provider attestation and agree to maintain or address healthy behaviors are eligible for an incentive. Of the 806,727 beneficiaries who have been enrolled in a health plan for at least six months, 143,498 or 17.8% have completed the Health Risk Assessment with their primary care provider as of March 2017.

The data displayed in Part 2 of this report reflect the healthy behavior goals selected jointly by Healthy Michigan Plan beneficiaries and their primary care provider in the final section of the Health Risk Assessment. As shown in Table 10, a total of 177,091 Health Risk Assessments were completed with primary care providers as of March 2017. Health Risk Assessment completion is reported by age, gender and Federal Poverty Level in Table 11.

Among beneficiaries who completed the Health Risk Assessment, 151,896 or 85.8% of beneficiaries agreed to address health risk behaviors. In addition, 23,680 or 13.4% of beneficiaries who completed the Health Risk Assessment chose to maintain current healthy behaviors, meaning that 99.1% of beneficiaries are choosing to address or maintain healthy behaviors. The healthy behaviors goal statements selected are reported in Table 12. Healthy behavior goal statements are also reported by age and gender in Figures 10-3 and 10-4.

Of the 151,896 beneficiaries who agreed to address health risk behaviors, 60.2% chose to address more than one healthy behavior. Tables 13 and 14 report the most frequently selected health risk behaviors to address, alone and in combination. Figure 10-5 is a Venn diagram representing the overlapping nature of the multiple healthy behaviors selected.

# Health Risk Assessment Completion with Primary Care Provider

**Table 10. Count of Health Risk Assessments (HRA) Completed with Primary Care Provider by Attestation**

| MONTH | COMPLETE | TOTAL |
|---|---|---|
| April 2016 | 5,759 | 128,574 |
| May 2016 | 5,521 | 134,113 |
| June 2016 | 5,280 | 139,420 |
| July 2016 | 4,479 | 143,963 |
| August 2016 | 5,473 | 149,491 |
| September 2016 | 4,677 | 154,197 |
| October 2016 | 4,802 | 159,026 |
| November 2016 | 4,805 | 163,860 |
| December 2016 | 4,022 | 167,903 |
| January 2017* | 4,039 | 171,991 |
| February 2017* | 3,985 | 176,071 |
| March 2017* | 1,019 | 177,091 |

*Many HRAs completed for this month have not yet been submitted.

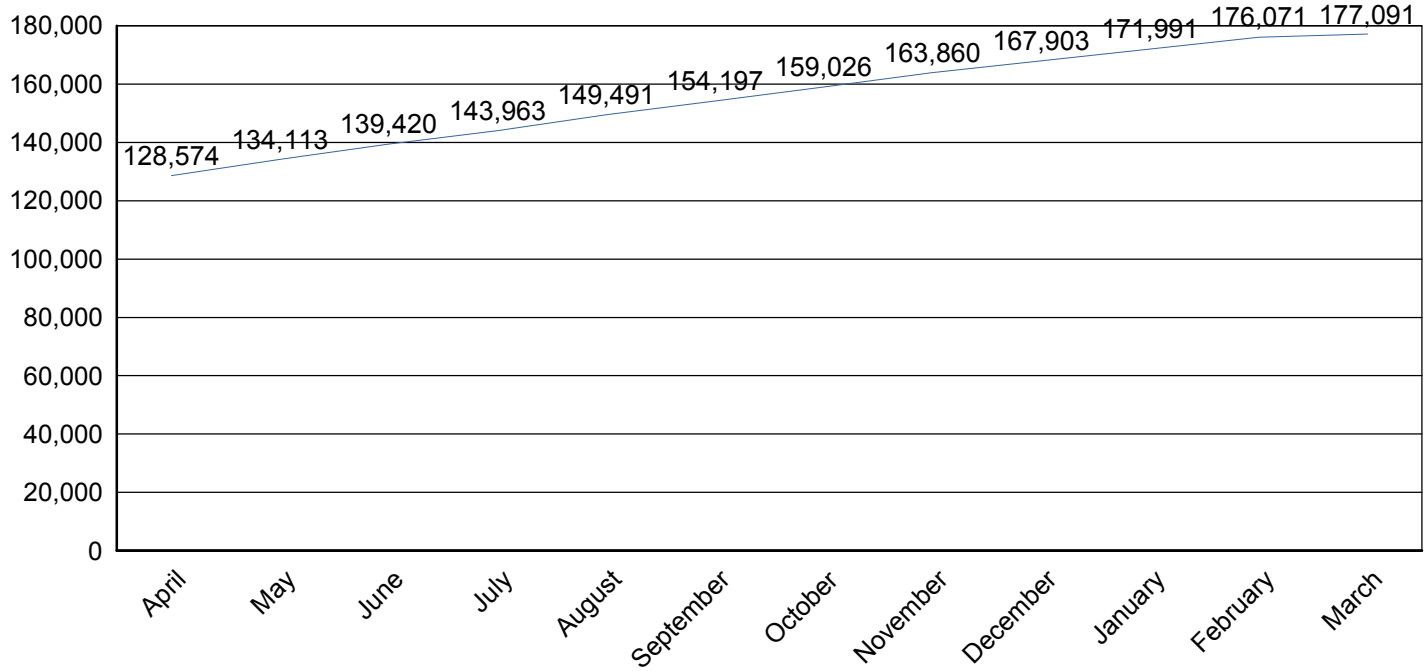
**Table 11. Demographics of Population that Completed HRA with Primary Care Provider**

**September 2014 - March 2017**

| AGE GROUP | COMPLETED HRA | |
|---|---|---|
| 19 - 29 | 35,624 | 20.12% |
| 30 - 39 | 31,240 | 17.64% |
| 40 - 49 | 34,104 | 19.26% |
| 50 - 59 | 50,628 | 28.59% |
| 60 + | 25,495 | 14.40% |
| **GENDER** | | |
| F | 101,670 | 57.41% |
| M | 75,421 | 42.59% |
| **FPL** | | |
| < 100% FPL | 144,994 | 81.88% |
| 100 - 133% FPL | 32,097 | 18.13% |
| **TOTAL** | **177,091** | **100.00%** |

**Figure 10-1. Health Risk Assessments Completed with Primary Care Provider**

**March 2017**



# Healthy Behaviors Statement Selection

Section 4. Healthy Behaviors: In discussion with the beneficiary, primary care providers choose between 4 statements to attest to the healthy behaviors goals that the beneficiary will strive for this year. The 4 statements are:

A. Patient does not have health risk behaviors that need to be addressed at this times

B. Patient has identified at least one behavior to address over the next year to improve their health

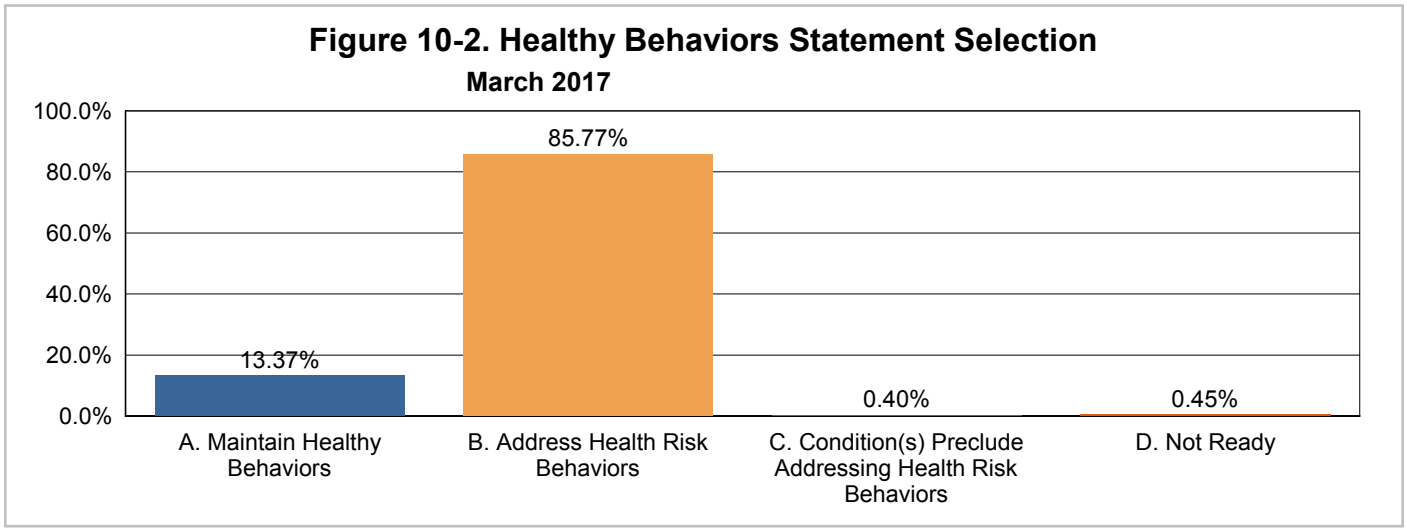
C. Patient has a serious medical, behavioral or social condition or conditions which precludes addressing unhealthy behaviors at this time.

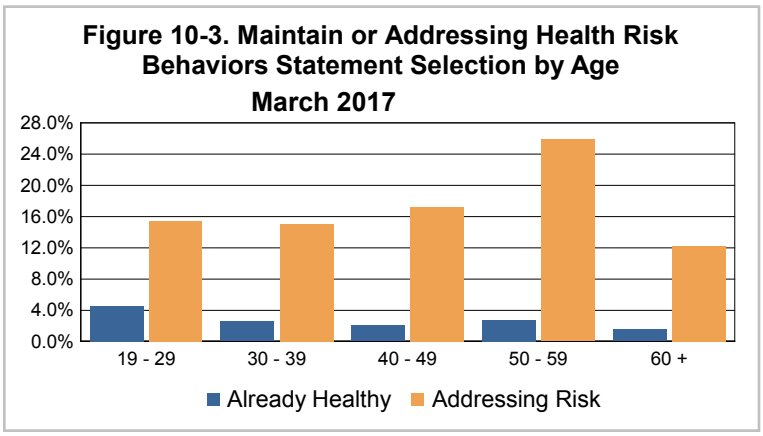
D. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.

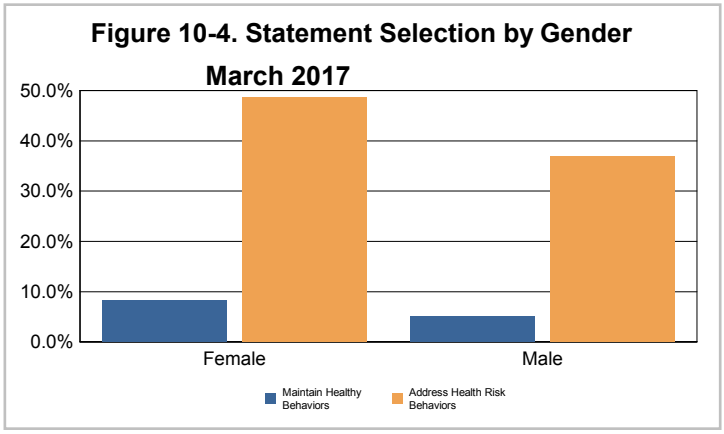
Figures 10-2 through 10-4 show Healthy Behaviors Statement Selections for the total population, and by age and gender.

**Table 12. Healthy Behaviors Statement Selection**
**March 2017**

| CHECK-UP | TOTAL | PERCENT |
|---|---|---|
| A. Maintain Healthy Behaviors | 23,680 | 13.37% |
| B. Address Health Risk Behaviors | 151,896 | 85.77% |
| C. Condition(s) Preclude Addressing Health Risk Behaviors | 714 | 0.40% |
| D. Not Ready | 801 | 0.45% |
| **TOTAL** | **177,091** | **100.00%** |



# Selection of Health Risk Behaviors to Address

Section 4. Healthy Behaviors: In discussion with the beneficiary, when Statement B, "Patient has identified at least one behavior they intend to address over the next year to improve their health" is selected, providers choose one or more of the following 7 statements to identify the healthy behaviors the beneficiary has chosen to address for the year:

1. Increase physical activity, Learn more about nutrition and improve diet, and/or weight loss
2. Reduce/quit tobacco use
3. Annual Influenza vaccine
4. Agrees to follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes
5. Reduce/quit alcohol consumption
6. Treatment for Substance Use Disorder
7. Other: explain _____

Of the 151,896 HRAs submitted through March 2017 where the beneficiary chose to address health risk behaviors, 60.25% of beneficiaries chose more than one healthy behavior to address. The top 7 most selected behavior combinations and the rate that each behavior was selected in combination and alone are presented in the tables below:

**Table 13. Top 7 Most Selected Health Risk Behavior Combinations**

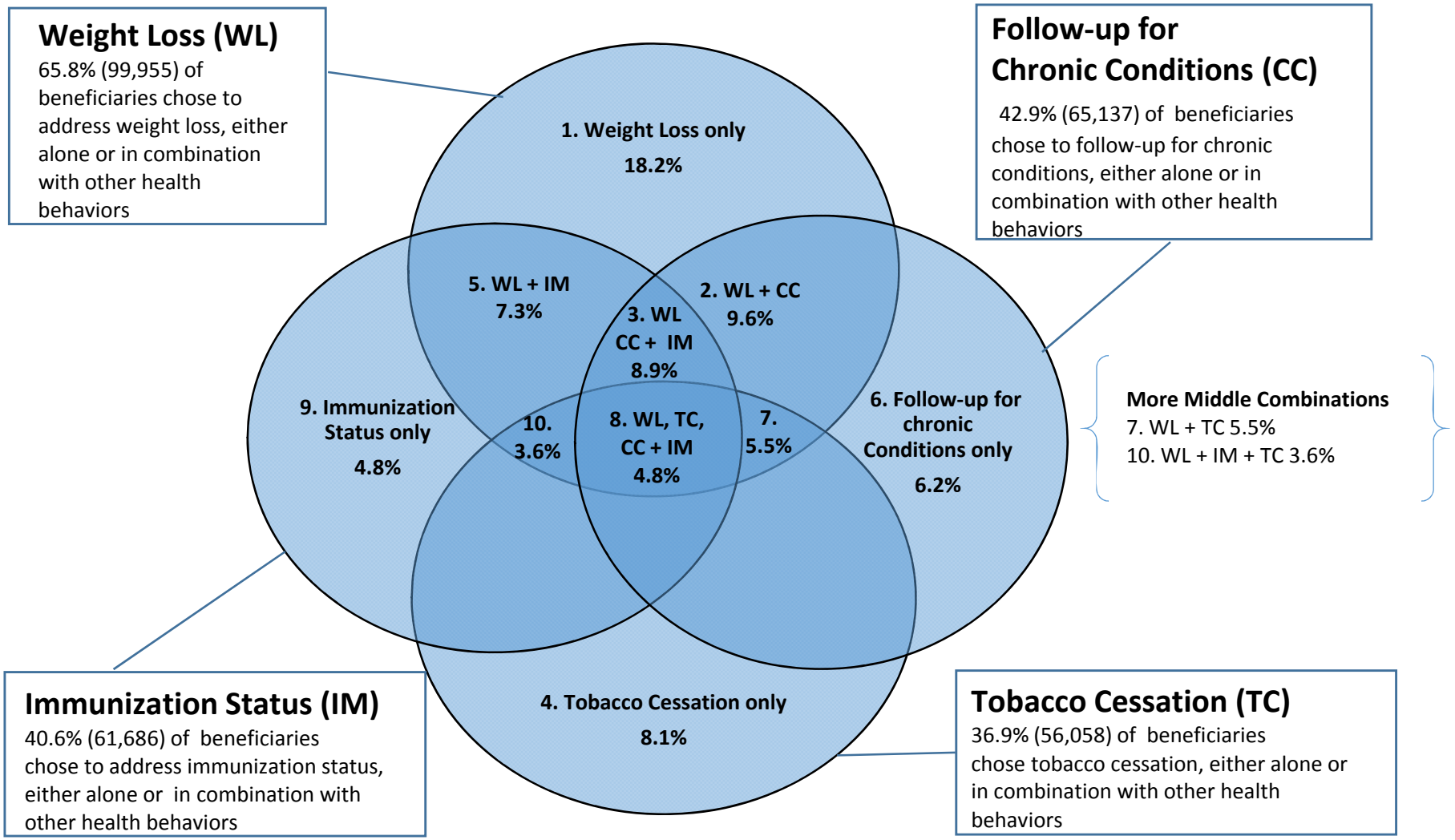
| Health Risk Behavior Combination | Count | Percent |
|---|---|---|
| 1. Weight Loss ONLY | 27,583 | 18.16% |
| 2. Weight Loss, Follow-up for Chronic Conditions | 14,568 | 9.59% |
| 3. Weight Loss, Immunization Status, Follow-up for Chronic Conditions | 13,536 | 8.91% |
| 4. Tobacco Cessation ONLY | 12,337 | 8.12% |
| 5. Weight Loss, Immunization Status | 11,119 | 7.32% |
| 6. Follow-up for Chronic Conditions | 9,456 | 6.23% |
| 7. Weight Loss, Tobacco Cessation | 8,317 | 5.48% |
| Total for Top 7 | 96,916 | 63.80% |
| Total for All Other Combinations | 54,980 | 36.20% |
| **Total** | **151,896** | **100.00%** |

**Table 14. Health Risk Behaviors Selected in Combination and Alone**

| Health Risk Behavior | Chose this behavior and at least one more | Chose ONLY this behavior |
|---|---|---|
| Weight Loss | 65.81% | 18.16% |
| Tobacco Cessation | 36.91% | 8.12% |
| Immunization Status (Annual Flu Vaccine) | 40.61% | 4.79% |
| Follow-up for Chronic Conditions | 42.89% | 6.23% |
| Addressing Alcohol Abuse | 4.45% | 0.35% |
| Addressing Substance Abuse | 1.22% | 0.11% |
| Other | 4.74% | 1.99% |

## Health Risk Assessment Completion with Primary Care Provider

**Representation of the overlapping nature of top 10 health risk behavior selections March 2017**



**Michigan Department of Health and Human Services**
Medical Services Administration

# Medical Care Advisory Council

Meeting Minutes

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**Date:** Thursday, February 16, 2017

**Time:** 1:00 pm – 4:30 pm

**Where:** Michigan Public Health Institute (MPHI)
2436 Woodlake Circle
Okemos, MI 48864

**Attendees:** **Council Members:** Robin Reynolds, Jeff Towns, Kim Singh, Amy Zaagman, Joanne Sheldon (for Loretta Bush), April Stopcyzinski, Pam Lupo, Julie Cassidy (for Emily Schwartzkopf), Alison Hirschel, Marilyn Litka-Klein, Dominick Pallone, Dave Lalumia, Mark Klammer, Marion Owen, Linda Vail, Travar Pettway, Eric Roath, Rebecca Blake, Warren White, Lisa Dedden Cooper, Dave Herbel

**Staff:** Chris Priest, Farah Hanley, Lynda Zeller, Kathy Stiffler, Brian Keisling, Brian Barrie, Marie LaPres, Pam Diebolt, Erin Emerson, Jon Villasurda, Michelle Best

## Welcome, Introductions and Announcements

Robin Reynolds opened the meeting and introductions were made.

## Federal Update

Chris Priest reported that the U.S. House of Representatives is scheduled to begin discussing legislation to repeal parts of the Affordable Care Act (ACA) beginning the week of February 27, 2017. Because the details of any potential new legislation and its impact on MDHHS are currently unknown, the Department is continuing to implement its programs as planned while also advocating for the Healthy Michigan Plan at the federal level. MDHHS staff and meeting attendees discussed ways to promote the Healthy Michigan Plan at length, while Robin Reynolds offered to draft a letter of support for the program on behalf of the Medical Care Advisory Council (MCAC).

## Budget/Boilerplate Update

### 2017 Update/2018 Proposed Budget

The Governor submitted a budget proposal for Fiscal Year (FY) 2018 to the legislature on February 8, 2017, which contained a recommendation of $25.6 billion gross and $4.5 billion

general fund (GF) for the Michigan Department of Health and Human Services (MDHHS). Highlights of the Executive Budget Recommendation for MDHHS include:

- $55.5 million GF to fund the Federal Matching Assistance Percentage (FMAP) reduction for the Healthy Michigan Plan across Medicaid and Behavioral Health
- A one percent increase in actuarial soundness for Prepaid Inpatient Health Plans (PIHPs) and Medicaid Health Plans (MHPs)
- A wage increase of $0.50 for direct care workers
- Funding for 72 new full-time staff members across five State hospitals
- Funding for a 200 bed replacement facility for the Caro Center
- $12 million gross ($3 million GF) to expand contracted Non-Emergency Medical Transportation (NEMT) broker services beyond Southeast Michigan
- Funding for 51 additional Pathways to Potential workers
- A recommended increase in the child clothing allowance from $140 per month to $200 per month
- Funding for 95 additional full-time adult services workers
- Increased funding for foster care parent support, as well as an increase in private foster care agency rates
- Funding for an Integrated Service Delivery Information Technology (IT) initiative
- Increase in the emergency shelter per diem rate from $12 to $16
- Additional funding for delivery of in-home meals and services for seniors
- Additional funding for Flint
- $1 million for university autism programs
- $2 million to implement the recommendations of the child lead poisoning elimination board

MDHHS staff noted that there were several earmark eliminations included in the Executive Budget Recommendation, but expressed the Department's support for the Governor's proposed budget for the MDHHS Medical Services Administration.

## Flint Update

MDHHS received approval from the Centers for Medicare & Medicaid Services (CMS) on May 9, 2016 for a waiver to provide coverage for children and pregnant women with incomes up to 400% of the Federal Poverty Level (FPL) impacted by Flint water, and the Department is continuing outreach and enrollment efforts among individuals eligible for coverage. On November 14, 2016, MDHHS received CMS approval for a State Plan Amendment to allow Michigan to implement a new health services initiative (HSI) for the enhancement and expansion of the current lead abatement program, effective January 1, 2017. As part of this expansion, the state will provide coordinated and targeted lead abatement services to eligible properties in the impacted areas of Flint, Michigan and other areas within the State of Michigan. As of February 16, 2017, 20 homes in Flint have received or are currently receiving lead abatement services, while 45 additional homes have been targeted for outreach. The

Department is also working to identify additional communities for lead abatement services. A residence located in Flint or other targeted community identified by MDHHS may be eligible for lead abatement services if a Medicaid or Children's Health Insurance Program (CHIP)-eligible child or pregnant woman lives in the home.

## Medicaid Managed Care

### Provider Surveys

The MHP provider survey that was discussed at the previous MCAC meeting has now been finalized. To conduct the survey, MDHHS will randomly select providers to complete surveys related to their experience working with a specific MHP. If a provider completes the survey for the MHP to which they are assigned, they may complete additional surveys for any MHP they choose. The survey will be distributed to providers electronically by February 28, 2017.

The Department also plans to conduct a phone survey in March 2017 related to beneficiaries' experiences using Medicaid NEMT services. In addition, the Michigan Health Endowment fund has provided a grant to the Michigan League for Public Policy to study various issues related to Medicaid NEMT services.

### Healthy Kids Dental Bid

MDHHS is preparing to release a Request for Proposal (RFP) for a new ***Healthy Kids Dental*** contract, and is aiming to issue contracts to more than one statewide vendor. Kathy Stiffler reported that the RFP has been delayed from its initial planned release, and that the new contract is not likely to be in effect by October 1, 2017 as discussed at the previous MCAC meeting. In response to a concern raised by a meeting attendee, MDHHS staff indicated that while the goal in seeking more than one vendor is to provide greater access to services, contracts will only be awarded to vendors that have an adequate provider network.

### Health Insurance Claims Assessment (HICA) Tax

In 2016, Governor Snyder vetoed legislation to reconfigure the way Michigan's 6% use tax on Health Maintenance Organizations (HMOs) is utilized. CMS has disallowed the use tax, and it was scheduled to sunset on December 31, 2016. Chris Priest reported that following the previous MCAC meeting, the Michigan House and Senate passed legislation placing a moratorium on the use tax in order to implement the CMS requirement. Legislation to reconfigure the way the use tax is utilized has been re-introduced in the state Senate, with the understanding that the State plans to discuss the details of a potential replacement with CMS after the new administration's leadership is in place.

### Other

A meeting attendee requested information on the Department's treatment of Substance Use Disorder (SUD) services. In response, MDHHS staff and meeting attendees discussed several programs within the Medical Services Administration and Behavioral Health and Developmental Disabilities Administration that have been developed for the treatment of SUD.

## Healthy Michigan Plan

### Second Waiver Update (MI Health Account, Marketplace Protocol, Healthy Behaviors)

Under the terms of the second waiver, beginning April 1, 2018, Healthy Michigan Plan beneficiaries with incomes above 100% of the FPL who do not meet the criteria for "Medically Frail" and who have not completed a Health Risk Assessment (HRA) must leave the Healthy Michigan Plan and receive coverage from the Federally Facilitated Marketplace (FFM). Kathy Stiffler reported that MDHHS has released guidance to the health plans related to eligibility criteria for members of the Healthy Michigan Plan to receive services on the FFM, and that MDHHS is continuing to work with the Department of Insurance and Financial Services (DIFS) to develop coverage parameters for the health plans that serve this population. MDHHS will not require health plans on the FFM to develop a new product specific to Healthy Michigan Plan beneficiaries, but will instead allow the plans to use existing products to provide services to this population, and sign a Memorandum of Understanding (MOU) to implement special coverage provisions required by the second waiver. Approximately 125,000 Healthy Michigan Plan beneficiaries currently have incomes above 100% of the FPL.

The Department is also working to update the Healthy Behavior Protocols and MI Health Account Statement. The revised MI Health Account Statements will be sent to Healthy Michigan Plan beneficiaries beginning April 1, 2017.

A meeting attendee raised a concern regarding the online MI Health Account Portal by reporting that a beneficiary is charged an additional fee if their bank account information is entered incorrectly when attempting to pay their bill. MDHHS staff indicated they would check into this concern.

## Behavioral Health Updates

### PA 298 – Models

Lynda Zeller introduced Jon Villasurda as the new State Assistant Administrator for the Behavioral Health and Developmental Disabilities Administration, and gave an update on the Stakeholder 298 work group process that was convened to discuss the integration of behavioral health and physical health services. As of February 16, 2017, the work group process is nearly complete, and as a result of the work group's efforts, the Department

submitted an interim report to the legislature containing 70 recommendations in 13 categories to improve behavioral health and physical health outcomes. MDHHS is currently working to complete financial models for the implementation of the group's recommendations, which are due to the legislature on March 15, 2017. A Stakeholder forum is also planned for February 24, 2017 to discuss the work group process. The interim legislative report will be posted for public comment beginning at 3:00 p.m. on February 16, 2017 until February 28, 2017. Following the public comment period, MDHHS will submit a final report to the legislature that will contain the group's 70 recommendations, financial models and service delivery models. After the submission of the final report, the Department will continue to discuss benchmarks and outcomes for the implementation of the report's recommendations with the legislature.

**1115 Waiver Status**

MDHHS submitted a Section 1115 waiver to CMS in July 2016 to allow the administration of behavioral health services under a single waiver authority. The Department is continuing to work through the approval process with CMS, and MDHHS staff noted that conversations with their federal partners have been constructive.

**Other**

On February 17, 2017, MDHHS will submit the state's response to the Substance Abuse and Mental Health Services Administration's (SAMHSA) Opioid State Targeted Response (STR) grant. The grant is made available only to states based on demographics, and will award a multi-year grant of $16 million to promote the recommendations of the Opioid Commission Report and the goals of the new opioid commission. The five areas outlined in the report include prevention, treatment, policy and outcomes, regulation, and enforcement.

**State Innovation Model (SIM)**

On January 1, 2017, the health plans began making payments to providers under the SIM program. Providers were previously reimbursed for these services as part of the Michigan Primary Care Transformation (MiPCT) initiative. Chris Priest also reported that Tom Curtis, who previously worked on the SIM project in the Policy, Planning & Legislative Services Administration, has been hired as the Quality Improvement and Program Development section manager within the Managed Care Plan Division of the Medical Services Administration.

On February 15, 2017, the Medicaid MiPCT evaluation team presented the Medicaid evaluation results of the MiPCT pilot to the MHPs. MiPCT formed the basis for the Patient-Centered Medical Home (PCMH) model within SIM, and the results of the evaluation demonstrated improved outcomes and costs among the high-risk population. Kathy Stiffler offered to share the evaluation results with meeting attendees.

## Long-Term Care Services and Supports Updates

Brian Barrie provided an update on several topics related to long-term care services and supports, which include:

- The federal comment period for Michigan's Section 1115 Brain Injury Waiver ended on February 12, 2017, and MDHHS has received CMS approval for its implementation effective April 1, 2017.
- MDHHS established a pilot program to coordinate NEMT services through the MI Choice Waiver agencies, which decreased NEMT prior authorization decisions for beneficiaries from two and a half weeks to approximately 20 minutes in the pilot regions. The Department has received CMS approval for a waiver amendment to expand the program statewide effective April 1, 2017, and is now working toward implementation.
- MDHHS is revising the redetermination process for the home help program by eliminating the requirement that certain beneficiaries whose circumstances are not expected to change submit a Medical Needs Assessment Form (DHS-54A) upon eligibility redetermination.
- MDHHS is working to improve the assessment process for home help program beneficiaries who have complex care needs.
- MDHHS is developing a quality initiative for the Adult Protective Services program in order to better assess outcomes for its beneficiaries.
- MDHHS is in the process of moving the Level of Care Determination (LOCD) operation from the Bridges system into CHAMPS, which will provide the Department with the opportunity to design and implement changes to the LOCD process based on recommendations from the LOCD stakeholder group that met in 2015.
- MDHHS is working with a design team to develop a sustainable program model for nursing facility transitions. The design team has identified 18 core values for the new system to follow, and four action teams have been created to address the pre-nursing facility transition phase, transition phase, post-transition phase, and policy implications of the new sustainable program model.
- Design teams will also begin work in the near future to address changes to Michigan Rehabilitation Services, the Preadmission Screening and Annual Resident Review (PASARR) assessment, the nursing facility admission and discharge processes, person-centered planning, and quality within the Michigan Veterans Administration (VA) homes.

MDHHS staff and meeting attendees discussed at length the importance of incorporating beneficiary input into the process of designing changes to the long-term care services and supports initiatives highlighted above, in order to ensure that the needs of consumers are being met.

## Policy Updates

A policy bulletin handout was distributed to attendees, and several updates were discussed.

The meeting was adjourned at 4:00 p.m.

**Next Meeting: Tuesday, May 23, 2017**

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

# *PERFORMANCE MONITORING REPORT*

# *HEALTHY MICHIGAN PLAN*

## Composite – All Plans



**April 2017**

Produced by:
Quality Improvement and Program Development – Managed Care Plan Division

## Table of Contents



## Healthy Michigan Plan



## Appendixes



## Figures



## Tables

## Executive Summary

This Performance Monitoring Report (PMR) is produced by the Quality Improvement and Program Development (QIPD) Section of the Managed Care Plan Division (MCPD) to track quality, access, and utilization in the Michigan Medicaid program to better support high quality care for beneficiaries.

The Michigan Department of Health and Human Services (MDHHS) monitors the performance of the State's Medicaid Health Plans (MHPs) through twenty-six (26) key performance measures aimed at improving the quality and efficiency of health care services provided to the Michigan residents enrolled in a Medicaid program. These measures include Medicaid Managed Care specific measures, Healthy Michigan Plan (HMP) measures, and HEDIS measures. **This report focuses only on the Healthy Michigan Plan (HMP) measures.** The following HMP measures will be included in this report:

| **Healthy Michigan Plan** | | | | |
|---|---|---|---|---|
| *Adults' Generic Drug Utilization* | *Timely Completion of HRA* | *Outreach & Engagement to Facilitate Entry to PCP* | *Plan All-Cause Acute 30-Day Readmissions* | *Adults' Access to Ambulatory Health Services* |

Data for these five measures are represented on a quarterly basis. The body of the report contains a cross-plan analysis of the most current data available for each of these measures. A composite summary of plan performance for all standards is displayed in Appendix A. Appendix B contains specific three letter codes identifying each of the MHPs. Appendix C contains the one-year plan specific analysis for each measure.

## Measurement Frequency

The data for each performance measure in this report will be run and represented on a quarterly basis. Measurement Periods may vary and are based on the specifications for that individual measure. In addition to this, Figures 3 through 7 depict only Managed Care Plan data, and not Fee-For-Service (FFS) data.

MHPs are contractually obligated to achieve specified standards for most measures. The following table displays the number of MHPs meeting or exceeding the standards for the performance measure versus total MHPs, as reported in the Performance Monitoring Report, during the listed quarter for fiscal year 2017 unless otherwise noted.

**Table 1: Fiscal Year 2017**

| Quarterly Reported Measures | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter |
|---|---|---|---|---|
| Adults' Generic Drug Utilization | 11/11 | 11/11 | | |
| Timely Completion of Initial HRA | 2/11 | 1/11 | | |
| Outreach & Engagement to Facilitate Entry to PCP | 0/11 | 0/11 | | |
| Plan All-Cause Acute 30-Day Readmissions | 2/10 | 2/10 | | |
| Adults' Access to Ambulatory Health Services | 5/11 | 5/11 | | |

## Managed Care Enrollment

The Healthy Michigan Plan (HMP-MC) enrollment has increased slightly over the past year. In April 2017. Unfortunately May 2016 HMP-MC enrollment data is unavailable. An increase of 16,923 enrollees (3.2%) was realized between March 2017 and April 2017.

**Figure 1: HMP-MC Enrollment, May 2016 – April 2017[1]**

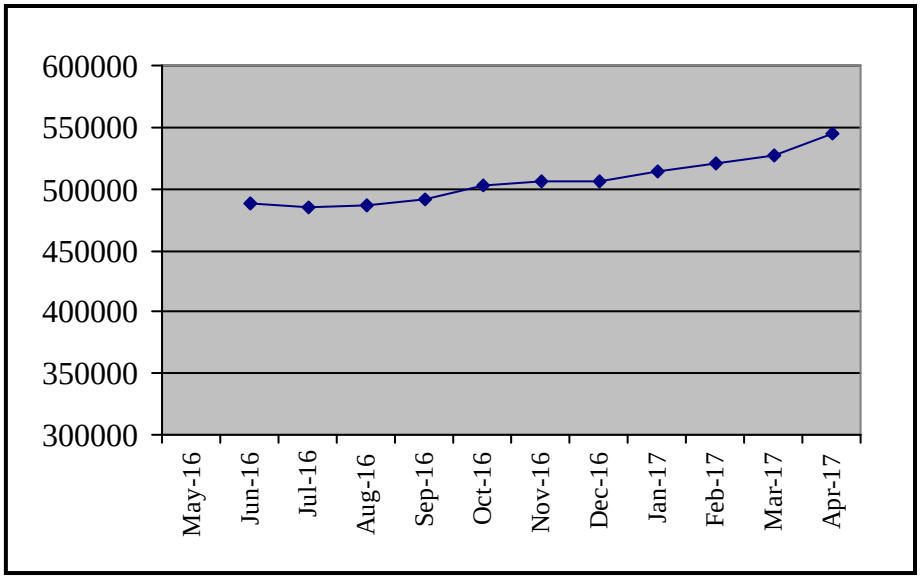
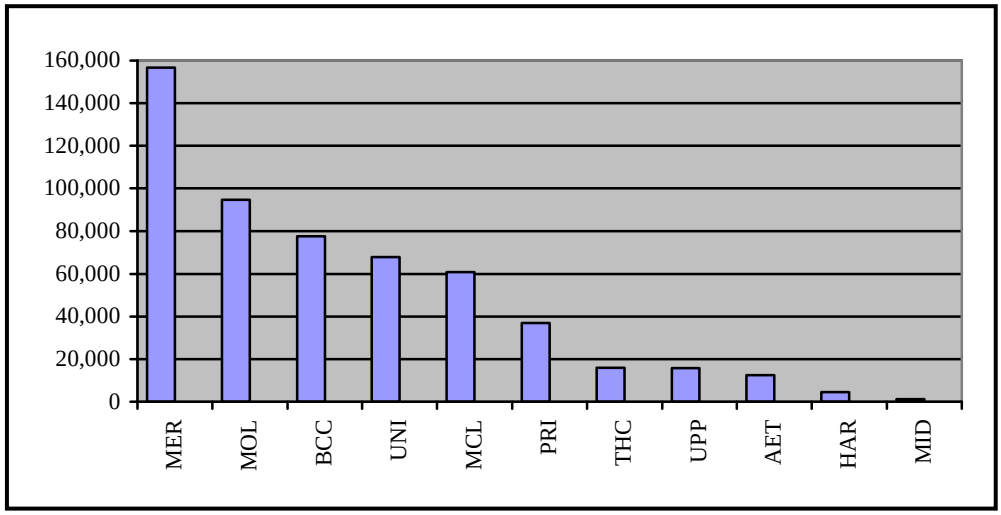



**Figure 2: HMP-MC Enrollment by Medicaid Health Plan, April 2017**




[1] Enrollment data was not available for HMP-MC Enrollment for May 2016 at the time of publication.

## Medicaid Health Plan News

The Performance Monitoring Report contains data for all Michigan Medicaid Health Plans, where data is available. Eleven Medicaid Health Plans are contracted with the State of Michigan to provide comprehensive health care services.

## Cross-Plan Performance Monitoring Analyses

The following section includes a cross-plan analysis for each performance measure. An analysis of the most current data available for each performance measure is included. For detailed questions regarding measurement periods or standards, see the Performance Monitoring Specifications.

## *Adults' Generic Drug Utilization*

**Measure**
Percentage of generic prescriptions filled for adult members of health plans during the measurement period.

**Standard**
At or above 80% (as shown on bar graph below)

**Measurement Period**
July 2016 –September 2016

**Data Source**
MDHHS Data Warehouse

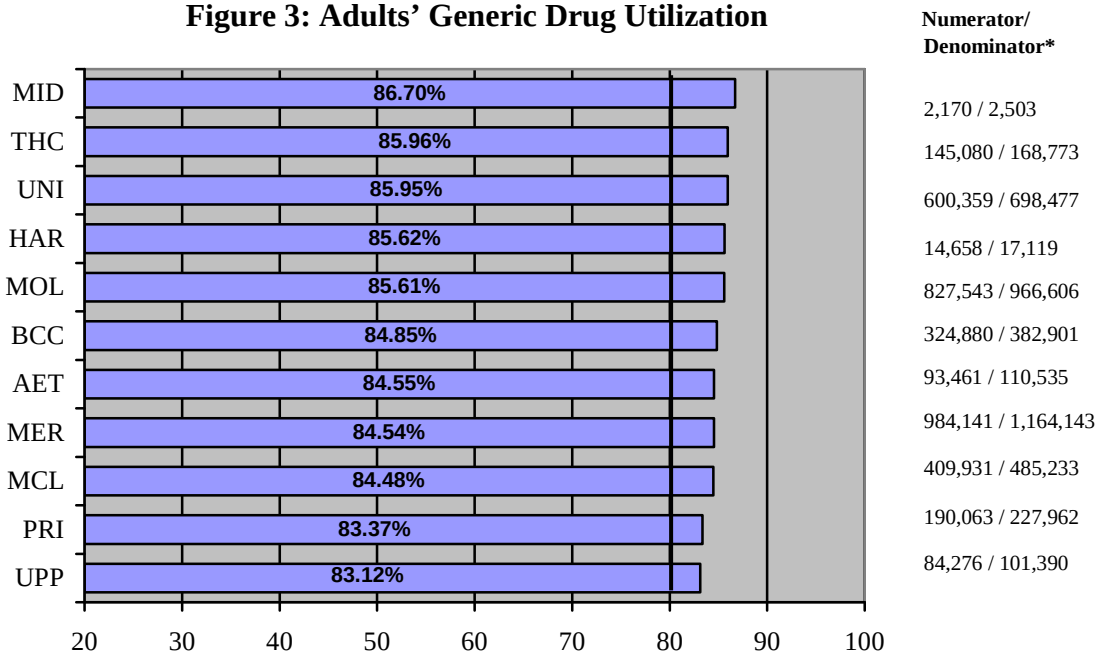
**Measurement Frequency**
Quarterly

**Summary:** All of the plans met or exceeded the standard. Results ranged from 83.12% to 86.70%.

**Table 2: Comparison across Medicaid Programs**

| Medicaid Program | Numerator | Denominator | Percentage |
|---|---|---|---|
| Michigan Medicaid All | 3,771,541 | 4,465,372 | 84.46% |
| Fee For Service (FFS) only | 22,561 | 49,488 | 45.59% |
| Managed Care only | 3,691,634 | 4,343,424 | 84.99% |
| MA-MC | 1,958,394 | 2,314,991 | 84.60% |
| HMP-MC | 1,694,296 | 1,982,902 | 85.45% |

**Figure 3: Adults' Generic Drug Utilization**




Adult's Generic Drug Utilization Percentages

*Numerator depicts the number of eligible beneficiaries who had generic prescriptions filled. Denominator depicts the total number of eligible beneficiaries.

## *Timely Completion of Initial Health Risk Assessment*

**Measure**
Percentage of Healthy Michigan Plan beneficiaries enrolled in a health plan who had a Health Risk Assessment (HRA) completed within 150 days of enrollment in a health plan.

**Standard**
At or above 15% (as shown on bar graph below)

**Enrollment Dates**
April 2016 – June 2016

**Data Source**
MDHHS Data Warehouse

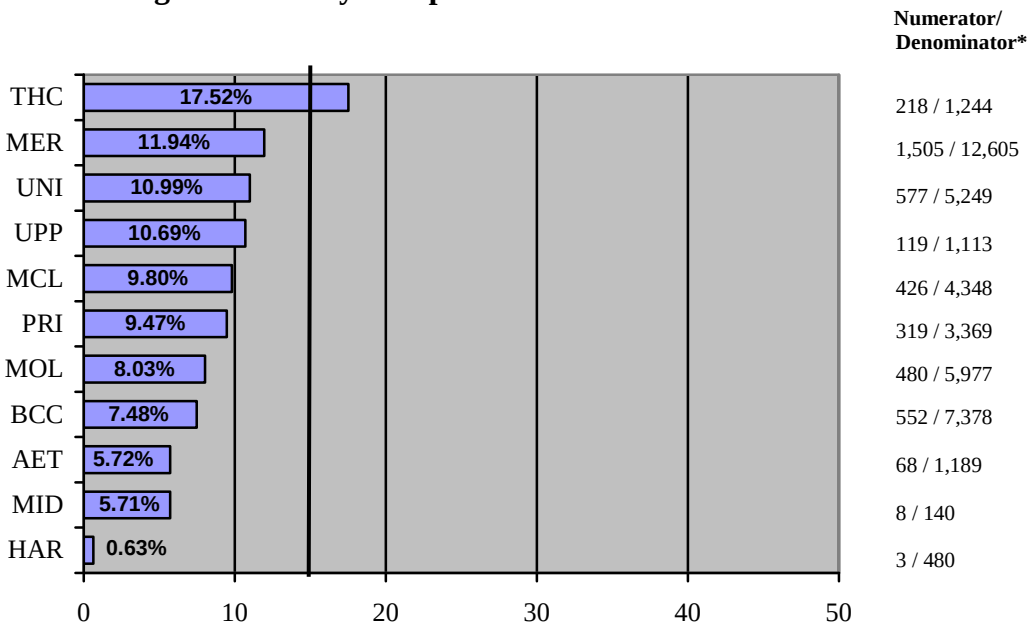
**Measurement Frequency**
Quarterly

**Summary:** One plan met or exceeded the standard, while ten plans (AET, BCC, HAR, MCL, MER, MID, MOL, PRI, UNI, and UPP). Results ranged from 0.63% to 17.52%.

**Table 3: Program Total[2]**

| Medicaid Program | Numerator | Denominator | Percentage |
|---|---|---|---|
| HMP-MC | 4,275 | 43,092 | 9.92% |

**Figure 4: Timely Completion of Initial HRA**




Timely Completion of Initial HRA Percentages

*Numerator depicts the number of eligible beneficiaries who completed an HRA within 150 days of enrollment in a health plan. Denominator depicts the total number of eligible beneficiaries.

[2] This includes HRAs completed during the HMP FFS period prior to enrollment in a Medicaid health plan.

## *Outreach and Engagement to Facilitate Entry to Primary Care*

**Measure**
Percentage of Healthy Michigan Plan health plan enrollees who have an ambulatory or preventive care visit within 150 days of enrollment into a health plan who had not previously had an ambulatory or preventive care visit since enrollment in Healthy Michigan Plan.

**Standard**
At or above 60% (as shown on bar graph below)

**Enrollment Dates**
April 2016 – June 2016

**Data Source**
MDHHS Data Warehouse

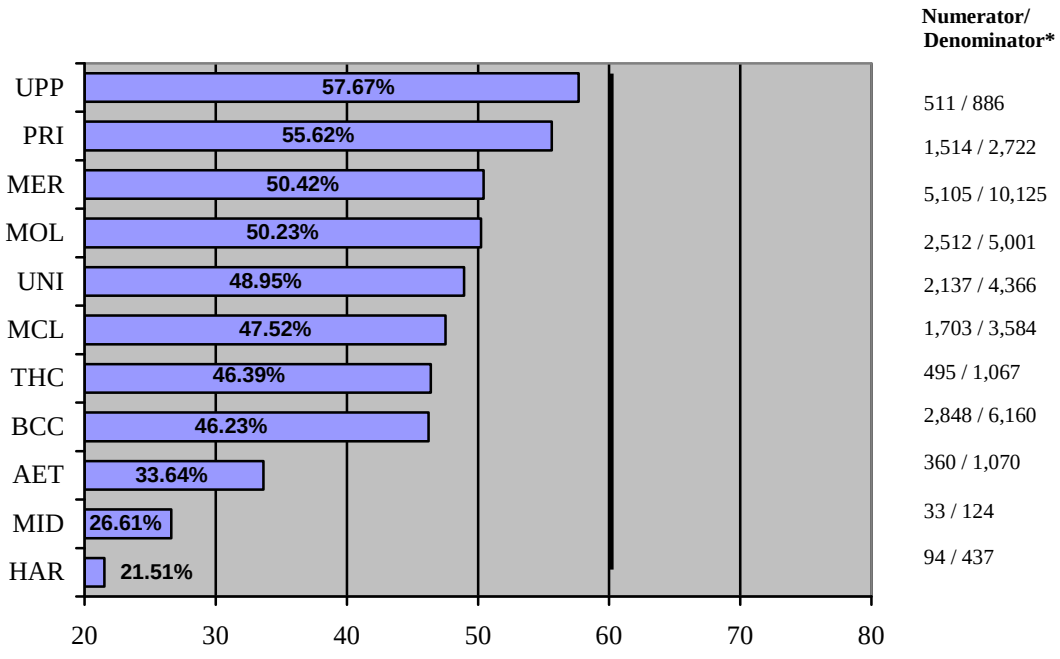
**Measurement Frequency**
Quarterly

**Summary:** None of the plans met or exceeded the standard. Results ranged from 21.51% to 57.67%.

**Table 4: Program Total[3]**

| Medicaid Program | Numerator | Denominator | Percentage |
|---|---|---|---|
| HMP-MC | 24,862 | 43,092 | 57.70% |

**Figure 5: Outreach & Engagement to Facilitate Entry to Primary Care**




Outreach & Engagement to Facilitate Entry to Primary Care Percentages

*Numerator depicts the number of eligible beneficiaries who had an ambulatory or preventive care visit within 150 days of enrollment in a health plan. Denominator depicts the total number of eligible beneficiaries.

[3] This includes visits during the HMP FFS period prior to enrollment in a Medicaid health plan.

## *Plan All-Cause Acute 30-Day Readmissions*

**Measure**
The percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.

**Standard**
At or below 16% (as shown on bar graph below)

**Enrollment Dates**
October 2015 –September 2016

**Data Source**
MDHHS Data Warehouse

**Measurement Frequency**
Quarterly

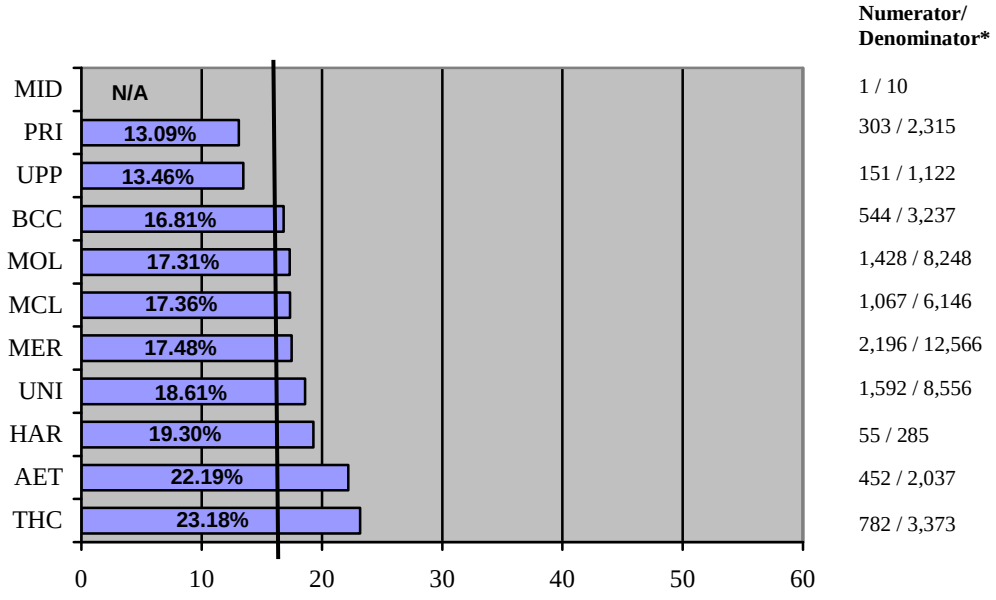
**Summary:** Two of the plans met or exceeded the standard, while eight plans (AET, BCC, HAR, MCL, MER, MOL, THC, and UNI) did not. Results ranged from 13.09% to 23.18%.

*****This is a reverse measure. A lower rate indicates better performance.***

**Table 5: Comparison across Medicaid Programs**

| Medicaid Program | Numerator | Denominator | Percentage |
|---|---|---|---|
| Michigan Medicaid All | 13,889 | 77,348 | 17.96% |
| Fee For Service (FFS) only | 631 | 2,843 | 22.19% |
| Managed Care only | 10,207 | 56,486 | 18.07% |
| MA-MC | 7,602 | 36,787 | 20.66% |
| HMP-MC | 1,998 | 15,918 | 12.55% |

**Figure 6: Plan All-Cause Acute 30-Day Readmissions[4]**




Plan All-Cause Acute 30-Day Readmissions Percentages

*Numerator depicts the number of acute readmissions for any diagnosis within 30 days of an Index Discharge Date. Denominator depicts the total number of Index Discharge dates during the measurement year, not enrollees.

[4] A rate was not calculated for plans with a numerator under 5 or a denominator under 30.

## *Adults' Access to Ambulatory Health Services*

**Measure**
The percentage of adults 19 to 64 years old who had an ambulatory or preventive care visit during the measurement period.

**Standard**
At or above 83% (as shown on bar graph below)

**Measurement Period**
October 2015 – September 2016

**Data Source**
MDHHS Data Warehouse

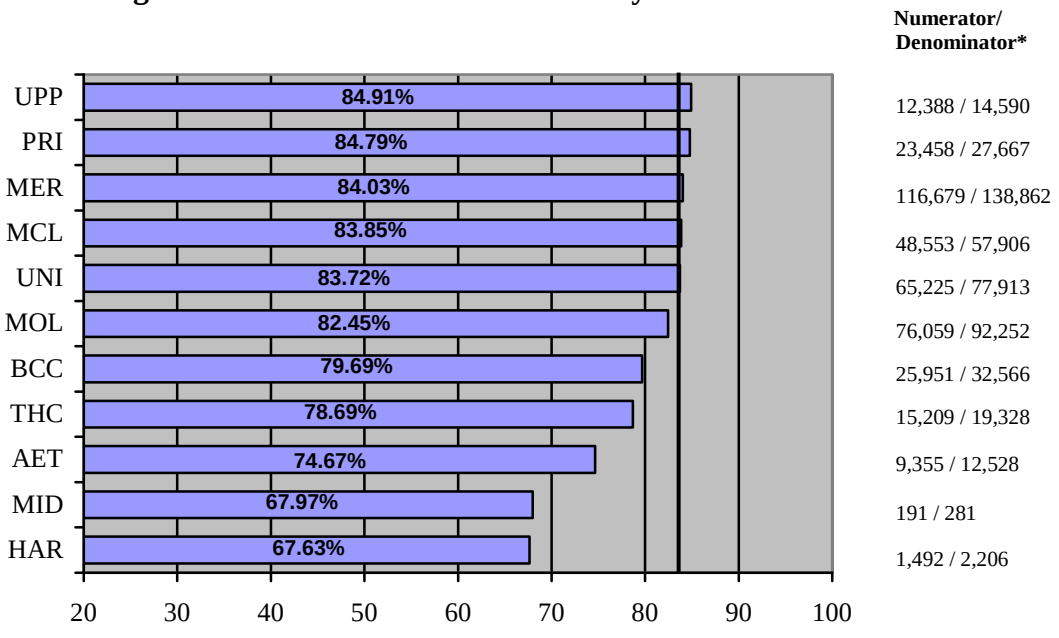
**Measurement Frequency**
Quarterly

**Summary:** Five of the plans met or exceeded the standard. While six plans (AET, BCC, HAR, MID, MOL, and THC) did not. Results ranged from 66.95% to 85.16%.

**Table 6: Comparison across Medicaid Programs**

| Medicaid Program | Numerator | Denominator | Percentage |
|---|---|---|---|
| Michigan Medicaid All | 576,031 | 708,180 | 81.34% |
| Fee For Service (FFS) only | 9,354 | 14,541 | 64.33% |
| Managed Care only | 442,967 | 533,158 | 83.08% |
| MA-MC | 215,581 | 257,970 | 83.57% |
| HMP-MC | 182,047 | 221,924 | 82.03% |

**Figure 7: Adults' Access to Ambulatory Health Services**




Adult's Access to Ambulatory Health Services Percentages

*Numerator depicts the number of eligible beneficiaries who had an ambulatory or preventive care visit. Denominator depicts the total number of eligible beneficiaries.

## Appendix A: Composite Performance Monitoring Summary[5]

**April 2017**

| Plans | Adults Generic Drug Utilization | Timely Completion of Initial HRA | Outreach & Engagement to Facilitate Entry to PCP | Plan All-Cause Acute 30-Day Readmission | Adults' Access to Ambulatory Health Services | Total Standards Achieved |
|---|---|---|---|---|---|---|
| AET | Y | **N** | **N** | **N** | **N** | **1** |
| BCC | Y | **N** | **N** | **N** | **N** | **1** |
| HAR | Y | **N** | **N** | **N** | **N** | **1** |
| MCL | Y | **N** | **N** | **N** | Y | **2** |
| MER | Y | **N** | **N** | **N** | Y | **2** |
| MID | Y | **N** | **N** | N/A | **N** | **1** |
| MOL | Y | **N** | **N** | **N** | **N** | **1** |
| PRI | Y | **N** | **N** | Y | Y | **3** |
| THC | Y | Y | **N** | **N** | **N** | **2** |
| UNI | Y | **N** | **N** | **N** | Y | **2** |
| UPP | Y | **N** | **N** | Y | Y | **3** |
| **Total** | **11/11** | **1/11** | **0/11** | **2/10** | **5/11** | |

## Appendix B: Three Letter Medicaid Health Plan Codes

Below is a list of three letter codes established by MDHHS identifying each Medicaid Health Plan.

| | |
|---|---|
| AET | Aetna Better Health of Michigan |
| BCC | Blue Cross Complete of Michigan, Inc. |
| HAR | Harbor Health Plan, Inc. |
| MCL | McLaren Health Plan |
| MER | Meridian Health Plan |
| MID | HAP Midwest Health Plan, Inc. |
| MOL | Molina Healthcare of Michigan |
| PRI | Priority Health Choice |
| THC | Total Health Care |
| UNI | UnitedHealthcare Community Plan |
| UPP | Upper Peninsula Health Plan |

[5] "N/A" in the Plan All-Cause Acute 30-Day Readmission column represents plans who had a denominator under 5 and a numerator under 30.

# Appendix C: One Year Plan-Specific Analysis

## Aetna Better Health of Michigan – AET

***HEALTHY MICHIGAN PLAN:***

| Performance Measure | Measurement Period | Standard | Plan Result | Standard Achieved |
|---|---|---|---|---|
| Adults' Generic Drug Utilization | Apr 16 – Jun 16 | 80% | 84.66% | Yes |
| | **Jul 16 – Sep 16** | **80%** | **84.55%** | **Yes** |
| Timely Completion of HRA | Jan 16 – Mar 16 | 15% | 4.14% | **No** |
| | **Apr 16 – Jun 16** | **15%** | **5.72** | **No** |
| Outreach/Engagement to Facilitate Entry to Primary Care | Jan 16 – Mar 16 | 60% | 35.59% | **No** |
| | **Apr 16 – Jun 16** | **60%** | **33.64%** | **No** |
| Plan All-Cause Acute 30-Day Readmissions | Jul 15 – Jun 16 | 16% | 22.55% | **No** |
| | **Oct 15 – Sep 16** | **16%** | **22.19%** | **No** |
| Adults' Access to Ambulatory Health Services | Jul 15 – Jun 16 | 83% | 75.38% | **No** |
| | **Oct 15 – Sep 16** | **83%** | **74.67%** | **No** |

****This is a reverse measure. A lower rate indicates better performance.***

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

# Appendix C: One Year Plan-Specific Analysis

## Blue Cross Complete of Michigan – BCC

***HEALTHY MICHIGAN PLAN:***

| Performance Measure | Measurement Period | Standard | Plan Result | Standard Achieved |
|---|---|---|---|---|
| Adults' Generic Drug Utilization | Apr 16 – Jun 16 | 80% | 84.47% | Yes |
| | **Jul 16 – Sep 16** | **80%** | **84.85%** | **Yes** |
| Timely Completion of HRA | Jan 16 – Mar 16 | 15% | 9.68% | **No** |
| | **Apr 16 – Jun 16** | **15%** | **7.48%** | **No** |
| Outreach/Engagement to Facilitate Entry to Primary Care | Jan 16 – Mar 16 | 60% | 50.64% | **No** |
| | **Apr 16 – Jun 16** | **60%** | **46.23%** | **No** |
| Plan All-Cause Acute 30-Day Readmissions | Jul 15 – Jun 16 | 16% | 16.68% | **No** |
| | **Oct 15 – Sep 16** | **16%** | **16.81%** | **No** |
| Adults' Access to Ambulatory Health Services | Jul 15 – Jun 16 | 83% | 79.32% | **No** |
| | **Oct 15 – Sep 16** | **83%** | **79.69%** | **No** |

***This is a reverse measure. A lower rate indicates better performance.***

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

# Appendix C: One Year Plan-Specific Analysis

## Harbor Health Plan, Inc. – HAR

***HEALTHY MICHIGAN PLAN:***

| Performance Measure | Measurement Period | Standard | Plan Result | Standard Achieved |
|---|---|---|---|---|
| Adults' Generic Drug Utilization | Apr 16 – Jun 16 | 80% | 85.37% | Yes |
| | **Jul 16 – Sep 16** | **80%** | **85.62%** | **Yes** |
| Timely Completion of HRA | Jan 16 – Mar 16 | 15% | 1.12% | **No** |
| | **Apr 16 – Jun 16** | **15%** | **0.63%** | **No** |
| Outreach/Engagement to Facilitate Entry to Primary Care | Jan 16 – Mar 16 | 60% | 27.18% | **No** |
| | **Apr 16 – Jun 16** | **60%** | **21.51%** | **No** |
| Plan All-Cause Acute 30-Day Readmissions | Jul 15 – Jun 16 | 16% | 22.08% | **No** |
| | **Oct 15 – Sep 16** | **16%** | **19.30%** | **No** |
| Adults' Access to Ambulatory Health Services | Jul 15 – Jun 16 | 83% | 66.95% | **No** |
| | **Oct 15 – Sep 16** | **83%** | **67.63%** | **No** |

****This is a reverse measure. A lower rate indicates better performance.***

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

# Appendix C: One Year Plan-Specific Analysis

## McLaren Health Plan – MCL

***HEALTHY MICHIGAN PLAN:***

| Performance Measure | Measurement Period | Standard | Plan Result | Standard Achieved |
|---|---|---|---|---|
| Adults' Generic Drug Utilization | Apr 16 – Jun 16 | 80% | 84.33% | Yes |
| | **Jul 16 – Sep 16** | **80%** | **84.48%** | **Yes** |
| Timely Completion of HRA | Jan 16 – Mar 16 | 15% | 10.34% | **No** |
| | **Apr 16 – Jun 16** | **15%** | **9.80%** | **No** |
| Outreach/Engagement to Facilitate Entry to Primary Care | Jan 16 – Mar 16 | 60% | 50.77% | **No** |
| | **Apr 16 – Jun 16** | **60%** | **47.52%** | **No** |
| Plan All-Cause Acute 30-Day Readmissions | Jul 15 – Jun 16 | 16% | 16.22% | **No** |
| | **Oct 15 – Sep 16** | **16%** | **17.36%** | **No** |
| Adults' Access to Ambulatory Health Services | Jul 15 – Jun 16 | 83% | 83.86% | Yes |
| | **Oct 15 – Sep 16** | **83%** | **83.85%** | **Yes** |

****This is a reverse measure. A lower rate indicates better performance.***

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

# Appendix C: One Year Plan-Specific Analysis

## Meridian Health Plan – MER

***HEALTHY MICHIGAN PLAN:***

| Performance Measure | Measurement Period | Standard | Plan Result | Standard Achieved |
|---|---|---|---|---|
| Adults' Generic Drug Utilization | Apr 16 – Jun 16 | 80% | 83.55% | Yes |
| | **Jul 16 – Sep 16** | **80%** | **84.54%** | **Yes** |
| Timely Completion of HRA | Jan 16 – Mar 16 | 15% | 14.04% | **No** |
| | **Apr 16 – Jun 16** | **15%** | **11.94%** | **No** |
| Outreach/Engagement to Facilitate Entry to Primary Care | Jan 16 – Mar 16 | 60% | 54.45% | **No** |
| | **Apr 16 – Jun 16** | **60%** | **50.42%** | **No** |
| Plan All-Cause Acute 30-Day Readmissions | Jul 15 – Jun 16 | 16% | 16.01% | **No** |
| | **Oct 15 – Sep 16** | **16%** | **17.48%** | **No** |
| Adults' Access to Ambulatory Health Services | Jul 15 – Jun 16 | 83% | 84.31% | Yes |
| | **Oct 15 – Sep 16** | **83%** | **84.03%** | **Yes** |

****This is a reverse measure. A lower rate indicates better performance.***

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

# Appendix C: One Year Plan-Specific Analysis

## HAP Midwest Health Plan, Inc. – MID

***HEALTHY MICHIGAN PLAN:***

| Performance Measure | Measurement Period | Standard | Plan Result | Standard Achieved |
|---|---|---|---|---|
| Adults' Generic Drug Utilization | Apr 16 – Jun 16 | 80% | 87.76% | Yes |
| | **Jul 16 – Sep 16** | **80%** | **86.70%** | **Yes** |
| Timely Completion of HRA | Jan 16 – Mar 16 | 15% | 5.60% | **No** |
| | **Apr 16 – Jun 16** | **15%** | **5.71%** | **No** |
| Outreach/Engagement to Facilitate Entry to Primary Care | Jan 16 – Mar 16 | 60% | 29.46% | **No** |
| | **Apr 16 – Jun 16** | **60%** | **26.61%** | **No** |
| Plan All-Cause Acute 30-Day Readmissions | Jul 15 – Jun 16 | 16% | N/A | N/A |
| | **Oct 15 – Sep 16** | **16%** | **N/A** | **N/A** |

***This is a reverse measure. A lower rate indicates better performance.***
***A rate was not calculated for plans with a numerator under 5 or a denominator under 30.***

| | | | | |
|---|---|---|---|---|
| Adults' Access to Ambulatory Health Services | Jul 15 – Jun 16 | 83% | 69.97% | **No** |
| | **Oct 15 – Sep 16** | **83%** | **67.97%** | **No** |

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

# Appendix C: One Year Plan-Specific Analysis

## Molina Healthcare of Michigan – MOL

***HEALTHY MICHIGAN PLAN:***

| Performance Measure | Measurement Period | Standard | Plan Result | Standard Achieved |
|---|---|---|---|---|
| Adults' Generic Drug Utilization | Apr 16 – Jun 16 | 80% | 85.75% | Yes |
| | **Jul 16 – Sep 16** | **80%** | **85.61%** | **Yes** |
| Timely Completion of HRA | Jan 16 – Mar 16 | 15% | 8.75% | **No** |
| | **Apr 16 – Jun 16** | **15%** | **8.03%** | **No** |
| Outreach/Engagement to Facilitate Entry to Primary Care | Jan 16 – Mar 16 | 60% | 50.52% | **No** |
| | **Apr 16 – Jun 16** | **60%** | **50.23%** | **No** |
| Plan All-Cause Acute 30-Day Readmissions | Jul 15 – Jun 16 | 16% | 17.18% | **No** |
| | **Oct 15 – Sep 16** | **16%** | **17.31%** | **No** |
| Adults' Access to Ambulatory Health Services | Jul 15 – Jun 16 | 83% | 82.07% | **No** |
| | **Oct 15 – Sep 16** | **83%** | **82.45%** | **No** |

****This is a reverse measure. A lower rate indicates better performance.***

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

# Appendix C: One Year Plan-Specific Analysis

## Priority Health Choice – PRI

***HEALTHY MICHIGAN PLAN:***

| Performance Measure | Measurement Period | Standard | Plan Result | Standard Achieved |
|---|---|---|---|---|
| Adults' Generic Drug Utilization | Apr 16 – Jun 16 | 80% | 83.11% | Yes |
| | **Jul 16 – Sep 16** | **80%** | **83.37%** | **Yes** |
| Timely Completion of HRA | Jan 16 – Mar 16 | 15% | 7.60% | **No** |
| | **Apr 16 – Jun 16** | **15%** | **9.47** | **No** |
| Outreach/Engagement to Facilitate Entry to Primary Care | Jan 16 – Mar 16 | 60% | 55.92% | **No** |
| | **Apr 16 – Jun 16** | **60%** | **55.62%** | **No** |
| Plan All-Cause Acute 30-Day Readmissions | Jul 15 – Jun 16 | 16% | 13.65% | Yes |
| | **Oct 15 – Sep 16** | **16%** | **13.09%** | **Yes** |
| Adults' Access to Ambulatory Health Services | Jul 15 – Jun 16 | 83% | 83.55% | Yes |
| | **Oct 15 – Sep 16** | **83%** | **84.79%** | **Yes** |

****This is a reverse measure. A lower rate indicates better performance.***

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

# Appendix C: One Year Plan-Specific Analysis

## Total Health Care – THC

***HEALTHY MICHIGAN PLAN:***

| Performance Measure | Measurement Period | Standard | Plan Result | Standard Achieved |
|---|---|---|---|---|
| Adults' Generic Drug Utilization | Apr 16 – Jun 16 | 80% | 86.53% | Yes |
| | **Jul 16 – Sep 16** | **80%** | **85.96%** | **Yes** |
| Timely Completion of HRA | Jan 16 – Mar 16 | 15% | 15.25% | Yes |
| | **Apr 16 – Jun 16** | **15%** | **17.52%** | **Yes** |
| Outreach/Engagement to Facilitate Entry to Primary Care | Jan 16 – Mar 16 | 60% | 46.74% | **No** |
| | **Apr 16 – Jun 16** | **60%** | **46.39%** | **No** |
| Plan All-Cause Acute 30-Day Readmissions | Jul 15 – Jun 16 | 16% | 22.26% | **No** |
| | **Oct 15 – Sep 16** | **16%** | **23.18%** | **No** |
| Adults' Access to Ambulatory Health Services | Jul 15 – Jun 16 | 83% | 79.01% | **No** |
| | **Oct 15 – Sep 16** | **83%** | **78.69%** | **No** |

****This is a reverse measure. A lower rate indicates better performance.***

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

# Appendix C: One Year Plan-Specific Analysis

## UnitedHealthcare Community Plan – UNI

***HEALTHY MICHIGAN PLAN:***

| Performance Measure | Measurement Period | Standard | Plan Result | Standard Achieved |
|---|---|---|---|---|
| Adults' Generic Drug Utilization | Apr 16 – Jun 16 | 80% | 84.29% | Yes |
| | **Jul 16 – Sep 16** | **80%** | **85.95%** | **Yes** |
| Timely Completion of HRA | Jan 16 – Mar 16 | 15% | 15.45% | Yes |
| | **Apr 16 – Jun 16** | **15%** | **10.99%** | **No** |
| Outreach/Engagement to Facilitate Entry to Primary Care | Jan 16 – Mar 16 | 60% | 50.23% | **No** |
| | **Apr 16 – Jun 16** | **60%** | **48.95%** | **No** |
| Plan All-Cause Acute 30-Day Readmissions | Jul 15 – Jun 16 | 16% | 18.70% | **No** |
| | **Oct 15 – Sep 16** | **16%** | **18.61%** | **No** |
| Adults' Access to Ambulatory Health Services | Jul 15 – Jun 16 | 83% | 83.85% | Yes |
| | **Oct 15 – Sep 16** | **83%** | **83.72%** | **Yes** |

****This is a reverse measure. A lower rate indicates better performance.***

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

# Appendix C: One Year Plan-Specific Analysis

## Upper Peninsula Health Plan – UPP

***HEALTHY MICHIGAN PLAN:***

| Performance Measure | Measurement Period | Standard | Plan Result | Standard Achieved |
|---|---|---|---|---|
| Adults' Generic Drug Utilization | Apr 16 – Jun 16 | 80% | 83.09% | Yes |
| | **Jul 16 – Sep 16** | **80%** | **83.12%** | **Yes** |
| Timely Completion of HRA | Jan 16 – Mar 16 | 15% | 12.12% | **No** |
| | **Apr 16 – Jun 16** | **15%** | **10.69%** | **No** |
| Outreach/Engagement to Facilitate Entry to Primary Care | Jan 16 – Mar 16 | 60% | 53.64% | **No** |
| | **Apr 16 – Jun 16** | **60%** | **57.67%** | **No** |
| Plan All-Cause Acute 30-Day Readmissions | Jul 15 – Jun 16 | 16% | 13.53% | Yes |
| | **Oct 15 – Sep 16** | **16%** | **13.46%** | **Yes** |
| Adults' Access to Ambulatory Health Services | Jul 15 – Jun 16 | 83% | 85.16% | Yes |
| | **Oct 15 – Sep 16** | **83%** | **84.91%** | **Yes** |

****This is a reverse measure. A lower rate indicates better performance.***

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

# MI HEALTH ACCOUNT


# EXECUTIVE SUMMARY REPORT

# APRIL 2017

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

MAXIMUS contracts with each Healthy Michigan Plan health plan to operate the MI Health Account (MIHA). The MIHA documents health care costs and payments for health plan members eligible for the Healthy Michigan Plan. Any amount the beneficiary owes to the MIHA is reflected in the quarterly statement that is mailed to the beneficiary. The MIHA quarterly statement shows the total amount owed for co-pays and/or contributions.

A co-pay is a fixed amount beneficiaries pay for a health care service. Before a beneficiary is enrolled in managed care, the beneficiary will pay any co-pays directly to their provider at the time of service. Once enrolled in managed care, co-pays for health plan covered services will be paid into the MIHA.

A contribution is the amount of money that is paid toward health care coverage. **Beneficiaries with incomes at or below 100% of the Federal Poverty Level (FPL) will NOT have a contribution.** Beneficiaries above 100% FPL are required to pay contributions that are based on income and family size. The quarterly statement informs beneficiaries what to pay for co-pays and contributions each month for the next three months, includes payment coupons with instructions on how to make a payment, as well as tips on how to reduce costs (Healthy Behavior incentives). The statement lists the services the beneficiary has received, the amount the beneficiary has paid, what amount they still need to pay, and the amount the health plan has paid.

Quarterly Statement Mailing Guidelines

- The first quarterly statement is mailed six months after a beneficiary joins a health plan. After that, quarterly statements are sent every three months.
- A beneficiary follows his or her own enrollment quarter based on their enrollment effective date**.**
- Quarterly statements are mailed by the 15th calendar day of each month
- Statements are not mailed to beneficiaries if there are no health care services to display or payment due for a particular quarter.

Chart 1 displays the statement mailing activity for the past three months. It also displays the calendar year totals since January 2016 and the program totals from October 2014 to January 2017.

**Chart 1: Account Statement Mailing**

| Month Statement Mailed | Statements Mailed | Statements Requiring a Copay Only | Statements Requiring a Contribution Only | Statements Requiring a Copay and Contribution | Percentage of Statements Requiring Payment |
|---|---|---|---|---|---|
| **Nov-16** | 85,287 | 18,264 | 9,393 | 11,592 | 46.02% |
| **Dec-16** | 91,792 | 19,700 | 8,203 | 11,736 | 43.18% |
| **Jan-17** | 107,797 | 25,165 | 8,668 | 14,078 | 44.45% |
| **Calendar YTD** | **107,797** | **25,165** | **8,668** | **14,078** | **44.45%** |
| **Program Total** | **2,039,576** | **458,071** | **184,775** | **217,080** | **42.16%** |

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

Payments for the MIHA are due on the 15th of the month following the month they were billed.

Chart 2 displays a collection history of the number of beneficiaries that have paid co-pays and contributions. Completed quarterly payment cycles are explained and reflected in Chart 3. Calendar year totals are from January 2016. Program totals are from October 2014 through January 2017. Please note that beneficiaries that pay both co-pays and contributions will show in each chart.

**Chart 2: Collection Amount by Copays/Contributions**

**Copays**

| Statement Month | Amount of copays owed | Amount of copays paid | Percentage of copays paid | Number of beneficiaries who owed copays | Number of beneficiaries who paid copays |
|---|---|---|---|---|---|
| **Nov-16** | $212,639.33 | $74,998.93 | 35% | 29,856 | 12,123 |
| **Dec-16** | $237,012.31 | $86,180.18 | 36% | 31,436 | 13,077 |
| **Jan-17** | $345,065.54 | $112,365.59 | 33% | 39,243 | 14,547 |
| **Calendar YTD** | **$345,065.54** | **$112,365.59** | **33%** | **39,243** | **14,547** |
| **Program Total** | **$4,988,544.65** | **$1,944,763.59** | **39%** | **675,151** | **283,414** |

**Contributions**

| Statement Month | Amount of contributions owed | Amount of contributions paid | Percentage of contributions paid | Number of beneficiaries who owed contributions | Number of beneficiaries who paid contributions |
|---|---|---|---|---|---|
| **Nov-16** | $1,262,390.07 | $366,770.82 | 29% | 20,985 | 8,541 |
| **Dec-16** | $1,209,513.34 | $344,786.31 | 29% | 19,939 | 7,934 |
| **Jan-17** | $1,381,466.93 | $339,390.25 | 25% | 22,746 | 7,813 |
| **Calendar YTD** | **$1,381,466.93** | **$339,390.25** | **25%** | **22,746** | **7,813** |
| **Program Total** | **$22,715,995.20** | **$7,276,480.13** | **32%** | **401,855** | **178,501** |

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

Chart 3 displays the total amount collected by completed quarter, by enrollment month. For example, beneficiaries who enrolled in May 2014 received their first quarterly statement in November 2014. These individuals had until February 2015 to pay in full, which constitutes a completed quarter. Please note that the Percentage Collected will change even in completed quarters because payments received are applied to the oldest invoice owed.

**Chart 3: Quarterly Collection**

| Enrollment Month | Quarterly Pay Cycles | Amount Owed | Amount Collected | Percentage Collected |
|---|---|---|---|---|
| Apr-14 | Oct 2014 - Dec 2014 | $23,658.03 | $15,686.53 | 66.31% |
| | Jan 2015 - Mar 2015 | $193,572.66 | $139,057.92 | 71.84% |
| | Apr 2015 - Jun 2015 | $166,002.35 | $112,043.19 | 67.49% |
| | Jul 2015 - Sep 2015 | $163,715.42 | $102,316.52 | 62.5% |
| | Oct 2015 - Dec 2015 | $154,403.57 | $93,046.93 | 60.26% |
| | Jan 2016 - Mar 2016 | $141,386.65 | $82,683.30 | 58.48% |
| | Apr 2016 - Jun 2016 | $189,332.48 | $92,967.58 | 49.1% |
| | Jul 2016 - Sep 2016 | $140,306.81 | $49,539.51 | 35.31% |
| | Oct 2016 - Dec 2016 | $176,304.28 | $65,056.13 | 36.9% |
| | Jan 2017 - Mar 2017 | $174,182.54 | $54,497.64 | 31.29% |
| May-14 | Nov 2014 - Jan 2015 | $35,769.76 | $26,715.29 | 74.69% |
| | Feb 2015 - Apr 2015 | $56,655.54 | $41,071.04 | 72.49% |
| | May 2015 - Jul 2015 | $45,965.47 | $31,881.95 | 69.36% |
| | Aug 2015 - Oct 2015 | $41,859.21 | $27,816.45 | 66.45% |
| | Nov 2015 - Jan 2016 | $39,768.66 | $26,741.38 | 67.24% |
| | Feb 2016 - Apr 2016 | $37,507.78 | $24,013.40 | 64.02% |
| | May 2016 - Jul 2016 | $45,177.39 | $23,381.29 | 51.75% |
| | Aug 2016 - Oct 2016 | $39,751.96 | $18,350.64 | 46.16% |
| | Nov 2016 - Jan 2017 | $45,532.96 | $19,676.94 | 43.21% |
| | Feb 2017 - Apr 2017 | $40,844.19 | $13,134.22 | 32.16% |
| Jun-14 | Dec 2014 - Feb 2015 | $456,897.11 | $344,371.08 | 75.37% |
| | Mar 2015 - May 2015 | $349,469.83 | $261,988.55 | 74.97% |
| | Jun 2015 - Aug 2015 | $348,276.78 | $251,692.86 | 72.27% |
| | Sep 2015 - Nov 2015 | $330,018.32 | $228,299.04 | 69.18% |
| | Dec 2015 - Feb 2016 | $236,246.13 | $158,115.21 | 66.93% |
| | Mar 2016 - May 2016 | $266,720.21 | $171,714.68 | 64.38% |
| | Jun 2016 - Aug 2016 | $223,535.37 | $111,970.78 | 50.09% |
| | Sep 2016 - Nov 2016 | $311,625.52 | $164,561.74 | 52.81% |
| | Dec 2016 - Feb 2017 | $287,032.70 | $130,946.98 | 45.62% |

**Chart 3 continued on page 5**

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

**Chart 3 continued from page 4**

| Chart 3: Quarterly Collection | | | | |
|---|---|---|---|---|
| **Enrollment Month** | **Quarterly Pay Cycles** | **Amount Owed** | **Amount Collected** | **Percentage Collected** |
| **Jul-14** | Jan 2015 - Mar 2015 | $340,608.83 | $241,759.31 | 70.98% |
| | Apr 2015 - Jun 2015 | $252,201.13 | $175,633.51 | 69.64% |
| | Jul 2015 - Sep 2015 | $242,970.21 | $160,871.01 | 66.21% |
| | Oct 2015 - Dec 2015 | $222,134.40 | $142,495.03 | 64.15% |
| | Jan 2016 - Mar 2016 | $196,055.18 | $121,873.58 | 62.16% |
| | Apr 2016 - Jun 2016 | $212,078.25 | $113,247.43 | 53.4% |
| | Jul 2016 - Sep 2016 | $165,609.01 | $64,974.91 | 39.23% |
| | Oct 2016 - Dec 2016 | $193,598.15 | $75,627.61 | 39.06% |
| | Jan 2017 - Mar 2017 | $185,479.54 | $57,132.26 | 30.8% |
| **Aug-14** | Feb 2015 - Apr 2015 | $169,943.88 | $121,696.26 | 71.61% |
| | May 2015 - Jul 2015 | $121,943.60 | $81,837.47 | 67.11% |
| | Aug 2015 - Oct 2015 | $111,434.87 | $78,218.25 | 70.19% |
| | Nov 2015 - Jan 2016 | $103,760.91 | $70,845.81 | 68.28% |
| | Feb 2016 - Apr 2016 | $96,960.41 | $61,313.20 | 63.24% |
| | May 2016 - Jul 2016 | $104,885.54 | $48,338.40 | 46.09% |
| | Aug 2016 - Oct 2016 | $86,468.87 | $33,665.98 | 38.93% |
| | Nov 2016 - Jan 2017 | $102,165.34 | $38,214.24 | 37.4% |
| | Feb 2017 - Apr 2017 | $96,475.03 | $26,341.08 | 27.3% |
| **Sep-14** | Mar 2015 - May 2015 | $212,589.51 | $136,753.72 | 64.33% |
| | Jun 2015 - Aug 2015 | $147,749.08 | $93,945.69 | 63.58% |
| | Sep 2015 - Nov 2015 | $150,579.55 | $95,366.44 | 63.33% |
| | Dec 2015 - Feb 2016 | $121,107.64 | $74,978.64 | 61.91% |
| | Mar 2016 - May 2016 | $136,278.97 | $74,478.44 | 54.65% |
| | Jun 2016 - Aug 2016 | $97,275.67 | $34,602.46 | 35.57% |
| | Sep 2016 - Nov 2016 | $113,058.37 | $43,949.66 | 38.87% |
| | Dec 2016 - Feb 2017 | $112,385.07 | $38,819.61 | 34.54% |
| **Oct-14** | Apr 2015 - Jun 2015 | $174,197.65 | $110,895.29 | 63.66% |
| | Jul 2015 - Sep 2015 | $126,055.34 | $81,308.57 | 64.5% |
| | Oct 2015 - Dec 2015 | $125,081.14 | $79,558.52 | 63.61% |
| | Jan 2016 - Mar 2016 | $119,598.11 | $73,789.89 | 61.7% |
| | Apr 2016 - Jun 2016 | $136,379.87 | $68,153.06 | 49.97% |
| | Jul 2016 - Sep 2016 | $100,633.12 | $34,576.86 | 34.36% |
| | Oct 2016 - Dec 2016 | $116,572.16 | $43,266.26 | 37.12% |
| | Jan 2017 - Mar 2017 | $114,103.24 | $34,942.13 | 30.62% |

**Chart 3 continued on page 6**

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

**Chart 3 continued from page 5**

| Chart 3: Quarterly Collection | | | | |
|---|---|---|---|---|
| **Enrollment Month** | **Quarterly Pay Cycles** | **Amount Owed** | **Amount Collected** | **Percentage Collected** |
| **Nov-14** | May 2015 - Jul 2015 | $194,912.71 | $121,991.27 | 62.59% |
| | Aug 2015 - Oct 2015 | $126,227.99 | $78,670.79 | 62.32% |
| | Nov 2015 - Jan 2016 | $133,118.68 | $85,735.85 | 64.41% |
| | Feb 2016 - Apr 2016 | $134,185.08 | $80,854.87 | 60.26% |
| | May 2016 - Jul 2016 | $155,026.52 | $64,699.20 | 41.73% |
| | Aug 2016 - Oct 2016 | $118,236.61 | $39,325.11 | 33.26% |
| | Nov 2016 - Jan 2017 | $139,596.20 | $47,113.71 | 33.75% |
| | Feb 2017 - Apr 2017 | $134,590.37 | $30,691.70 | 22.8% |
| **Dec-14** | Jun 2015 - Aug 2015 | $105,155.89 | $68,353.16 | 65% |
| | Sep 2015 - Nov 2015 | $81,853.72 | $53,981.33 | 65.95% |
| | Dec 2015 - Feb 2016 | $67,516.28 | $44,931.10 | 66.55% |
| | Mar 2016 - May 2016 | $80,404.63 | $48,694.35 | 60.56% |
| | Jun 2016 - Aug 2016 | $68,267.21 | $24,305.92 | 35.6% |
| | Sep 2016 - Nov 2016 | $72,013.23 | $25,587.62 | 35.53% |
| | Dec 2016 - Feb 2017 | $70,234.73 | $22,250.22 | 31.68% |
| **Jan-15** | Jul 2015 - Sep 2015 | $211,292.27 | $145,026.50 | 68.64% |
| | Oct 2015 - Dec 2015 | $170,295.60 | $112,040.09 | 65.79% |
| | Jan 2016 - Mar 2016 | $166,442.81 | $110,102.81 | 66.15% |
| | Apr 2016 - Jun 2016 | $191,785.54 | $106,458.62 | 55.51% |
| | Jul 2016 - Sep 2016 | $157,065.07 | $59,492.48 | 37.88% |
| | Oct 2016 - Dec 2016 | $163,838.96 | $63,874.81 | 38.99% |
| | Jan 2017 - Mar 2017 | $166,334.03 | $54,769.65 | 32.93% |
| **Feb-15** | Aug 2015 - Oct 2015 | $206,200.52 | $137,595.19 | 66.73% |
| | Nov 2015 - Jan 2016 | $132,926.64 | $90,557.82 | 68.13% |
| | Feb 2016 - Apr 2016 | $147,748.12 | $101,855.67 | 68.94% |
| | May 2016 - Jul 2016 | $191,784.79 | $94,415.16 | 49.23% |
| | Aug 2016 - Oct 2016 | $154,056.72 | $59,688.89 | 38.74% |
| | Nov 2016 - Jan 2017 | $154,762.14 | $56,320.05 | 36.39% |
| | Feb 2017 - Apr 2017 | $154,743.35 | $42,640.40 | 27.56% |

**Chart 3 continued on page 7**

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

**Chart 3 continued from page 6**

| Chart 3: Quarterly Collection | | | | |
|---|---|---|---|---|
| **Enrollment Month** | **Quarterly Pay Cycles** | **Amount Owed** | **Amount Collected** | **Percentage Collected** |
| **Mar-15** | Sep 2015 - Nov 2015 | $221,898.84 | $139,022.82 | 62.65% |
| | Dec 2015 - Feb 2016 | $100,647.04 | $65,583.29 | 65.16% |
| | Mar 2016 - May 2016 | $110,097.50 | $71,646.29 | 65.08% |
| | Jun 2016 - Aug 2016 | $125,826.44 | $56,513.23 | 44.91% |
| | Sep 2016 - Nov 2016 | $130,675.49 | $53,822.22 | 41.19% |
| | Dec 2016 - Feb 2017 | $115,777.31 | $40,770.46 | 35.21% |
| **Apr-15** | Oct 2015 - Dec 2015 | $276,361.26 | $171,728.65 | 62.14% |
| | Jan 2016 - Mar 2016 | $137,737.87 | $89,886.67 | 65.26% |
| | Apr 2016 - Jun 2016 | $172,425.70 | $102,580.18 | 59.49% |
| | Jul 2016 - Sep 2016 | $150,189.56 | $69,044.36 | 45.97% |
| | Oct 2016 - Dec 2016 | $158,007.64 | $65,561.61 | 41.49% |
| | Jan 2017 - Mar 2017 | $145,870.47 | $51,514.73 | 35.32% |
| **May-15** | Nov 2015 - Jan 2016 | $190,420.26 | $119,624.92 | 62.82% |
| | Feb 2016 - Apr 2016 | $125,493.03 | $86,297.70 | 68.77% |
| | May 2016 - Jul 2016 | $167,798.38 | $91,944.91 | 54.79% |
| | Aug 2016 - Oct 2016 | $145,208.86 | $67,995.02 | 46.83% |
| | Nov 2016 - Jan 2017 | $142,580.78 | $56,759.34 | 39.81% |
| | Feb 2017 - Apr 2017 | $122,044.74 | $35,193.94 | 28.84% |
| **Jun-15** | Dec 2015 - Feb 2016 | $159,661.05 | $92,213.78 | 57.76% |
| | Mar 2016 - May 2016 | $106,610.18 | $63,760.37 | 59.81% |
| | Jun 2016 - Aug 2016 | $98,454.47 | $45,083.93 | 45.79% |
| | Sep 2016 - Nov 2016 | $111,589.11 | $45,037.73 | 40.36% |
| | Dec 2016 - Feb 2017 | $100,843.97 | $33,193.38 | 32.92% |
| **Jul-15** | Jan 2016 - Mar 2016 | $151,151.65 | $92,358.88 | 61.1% |
| | Apr 2016 - Jun 2016 | $111,659.64 | $60,240.96 | 53.95% |
| | Jul 2016 - Sep 2016 | $94,734.85 | $39,353.16 | 41.54% |
| | Oct 2016 - Dec 2016 | $98,536.07 | $37,660.03 | 38.22% |
| | Jan 2017 - Mar 2017 | $92,033.45 | $26,847.73 | 29.17% |
| **Aug-15** | Feb 2016 - Apr 2016 | $158,254.92 | $85,283.30 | 53.89% |
| | May 2016 - Jul 2016 | $112,748.32 | $48,800.09 | 43.28% |
| | Aug 2016 - Oct 2016 | $95,287.03 | $36,763.24 | 38.58% |
| | Nov 2016 - Jan 2017 | $106,040.83 | $34,555.25 | 32.59% |
| | Feb 2017 - Apr 2017 | $95,152.01 | $21,490.09 | 22.59% |

**Chart 3 continued on page 8**

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

**Chart 3 continued from page 7**

| Chart 3: Quarterly Collection | | | | |
|---|---|---|---|---|
| **Enrollment Month** | **Quarterly Pay Cycles** | **Amount Owed** | **Amount Collected** | **Percentage Collected** |
| **Sep-15** | Mar 2016 - May 2016 | $126,091.70 | $66,573.50 | 52.8% |
| | Jun 2016 - Aug 2016 | $80,659.45 | $29,275.42 | 36.3% |
| | Sep 2016 - Nov 2016 | $74,970.26 | $29,997.50 | 40.01% |
| | Dec 2016 - Feb 2017 | $79,017.91 | $24,858.78 | 31.46% |
| **Oct-15** | Apr 2016 - Jun 2016 | $145,826.56 | $49,776.61 | 34.13% |
| | Jul 2016 - Sep 2016 | $89,215.13 | $30,480.48 | 34.17% |
| | Oct 2016 - Dec 2016 | $96,685.67 | $33,560.37 | 34.71% |
| | Jan 2017 - Mar 2017 | $95,120.81 | $25,763.48 | 27.09% |
| **Nov-15** | May 2016 - Jul 2016 | $173,055.42 | $56,138.42 | 32.44% |
| | Aug 2016 - Oct 2016 | $117,305.59 | $36,707.70 | 31.29% |
| | Nov 2016 - Jan 2017 | $130,800.35 | $37,871.62 | 28.95% |
| | Feb 2017 - Apr 2017 | $124,201.25 | $23,970.92 | 19.3% |
| **Dec-15** | Jun 2016 - Aug 2016 | $158,271.66 | $54,704.35 | 34.56% |
| | Sep 2016 - Nov 2016 | $127,407.65 | $39,662.36 | 31.13% |
| | Dec 2016 - Feb 2017 | $130,332.62 | $36,689.17 | 28.15% |
| **Jan-16** | Jul 2016 - Sep 2016 | $205,150.00 | $80,553.39 | 39.27% |
| | Oct 2016 - Dec 2016 | $163,173.79 | $57,067.43 | 34.97% |
| | Jan 2017 - Mar 2017 | $157,002.22 | $49,360.25 | 31.44% |
| **Feb-16** | Aug 2016 - Oct 2016 | $277,203.59 | $118,446.35 | 42.73% |
| | Nov 2016 - Jan 2017 | $217,882.64 | $80,849.73 | 37.11% |
| | Feb 2017 - Apr 2017 | $199,681.48 | $55,114.66 | 27.6% |
| **Mar-16** | Sep 2016 - Nov 2016 | $249,953.39 | $92,851.19 | 37.15% |
| | Dec 2016 - Feb 2017 | $179,430.76 | $57,457.84 | 32.02% |
| **Apr-16** | Oct 2016 - Dec 2016 | $237,491.79 | $77,269.67 | 32.54% |
| | Jan 2017 - Mar 2017 | $185,404.66 | $50,683.64 | 27.34% |
| **May-16** | Nov 2016 - Jan 2017 | $242,160.65 | $70,920.52 | 29.29% |
| | Feb 2017 - Apr 2017 | $186,740.09 | $35,709.97 | 19.12% |
| **Jun-16** | Dec 2016 - Feb 2017 | $148,713.17 | $47,029.87 | 31.62% |
| **Jul-16** | Jan 2017 - Mar 2017 | $173,811.53 | $46,838.51 | 26.95% |
| **Aug-16** | Feb 2017 - Apr 2017 | $189,386.68 | $45,314.28 | 23.93% |

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

Payments for the MIHA can be made one of two ways. Beneficiaries can mail a check or money order to the MIHA payment address. The payment coupon is not required to send in a payment by mail. Beneficiaries also have the option to pay online using a bank account.

Chart 4 displays a three month history of the percentage of payments made into the MIHA.

**Chart 4: Methods of Payment**

| | Nov-16 | Dec-16 | Jan-17 |
|---|---|---|---|
| **Percent Paid Online** | 31.59% | 29.57% | 29.48% |
| **Percent Paid by Mail** | 68.41% | 70.43% | 70.52% |

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

Adjustment Activities

Beneficiaries are not required to pay co-pays and/or contributions when specific criteria are met. In these cases, an adjustment is made to the beneficiary's quarterly statement.

This includes populations that are exempt; beneficiaries that are under age 21, pregnant, in hospice and Native American beneficiaries. It also includes beneficiaries who were not otherwise exempt, but have met their five percent maximum cost share and beneficiaries whose Federal Poverty Level is no longer in a range that requires a contribution.

Chart 5A shows the number of beneficiaries that met these adjustments for the specified month, calendar year since January 2016 and the cumulative total for the program from October 2014 through January 2017.

**Chart 5A: Adjustment Activities**

| | Nov-16 | | Dec-16 | | Jan-17 | |
|---|---|---|---|---|---|---|
| | # | Total $ | # | Total $ | # | Total $ |
| **Beneficiary is under age 21** | 770 | $46,580.01 | 737 | $44,921.00 | 753 | $46,346.00 |
| **Pregnancy** | 240 | $5,580.19 | 237 | $5,709.34 | 251 | $6,039.77 |
| **Hospice** | 0 | $0.00 | 0 | $0.00 | 0 | $0.00 |
| **Native American** | 25 | $2,072.00 | 28 | $2,299.00 | 27 | $1,735.00 |
| **Five Percent Cost Share Limit Met** | 25,510 | $267,756.40 | 31,135 | $356,905.17 | 38,547 | $413,815.23 |
| **FPL No longer >100% - Contribution** | 3 | $12.00 | 11 | $86.72 | 4 | $45.00 |
| **TOTAL** | **26,548** | **$322,000.60** | **32,148** | **$409,921.23** | **39,582** | **$467,981.00** |
| | **Nov-16 to Jan-17** | | **Calendar YTD** | | **Program YTD** | |
| | # | Total $ | # | Total $ | # | Total $ |
| **Beneficiary is under age 21** | 2,260 | $137,847.01 | 753 | $46,346.00 | 13,230 | $721,462.29 |
| **Pregnancy** | 728 | $17,329.30 | 251 | $6,039.77 | 6,904 | $164,654.58 |
| **Hospice** | 0 | $0.00 | 0 | $0.00 | 0 | $0.00 |
| **Native American** | 80 | $6,106.00 | 27 | $1,735.00 | 657 | $37,866.84 |
| **Five Percent Cost Share Limit Met** | 95,192 | $1,038,476.44 | 38,547 | $413,815.23 | 682,771 | $8,116,386.97 |
| **FPL No longer >100% - Contribution** | 18 | $143.72 | 4 | $45.00 | 258 | $10,794.38 |
| **TOTAL** | **98,278** | **$1,199,902.47** | **39,582** | **$467,981.00** | **703,820** | **$9,051,165.06** |

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

Healthy Behavior Incentives

Beneficiaries may qualify for reductions in co-pays and/or contributions due to Healthy Behavior incentives. All health plans offer enrolled beneficiaries financial incentives that reward healthy behaviors and personal responsibility. To be eligible for incentives a beneficiary must first complete a health risk assessment (HRA) with their primary care provider (PCP) and agree to address or maintain health behaviors.

*Co-pays* – Beneficiaries can receive a 50% reduction in co-pays once they have paid 2% of their income in co-pays AND agree to address or maintain healthy behaviors.

*Contributions* - Beneficiaries can receive a 50% reduction in contributions if they complete an HRA with a PCP attestation AND agree to address or maintain healthy behaviors.

*Gift Cards* – Beneficiaries at or below 100% FPL receive a $50.00 gift card if they complete an HRA with a PCP attestation AND agree to address or maintain healthy behaviors.

Chart 5B shows the number of beneficiaries that qualified for a reduction in co-pays and/or contributions due to Healthy Behavior incentives for the specified month, calendar year since January 2016 and the cumulative total for the program from October 2014 through January 2017.

**Chart 5B: Healthy Behaviors**

| | Nov-16 | | Dec-16 | | Jan-17 | |
|---|---|---|---|---|---|---|
| | # | Total $ | # | Total $ | # | Total $ |
| **Co-pay** | 813 | $3,478.61 | 853 | $3,957.66 | 983 | $5,320.74 |
| **Contribution** | 1,837 | $63,966.00 | 1,673 | $63,278.63 | 1,608 | $59,613.00 |
| **Gift Cards** | 2,494 | n/a | 2,416 | n/a | 2,881 | n/a |
| **TOTAL** | **5,144** | **$67,444.61** | **4,942** | **$67,236.29** | **5,472** | **$64,933.74** |
| | **Nov 16 to Jan-17** | | **Calendar YTD** | | **Program YTD** | |
| | # | Total $ | # | Total $ | # | Total $ |
| **Co-pay** | 2,649 | $12,757.01 | 983 | $5,320.74 | 29,001 | $181,588.75 |
| **Contribution** | 5,118 | $186,857.63 | 1,608 | $59,613.00 | 58,175 | $2,073,437.88 |
| **Gift Cards** | 7,791 | n/a | 2,881 | n/a | 101,314 | n/a |
| **TOTAL** | **15,558** | **$199,614.64** | **5,472** | **$64,933.74** | **188,490** | **$2,255,026.63** |

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

Typically, beneficiaries will pay a co-pay for the following services:

- Physician Office Visits (including free standing Urgent Care Centers)
- Outpatient Hospital Clinic Visit
- Outpatient Non-Emergent ER Visit (co-pay not required for emergency services)
- Inpatient Hospital Stay (co-pay not required for emergency admissions)
- Pharmacy (brand name and generic)
- Vision Services
- Dental Visits
- Chiropractic Visits
- Hearing Aids
- Podiatric Visits

If a beneficiary receives any of the above services for a chronic condition, the co-pay will be waived and the beneficiary will not be billed. This promotes greater access to high value services that prevent the progression of and complications related to chronic disease.

Chart 6 shows the number of beneficiaries whose co-pays were waived and the dollar amount waived due to receiving services for chronic conditions. Co-pay adjustments for high value services are processed quarterly based on the beneficiaries' individual enrollment and statement cycles.

**Chart 6: Waived Copays for High Value Services**

| Month | # of Beneficiaries with Copays Waived | Total Dollar Amount Waived |
|---|---|---|
| **Nov-16** | 28,517 | $233,329 |
| **Dec-16** | 33,875 | $287,418 |
| **Jan-17** | 43,626 | $328,779 |
| **Calendar YTD** | **43,626** | **$328,779** |
| **Program Total** | **300,942** | **$2,557,961** |

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

Beneficiaries that do not pay three consecutive months they have been billed co-pays or contributions are considered "consistently failing to pay (CFP)" status. Once a beneficiary is in CFP status, the following language is added to the quarterly statement: "If your account is overdue, you may have a penalty. For example, if you have a healthy behavior reduction, you could lose it. Your information may also be sent to the Michigan Department of Treasury. They can take your overdue amount from your tax refund or future lottery winnings. Your doctor cannot refuse to see you because of an overdue amount." Beneficiaries that are in CFP status and have a total amount owed of at least $50 can be referred to the Department of Treasury for collection. Beneficiaries that have not paid at least 50% of their total contributions and co-pays billed to them in the past 12 months can also be referred to the Department of Treasury for collection.

Chart 7 displays the past due collection history and the number of beneficiaries that have past due balances that can be collected through the Department of Treasury. These numbers are cumulative from quarter to quarter.

**Chart 7: Past Due Collection Amounts**

| Month | # of Beneficiaries with Past Due Co-pays/Contributions | # of Beneficiaries with Past Due Co-pays/Contributions that Can be Sent to Treasury |
|---|---|---|
| **Nov-16** | 135,952 | 56,033 |
| **Dec-16** | 143,809 | 60,802 |
| **Jan-17** | 151,382 | 64,953 |

Chart 8 displays the total amount of past due invoices according to the length of time the invoice has been outstanding. Each length of time displays the unique number of beneficiaries for that time period. The total number of delinquent beneficiaries is also listed along with the corresponding delinquent amount owed.

**Chart 8: Delinquent Copay and Contribution Amounts by Aging Category**

| Days | 0-30 Days | 31-60 Days | 61-90 Days | 91-120 Days | >120 Days | TOTAL |
|---|---|---|---|---|---|---|
| **Amount Due** | $1,047,696.66 | $955,880.15 | $905,361.78 | $851,586.02 | $8,091,141.00 | **$11,851,665.61** |
| **Number of Beneficiaries That Owe** | 82,675 | 74,899 | 70,580 | 66,355 | 157,125 | **201,281** |

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

Beneficiaries are mailed a letter that informs them of the amount that could be garnished by the Department of Treasury. This pre-garnishment notice is mailed each year in July. Beneficiaries are given 30 days from the date of the letter to make a payment or file a dispute with the Department of Health and Human Services (DHHS) for the amount owed.

Chart 9 displays the beneficiary payment activity as a result of the pre-garnishment notice.

**Chart 9: Pre-Garnishment Notices**

| Month/Year | # of Beneficiaries that Received a Garnishment Notice | Total Amount Owed | # of Beneficiaries that Paid Following Pre-Garnishment Notice | Total Amount Collected |
|---|---|---|---|---|
| **Jul-15** | 5,893 | $589,770.20 | 2,981 | $78,670.02 |
| **Jul-16** | 41,460 | $5,108,153.13 | 3,832 | $404,921.47 |
| **Calendar YTD** | **41,460** | **$5,108,153.13** | **3,832** | **$404,921.47** |
| **Program Total** | **47,353** | **$5,697,923.33** | **6,813** | **$483,591.49** |

Beneficiaries are referred to the Department of Treasury each year in November if they still owe at least $50 following the pre-garnishment notice.

Chart 10 displays the number of beneficiaries that were referred to Treasury.

**Chart 10: Garnishments Sent to Treasury**

| Month | # of Beneficiaries Sent to Treasury for Garnishment | Total Amount Sent to Treasury for Garnishment |
|---|---|---|
| **Nov-15** | 4,635 | $460,231.19 |
| **Nov-16** | 31,932 | $3,946,091.28 |

# HEALTHY MICHIGAN PLAN
# MI HEALTH ACCOUNT: APRIL 2017

The Department of Treasury may garnish tax refunds or lottery winnings up to the amount referred to them from the MI Health Account.

Chart 11 displays collection activities by the Department of Treasury.

**Chart 11: Garnishments Collected by Treasury**

| Tax Year | Collected by Taxes | | Collected by Lottery | | Total Garnishments Collected | |
|---|---|---|---|---|---|---|
| | # | Total | # | Total | # | Total |
| **2015** | 2,151 | $207,873.10 | 7 | $485.67 | **2,158** | **$208,358.77** |
| **2016** | 15,763 | $1,824,535.87 | 38 | $4,211.51 | **15,801** | **$1,828,747.38** |
| **Calendar YTD** | **15,763** | **$1,824,535.87** | **38** | **$4,211.51** | **15,801** | **$1,828,747.38** |
| **Program Total** | **17,914** | **$2,032,408.97** | **45** | **$4,697.18** | **17,959** | **$2,037,106.15** |

**The Healthy Michigan Plan**
**Public Act 107 of 2013 §105d (8), (9)**
**2015 Report on Uncompensated Care and Insurance Rates**

*December 31, 2016*

Submitted to the Michigan Department of Health and Human Services
and the Michigan Department of Insurance and Financial Services

Prepared by the University of Michigan Institute for Healthcare Policy & Innovation
in collaboration with the University of Michigan School of Public Health

§*105d (8)* The program described in this section is created in part to extend health coverage to the state's low-income citizens and to provide health insurance cost relief to individuals and to the business community by reducing the cost shift attendant to uncompensated care. Uncompensated care does not include courtesy allowances or discounts given to patients. The Medicaid hospital cost report shall be part of the uncompensated care definition and calculation. In addition to the Medicaid hospital cost report, the department of community health shall collect and examine other relevant financial data for all hospitals and evaluate the impact that providing medical coverage to the expanded population of enrollees described in subsection (1)(a) has had on the actual cost of uncompensated care. This shall be reported for all hospitals in the state. By December 31, 2014, the department of community health shall make an initial baseline uncompensated care report containing at least the data described in this subsection to the legislature and each December 31 after that shall make a report regarding the preceding fiscal year's evidence of the reduction in the amount of the actual cost of uncompensated care compared to the initial baseline report. The baseline report shall use fiscal year 2012-2013 data. Based on the evidence of the reduction in the amount of the actual cost of uncompensated care borne by the hospitals in this state, beginning April 1, 2015, the department of community health shall proportionally reduce the disproportionate share payments to all hospitals and hospital systems for the purpose of producing general fund savings. The department of community health shall recognize any savings from this reduction by September 30, 2016. All the reports required under this subsection shall be made available to the legislature and shall be easily accessible on the department of community health's website.

§*105d (9)* The department of insurance and financial services shall examine the financial reports of health insurers and evaluate the impact that providing medical coverage to the expanded population of enrollees described in subsection (1)(a) has had on the cost of uncompensated care as it relates to insurance rates and insurance rate change filings, as well as its resulting net effect on rates overall. The department of insurance and financial services shall consider the evaluation described in this subsection in the annual approval of rates. By December 31, 2014, the department of insurance and financial services shall make an initial baseline report to the legislature regarding rates and each December 31 after that shall make a report regarding the evidence of the change in rates compared to the initial baseline report. All the reports required under this subsection shall be made available to the legislature and shall be made available and easily accessible on the department of community health's website.

## Table of Contents

## Executive Summary

This report, pursuant to §105d (8) and (9) of Public Act 107 of 2013, provides the annual update to the baseline estimate of uncompensated care borne by Michigan hospitals as it relates to insurance rates and rate setting.

The main source of data for the uncompensated care portion is cost reports that hospitals submit annually to the Michigan Department of Health and Human Services (MDHHS). The initial report, submitted in December 2014, provided baseline data on hospital uncompensated care from 2013, i.e., prior to the implementation of the Healthy Michigan Plan (HMP). The December 2015 report presented data from 2014. Because of reporting lags and the timing of hospital fiscal years, these data represented post-HMP experience for only a subset of hospitals, and even in those cases the most recent data represented a mix of pre- and post-HMP data. The most recent data used in this report were submitted in 2015. For most hospitals, these data pertain to fiscal year 2015 and represent a full 12 months of post-HMP experience. For a subset of hospitals, the most recent data available are for fiscal year 2014 and therefore represent a mix of pre- and post-HMP data. We present results for 2013, 2014 and 2015, though for the purposes of evaluating the effect of the HMP on hospital uncompensated care, the cleanest comparisons are between 2013 and 2015.

Two main sources of data, key informant interviews and Michigan DIFS rate filings, provide information on the contribution of uncompensated care to premium rates, rate change filings, and the net effect on rates overall, in the year before and each of the two years following implementation of the Healthy Michigan Plan.

### Key findings: §105d (8) Uncompensated Care

The cost report data indicate that the cost of uncompensated care provided by Michigan hospitals fell dramatically after the implementation of the Healthy Michigan Plan. Comparing data from 2013 and 2015 for a consistent set of hospitals, uncompensated care costs decreased by almost 50 percent. For the average hospital, annual uncompensated care expenses fell from $7.21 million to $3.77 million. Expressed as a percentage of total hospital expenses, uncompensated care decreased from 5.2 percent to 2.9 percent. Over 90 percent of hospitals submitting data for both FY 2013 and FY 2015 saw a decline in uncompensated care between those two years.

### Key findings: §105d (9) Insurance Premium Rates

There was no evidence from the interviews and rate filings that the Healthy Michigan Plan affected health plan premium rates. Review and analysis of DIFS rate filings showed changes in the increases requested in premium rates by year and by product and market. The average weighted premium rate increase requested in filings declined from 2013-2015: 7.55% in 2013, 5.77% in 2014, and 5.20% in 2015. While the requested rate increase varied by products and markets, reasons given in the filings for the rate requests were related most often to increasing medical and pharmaceutical costs.

Interviews with key stakeholders revealed concerns with increasing medical and pharmacy costs. Some respondents expressed concerns about future premium changes as a result of changes in the methodology for determining risk adjustment or expiration in 2016 of the Federal reinsurance program. With the reinsurance program, all individual, small group, and large group market issuers of fully-insured major medical products, as well as self-funded plans, contributed funds to the reinsurance program since 2014, with proceeds distributed to insurers who had enrollees with high medical expenses. For 2016, these reinsurance payments reduced individual market premiums by an estimated 4 to 6 percent. Without the reinsurance program, some insurers will need to raise their premiums in 2017 by a comparable percentage to make up for the loss of the reinsurance funds.[1]

The report details the decrease in uncompensated care costs since the Medicaid expansion; however, there was no evidence from the interviews and rate filings that the Healthy Michigan Plan affected health plan premium negotiations or premium rates.

**Challenges in Quantifying the Impact of Uncompensated Care Costs and the Healthy Michigan Plan on Premium Rates**

Developing health insurance premium rates involves numerous stakeholders, such as insurers, hospitals, employers, physicians, pharmacy benefit managers, pharmaceutical and medical device manufacturers, to name a few. There are also complex rate setting methodologies, and propriety information, overlaid on continually changing medical and insurance markets. In addition, not all plans and policies offered in a state are subject to regulation, review, and approval by the state. There is no single source of data that provides all necessary elements for analysis. These and other factors make it difficult to attribute observed premium rate changes to the Healthy Michigan Plan.

The academic literature in health economics and health policy does not provide direct theoretical or empirical support for a transfer of the costs of uncompensated care or of shortfalls in Medicare and Medicaid payments to private payers, despite perceptions of the existence of cost shift.[2] Cost shifting has been defined as "the phenomenon in which changes in administered prices of one payer lead to compensating changes in prices charged to other payers."[3] Prior research demonstrates that uncompensated care as a share of overall health care costs has remained relatively flat while the private payment to cost ratio has increased, suggesting that factors other than changes in uncompensated care explain changes in private insurance premiums.[4]

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[1] http://kff.org/private-insurance/perspective/what-to-look-for-in-2017-aca-marketplace-premium-changes/

[2] Couglin TA, Holahan, J, Caswell, K, McGrath, M. Uncompensated care for the uninsured: A detailed examination. Kaiser Family Foundation report. May 30, 2013. Available from: http://kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-cost-shifting-and-remaining-uncompensated-care-costs-8596/

[3] Ginsburg P. Can hospitals and physicians shift the effects of cuts in Medicare reimbursement to private payers? Health Aff [Internet]. 2003;(Web Exclusive):W3–472 to W3–479. Available from: http://content.healthaffairs.org/content/early/2003/10/08/hlthaff.w3.472.full.pdf

[4] Forslund TO. Cost shifting and the impact of new hospitals on existing markets. Wyoming Department of Health. 2014.

A number of factors contribute to changes in private insurance premiums, with changes in public payer rates and in uncompensated care being just two of these factors. Even in situations where a hospital has a large share of market power, hospitals may employ other strategies rather than increase prices when faced with revenue shortfalls, including cost cutting and "volume shifting," and lowering private prices to attract more private volume.[5] Even if cost shifting does occur at its maximum, the amount that would potentially be shifted to employers is less than 3% of private insurance premiums.[6] The complex interplay of factors that explain changes in private insurance rates, as also noted in the literature, makes it very difficult to attribute changes in insurance premiums to the reductions in uncompensated care resulting from the Healthy Michigan Plan.

**Conclusion**

Based on hospital cost reports submitted to MDHHS, Michigan hospitals experienced a substantial decline in the costs of uncompensated care in FY 2015 compared to FY 2013. Yet rate filings and interviews with key stakeholders do not demonstrate a connection between reductions in uncompensated care and premium rates.

[5] Frakt A. How much do hospitals cost shift? A review of the evidence. Milbank Q. 2011;89(1):90–130.
[6] Couglin TA, Holahan, J, Caswell, K, McGrath, M. Uncompensated care for the uninsured: A detailed examination. Kaiser Family Foundation report. May 30, 2013. Available from: http://kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-cost-shifting-and-remaining-uncompensated-care-costs-8596/

## §105d (8): Uncompensated Care

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### Introduction

In order to measure the effect of the Healthy Michigan Plan, §105(d)(8) of Public Act 107 requires the Department of Community Health (DCH), now the Department of Health and Human Services (DHHS), to publish annual reports on uncompensated care in Michigan. This section of the report, *The Healthy Michigan Plan: Uncompensated Care*, fulfills the requirement of §105(d)(8). The analysis is based on data from Medicaid cost reports submitted to the state annually from 2013 to 2015.

### Background

The 2015 PA 107 report presented quarterly state-level data on inpatient hospital discharges from 2003 to the third quarter of 2014. These data revealed immediate changes in payer mix in Michigan after the implementation of the Healthy Michigan Plan. The Medicaid share of hospital discharges rose from 17 percent in the 1st quarter of 2014 – before HMP – to 20 percent in the 3rd quarter of 2014. At the same time the uninsured share of discharges also fell by three percentage points, from 4 percent to 1 percent. These sharp changes, which followed a decade in which payer mix shifted very gradually, suggested a significant effect of the Healthy Michigan Plan. Other published research using data from Michigan[7] and comparing a greater number of states that implemented the ACA Medicaid expansion also indicate a significant reduction in uninsured discharges and an increase in Medicaid discharges after Medicaid expansion.[8]

### Data: Medicaid cost reports

Each year, Michigan hospitals submit cost reports to the State Medicaid program. Based on several data elements contained in these reports, it is possible to calculate the cost of uncompensated care provided by each hospital.

Uncompensated care is the sum of two different types of costs: charity care and bad debt. ***Charity care*** is the cost of medical care for which there was no expectation of payment because the patient has been deemed unable to pay. ***Bad debt*** is the cost of medical care for which there was an expectation of payment because the patient was deemed to be able to pay for care, but ultimately payment was not received. Both types of uncompensated care may arise from patients

[7] Davis MA, Gebremariam A, Ayanian JZ. Changes in insurance coverage among hospitalized non-elderly adults after Medicaid expansion in Michigan. JAMA 2016; 315:2617-8.
[8] Hempstead K, Cantor JC. State Medicaid expansion and changes in hospital volume according to payer. New England Journal of Medicine 2016; 374(2): 196-198. Nikpay S, Buchmueller T, Levy HG. 2016. Affordable Care Act Medicaid expansion reduced uninsured hospital stays in 2014. Health Affairs 2016; 35 (1):106-110.

who are uninsured or from those who are under-insured and unable to afford deductibles or other cost-sharing required by their insurance plans when they receive hospital care. Changes in Disproportionate Share Hospital (DSH) payments do not have a direct impact on uncompensated care. For more information on the definition of uncompensated care, please see Appendix A.

The cost reports for state fiscal year (FY) 2015 include data on 142 hospitals. Hospitals vary in the timing of their fiscal years and this variation affects the timing of when data is reported to the state. Table 1 summarizes the timing of hospital fiscal years and indicates how this timing affects our ability to measure changes in uncompensated care before and after the implementation of the Healthy Michigan Plan (HMP).

For hospitals with fiscal years ending in the first three quarters of the calendar year (i.e., before September 30) the most recent submission pertains to their 2015 fiscal year. Regardless of the exact timing, FY 2015 started after April 1, 2014. Thus, all data from FY 2015 represents 12 months of post-HMP experience. There is variation, however, in how data for FY 2014 lines up with the start of the HMP. For hospitals with fiscal years ending in the first quarter, FY 2014 ended before the start of HMP enrollment, which means that FY 2014 represents 12 months of pre-HMP data. In contrast, for hospitals with fiscal years ending in the second or third quarter, FY 2014 started before and ended after the establishment of the program. Thus, for these hospitals FY 2014 represents a mix of pre- and post-HMP experience. Hospitals with fiscal years ending in the fourth quarter always submit their cost report data with a lag. For this group, the most recent (2015) submission contains data from FY 2014. For a large majority of these hospitals, the fiscal year ends on December 31, which means that 9 months of FY 2014 fell in the post-HMP period.

**Uncompensated care, FY 2013 to FY 2015**

Table 2 presents data on hospital uncompensated care for FY 2013, FY 2014 and FY 2015. Two sets of results are presented for FY 2013 and FY 2014. One pertains to all hospitals reporting data for those years—142 hospitals in 2013 and 141 hospitals in 2014. To facilitate comparisons with FY 2015, results for 2013 and 2014 are also reported for the subset of hospitals for which FY 2015 data are available. Results for each individual hospital are reported in Appendix C Table 1.

The data show that all Michigan hospitals provided approximately $1.1 billion in uncompensated care in FY 2013, which represented 4.8 percent of total hospital expenses. This amount declined to $913.5 million in FY 2014, representing 4.1 percent of total hospital expenses. As noted, only a fraction of FY 2014 fell after the start of the HMP.

FY 2015 is the first fiscal year that began after the HMP was in place. Thus, the impact of the HMP is more readily seen by focusing on the 88 hospitals that reported data for 2013 and 2015.[9] In the baseline year, the average amount of uncompensated care for this subset of hospitals was lower than the average for all hospitals ($7.2 million vs. 7.8 million) though uncompensated care as a percentage of total expenses was slightly higher (5.2 percent vs. 4.8 percent). For these

[9] For one hospital that changed the timing of its fiscal year, no data from 2014 are available. This hospital is in the data set in both 2013 and 2015. Therefore, comparisons between those two years are for the same set of hospitals.

hospitals, the mean number of months of HMP exposure for this group in FY 2014 was 3.3 months. The results show that uncompensated care expenses fell 0.4 percentage points between FY 2013 and FY 2014, to an average of 4.8 percent. There was a further decline in FY 2015 to 2.9 percent of total expenses. For the 88 hospitals reporting 2015 data, the total amount of uncompensated care provided in 2015 was $332.1 million, or 53 percent of the amount of uncompensated care provided by those same hospitals in 2013.

Figure 1 presents the results in graphical form, breaking out the results for FY 2014 in a slightly different way. For that year, hospitals are grouped according to HMP exposure, i.e., the number of months in FY 2014 that fell after April 1, 2014, when the HMP plan started. It is important to note that the separate categories for FY 2014 consist of different hospitals, and therefore comparisons among the different results for 2014 should be interpreted cautiously. With that caveat noted, the data suggest that uncompensated care fell shortly after the HMP went into effect. Among hospitals for which half of FY 2014 occurred after the HMP was in place, uncompensated care was 4.3 percent of total expenses, reduced from 4.8 percent for all hospitals in 2013. Among hospitals with 9 months of post-HMP experience in FY 2014, uncompensated care was 2.9 percent of total expenses, essentially the same as the rate in 2015.

Figure 2 presents the full distribution of the change between 2013 and 2015 in uncompensated care as a percentage of total expenses for the 89 hospitals submitting data for both years. Uncompensated care fell as a percentage of expenses for 94 percent of these hospitals (83 out of 88). The median change was 2.0 percentage points, just slightly below the mean difference of 2.3 percentage points shown in Table 2. Thirty percent of hospitals experienced a decline of 3 percentage points or more.

**Conclusion**

This is the third in a series of annual reports analyzing changes in uncompensated care following the implementation of the Healthy Michigan Plan. This year's report is the first to present data representing a full year of experience after the program was in place (for most, but not all, hospitals). The results indicate a substantial decline in uncompensated care. Over 90 percent of hospitals submitting data for FY 2015 saw a decline in uncompensated care measured as a percentage of total expenses between 2013 and 2015. For this group as a whole, uncompensated care expenses fell nearly by half between 2013 and 2015.

**Table 1. The Distribution of Michigan Hospitals by the Timing of their Fiscal Year and Availability of Medicaid Cost Report Data**

| FY ends in: | | Data Available for Hospital Fiscal Year 2013 | 2014 | 2015 |
|---|---|---|---|---|
| **1st Quarter** | number of hospitals | 9 | 9 | 9 |
| | months post-HMP | 0 | 0 | 12 |
| **2nd Quarter** | number of hospitals | 61 | 60 | 60 |
| | months post-HMP | 0 | 3 | 12 |
| **3rd Quarter** | number of hospitals | 19 | 19 | 19 |
| | months post-HMP | 0 | 6 | 12 |
| **4th Quarter** | number of hospitals | 53 | 53 | 0 |
| | months post-HMP | 0 | 9 | --- |

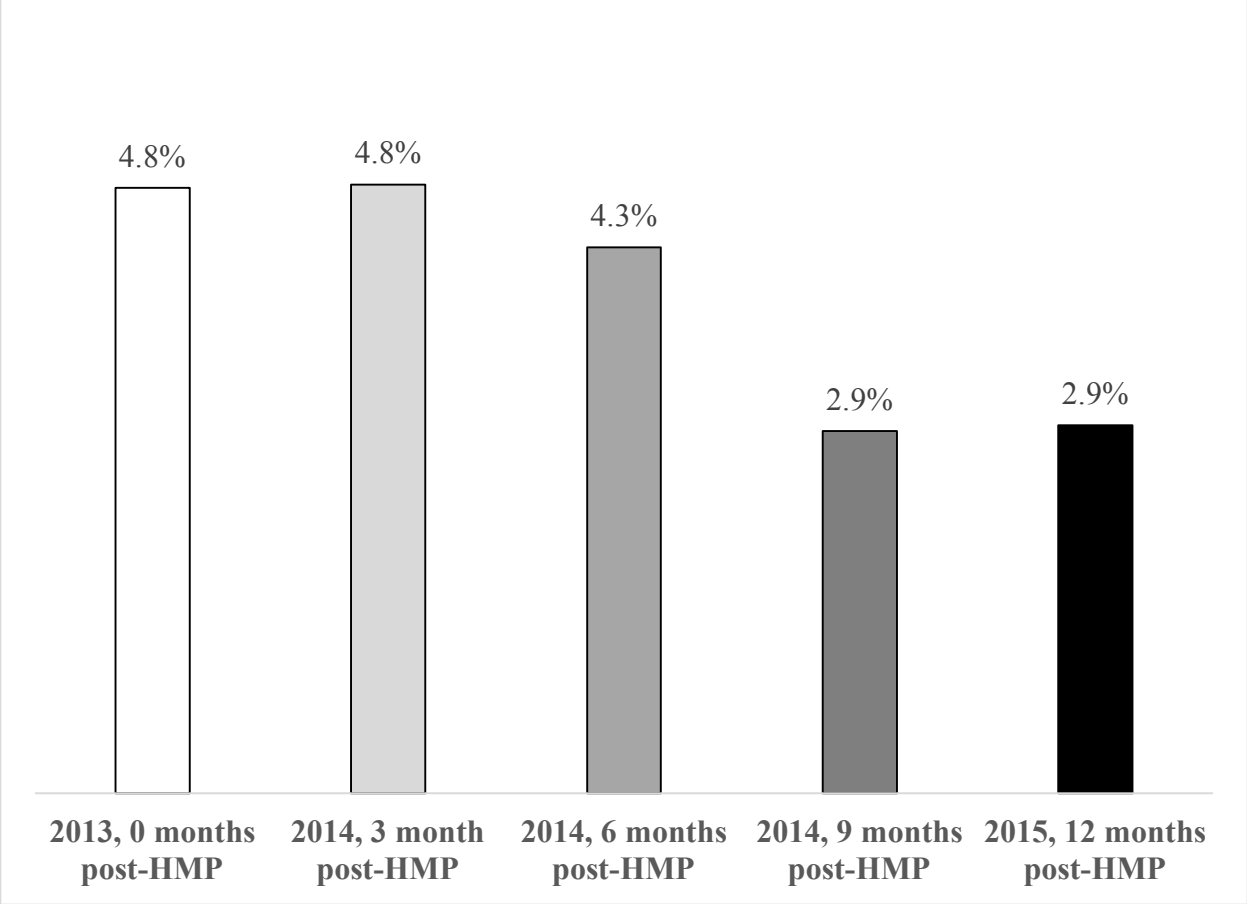
Notes: Hospitals are categorized according to the timing of the fiscal years. The first row in panel gives the number of hospitals in the category reporting data for each fiscal year. Because hospitals submit data with a lag, for hospitals with fiscal years ending in the fourth quarter, the 2015 submission pertains to their FY 2014. The second row in each panel gives the mean number of months in that fiscal year that fell after April 1, 2014.

**Table 2. Uncompensated Care Costs, Hospital FY 2013, FY 2014 and FY 2015**

| | All Hospitals | | Hospital FY Ends Q1 – Q3 | | |
|---|---|---|---|---|---|
| | **2013** | **2014** | **2013** | **2014** | **2015** |
| Number of Hospitals | 142 | 141 | 88 | 87 | 88 |
| Mean months post-HMP | 0 | 5.4 | 0 | 3.3 | 12 |
| **Uncompensated Care Costs** | | | | | |
| Total (millions) | $1110.4 | $913.5 | $627.0 | $590.0 | $332.1 |
| Mean (millions) | $7.82 | $6.47 | $7.21 | $6.78 | $3.77 |
| As a % of Total Costs | 4.8% | 4.1% | 5.2% | 4.8% | 2.9% |

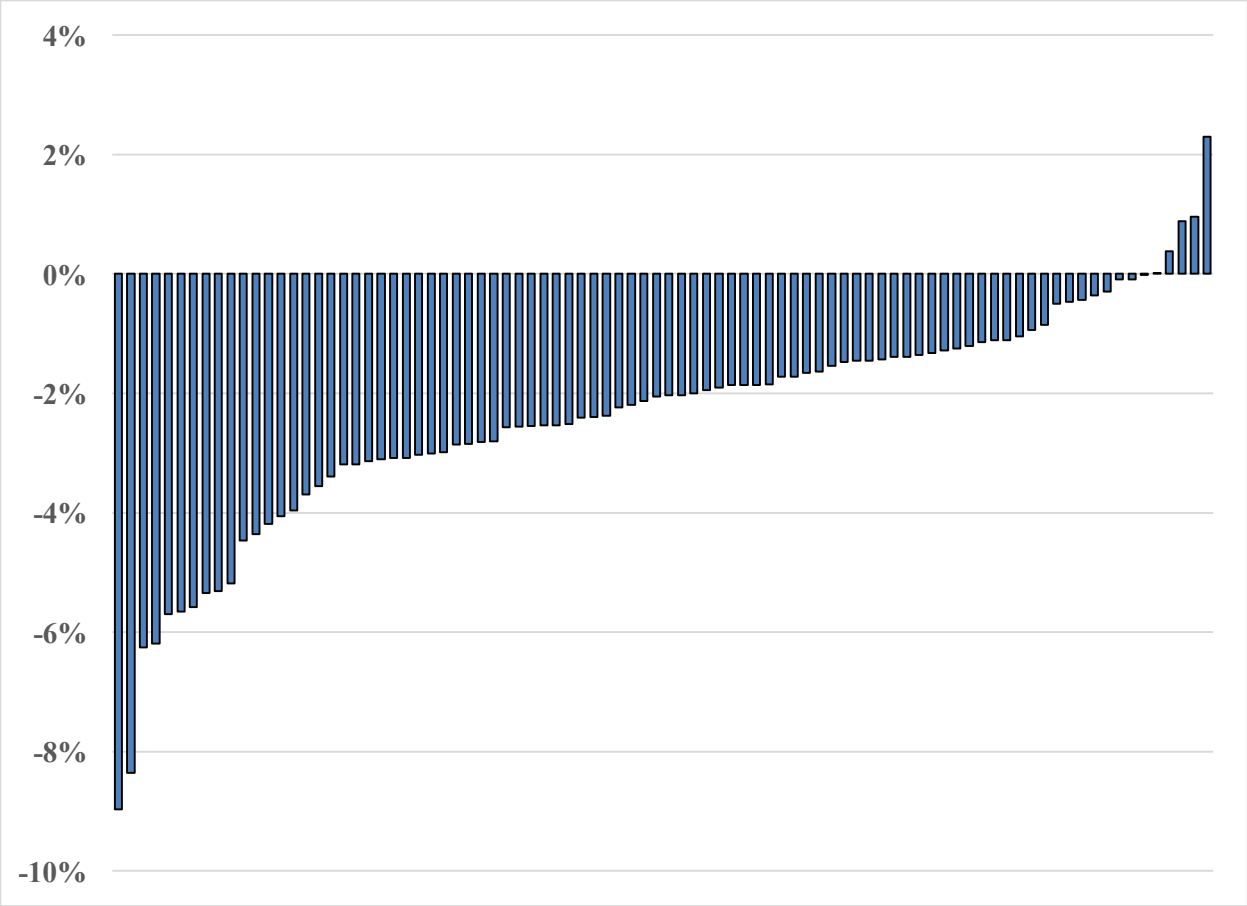
Notes: The figures for uncompensated care as a percentage of total hospital costs represent unweighted means.

**Figure 1. Uncompensated Care as a Percentage of Total Expenses, by Exposure to the Healthy Michigan Plan, 2013 to 2015**




Notes: The figures represent unweighted means for hospitals in each category. The first column presents data for all 142 hospitals that submitted data for FY 2013. This corresponds to column 1 of Table 2. The next 3 columns report FY 2014 results for hospitals with 3, 6 and 9 months of exposure to the HMP. The number of hospitals in these categories are 61, 19 and 53, respectively. Data are not reported for 9 hospitals for which FY 2014 ended before the HMP start date of April 1, 2014. FY 2015 data are for 88 hospitals that submitted data for that year. This figure corresponds to column 5 of Table 2.

**Figure 2. Change in Uncompensated Care as a Percentage of Total Expenses Between 2013 and 2015 for Hospitals Reporting Data in Both Years**




Notes: The sample consists of 88 hospitals for which FY 2015 data are available. Each bar represents the change for an individual hospital.

## §105d (9): Insurance Premium Rates

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### Introduction

To measure the effect the Healthy Michigan Plan "has had on the cost of uncompensated care as it relates to insurance rates and insurance rate change filings, as well as its resulting net effect on rates overall," §105d (9) of Public Act 107 of 2013 requires the Department of Insurance and Financial Services (DIFS) to make an annual report each December 31 regarding the evidence of the change in rates compared to the initial baseline report in December 2014. This section of the report, *The Healthy Michigan Plan: Insurance Premium Rates,* fulfills the requirement of §105d (9) of 2013.

Two main sources of data, key informant interviews and Michigan DIFS rate filings, provide information on the contribution of uncompensated care to premium rates, rate change filings, and the net effect on rates overall, in the year before and each of the two years following implementation of the Healthy Michigan Plan.

To summarize the complex processes of premium rate setting and factors that affect changes in those rates, and to provide context for the analysis, the appendices to this report provide a synopsis of the methodology for premium setting, a table of factors that contribute to rate increases, and additional figures referenced in the report.

### Background

Gathering all the necessary data to determine the cost of uncompensated care as it relates to insurance premiums is challenging and complex. Determining the reasons and mechanisms behind changes in premium rates by different types of plans and in different markets requires actuarial science, as well as knowledge of the local, state, and federal business, health, and political environments. Additionally, some ACA regulations and guidance affect individual markets differently from small and large group markets, including some ACA provisions that sunset. For instance, the Federal transitional reinsurance program ends in 2016.

Developing health insurance premium rates involves numerous stakeholders, such as insurers, hospitals, employers, physicians, pharmacy benefit managers, pharmaceutical and medical device manufacturers, to name a few. There are also complex rate setting methodologies, and propriety information, overlaid on continually changing medical and insurance markets.

Additionally, not all plans offered in the state are subject to regulation, review, and approval by the state. More than half of Michigan employees of organizations offering health insurance are in self-insured plans; these employers are not subject to state plan rate review and approval, premium taxes, or mandated benefits. Rate filings do not include the detailed information required to determine the contribution of uncompensated care to rates, even for fully insured health plans that are subject to DIFS regulatory authority. In addition, contracts that might detail

the relationship between health care costs and insurance prices are often proprietary. Although DIFS and MDHHS collect data supporting their functions and mandates, they do not have access or authority to collect detailed data from those proprietary contracts.

There is no single source of data that provides all necessary elements for analysis. These and other factors make it difficult to attribute observed premium rate changes to the Healthy Michigan Plan.

To help inform understanding of insurance rates and rate changes in the year before and each of the two years following implementation of the Healthy Michigan Plan, the next sections of the report provides analysis of interviews with key informants and analysis of filings data available from DIFS.

**Analysis of Key Informant Interviews**

A stratified sampling approach used type and size of organization and region of the state to identify the interviewees.[10] Semi-structured telephone interviews were conducted in each of the last three years with Michigan employers, healthcare insurers, and healthcare providers.[11] The interviews focused on the respondent's experiences with and impressions of the effects of the Healthy Michigan Plan on premium rates and the processes used to determine those rates. Respondents were specifically asked to comment on premium rate negotiations and rate setting, and the role of uncompensated care costs in those processes.

Thirty-one employers, health insurers and healthcare providers provided responses in the summer 2016. Characteristics of respondents appear in Appendix D. Interviewees were designated decision-makers or persons with appropriate expertise and experience in their organizations; these included benefits managers, senior-level financial officers, executives, and contract negotiators.[12]

Although a small sample of employers cannot be representative of the state's business types, locations, size, industry, or insurance behaviors, we sought to include comments from employers from across the state who could contribute unique and varying perspectives that might be associated with public and employer opinion on the impact of HMP on health coverage in Michigan.

**Interview Responses**

Respondents' reports of factors affecting premium rates, and excerpts from their interviews appear in Appendix F. This section provides a summary of these responses by category of respondent.

[10] The Michigan Care Improvement Registry (MCIR) groups Michigan counties into six regions (https://www.mcir.org/). Key informant interviews for the three years used a convenience sample, loosely stratified by all six MCIR geographic regions with additional targeting in the southeast and southwest markets with the highest number of HMP enrollees, and a range of industry codes across the state.

[11] Given the Institutional Review Board (IRB) conditions of approval, no firms are identified by name in this report.

[12] The initial interviews for the 2013 baseline report were conducted with 29 Michigan-based employers. The 2014 report included completed interviews with 56 employers located in all MCIR sections of the state.

**All Respondents**

- Employers, health insurers, and healthcare providers did not identify the Healthy Michigan Plan or changes in uncompensated care as affecting insurance premium rates.

**Employers**

- Large employers were concerned about the current and future regulations on cost of benefits, risk pools, penalty payments, and special taxes.
- Large and small employers are seeking ways to reduce the costs of benefits through plan management and benefit design; large employers were using workplace wellness approaches to improve employee health and use of services.
- Large employers expressed concern about needing to offer less-competitive benefit packages in the future to avoid the Cadillac tax.
- Small employers expected instability in the individual and small group markets.
- Small employers noted their concern with their ability to offer health benefits to employees at an affordable price.

**Hospitals and Healthcare Providers**

- Healthcare providers noted fluctuations in patient volume related to changes in healthcare coverage. The changes in volume and patient insurance coverage affect operating margins that impact payment rates and negotiations.
- Hospitals noted concern with decreasing federal and nonfederal reimbursement rates relative to costs of providing services.
- Hospitals reported decreases in their bad debt post-ACA, market plans, and Medicaid expansion, but did not associate these policies with premium rate changes.
- Hospitals and hospital systems reported separately negotiated contracts with payers, but reported no detectible impact of uncompensated care or the Healthy Michigan Plan on those negotiations.
- Hospital uncompensated care costs have decreased since Medicaid expansion but it was unlikely that these decreases have a material impact on premium rates or are technically detectable in changes in premium rates.

**Insurers and Health Plans**

- Insurers were unable to negotiate for reductions in price increases as a result of the decrease in hospital uncompensated care costs.
- Insurers expressed concern over the increasing costs of pharmaceuticals and their impact on premiums.
- Insurers expressed concern about ending the federal transitional reinsurance program in 2017 and the effects on premiums.
- Insurers noted the impact on current and future revenues of the ACA regulations on risk adjustment and reinsurance.

**Analysis of Department of Financial and Insurance Services (DIFS) Rate Filings**

Each year, health plans are required to submit rates for review by DIFS. This requirement applies to health insurers selling individual plans, group conversion policies, Medicare supplemental

policies, small employer group plans, and plans sold by health maintenance organizations. DIFS does not set health insurance rates.[13] DIFS does not review the rates for government entities, commercial large group plans (coverage through an employer with more than 50 employees), or self-insured employers (health benefits provided by an employer with its own funds). Approximately 54% of private sector enrollees in Michigan firms offering health insurance are in self-insured plans. [14, 15]

In 2016, DIFS provided all health plan filings submitted and with dispositions in 2013, 2014, and 2015, with tracking codes to link individual filings for download from the public access System for Electronic Rate/Form Filing (SERFF) portal. Rate filings consist of multiple Federal and state-mandated forms, formats, and templates for each product.[16] The list of abstracted elements from filings from 2013, 2014, and 2015, as well as inclusions and exclusions in selection of filings for analysis appear in Appendix E. There is no specific line item or cell in the filings forms or templates for the cost of "uncompensated care" or its contribution to rates. Filings analysis includes only those filings that noted a requested increase or decrease in premium rates. New products were excluded due to the absent experience period**.**

To provide context for the analysis, and to summarize the processes of premium rate setting and review, Appendices G and H provide definitions, a synopsis of the methodology for premium setting, and a table of factors that contribute to rate increases.

**Findings from Rate Filings Analysis**

Table 4 presents selected characteristics of the filings by year. Appendix E supplements this table with additional analysis of market, product, reasons for increase/decrease, and trend rates presented in tables and charts.

[13] DIFS Health Coverage Rates and Rate Reviews: http://www.michigan.gov/difs/0,5269,7-303-12902_35510-113481--,00.html
[14] Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2013, 2014, 2015 Medical Expenditure Panel Survey-Insurance Component.
[15] Self-Insured Health Plans: Recent Trends by Firm Size, 1996–2015 By Paul Fronstin, Ph.D., Employee Benefit Research Institute "examines recent trends in self-insured health plans among private-sector establishments and workers based on data from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC). Data are presented in the aggregate and by establishment size." 2016, Employee Benefit Research Institute–Education and Research Fund.
[16] These may include but are not limited to written (free form text) description of methodology for determination of premium rates, medical rates forms, network data, rates tables with free text annotations, actuarial memorandum, unified rate review template (URRT), justifications and attestations, summary of benefits and coverage and associated rates, evidence of accreditation, SERFF tracking numbers of any document that is amended from its original version, filing notes, correspondence, disposition.

**Table 4: Selected Characteristics of DIFS Rate Filings Analyzed by Year [17]**

| | 2015 | 2014 | 2013 |
|---|---|---|---|
| | | | |
| **Percent premium rate change requested** (Average Weighted) | 5.22 | 5.77 | 7.55 |
| | | | |
| **Health plan filings for premium rate changes** | 59 | 44 | 54 |
| **Number of filings requesting a decrease in premium rates** | 7 | 8 | 4 |
| | | | |
| **Number (Percent) of filings, by market** | N (%) | N (%) | N (%) |
| Individual | 19 (32) | 7 (16) | 10 (19) |
| Small Group | 19 (32) | 18 (41) | 2 (4) |
| Large Group | 21 (36) | 19 (43) | 42 (78) |
| | | | |
| **Number (Percent) of filings, by product** | N (%) | N (%) | N (%) |
| HMO | 31 (53) | 22 (50) | 36 (67) |
| PPO | 14 (24) | 12 (27) | 7 (13) |
| MM | 11 (19) | 8 (18) | 10 (19) |
| POS | 3 (5) | 2 (5) | 1 (2) |
| | | | |
| **Percent rate change requested, by product** | Ave % | Ave % | Ave % |
| HMO | 3.4 | 2.4 | 6.2 |
| PPO | 6.5 | 7.8 | 8.7 |
| MM | 8.6 | 12.0 | 11.7 |
| POS | 5.7 | 5.8 | 6.7 |
| | | | |
| **Reasons for premium rate change, by percent of filings** | % | % | % |
| Medical costs | 93 | 68 | 85 |
| Use of services | 88 | 64 | 52 |
| Benefit changes | 58 | 48 | 44 |
| ACA non-benefit changes (Taxes, risk pools, provider networks) | 58 | 55 | 37 |
| Morbidity of enrollees | 49 | 64 | 52 |
| | | | |
| **Medical Costs Trend Rate** (Ave %) reported in Actuarial Memoranda, etc. | 6.73% | 8.70% | 7.33 % |

[17] Additional data tables and charts appear in Appendix E.

**Summary Findings**

- The filings do not indicate that the Healthy Michigan Plan affected the number, plan type, or market of premium rate change requests.

- Filings do not reveal an effect of changes in uncompensated care on premium rate changes.

- The number of rate filings submitted for premium rate change requests increased slightly in 2015. This likely reflects the transitions in plan design, addition of essential benefits, and ACA policies and formula for reinsurance and risk adjustment.

- The percent premium rate change requested (average weighted) per filing decreased each year of the study, to its lowest rate in 2015, 5.22%.
    - Percent premium rate change requested ("Average Weighted"): 2013: 7.55%; 2014: 5.77%; 2015: 5.22%

- There were fewer and a smaller proportions of filings with very high (above 10%) rate change requests in 2015 and 2014 than in 2013; there were more single outlier negative and positive rate requests in 2015.

- The individual market showed the most variation in premium rates requested. The outlier rates appear more often in the individual market, and in the HMO product, in every year.

- The smallest rate changes requested in each year were in HMO product filings; largest rate change requested were in filings for the Major Medical products in each year.

- In all product categories, the average rate change requested was lowest in 2015, compared with 2013 and 2014.

- Filings noted the following reasons for requesting a premium rate increase:
    - Medical costs: Changes in prices and costs of medical services were noted in 85% of filings in 2013; 68% of filings in 2014; and in 93% of filings in 2015.
    - Utilization of Services: Increases in use of medical and health services, and in intensity of services: 2013: 52%; 2014: 64%; 2015: 88%.
    - Benefits: Changes in benefit design, plan features, out of pocket costs, and provider networks: 2013: 44%; 2014: 48%; 2015: 58%.
    - ACA: Changes in required coverage, medical loss ratios, single risk pools, taxes, fees: 2013: 37%; 2014: 55%; 2015: 58%.
    - Morbidity: Changes in the extent and types of disease or illness within the intended pool of covered individuals: 2013: 52%; 2014: 64%; 2015: 49%.

- Increases in medical prices and costs was the most common reason for requesting a rate change by large group, small group, and individual plans; and for HMO, PPO, and Major Medical (MM) plans in each of the three years. There were too few Point of Service (POS) plans to note trends.

- Changes in plan benefits was noted as the reason for changes in rates by large group plans in 2013 and 2014; and in individual markets in 2015.

- An increasing proportion of all filings each year noted utilization of services as a reason for the rate change.

- Medical Cost Trend rate was at its lowest of the three years in 2015, at 6.73% (2013: 7.33%; 2014: 8.70%)

- The Medical Cost Trend rates tended to be higher in large and small groups filings, rather than in the individual market filings. The distribution of Medical Cost Trend rates reported by large groups was wider and more variable.

- HMO plan filings noted increases in premium rates due to increasing pharmacy costs and increasing outpatient visits and professional services. Inpatient hospital use remained stable over the three years.

**Conclusion**

Interview respondents and rate filings did not identify the Healthy Michigan Plan as a factor affecting changes in premiums in 2013, 2014, or 2015.

**Overall Conclusion**

Based on hospital cost reports submitted to MDHHS, Michigan hospitals experienced a substantial decline in the costs of uncompensated care in FY 2015 compared to FY 2013. Yet rate filings and interviews with key stakeholders do not offer a connection between reductions in uncompensated care and premium rates.

**Appendix A: Literature Review on Cost Shifting**

Governmental reports

1. Key issues in analyzing major health insurance proposals. [Internet]. Congress of the United States Congressional Budget Office. 2008 [cited 2014 Nov 21]. p. 112. Available from: http://www.cbo.gov/sites/default/files/12-18-keyissues.pdf

This CBO report notes that cost shifting can only occur under certain conditions. One example is limited competition in which an isolated community is served by a single hospital or in a competitive provider market to offset the costs of uncompensated care or to make up for low public payment rates. Uncompensated care and low payment rates from public programs may result in hospitals reducing their costs by providing care that is less intensive or of lower quality.

2. Forslund TO. Cost shifting and the impact of new hospitals on existing markets. Wyoming Department of Health. 2014.

In its analysis of cost shifting in Wyoming, the Wyoming Department of Health reached two conclusions: First, cost shifting is one of three potential strategies that hospitals can pursue in the face of revenue shortfalls. Two other strategies, including cost cutting and "volume shifting" or lowering private prices to attract more private volume, may also be used. Second, hospitals' ability to cost shift depends on their market power. This analysis of Wyoming data supports the conclusion that hospital market concentration is one of the more significant factors driving prices paid by the private sector. Market power is more strongly associated with changes in private prices than uncompensated or unreimbursed care. However, the report notes that just because a hospital has more market power does not necessarily mean that they engage in cost shifting.

Reviews of the literature and observable trends

1. Frakt AB. How much do hospitals cost shift? A review of the evidence. Millbank Q; 2011; 89(1): 90-130.

In reviewing the evidence on cost shifting, Frakt notes that policymakers should view with skepticism hospital and insurance industry commentary on the existence of inevitable, visible, or large-scale cost shifting. Some cost shifting may be caused by changes in public payment policy, but this is one of many possible effects on private insurance prices. Rather the author cautions that changes in the balance of market power between hospitals and health insurers which result in consolidation can have a significant impact on private insurance rates.

2. Couglin TA, Holahan, J, Caswell, K, McGrath, M. Uncompensated care for the uninsured: A detailed examination. Kaiser Family Foundation. May 30, 2013. Available from: http://kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-cost-shifting-and-remaining-uncompensated-care-costs-8596/

This Kaiser Family Foundation report notes that there is limited evidence to indicate that increases in uncompensated care have caused hospitals to increase their charges for those with private insurance. The report notes that even as the uninsured rate grew over the past two decades, hospitals' uncompensated care as a share of overall cost has remained steady. Further,

the private payment to cost ratio has steadily increased since 2001, which suggests that the rise in private surpluses is related to other forces, not a result of the cost of care provided to the uninsured. The authors estimate that in 2013, $21.1 billion in providers' uncompensated care costs could be financed by private insurance in the form of higher payments and ultimately higher insurance premiums. Total private health insurance expenditures in 2013 are estimated to be $925.2 billion, so the amount potentially associated with uncompensated care cost shift would be 2.3% of private health insurance costs in 2013. The authors note that even if the $21.1 billion estimate is an underestimate by a wide margin, the potential cost shift from uncompensated care would account for only 4.6% of private health insurance in 2013.

3. Lee J, Berenson R, Mayes R, Gauthier A. Medicare payment policy: Does cost shifting matter? Heal Aff. 2003;W3–480.

The authors examine cost shifting through the lens of Medicare payment policy and state that the extent to which cost shifting impacts private payers and hospitals is a result of their market power and the amount of revenue in the system. Medicare payment policy is based on responsibility to patients as well as supporting the public good. Payment rates are influenced by interest groups and budgetary considerations. The majority of the time Medicare payments cover their responsibilities to Medicare patients and the community. However, if providers' prices rise, and neither public nor private payers' compensation follows suit, consumers pay more. The result is that people lose coverage, which the authors note is the ultimate cost shift.

Theoretical understandings of cost shift

1. Dobson A, DaVanzo J, Sen N. The cost-shift payment "hydraulic": Foundation, history, and implications. Health Aff. 2006;25(1):22-33.

This paper reviews empirical examples of cost shift that show a correlation between lower Medicaid reimbursements and higher private insurance premiums leading to the explanation of cost shift as a potential explanation for increase in private premiums. In reality, the authors note that the potential for cost shift varies greatly over time and across health care markets. Hospitals can absorb some degree of cost shifting pressure through increases in efficiency and decreases in service intensity.

2. Frakt A. The end of cost shifting and the quest for hospital productivity. Health Serv Res. 2014;49(1):1–10.

This article explores the ways hospitals may respond to reductions in Medicare payments. Frakt describes cost shifting as one hypothesis for the ways in which hospitals may attempt to gain revenue in the face of declining Medicare payments. However, hospitals can also raise private prices commensurate with their market power in the absence of a public payment shortfall. Frakt notes that although there are circumstances under which hospitals could and did cost shift at high rates, recent research suggests that it is a far less pervasive phenomenon today.

3. Ginsburg P. Can hospitals and physicians shift the effects of cuts in Medicare reimbursement to private payers? Health Aff [Internet]. 2003;(Web Exclusive):W3–472 to W3–479. Available from: http://content.healthaffairs.org/content/early/2003/10/08/hlthaff.w3.472.full.pdf

This paper attempts to reconcile the different thinking between health care executives and economists regarding cost shifting. The potential for cost shifting varies according to structural factors that in turn vary by time and geography, and while Ginsburg says there is a theoretical basis exists for cost shifting, he shows other models where hospitals have room to adjust before cost shifting occurs.

4. Santerre R. The welfare loss from hospital cost-shifting behavior: A partial equilibrium analysis. Health Econ. 2005;14(6):621–6.

Microeconomic theory suggests that cost shifting can take place under specific conditions, and empirical studies indicate that cost shifting may have occurred in certain instances. This study models potential welfare loss caused by hospital cost shifting under ideal yet possible conditions.

Empirical studies

1. Friesner D, Rosenman R. Cost shifting revisited: The case of service intensity. Health Care Manag Sci. 2002;5(1):15–24.

This research found support for cost shift in some nonprofit hospitals in California while no cost shift was observed in profit-maximizing hospitals. However, both types of hospitals respond to lower service intensity, thus supporting the theoretical conclusion that lower service intensity may be utilized as an alternative to cost shifting.

2. Garthwaite C, Gross T, Notowidigdo MJ. Hospitals as insurers of last resort [Internet]. NBER Working Paper. 2015. Available from: http://www.nber.org/papers/w21290

The authors used previously confidential hospital financial data obtained through a research partnership with the American Hospital Association from 1984 to 2011 to study uncompensated care provided by hospitals and found that the uncompensated care costs for hospitals increase in response to the size of the uninsured population. They found that each additional uninsured person costs local hospitals $900 each year in uncompensated care. Nonprofit hospitals were found to be more exposed to changes in demand for uncompensated care. The closure of a nearby hospital increases the uncompensated care costs of remaining hospitals. Increases in the uninsured population were found to lower hospital profit margins, which suggests that hospitals cannot or do not pass along all increased costs onto patients with private insurance.

3. Showalter M. Physicians' cost shifting behavior: Medicaid versus other patients. Contemp Econ Policy. 1997;15(2):74–84.

This article examines whether physicians practice cost shifting. This study found, in contradiction to cost shift, that lower Medicaid reimbursement rates resulted in physicians charging lower fees to privately insured patients though evidence also suggests that lower Medicaid reimbursements tend to cause physicians to treat fewer Medicaid patients.

4. Wagner KL. Shock, but no shift: Hospitals' responses to changes in patient insurance mix. J Health Econ. 2016;49:46-58.

Wagner analyzes hospital cost-shifting in response to a change in patient insurance mix resulting from recent Medicaid expansions for individuals with disabilities. Wagner found that hospitals actually reduced charges for disabled patients with private insurance. While the ACA Medicaid expansions affect a broader population and the results of this study may not be generalizable, the findings do suggest that cost-shifting is not the only way in which hospitals respond to a revenue reduction.

5. White C. Contrary to cost-shift theory, lower Medicare hospital payment rates for inpatient care lead to lower private premium rates. Health Aff. 2013;32(5):935–43.

Policymakers believe when Medicare constrains its payment rates for hospital inpatient care, private insurers pay higher rates. This demonstrates that slow growth in Medicare inpatient hospital payment rates also results in slow growth in private hospital payment rates. Greater reductions in Medicare payment rates led to a reduction in private payment rates, reflecting hospitals' efforts to rein in operating costs at a time of lower Medicare payments. Hospitals facing cuts in Medicare payment rates may also reduce the payment rates they seek from private payers to attract more privately insured patients.

6. White C, Wu V. How Do Hospitals Cope with Sustained Slow Growth in Medicare Prices? Health Serv Res. 2013;49(1):11-31.

White and Wu analyze the effects of changes in Medicare inpatient hospital prices on hospitals' overall revenues, operating expenses, profits, assets, and staffing. The authors findings suggest that hospitals recoup Medicare cuts not through cost shifting, but instead they adjust their operating expenses over time.

7. Wu V. Hospital cost shifting revisited: new evidence from the Balanced Budget Act of 1997. Int J Healthc Financ Econ. 2010;10(1):61–83.

Wu analyzes hospital cost shifting using a natural experiment generated by the Balanced Budget Act of 1997. This study found that urban hospitals were able to shift part of the burden of Medicare payment reductions onto private payers, but the overall degree of cost shifting was very small, and changes were based on the hospital's share of privately insured patients.

8. Zwanziger J, Bamezai A. Evidence of cost shifting in California hospitals. Health Aff. 2006;25(1):197–203.

This study of California hospitals examines whether decreases in Medicare/Medicaid payments were associated with increases in private insurance payments. A 1% decrease in Medicare price was associated with a 0.17% increase in the price for privately insured patients. This suggests that cost shifting from public to private payers accounted for a small percentage of the total increase in private payer prices from 1997-2001 in California.

## Appendix B: Data Elements for Calculating Uncompensated Care and Discharges

Data Elements and Methods for Calculating Uncompensated Care

*1. Defining uncompensated care*

Uncompensated care is defined as the cost of charity care plus the cost of bad debt.

Charity care is the cost of medical care for which there was no expectation of payment because the patient has been deemed unable to pay for care. Each hospital has its own criteria for identifying patients who are eligible for charity care. For example, hospitals in the Mercy Health system pay 100% of the charges for patients who are uninsured and have family income below 100% of the federal poverty level. The University of Michigan's charity care program pays 55% of total charges for uninsured patients that do not qualify for public insurance programs, have family income below 400% of the federal poverty level, and meet several other criteria. However, not all discounted medical care is charity care. Discounts provided for prompt payment or discounts negotiated between the patient and the provider to standard managed care rates do not represent charity care.

Bad debt is the cost of medical care for which there was an expectation of payment because the patient was deemed to be able to pay for care. For example, bad debt includes the unpaid medical bills of an uninsured patient who applied for charity care but did not meet the hospital's specific criteria. Insured patients who face deductibles and coinsurance payments for hospital care can also generate bad debt.

Hospitals report charity care and bad debt separately on the Michigan Medicaid Forms, though as just noted hospitals vary in the criteria they use to distinguish charity care from bad debt. Even within a particular hospital, rules governing eligibility for charity care are often not strictly applied and may take into account the judgment of individuals determining eligibility.

For purposes of this report, Medicaid and Medicare shortfalls — the difference between reimbursements by these programs and the cost of care— are not included in the estimate of uncompensated care. Similarly, expenditures for community health education, health screening or immunization, transportation services, or loss on health professions education or research are not considered uncompensated care. Although the hospital does not expect to receive reimbursement for these services, they do not represent medical care for an individual. These costs incurred by hospitals fall into the broader category of "community benefit," a concept used by the Internal Revenue Service in assessing hospitals' non-profit status.

*2. Measuring uncompensated care using Michigan Medicaid cost report data*

The cost of charity care is measured as full charges for uninsured charity care patients minus patient payments toward partial charity discounts, multiplied by the cost-to-charge ratio. The cost of bad debt is measured as unpaid patient charges for which an effort was made to collect payment minus any recovered payments, multiplied by the cost-to-charge ratio. Bad debts

include charges for uninsured patients who did not qualify for a reduction in charges through a charity care program, and unpaid coinsurance, co-pays and deductibles for insured patients.

The cost-to-charge ratio is the ratio of the cost of providing medical care to what is charged for medical care, aggregated to the hospital-level. For example, a cost-to-charge ratio of 0.6 means that on average, 60 cents of every charged dollar covers the cost of care. Variation in cost-to-charge ratios among different payment source categories reflects differences in the mix of services received by patients in those categories. Charity care and bad debt charges for uninsured patients are translated to costs using the cost-to-charge ratio for uninsured patients. Bad debt charges for insured patients are translated to costs using the whole hospital cost-to-charge ratio.

The specific data elements from the Michigan Medicaid Forms (MMF) that are used for these calculations are as follows.

Measures of care for which payment was not received enter positively:

- Uninsured charity care charges (MMF line 6.00)
  Full charge of care provided to patients who have no insurance and qualify for full or partial charity care. Payment is not expected.

- Uninsured patient-pay charges (MMF line 6.10)
  Full charge of care provided to patients who have no insurance and do not qualify for full or partial charity care (self-pay). Payment is expected but hospital has not yet made a reasonable attempt to collect payment.

- Uninsured bad debts (MMF line 6.36)
  Full charge of care provided to patients who have no insurance and do not qualify for charity care. Payment is expected and hospital has made a reasonable attempt to collect payment.

- Third party bad debts (MMF line 6.38)
  Insured patients' unpaid coinsurance, co-pays or deductibles when there is an expectation of payment. This includes gross Medicare bad debts. Payment is expected and the hospital has made a reasonable attempt to collect the amount from the patient

These amounts are offset by payments that were received by patients who qualify for charity care as well as bad debt recoveries. These payments enter the calculation of uncompensated care negatively:

- Uninsured payments from charges (MMF line 6.60)
  Total payments made by uninsured charity care patients and uninsured self-pay patients towards charges.

- Recoveries for uninsured bad debt (MMF line 10.96)

Recovered amounts for uninsured bad debts, which can include amounts that were collected from patients or amounts from community sources (such as an uncompensated care pool).

- Recoveries for third party bad debts and offsets (MMF line 10.98)
  Recovered amounts for insured patients' co-pays, co-insurance and deductibles, including Medicare beneficiaries.

The cost-to-charge ratios used in the calculation are:

- Uninsured inpatient cost-to-charge ratio
  Cost-to-charge ratio calculated by MDHHS for the purposes of determining Disproportionate Share Hospital (DSH) payments. It is used to convert charges for care provided to uninsured patients to costs.

- Whole hospital cost-to-charge ratio
  Cost-to-charge ratio calculated by MDHHS and used to convert charges for care provided to insured patients to costs.

In addition to measuring the dollar amount of uncompensated care costs, we also measure these costs relative to total hospital costs (MMF line 11.30) as a percentage.

## Appendix C: Uncompensated Care Data by Hospital

**Table 1. Uncompensated Care Expenses by Individual Hospital, FY 2013, FY 2014 and FY 2015**

| Hospital Name | CMS ID | Qtr of FY end | FY 2013 Total UC | FY 2013 as a % of Cost | FY 2014 Total UC | FY 2014 as a % of Cost | FY 2015 Total UC | FY 2015 as a % of Cost |
|---|---|---|---|---|---|---|---|---|
| Allegan General Hospital | 1328 | 4 | 1.73 | 4.5% | 1.69 | 4.4% | ---- | ---- |
| Allegiance Health | 92 | 2 | 35.39 | 9.8% | 29.41 | 8.0% | 15.50 | 4.2% |
| Alpena Regional Medical Center | 36 | 2 | 2.53 | 2.9% | 1.84 | 2.0% | 0.94 | 1.0% |
| Aspirus Grand View Hospital | 1333 | 2 | 1.98 | 5.1% | 2.30 | 5.9% | 0.59 | 1.6% |
| Aspirus Keweenaw Hospital | 1319 | 2 | 1.34 | 4.5% | 1.40 | 4.2% | 0.90 | 2.5% |
| Aspirus Ontonagon Hospital | 1309 | 2 | 0.16 | 1.7% | 0.11 | 1.1% | 0.42 | 4.0% |
| Baraga County Memorial Hospital | 1307 | 3 | 0.99 | 6.7% | 0.78 | 5.1% | 0.47 | 3.0% |
| Barbara Ann Karmanos Cancer Hospital | 297 | 3 | 2.11 | 1.0% | 1.98 | 1.0% | 1.41 | 0.6% |
| BCA StoneCrest Center | 4038 | 4 | 0.13 | 0.8% | 0.11 | 0.7% | ---- | ---- |
| Beaumont Hospital - Dearborn | 20 | 4 | 17.82 | 3.5% | 13.14 | 2.4% | ---- | ---- |
| Beaumont Hospital - Farmington Hills | 151 | 4 | 16.42 | 6.9% | 7.57 | 3.1% | ---- | ---- |
| Beaumont Hospital - Taylor | 270 | 4 | 6.05 | 5.1% | 3.50 | 2.8% | ---- | ---- |
| Beaumont Hospital - Trenton | 176 | 4 | 3.44 | 2.8% | 2.33 | 1.8% | ---- | ---- |
| Beaumont Hospital - Wayne | 142 | 4 | 7.84 | 6.6% | 5.10 | 4.1% | ---- | ---- |
| Beaumont Hospital, Grosse Pointe | 89 | 4 | 9.01 | 5.4% | 5.48 | 3.3% | ---- | ---- |
| Beaumont Hospital, Royal Oak | 130 | 4 | 45.87 | 4.0% | 22.50 | 2.0% | ---- | ---- |
| Beaumont Hospital, Troy | 269 | 4 | 19.35 | 3.9% | 12.35 | 2.3% | ---- | ---- |
| Bell Memorial Hospital | 1321 | 2 | 3.18 | 8.7% | 1.38 | 4.4% | 0.33 | 1.1% |
| Borgess Hospital | 117 | 2 | 27.17 | 7.6% | 20.59 | 5.8% | 12.92 | 3.6% |
| Borgess-Lee Memorial Hospital | 1315 | 2 | 4.00 | 13.7% | 3.70 | 12.7% | 2.18 | 7.6% |
| Brighton Hospital | 279 | 2 | ---- | ---- | ---- | ---- | ---- | ---- |
| Bronson Battle Creek Hospital | 75 | 4 | 15.34 | 8.5% | 11.31 | 6.6% | ---- | ---- |
| Bronson Lake View Hospital | 1332 | 4 | 2.76 | 6.2% | 2.43 | 5.9% | ---- | ---- |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Bronson Methodist Hospital | 17 | 4 | 49.41 | 10.2% | 30.27 | 6.4% | ---- | ---- |
| Caro Community Hospital | 1329 | 4 | 0.47 | 4.8% | 0.48 | 4.5% | ---- | ---- |
| Charlevoix Area Hospital | 1322 | 1 | 0.87 | 3.1% | 0.96 | 3.2% | 0.45 | 1.4% |
| Children's Hospital of Michigan | 3300 | 4 | 3.48 | 1.1% | 3.56 | 1.1% | ---- | ---- |
| Chippewa War Memorial Hospital | 239 | 4 | 2.35 | 3.3% | 1.03 | 1.3% | ---- | ---- |
| Clinton Memorial Hospital | 1326 | 4 | 0.62 | 2.6% | 0.71 | 3.1% | ---- | ---- |
| Community Health Center, Branch County | 22 | 4 | 5.55 | 9.2% | 3.60 | 5.9% | ---- | ---- |
| Covenant Medical Center, Inc. | 70 | 2 | 9.72 | 2.7% | 8.08 | 2.3% | 3.35 | 0.9% |
| Crittenton Hospital | 254 | 4 | 5.26 | 2.6% | 3.32 | 1.8% | ---- | ---- |
| Deckerville Community Hospital | 1311 | 2 | 0.21 | 3.5% | 0.41 | 6.0% | 0.25 | 3.9% |
| Detroit Receiving Hospital | 273 | 4 | 31.25 | 14.3% | 14.65 | 6.7% | ---- | ---- |
| Dickinson County Memorial Hospital | 55 | 4 | 1.57 | 2.2% | 0.91 | 1.2% | ---- | ---- |
| Doctors' Hospital of Michigan | 13 | 4 | 3.48 | 12.9% | 1.62 | 7.0% | ---- | ---- |
| Eaton Rapids Medical Center | 1324 | 2 | 1.55 | 9.9% | 1.76 | 9.5% | 1.25 | 7.1% |
| Edward W. Sparrow Hospital | 230 | 4 | 21.31 | 3.1% | 17.34 | 2.5% | ---- | ---- |
| Forest Health Medical Center, Inc. | 144 | 4 | 0.40 | 1.2% | 0.28 | 0.8% | ---- | ---- |
| Forest View Psychiatric Hospital | 4030 | 4 | 0.19 | 1.4% | 0.17 | 1.2% | ---- | ---- |
| Garden City Hospital | 244 | 4 | 6.08 | 5.2% | 5.24 | 4.4% | ---- | ---- |
| Garden City Hospital | 244 | 4 | 6.08 | 5.2% | 5.24 | 4.4% | ---- | ---- |
| Genesys Regional Medical Center | 197 | 2 | 14.78 | 4.0% | 14.46 | 3.8% | 5.59 | 1.5% |
| Harbor Beach Community Hospital | 1313 | 4 | 0.06 | 0.8% | 0.14 | 1.6% | ---- | ---- |
| Harbor Oaks Hospital | 4021 | 2 | 0.06 | 0.5% | 0.15 | 1.3% | 0.18 | 1.4% |
| Harper University Hospital | 104 | 4 | 8.63 | 2.2% | 6.90 | 1.6% | ---- | ---- |
| Havenwyck Hospital | 4023 | 2 | 0.22 | 0.9% | 0.32 | 1.1% | 0.22 | 0.7% |
| Hayes Green Beach Memorial Hospital | 1327 | 1 | 3.56 | 7.8% | 4.23 | 9.8% | 2.21 | 4.9% |
| Healthsource Saginaw | 275 | 4 | 0.19 | 0.8% | 0.29 | 1.1% | ---- | ---- |
| Helen Newberry Joy Hospital | 1304 | 4 | 1.85 | 7.4% | 1.21 | 4.8% | ---- | ---- |
| Henry Ford Hospital | 53 | 4 | 96.32 | 8.5% | 83.36 | 7.6% | ---- | ---- |
| Henry Ford Macomb Hospital | 47 | 4 | 14.63 | 4.7% | 12.39 | 4.1% | ---- | ---- |

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|---|---|---|---|---|---|---|---|---|
| Henry Ford West Bloomfield Hospital | 302 | 4 | 6.24 | 2.5% | 6.91 | 2.8% | ---- | ---- |
| Henry Ford Wyandotte Hospital | 146 | 4 | 21.43 | 9.1% | 16.46 | 7.2% | ---- | ---- |
| Hills & Dales General Hospital | 1316 | 3 | 0.61 | 3.2% | 0.50 | 2.5% | 0.45 | 2.2% |
| Hillsdale Community Health Center | 37 | 2 | 2.65 | 5.6% | 2.10 | 4.6% | 1.86 | 4.1% |
| Holland Community Hospital | 72 | 1 | 4.82 | 3.0% | 5.50 | 3.3% | 3.38 | 1.9% |
| Hurley Medical Center | 132 | 2 | 27.29 | 9.4% | 16.01 | 5.4% | 10.04 | 3.2% |
| Huron Medical Center | 118 | 3 | 0.80 | 2.9% | 0.75 | 2.5% | 0.40 | 1.3% |
| Huron Valley - Sinai Hospital | 277 | 4 | 8.62 | 5.7% | 3.35 | 2.0% | ---- | ---- |
| Ionia County Memorial Hospital | 1331 | 4 | 1.39 | 5.4% | 1.08 | 4.2% | ---- | ---- |
| Kalkaska Memorial Health Center | 1301 | 2 | 1.90 | 8.9% | 1.83 | 8.4% | 0.70 | 3.6% |
| Kingswood Psychiatric Hospital | 4011 | 4 | 0.20 | 1.0% | 0.11 | 0.6% | ---- | ---- |
| Lakeland Community Hospital - Watervliet | 78 | 3 | 2.04 | 9.2% | 1.56 | 6.3% | 0.38 | 1.5% |
| Lakeland Hospital - St. Joseph | 21 | 3 | 13.91 | 5.3% | 12.10 | 4.3% | 7.20 | 2.5% |
| Mackinac Straits Hospital | 1306 | 1 | 2.20 | 11.3% | 2.03 | 9.2% | 1.73 | 7.2% |
| Marlette Regional Hospital | 1330 | 2 | 0.76 | 3.4% | 0.85 | 4.0% | 0.64 | 3.1% |
| Marquette General Hospital | 54 | 2 | 3.95 | 2.0% | 3.37 | 1.9% | 0.76 | 0.4% |
| Mary Free Bed Hospital & Rehab. Center | 3026 | 1 | 0.86 | 1.9% | 1.48 | 3.0% | 0.67 | 1.4% |
| McKenzie Memorial Hospital | 1314 | 3 | 0.59 | 4.6% | 0.42 | 3.3% | 0.30 | 2.4% |
| McLaren - Central Michigan | 80 | 3 | 2.23 | 2.9% | 2.08 | 2.7% | 1.19 | 1.6% |
| McLaren - Greater Lansing | 167 | 3 | 7.52 | 2.7% | 11.18 | 4.2% | 6.52 | 2.2% |
| McLaren Bay Regional | 41 | 3 | 6.79 | 2.9% | 5.82 | 2.3% | 4.01 | 1.5% |
| McLaren Flint | 141 | 3 | 14.07 | 3.7% | 12.86 | 3.3% | 4.75 | 1.2% |
| McLaren Lapeer Region | 193 | 3 | 5.64 | 5.6% | 5.77 | 5.8% | 3.25 | 3.2% |
| McLaren Oakland | 207 | 3 | 5.87 | 5.0% | 6.49 | 5.2% | 3.65 | 2.9% |
| McLaren-Northern Michigan | 105 | 3 | 5.05 | 2.9% | 3.42 | 1.9% | 1.75 | 0.9% |
| Memorial Healthcare | 121 | 4 | 2.04 | 2.6% | 1.21 | 1.6% | ---- | ---- |
| Memorial Medical Center of W. Michigan | 110 | 2 | 2.25 | 4.1% | 1.84 | 3.3% | 1.63 | 2.8% |
| Mercy Health Partners - Hackley Campus | 66 | 2 | 10.88 | 6.8% | 6.80 | 4.2% | 4.02 | 2.4% |
| Mercy Health Partners - Lakeshore Campus | 1320 | 2 | 1.03 | 6.4% | 0.81 | 4.0% | 0.54 | 3.3% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Mercy Health Partners - Mercy Campus | 4 | 2 | 8.79 | 6.2% | 7.47 | 3.4% | 4.17 | 1.8% |
| Metro Health Hospital | 236 | 2 | 13.20 | 6.1% | 11.79 | 4.9% | 10.60 | 3.7% |
| Mid Michigan Medical Center - Gladwin | 1325 | 2 | 0.87 | 4.4% | 0.91 | 4.4% | 0.72 | 3.2% |
| Mid Michigan Medical Center - Clare | 180 | 2 | 1.62 | 5.3% | 2.77 | 8.4% | 0.94 | 2.7% |
| Mid Michigan Medical Center - Gratiot | 30 | 2 | 3.06 | 3.8% | 2.74 | 3.5% | 1.59 | 2.0% |
| Mid Michigan Medical Center - Midland | 222 | 2 | 7.50 | 3.1% | 7.27 | 2.9% | 5.32 | 1.9% |
| Mount Clemens Regional Medical Center | 227 | 3 | 19.85 | 8.1% | 18.17 | 6.9% | 8.90 | 3.3% |
| Munising Memorial Hospital | 1308 | 1 | 0.44 | 5.8% | 0.55 | 7.6% | 0.32 | 4.1% |
| Munson Healthcare Cadillac Hospital | 81 | 2 | 2.73 | 4.5% | 2.64 | 3.7% | 1.76 | 2.6% |
| Munson Healthcare Grayling Hospital | 58 | 2 | 2.48 | 4.2% | 1.87 | 2.6% | 1.57 | 2.6% |
| Munson Medical Center | 97 | 2 | 22.54 | 5.0% | 17.25 | 3.8% | 8.12 | 1.8% |
| North Ottawa Community Hospital | 174 | 2 | 2.03 | 4.7% | 1.73 | 3.8% | 1.15 | 2.2% |
| Oakland Regional Hospital | 301 | 4 | 0.10 | 0.4% | 0.11 | 0.5% | ---- | ---- |
| Oaklawn Hospital | 217 | 1 | 4.35 | 5.1% | 2.99 | 3.5% | 1.62 | 1.9% |
| Otsego County Memorial Hospital | 133 | 4 | 1.34 | 2.6% | 0.97 | 1.8% | ---- | ---- |
| Paul Oliver Memorial Hospital | 1300 | 2 | 1.09 | 8.2% | 0.97 | 7.2% | 0.72 | 5.2% |
| Pennock Hospital | 40 | 3 | 2.23 | 4.7% | 2.57 | 5.9% | 2.07 | 4.6% |
| Pine Rest Christian Hospital | 4006 | 2 | 0.53 | 1.0% | 0.63 | 1.0% | 0.61 | 0.9% |
| Port Huron Hospital | 216 | 3 | 7.58 | 4.7% | 7.10 | 4.3% | 4.45 | 2.8% |
| Promedica Bixby Hospital | 5 | 4 | 1.18 | 1.7% | 1.33 | 1.9% | ---- | ---- |
| ProMedica Herrick Hospital | 1334 | 4 | 0.58 | 1.9% | 0.65 | 2.4% | ---- | ---- |
| ProMedica Monroe Regional Hospital | 99 | 2 | 9.39 | 6.5% | 9.08 | 6.9% | 6.34 | 4.6% |
| Providence Hospital | 19 | 2 | 0.00 | 0.0% | 20.71 | 3.6% | 14.43 | 2.4% |
| Rehabilitation Institute | 3027 | 4 | 1.51 | 1.9% | 0.93 | 1.2% | ---- | ---- |
| Saint Mary's Standish Community Hospital | 1305 | 2 | 0.87 | 4.5% | 0.84 | 4.6% | 0.49 | 2.6% |
| Samaritan Behavioral Center | 4040 | 4 | 0.08 | 1.0% | 0.05 | 0.6% | ---- | ---- |
| Scheurer Hospital | 1310 | 2 | 1.54 | 5.4% | 1.38 | 4.5% | 1.35 | 4.0% |
| Schoolcraft Memorial Hospital | 1303 | 4 | 0.33 | 1.7% | 0.28 | 1.4% | ---- | ---- |
| Sheridan Community Hospital | 1312 | 1 | 1.02 | 8.1% | 1.01 | 7.4% | 1.28 | 9.1% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Sinai-Grace Hospital | 24 | 4 | 27.02 | 8.7% | 11.42 | 3.8% | ---- | ---- |
| South Haven Community Hospital | 85 | 2 | 1.42 | 4.6% | 0.95 | 2.9% | 0.39 | 1.2% |
| Southeast Michigan Surgical Hospital | 264 | 4 | 0.04 | 0.3% | 0.11 | 0.9% | ---- | ---- |
| Southwest Regional Rehabilitation Hospital | 3025 | 2 | 0.45 | 3.9% | 0.32 | 3.3% | ---- | ---- |
| Sparrow Carson Hospital | 208 | 4 | 1.37 | 3.2% | 1.77 | 4.3% | ---- | ---- |
| Spectrum Health | 38 | 2 | 32.61 | 2.9% | 40.51 | 3.4% | 20.39 | 1.6% |
| Spectrum Health - Reed City Campus | 1323 | 2 | 2.87 | 6.8% | 3.14 | 6.8% | 1.72 | 3.6% |
| Spectrum Health Big Rapids | 93 | 2 | 2.61 | 5.8% | 2.06 | 4.3% | 1.99 | 3.8% |
| Spectrum Health Gerber Memorial | 106 | 2 | 2.92 | 5.0% | 3.37 | 5.6% | 2.51 | 4.1% |
| Spectrum Health United Memorial - Kelsey | 1317 | 2 | 0.87 | 7.0% | 1.22 | 9.4% | 0.91 | 7.0% |
| Spectrum Health United Memorial - United | 35 | 2 | 2.55 | 4.4% | 0.00 | 0.0% | 2.26 | 3.3% |
| Spectrum Health Zeeland Community | 3 | 2 | 1.56 | 3.9% | 2.35 | 5.3% | 1.72 | 3.4% |
| St Joseph Mercy Chelsea | 259 | 2 | 2.55 | 2.8% | 2.72 | 2.9% | 0.99 | 1.0% |
| St. Francis Hospital & Medical Group | 1337 | 3 | 4.16 | 7.3% | 3.24 | 6.0% | 1.87 | 3.2% |
| St. John Hospital and Medical Center | 165 | 2 | 35.80 | 5.5% | 34.65 | 5.3% | 19.52 | 2.9% |
| St. John Macomb-Oakland, Macomb | 195 | 2 | 21.95 | 6.2% | 20.03 | 5.9% | 11.44 | 3.3% |
| St. John River District Hospital | 241 | 2 | 1.17 | 2.7% | 1.11 | 2.4% | 0.63 | 1.5% |
| St. Joseph Mercy Hospital - Ann Arbor | 156 | 2 | 29.89 | 4.5% | 26.09 | 4.3% | 11.34 | 1.9% |
| St. Joseph Mercy Livingston Hospital | 69 | 2 | 8.23 | 8.9% | 7.23 | 8.0% | 2.51 | 3.4% |
| St. Joseph Mercy Oakland | 29 | 2 | 13.68 | 4.8% | 18.41 | 6.7% | 5.27 | 1.8% |
| St. Joseph Mercy Port Huron | 31 | 2 | 4.87 | 7.3% | 3.66 | 5.8% | 1.26 | 2.0% |
| St. Mary Mercy Hospital | 2 | 2 | 10.55 | 5.3% | 14.36 | 7.1% | 6.04 | 2.9% |
| St. Mary's Health Care (Grand Rapids) | 59 | 2 | 15.48 | 4.7% | 12.72 | 3.6% | 7.78 | 1.8% |
| St. Mary's of Michigan Medical Center | 77 | 2 | 17.86 | 8.0% | 13.69 | 6.5% | 5.33 | 2.6% |
| Straith Memorial Hospital | 71 | 4 | 0.03 | 0.3% | 0.03 | 0.3% | ---- | ---- |
| Sturgis Memorial Hospital | 96 | 3 | 2.29 | 7.0% | 1.86 | 5.5% | 1.33 | 3.9% |
| Tawas St. Joseph Hospital | 100 | 2 | 2.17 | 5.3% | 1.41 | 3.6% | 1.21 | 3.0% |
| The Behavioral Center of Michigan | 4042 | 4 | 0.08 | 0.9% | 0.09 | 1.0% | ---- | ---- |
| Three Rivers Health | 15 | 4 | 2.54 | 6.6% | 1.68 | 4.4% | ---- | ---- |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| University of Michigan Health System | 46 | 2 | 51.02 | 2.4% | 54.64 | 2.4% | 37.08 | 1.5% |
| UP Health System - Portage | 108 | 4 | 1.09 | 1.9% | 0.54 | 1.1% | ---- | ---- |
| West Branch Regional Medical Center | 95 | 1 | 2.17 | 5.8% | 2.02 | 5.3% | 1.75 | 4.5% |

Notes: Because hospitals submit their data with a lag, for hospitals with fiscal years ending in the fourth quarter the most recent data available are from hospital FY 2014.

## Appendix D: Key Stakeholder Interviews: Respondent Characteristics

| *Healthcare Providers* | | *N=9* |
|---|---|---|
| Size | Small/Private Practice | 2 |
| | Medium/Hospital | 1 |
| | Large/Regional Hospital System | 6 |
| Payer Mix | Primarily Private | 6 |
| | Primarily Public | 1 |
| | Mixed | 1 |
| | Other | 1 |
| | | |
| *Employers* | | *N=17* |
| Size | Small Employer 50 or fewer Employees | 9 |
| | Medium Employer 51-499 | 4 |
| | Large Employer 500+ | 4 |
| Payer Mix | Self-Funded | 4 |
| | Mixed | 2 |
| | Fully Insured | 9 |
| | N/A | 2 |
| Economic Sector | Professional, Scientific and Technical Services | 3 |
| | Retail Trade | 3 |
| | Healthcare | 1 |
| | Accommodation and Food Service | 3 |
| | Construction | 2 |
| | Finance and Insurance | 1 |
| | Manufacturing | 2 |
| | Other Services | 2 |
| | | |
| *Health Insurers* | | *N=6* |
| Market | Public | 2 |
| | Private | 4 |
| Covered members | < 250,000 | 1 |
| | 500,000 -1 million | 2 |
| | >1 million | 3 |

## Appendix E: DIFS Filings Sampling Exclusions, Inclusions and Rationale

### Filings Sampling Exclusions

- Filings without a requested premium rate change. We are interested in the causes of rate change; thus we are excluding from our sample filings that did not submit a rate increase or decrease.
- New products. New products are filings that are submitted to go on the market in the coming year. These filings do not have any prior experience or claims data to compare or predict change in premium rates.
- 2016 filing data. 2016 filing data are incomplete; not all of the filings have been submitted which will apply to 2017 premium rates.

### Filings Sampling Inclusions

Insurance filings provide a multitude of data. The following elements were abstracted from each 2015 filing for which a change (negative or positive) in rates was requested.

- Descriptive Data:
  - Filing Number
  - Date
  - Company Name

- Market
  - Health Insurance Market (Individual, Small Group, Large Group, Other)
  - Product Type

- Reason(s) for Rate Change
  - Reason for Rate Change (direct quotes from filings if available)
  - Medical Costs (trend in cost of medical care, physician contracts, etc.)
  - Morbidity (change in morbidity level of risk pool)
  - Benefits (change in benefits offered)
  - ACA (i.e., taxes and fees, legislative compliance, essential health benefits)
  - Utilization of Services (increasing or decreasing)
  - Demographics (age, community rating)
  - Other (i.e., tobacco Status)

Experience [Experience period is a time period used to calculate the premium in order to evaluate risk and return] and Claims

- Affected Policy Holders
- Covered Lives Benefit Change
- Benefit Change
- % Change Approved – weighted average
- Percent Rate Change Requested – weighted average
- Requested Rate: Annual – weighted average

Total Annual Premium Rate

- Premium Rate Change
- Prior Rate: Annual – weighted average
- Projected Earned Premium
- Projected Incurred Claims (Annual Dollars)

Medical Costs
- Trend Factors %
- Medical Trend %
- MLR %
- Pharmacy Trend %

Administrative
- Administrative Fees (Dollars PMPM)
- Administrative Fees % of Premium
- Profit and Risk % of Premium
- Taxes and Fees
    - Taxes and Fees % of Premium
- Uniform Rate Review Template
    - Administrative Expenses % (projected experience)
    - Profit and Risk % (projected experience)
    - Taxes and Fees % (PMPM component of premium increase)
    - Taxes and Fees as a percentage % (projected experience)
    - Single Risk Pool Gross Premium Avg Rate (PMPM)
    - Inpatient (Component of Premium Increase Dollars PMPM)
    - Outpatient (Component of Premium Increase Dollars PMPM)
    - Professional (Component of Premium Increase Dollars PMPM)
    - Prescription (Component of Premium Increase Dollars PMPM)
    - Other (Component of Premium Increase Dollars PMPM)

**Rationale for DIFS Filings Inclusions (Drivers of Premium Rates)**

Health insurers include several factors in the creation of the premium rate. The state requires that filings include the actuarial methods and data used. Often, this section of the filings is noted as "Confidential/Proprietary/Trade Secret." Many insurers contract with actuarial firms; these firms often use proprietary methods for estimating risk, based on data specific to a number of plan and population features, including the plan type, size, benefits, region, and estimated numbers and types of claims.

**Proposed Rate Increases:** When included, the filing sections enumerate the contributions of the following (as titled on the forms) to the rate:

- **Medical Loss Ratio (MLR)**: The claims experience on Michigan policies in a specific block of business must be adequate to achieve an 80% Federal Medical Loss Ratio.

- **Allowed and Incurred Claims Incurred during the Experience Period**: Allowed Claims data are available to the company directly from company claims records, with some estimation due to timing issues.

- **Claim Liabilities for Medical Business** are often calculated using proprietary methods.

- **Benefit Categories:** Claims are assigned to each of the varying benefit category by place services were administered, and types of medical services rendered.

- **Projection Factors**
    - **Single Risk Pools**, for policy years beginning after 1/1/14.
    - **Changes in Morbidity of the Population Insured**: The assumptions used are from the experience period to the projection period.
    - **Trend Factors (cost/utilization):** The assumption for cost and utilization is often developed from nationwide claim trend studies, using experience from similar products that were marketed earlier.
    - **Changes in Benefits, Demographics, and other factors: Non-Benefit Expenses and Risk Margin Profit & Risk Margin:** Projected premiums include a percent of premium for risk, contingency, and profit margin. Assumptions are often derived from analysis of pre-tax underwriting gain, less income taxes payable on the underwriting gain, and on the insurer fee, which is not deductible for income tax purposes.

- **Taxes and Fees** include premium tax, insurer fees, risk adjustment fees, exchange fees, and federal income tax.
    - **Premium Tax**: The premium tax rate is 1.25% on Michigan gross direct premiums written in the state of Michigan.
    - **Insurer Fees**: This is a permanent fee that applies to fully insured coverage. This fee will fund tax credits for insurance coverage purchased on the exchanges. The total fee increases from $8B in 2014 to $14.3B in 2018 (indexed to premium for subsequent years). Each insurer's assessment will be based on earned health insurance premiums in the prior year, with certain exclusions.
    - **Risk Adjustment Fees**: The HHS Notice of Benefit and Payment Parameters includes a section on risk adjustment user fees and specifies a $0.08 per member per month user fee for the benefit year 2014. For benefit year 2015, HHS imposes a per-enrollee-per-month risk adjustment fee of $0.10, and for 2016 benefit year, $0.15. (See Federal Register / Vol. 80, No. 39 / Friday, February 27, 2015 / Rules and Regulations 10759).
    - **Federal Income Tax**: Income tax is calculated as 35% * (Pre-Tax Income + Insurer Fees), since insurer fees are not tax deductible.
    - **Reinsurance Fees**: This is a temporary fee that applies to all commercial groups (both fully insured and self-funded) and individual business from 2014 to 2016 for the purpose of funding the reinsurance pool for high cost claimants in the individual market during this three-year transitional period. The total baseline amounts to be collected to fund this pool are $12B in 2014, $8B in 2015, and $5B in 2016, and

individual states can add to this baseline. Each insurer is assessed on a per capita basis. This fee expires in 2017.

- **Changes in Medical Service Costs:** There are many different health care cost trends that contribute to increases in the overall U.S. health care spending each year. These trend factors affect health insurance premiums, which can mean a premium rate increase to cover costs. Some of the key health care cost trends that have affected this year's rate actions include:
    - **Coverage Mandates** – Estimated impacts of changes in benefit design and administration due to the Patient Protection and Affordable Care Act mandates. Direct impacts include the effects of specific changes made to comply with new Federal and State laws.
    - **Increasing Cost of Medical Services** – Annual increases in reimbursement rates to health care providers, such as hospitals, doctors and pharmaceutical companies. The price of care can be affected by the use of expensive procedures, such as surgery, as opposed to monitoring or certain medications.
    - **Increased Utilization** – Annual increases in the number of office visits and other services. In addition, total health care spending may vary by the intensity of care and/or use of different types of health services.
    - **Higher Costs from Deductible Leveraging** – Health care costs may rise every year, while deductibles and copayments may remain the same.
    - **Impact of New Technology** - Improvements to medical technology and clinical practice may require use of more expensive services, leading to increased health care spending and utilization.
    - **Underwriting Wear Off** – The variation by policy duration in individual medical insurance claims, where claims are higher at later policy durations as more time has elapsed since initial underwriting.

- **Administrative Costs:** Expected benefit and administrative costs.

**Factors that determine premiums vary by type of plan *market*** (individual plans, small group plans, and large group plans):

**Individual Plans** (for those who purchase their coverage directly from an insurer, not job-based coverage):

- Age (the premium rate cannot vary more than 3 to 1 for adults for all plans)
- Benefits and cost-sharing selected
- Number of family members on the plan
- Location of residence in Michigan
- Tobacco use (the premium rate cannot vary by more than 1.5 to 1)

**Small Group Plans** (for those who have coverage through an employer with 50 or fewer employees):

- Benefits the employer selects
- How much the employer contributes to the cost
- Family size

- Age (the premium rate cannot vary more than 3 to 1 for adults for all plans)
- Tobacco use (the premium rate cannot vary by more than 1.5 to 1)
- Location of employer in Michigan

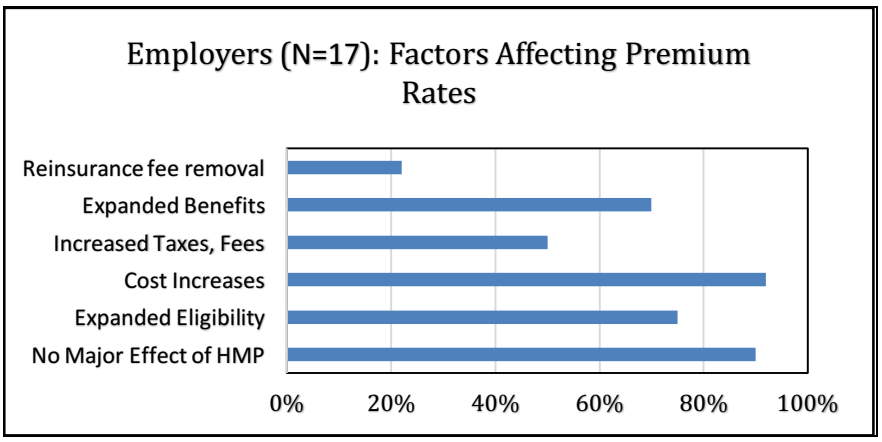
**Large Group Plans** (for those who have coverage through an employer with more than 50 employees):

- Benefits the employer selects
- Employee census information including age, gender, family status, health status and geographic location
- How much the employer contributes to the cost
- Industry
- Group size
- Wellness programs

**Appendix F: Results from Stakeholder Interviews and DIFS Rate Filings Analysis**

**I. Interview Respondents' Reports on Factors Affecting Premium Rates**

**Employers:**




"…yes, we are paying a lot more fees, we pay a lot of fees and don't get more administrative effort to file reports for all folks …"

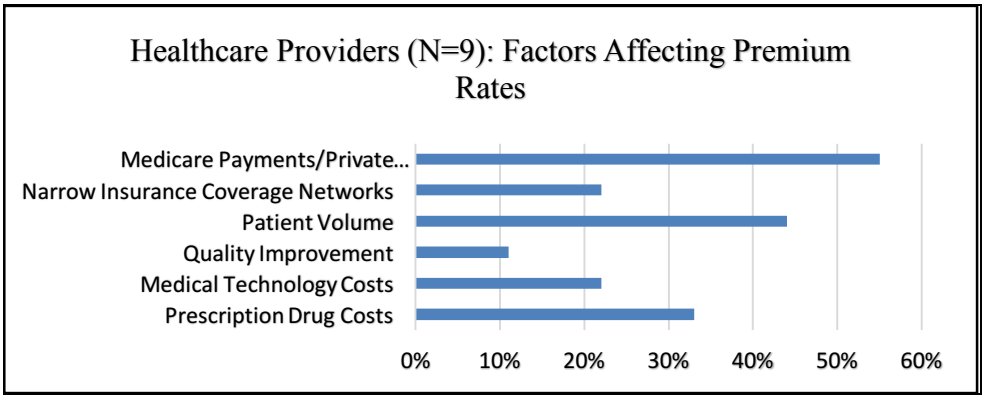
"Decision-making for benefits and ACA has seen the biggest changes…"

"It's [the decision to offer health insurance] almost entirely based on cost; I don't think changes to the Medicaid expansion have influenced it… it's been pretty consistently cost-prohibitive… would like to be able to offer it, but it has just been so expensive that we haven't been able to."

"…Same portfolio as the previous year…Overall, we didn't have to make the drastic adjustments that other employers or insurers did - our rates didn't change much because we already offered pretty extensive coverage."

"…Employees have a larger co-premium pay than before. That increased co-premium has been the biggest change this year. We pay more out of pocket."

**Hospitals and Healthcare Providers**




"Medicare reimbursement definitely affects the payment rates, depending on if it changes."

"If a major payer comes to us and says 'your case costs are too high- we are excluding you from our network' this has major implications for who we treat, our volumes, and all; if they include us in their narrow network, they have the bargaining power to keep their rates below our costs- this puts us in a financial bind…"

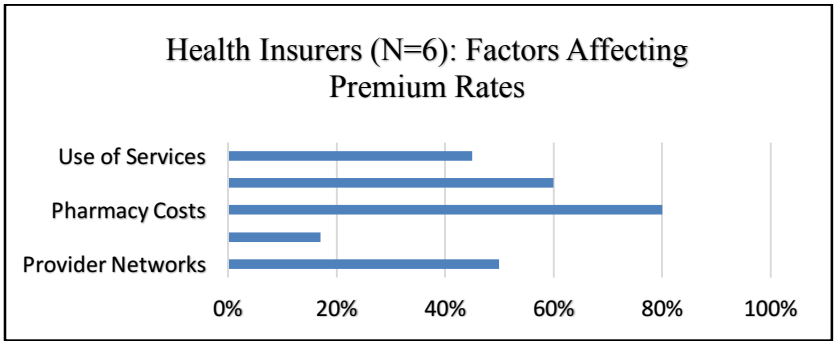
"Volume is critical, and so is the role of consumerism…the dynamics have changed where it is not just the payers making the payments, a key piece is coming from the patient …"

"Patient safety and quality often increase costs in the short run, with reporting and payment tied to quality, but in the long run, quality and quality improvement are why we exist."

"…we've actually thought of changes to charity care to include people who are underinsured because of the [now] significant contributions people have to make…"

"Technology and device costs and the prescription drug costs are the biggest concerns for our payment rates."

**Health Insurers**



"In the individual market it becomes enrollee membership, a lot of selection issues, lots of healthy enrollees are not enrolling, so we are seeing issues of high use and cost with too many unhealthy persons in the market."

"Then there is also the issue of more of a regulation in terms of the federal reinsurance is going away, so we are losing the protections there for the individual and small group markets."

"As we are reflecting on changes in healthcare costs, pharmacy is becoming a big driver of it…."

"The biggest factors [affecting premium rates] are medical costs and pharmacy cost trends, medical inflation in general. Medical cost has been relatively low over the past year, and pharmacy has really been the biggest contributor."

"Pharmaceutical absolutely, specialty especially… you need the tools and care coordination to handle it … but pharmacy is so out of control, these single patent companies charging whatever they want…."

"I think [Healthy Michigan] has helped hospitals, but they definitely don't say, 'because we've got more money, because our uncompensated care has decreased, we're going to give you a price discount'…and we can't say the same thing in fairness, 'we had a good operating margin, so we'll pay you more,' we don't do it either, in all fairness. It just doesn't work that way, in consideration of all of the other costs and factors affecting costs."

"For the health insurance exchange we had to build our own premium – we based that on our hospital contracts, this is the number one factor, and it's a new market, so that is difficult."

"We are trying to keep premiums down and narrow our provider networks [to keep the costs down]."

## II. DIFS Rate Analysis Tables and Charts

The findings from the rate filings analysis are organized into four sections:

A. Number and type of filing
B. Magnitude of the premium rate change requested
C. Reasons for premium rate changes requested
D. Medical cost trend rates noted in filings
All data are presented by year of filing (2013, 2014, and 2015).

### A. Number and Type of Filing

**Number of filings with rate change increase or decrease by market, by year**

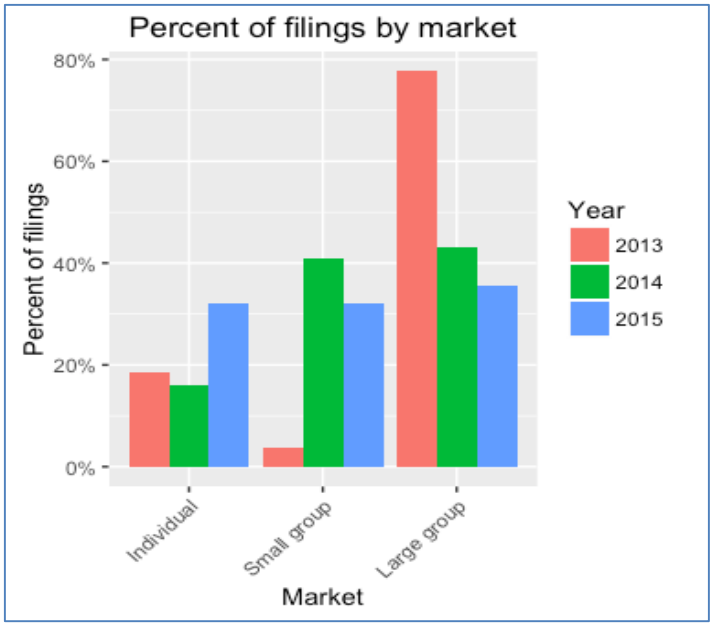
| Year | Market | Decrease | Increase |
|---|---|---|---|
| 2013 | Individual | 1 | 9 |
| | Small group | 0 | 2 |
| | Large group | 3 | 39 |
| 2014 | Individual | 1 | 6 |
| | Small group | 1 | 17 |
| | Large group | 6 | 13 |
| 2015 | Individual | 3 | 16 |
| | Small group | 4 | 15 |
| | Large group | 0 | 21 |

**Number of filings with rate change increase or decrease by product, by year**

| Year | Product | Decrease | Increase |
|---|---|---|---|
| 2013 | HMO | 4 | 32 |
| | PPO | 0 | 7 |
| | MM | 0 | 10 |
| | POS | 0 | 1 |
| 2014 | HMO | 8 | 14 |
| | PPO | 0 | 12 |
| | MM | 0 | 8 |
| | POS | 0 | 2 |
| 2015 | HMO | 6 | 25 |
| | PPO | 1 | 13 |
| | MM | 0 | 11 |
| | POS | 0 | 3 |

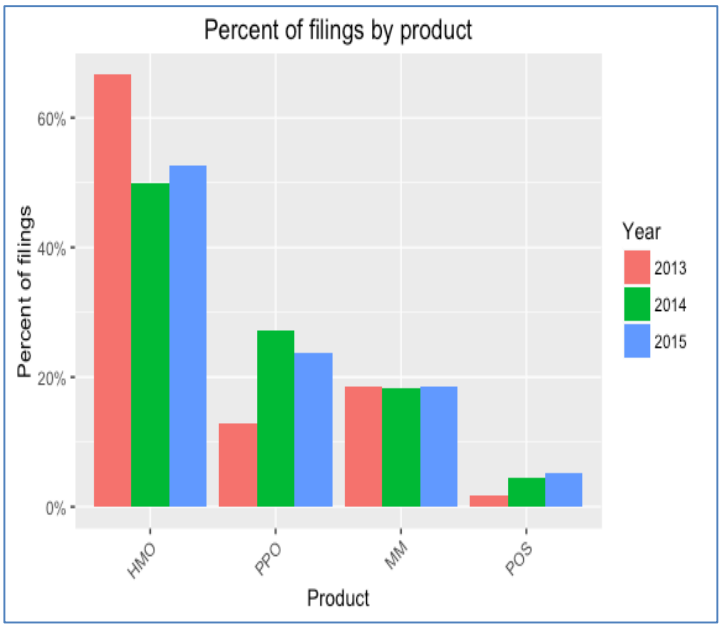
**Percent of Filings Requesting Rate Change, by Market, by Year**

| Year | Individual | Small group | Large group |
|---|---|---|---|
| 2013 | 18.5% | 3.7% | 77.8% |
| 2014 | 15.9% | 40.9% | 43.2% |
| 2015 | 32.2% | 32.2% | 35.6% |



**Percent of Filings Requesting Rate Change, by Product, by Year**

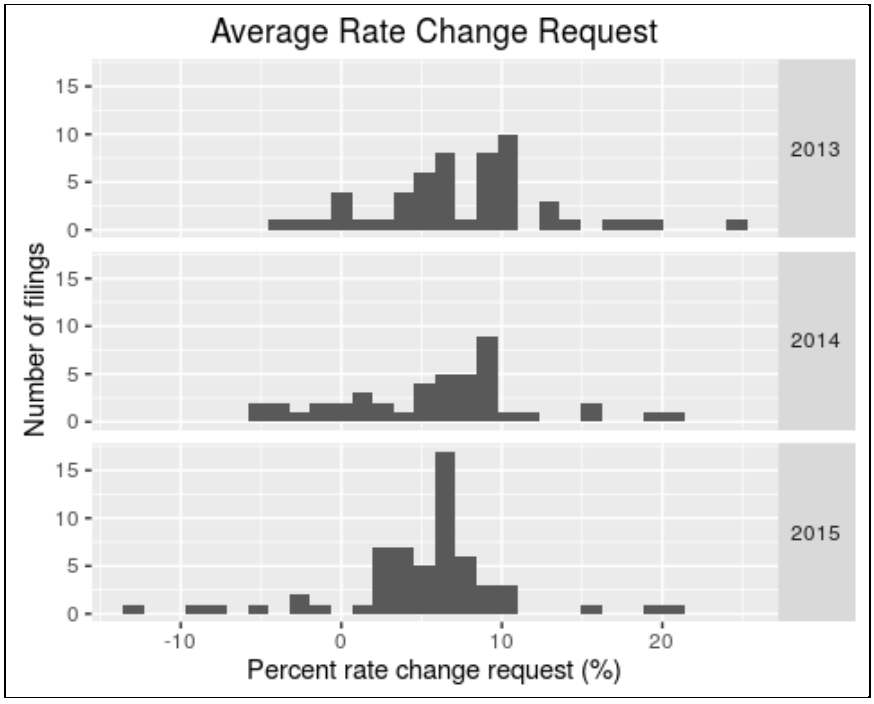
| Year | HMO | PPO | MM | POS |
|---|---|---|---|---|
| 2013 | 66.7% | 13.0% | 18.5% | 1.9% |
| 2014 | 50.0% | 27.3% | 18.2% | 4.5% |
| 2015 | 52.5% | 23.7% | 18.6% | 5.1% |



**B. Magnitude of the Premium Rate Requested**

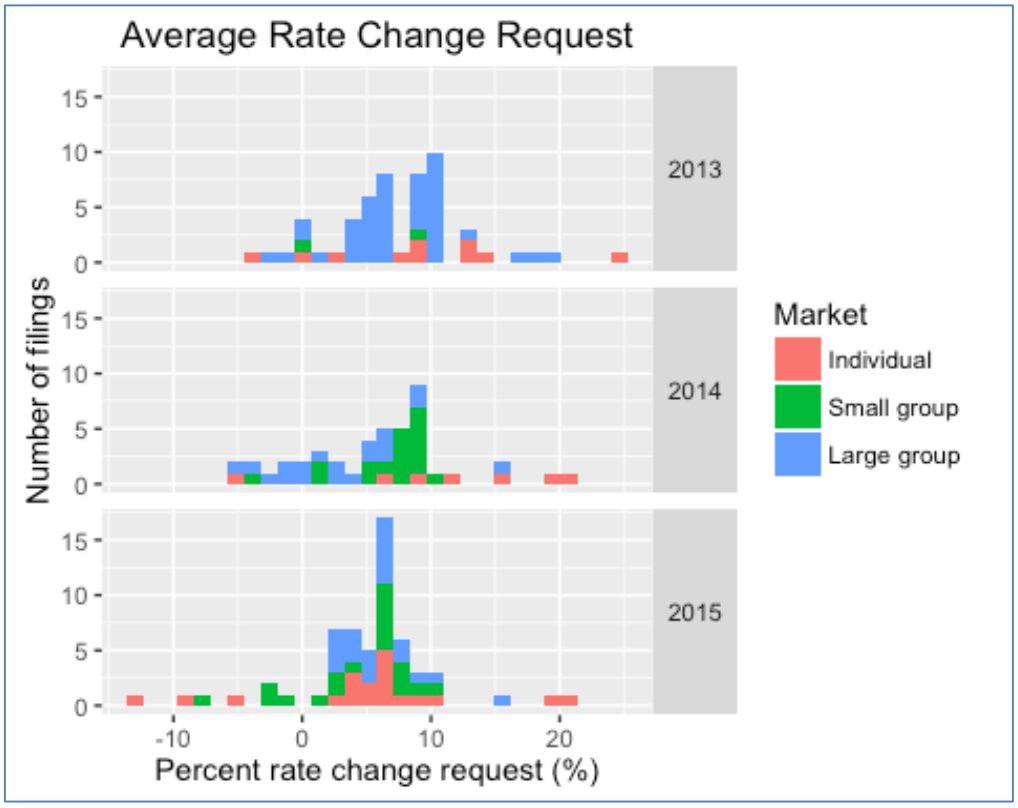
**Percent Rate Change Request by Year (%)**

| Year | Filings | Average (%) | Min (%) | Max (%) |
|---|---|---|---|---|
| 2013 | 54 | 7.55 | -3.97 | 25.0 |
| 2014 | 44 | 5.77 | -5.10 | 21.0 |
| 2015 | 59 | 5.22 | -12.60 | 20.5 |



**Percent Rate Change Request, by Market, by Year (%)**

| Year | Market | Filings | Average (%) | Min (%) | Max (%) |
|---|---|---|---|---|---|
| 2013 | Individual | 10 | 8.87 | -3.97 | 25.00 |
| | Small group | 2 | 4.68 | 0.50 | 8.86 |
| | Large group | 42 | 7.37 | -3.19 | 19.80 |
| 2014 | Individual | 7 | 10.90 | -4.90 | 21.00 |
| | Small group | 18 | 6.63 | -3.70 | 9.90 |
| | Large group | 19 | 3.07 | -5.10 | 15.00 |
| 2015 | Individual | 19 | 5.20 | -12.60 | 20.50 |
| | Small group | 19 | 4.13 | -8.30 | 9.90 |
| | Large group | 21 | 6.21 | 2.90 | 15.00 |



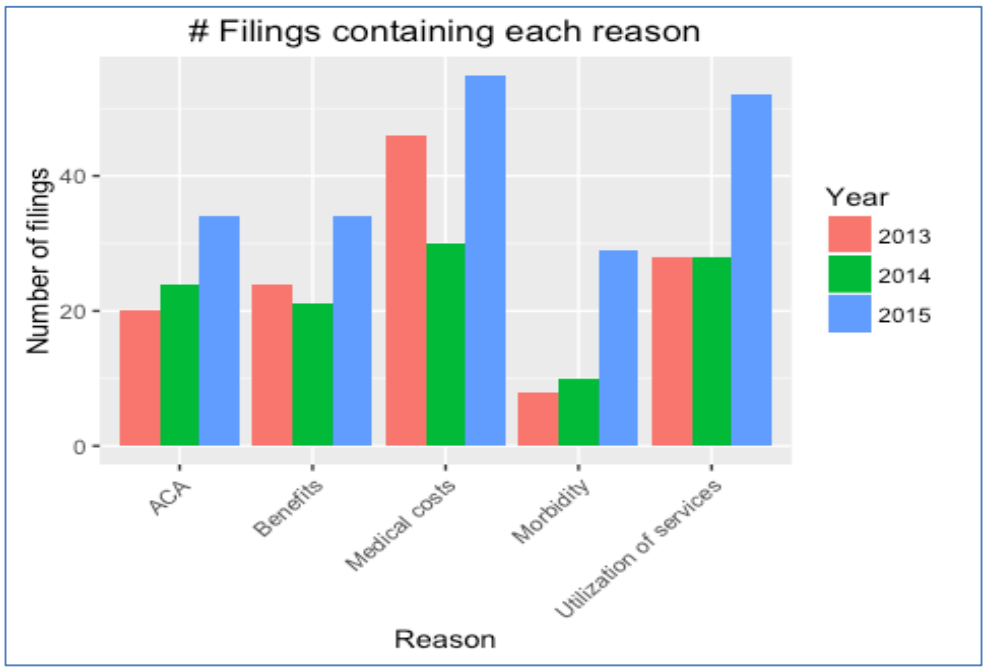
**Percent Rate Change Request, by Product, by Year**

| Year | Product | Filings | Average (%) | Min (%) | Max (%) |
|---|---|---|---|---|---|
| 2013 | HMO | 36 | 6.20 | -3.97 | 18.50 |
| | PPO | 7 | 8.67 | 0.50 | 14.60 |
| | MM | 10 | 11.69 | 5.48 | 25.00 |
| | POS | 1 | 6.73 | 6.73 | 6.73 |
| 2014 | HMO | 22 | 2.41 | -5.10 | 9.50 |
| | PPO | 12 | 7.76 | 1.27 | 19.00 |
| | MM | 8 | 12.00 | 9.00 | 21.00 |
| | POS | 2 | 5.84 | 2.90 | 8.77 |
| 2015 | HMO | 31 | 3.40 | -12.60 | 9.90 |
| | PPO | 14 | 6.48 | -8.30 | 20.50 |
| | MM | 11 | 8.58 | 0.80 | 20.00 |
| | POS | 3 | 5.70 | 4.10 | 6.50 |

## C. Reasons for Premium Rate Changes Requested

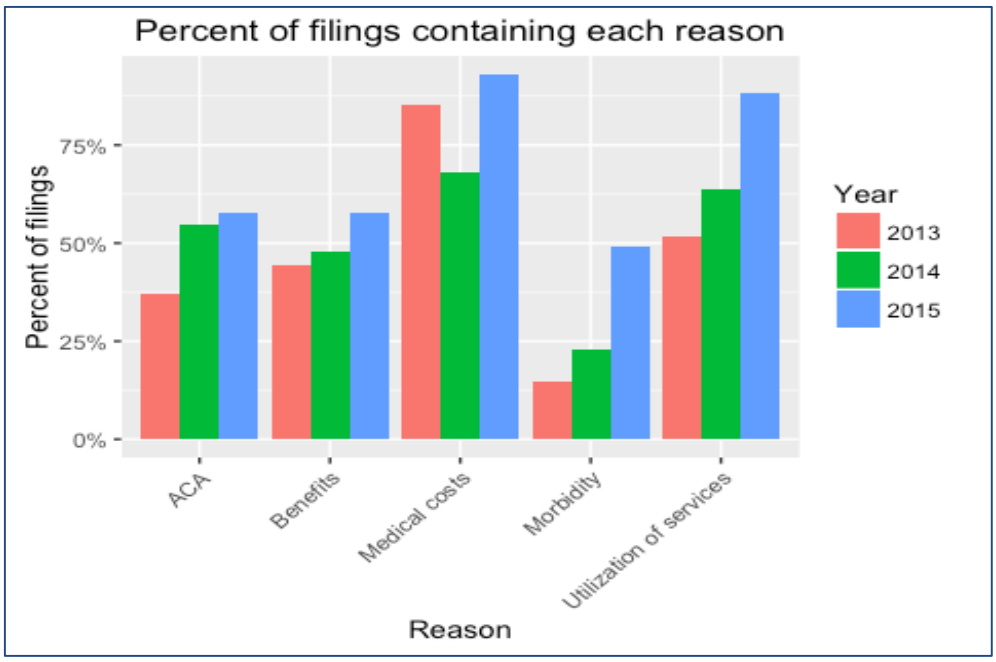
**Number of Filings by Reasons for Rate Change Request, by Year**

| Year | ACA | Benefits | Medical costs | Morbidity | Utilization of services |
|---|---|---|---|---|---|
| 2013 | 20 | 24 | 46 | 8 | 28 |
| 2014 | 24 | 21 | 30 | 10 | 28 |
| 2015 | 34 | 34 | 55 | 29 | 52 |



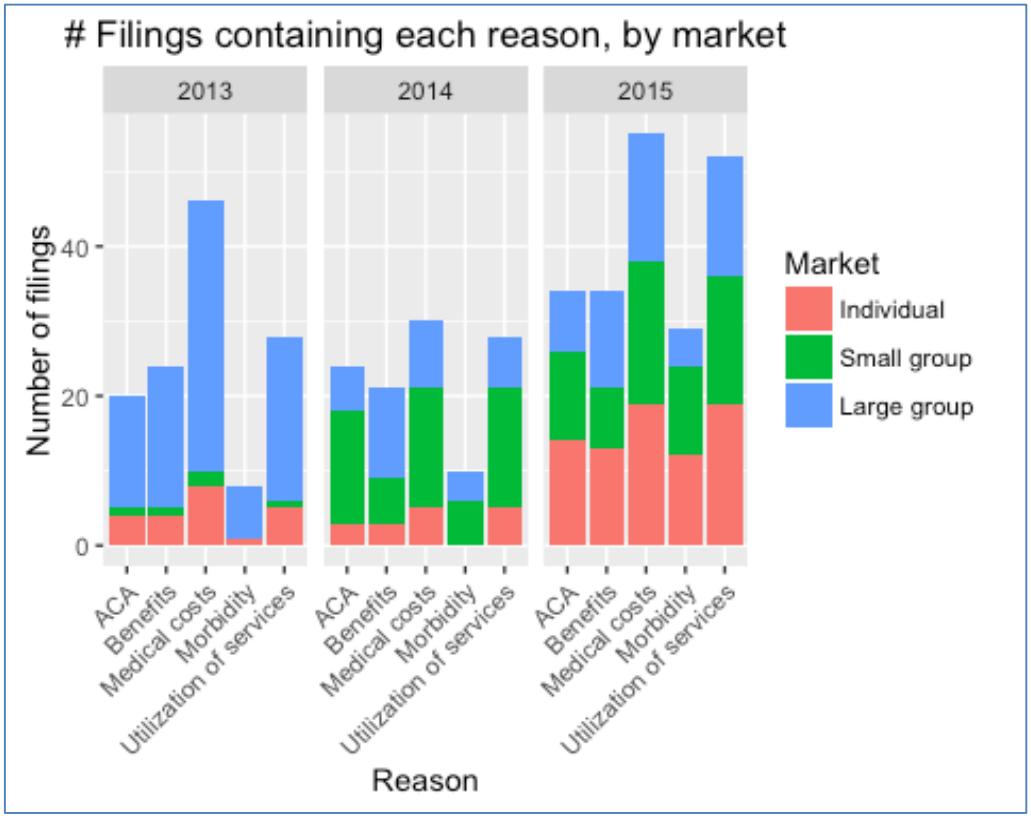
**Percent of Filings by Reason for Rate Change Request, by Year**

| Year | ACA | Benefits | Medical costs | Morbidity | Utilization of services |
|---|---|---|---|---|---|
| 2013 | 37.0% | 44.4% | 85.2% | 14.8% | 51.9% |
| 2014 | 54.5% | 47.7% | 68.2% | 22.7% | 63.6% |
| 2015 | 57.6% | 57.6% | 93.2% | 49.2% | 88.1% |



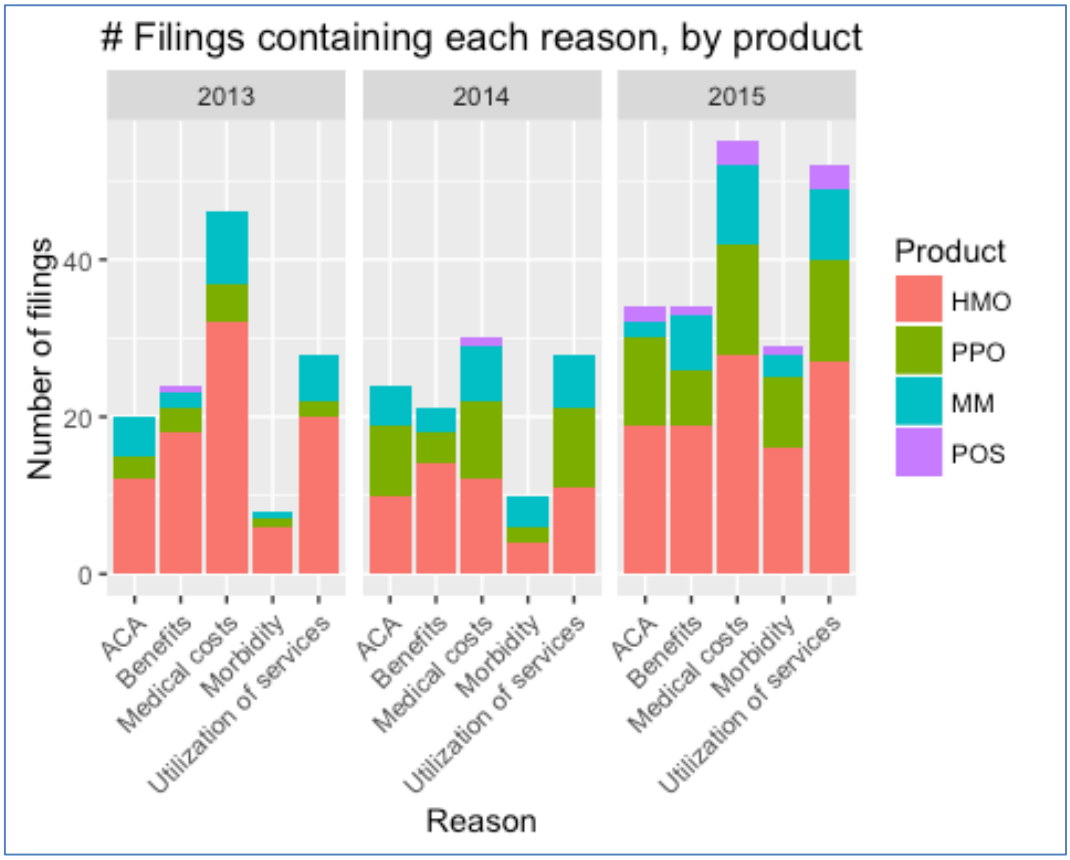
**Number of Filings Noting Selected Reasons for Changes in Premium Rates, by Market, by Year**

| Year | Market | ACA | Benefits | Medical costs | Morbidity | Utilization of services |
|---|---|---|---|---|---|---|
| 2013 | Individual | 4 | 4 | 8 | 1 | 5 |
| | Small group | 1 | 1 | 2 | 0 | 1 |
| | Large group | 15 | 19 | 36 | 7 | 22 |
| 2014 | Individual | 3 | 3 | 5 | 0 | 5 |
| | Small group | 15 | 6 | 16 | 6 | 16 |
| | Large group | 6 | 12 | 9 | 4 | 7 |
| 2015 | Individual | 14 | 13 | 19 | 12 | 19 |
| | Small group | 12 | 8 | 19 | 12 | 17 |
| | Large group | 8 | 13 | 17 | 5 | 16 |



**Number of Filings Noting Selected Reasons for Changes in Premium Rates, by Product, by Year**

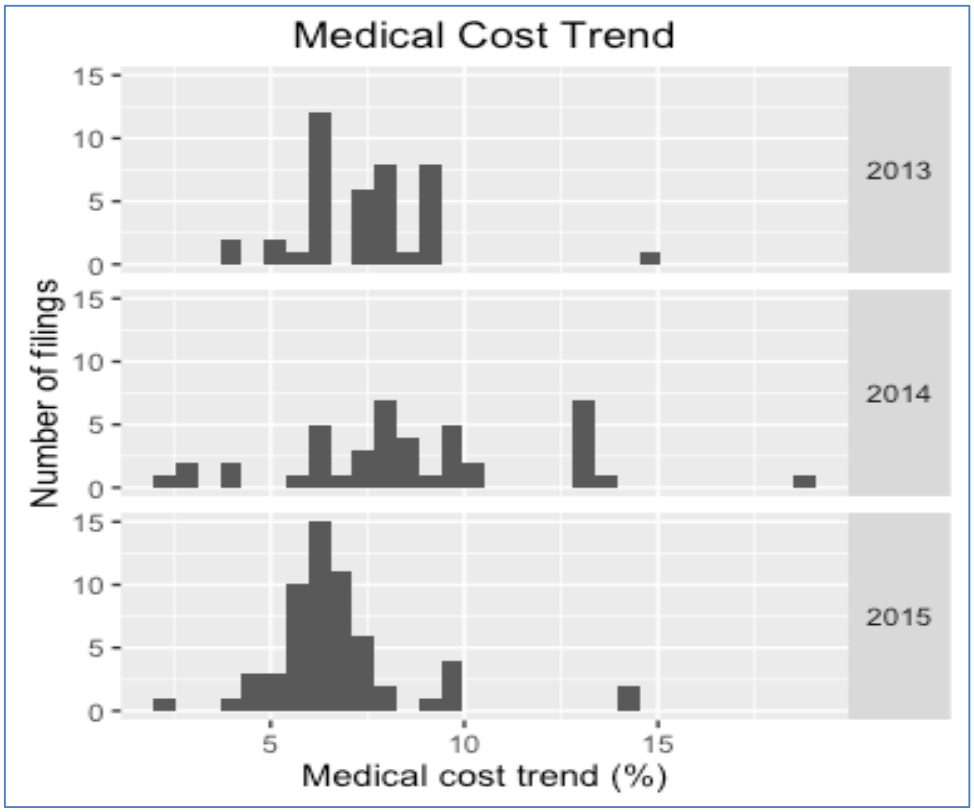
| Year | Product | ACA | Benefits | Medical costs | Morbidity | Utilization of services |
|---|---|---|---|---|---|---|
| 2013 | HMO | 12 | 18 | 32 | 6 | 20 |
| | PPO | 3 | 3 | 5 | 1 | 2 |
| | MM | 5 | 2 | 9 | 1 | 6 |
| | POS | 0 | 1 | 0 | 0 | 0 |
| 2014 | HMO | 10 | 14 | 12 | 4 | 11 |
| | PPO | 9 | 4 | 10 | 2 | 10 |
| | MM | 5 | 3 | 7 | 4 | 7 |
| | POS | 0 | 0 | 1 | 0 | 0 |
| 2015 | HMO | 19 | 19 | 28 | 16 | 27 |
| | PPO | 11 | 7 | 14 | 9 | 13 |
| | MM | 2 | 7 | 10 | 3 | 9 |
| | POS | 2 | 1 | 3 | 1 | 3 |



**D. Medical/ RX Cost Trend Rates Noted in Filings (Actuarial memos)**

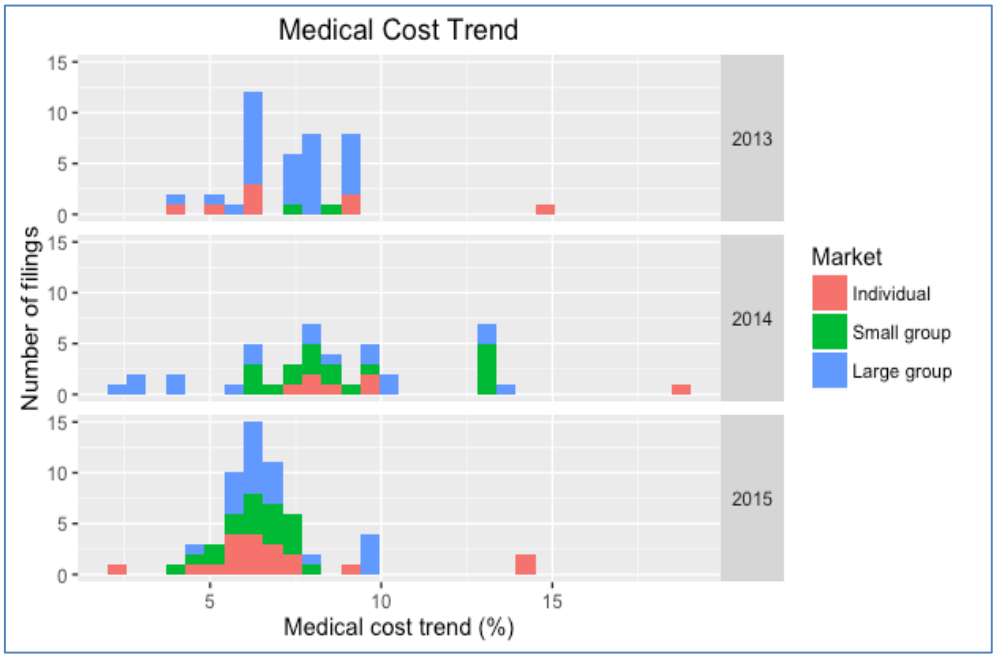
**Medical/RX Cost Trend Rate, by Year**

| Year | Filings | Average (%) | Min (%) | Max (%) |
|---|---|---|---|---|
| 2013 | 54 | 7.33 | 4.0 | 14.6 |
| 2014 | 44 | 8.70 | 2.5 | 19.0 |
| 2015 | 59 | 6.73 | 2.5 | 14.5 |



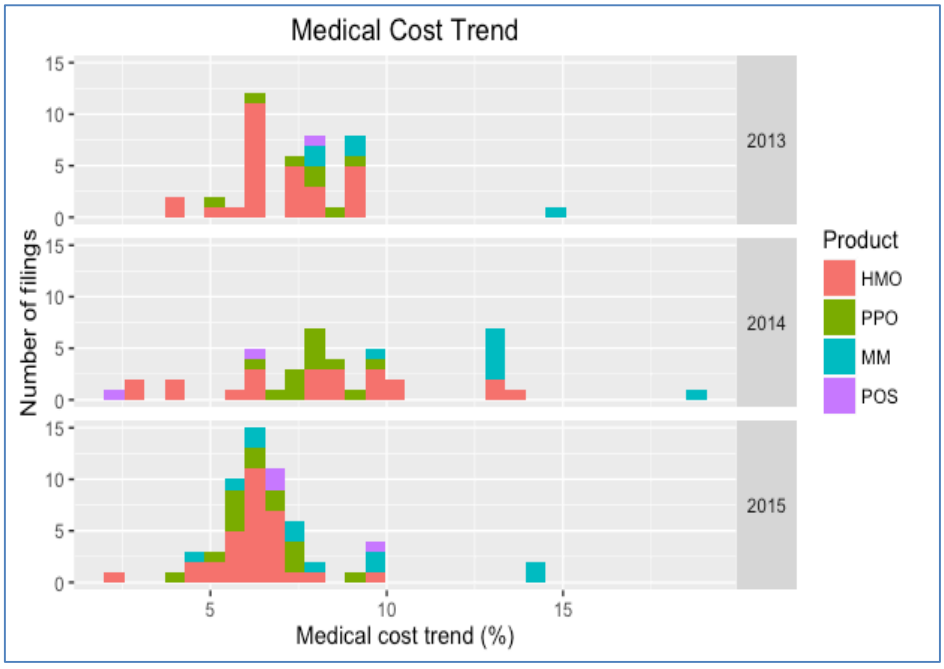
**Medical/RX Cost Trend Rate, by Market, by Year**

| Year | Market | Filings | Average (%) | Min (%) | Max (%) |
|---|---|---|---|---|---|
| 2013 | Individual | 10 | 7.60 | 4.0 | 14.60 |
| | Small group | 2 | 7.85 | 7.2 | 8.50 |
| | Large group | 42 | 7.22 | 4.2 | 8.84 |
| 2014 | Individual | 7 | 10.06 | 7.5 | 19.00 |
| | Small group | 18 | 9.16 | 6.0 | 13.00 |
| | Large group | 19 | 7.71 | 2.5 | 13.70 |
| 2015 | Individual | 19 | 6.98 | 2.5 | 14.50 |
| | Small group | 19 | 6.29 | 4.0 | 7.90 |
| | Large group | 21 | 6.89 | 4.6 | 9.60 |



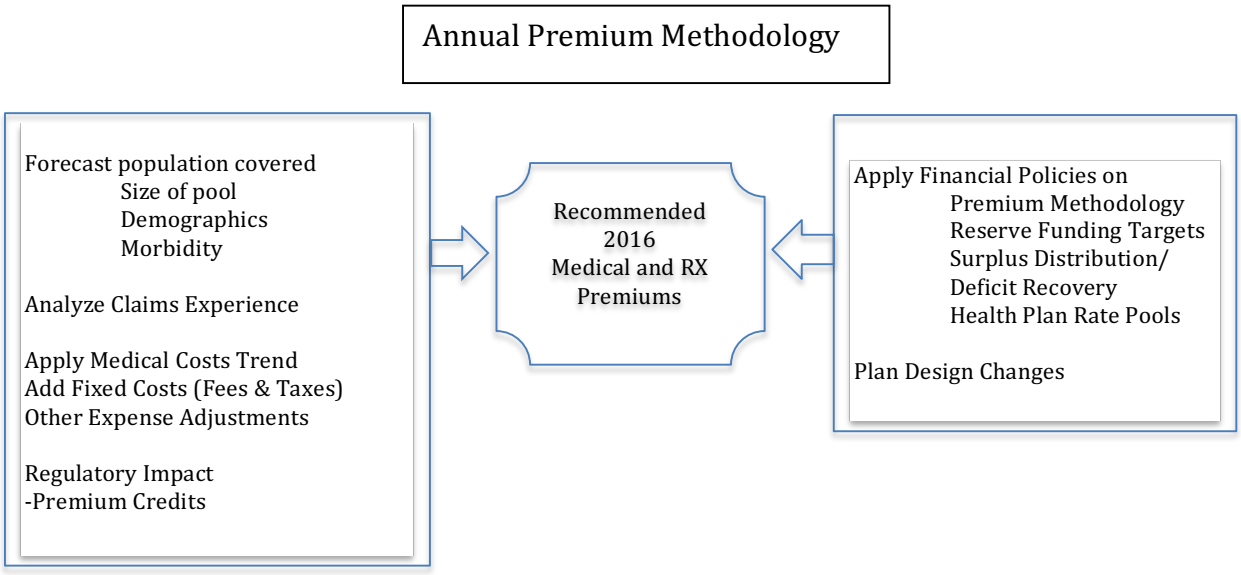
**Medical/RX Cost Trend Rate, by Product, by Year**

| Year | Product | Filings | Average (%) | Min (%) | Max (%) |
|---|---|---|---|---|---|
| 2013 | HMO | 36 | 6.88 | 4.0 | 8.9 |
| | PPO | 7 | 7.41 | 5.2 | 9.1 |
| | MM | 10 | 9.64 | 7.9 | 14.6 |
| | POS | 1 | 7.70 | 7.7 | 7.7 |
| 2014 | HMO | 22 | 8.05 | 2.9 | 13.7 |
| | PPO | 12 | 7.91 | 6.0 | 9.9 |
| | MM | 8 | 13.37 | 9.6 | 19.0 |
| | POS | 2 | 4.25 | 2.5 | 6.0 |
| 2015 | HMO | 31 | 6.16 | 2.5 | 9.5 |
| | PPO | 14 | 6.36 | 4.0 | 9.0 |
| | MM | 11 | 8.54 | 4.3 | 14.5 |
| | POS | 3 | 7.70 | 6.8 | 9.5 |



## Appendix G: Overview of Process for Setting Health Insurance Premiums

Actuaries develop premiums based on projected medical claims and administrative costs for a pool of individuals or groups with insurance. Pooling risks allows the costs of the less healthy to be subsidized by the healthy. In general, the larger the risk pool, the more predictable and stable premiums can be. But, the composition of the risk pool is also important. Although the ACA prohibits insurers from charging different premiums to individuals based on their health status, premium levels reflect the health status of an insurer's risk pool as a whole. The majority of premium dollars goes to medical claims, which reflect unit costs (e.g., the price for a given health care service), utilization, the mix and intensity of services, and plan design. Premiums must cover administrative costs, including those related to product development, enrollment, claims processing, and regulatory compliance. They also must cover taxes, assessments and fees, as well as profit (or, for not-for-profit insurers, a contribution to surplus). Laws and regulations can affect the composition of risk pools, projected medical spending, and the amount of taxes, assessments and fees that need to be included in premiums.



**Appendix H: Major Drivers of Premium Rate Changes Over Time**

| ***FACTORS IN PREMIUM INCREASES*** | |
|---|---|
| ***Risk Pool Composition*** | |
| Composition of the risk pool and How it compares to what was projected<br>How it is expected to change | CMS Proposed Standard Age Curve published in the Federal Register on November 26, 2012. This age curve has a 3:1 ratio for age rating. There is also a published factor for children.<br>Insurer expectations regarding the composition of the enrollee risk pool, including the distribution of enrollees by age, gender, and health status. |
| Single risk pool requirement | The ACA requires that insurers use a single risk pool when developing rates. That is, experience inside and outside the health insurance marketplaces (exchanges) must be combined when determining premiums. Premiums for 2016 will reflect demographics and health status factors of enrollees both inside and outside of the marketplace, as was true for 2014 and 2015. |
| Transitional policy for non-ACA-compliant plans | For states that adopted the transitional policy that allowed non-ACA compliant plans to be renewed, the risk profile of 2014 ACA-compliant plans might be worse than insurers projected. This would occur if lower-cost individuals retain their prior coverage and higher-cost people move to new coverage. The transitional policy was instituted after 2014 premiums were finalized; meaning insurers were not able to incorporate this policy into their premiums. |
| Regional, within-Michigan variations | Premiums are set at the state level (with regional variations allowed within a state) and will reflect state- and insurer-specific experience. These factors are reflected in the trend factors reported by insurers. |
| Reduction of reinsurance program funds | The ACA transitional reinsurance program provides for payments to plans when they have enrollees with especially high claims, thereby offsetting a portion of the costs of higher-cost enrollees in the individual market. This reduces the risk to insurers, allowing them to offer premiums lower than they otherwise would be. Funding for the reinsurance program comes from contributions from all health plans; these contributions are then used to make payments to ACA-compliant plans in the individual market (For more information see: http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/). |

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|---|---|
| ***Prices & use of services*** | |
| Medical trend: Underlying growth in health care costs | The increase in medical trend reflects the increase in per-unit costs of services and increases in health care utilization and intensity |
| | Short term National projection: National Health spending growth projected to rise 6.1% 2014-2015 (adjusted for inflation (CPI-U)).<br>Long term projection: 2015-2022 national health spending projected to grow 6.2% annually.<br>Health care reform impact on trend projected to be an average increase of 0.1% annually from 2012 to 2022 (CMS report on National Heath Expenditure Projections 2012-2022). |
| ***Employer Plan Taxes & Fees*** | |
| Temporary Reinsurance Fees (2014 thru 2016) | Fees from self-insured plans will be used to make reinsurance payments to individual market insurers that cover high-cost individuals in each state.<br><br>National fee rate of $63 per (non-Medicare) member per year for 2014, $44 PMPY for 2015, and $31.50 PMPY for 2016. |
| Temporary tax for PCORI fees (2012 thru 2018) | Assessments will fund "patient centered outcomes research trust fund"<br><br>Fees basis: $1 per covered health plan member per year for CY 2012, $2 per member per year for CY 2013, with PMPY amounts indexed to per capita increases in National Health Expenditures for years 2014-2018. |
| Employer Shared Responsibility for Health Care, "Pay or Play" | Requires large employers to "offer" medical coverage to employees averaging 30 or more hours of work per week<br><br>Health care coverage will be offered to temporary employees<br><br>Medical plans offered must satisfy mandated coverage levels; Employee premium must not exceed 9.5% of the employees pay rate<br><br>Employers must successfully "offer" coverage to 70% of their qualified population beginning 2015, and 95% by 2016 |

| | |
|---|---|
| Health claims assessment tax of 1% of claims and/or premium | State of Michigan Public Act 142 of 2011: Effective Jan 2012, applies to medical, Rx and dental services delivered in Michigan to Michigan residents |
| ***Plan Structure & Operations*** | |
| Changes in provider networks | Mix of practitioner specialties; "narrowness" of network |
| Changes in provider reimbursement structures | Per service payment formulae; example: Inpatient stays paid on DRG, Percent of Charges, bundled rates |
| Benefit package changes | Changes to benefit packages (e.g., through changes in cost-sharing requirements or benefits covered) can affect claim costs and therefore premiums. This can occur even if a plan's actuarial value level remains unchanged. |
| Risk margin changes | Insurers build risk margins into the premiums to reflect the level of uncertainty regarding the costs of providing coverage. These margins provide a cushion in case costs are greater than projected. Greater levels of uncertainty typically result in higher risk margins and higher premiums. |
| Changes in administrative costs | Wages, information technology, profit |
| Increase in the health insurer fee | In 2014, the ACA health insurer fee is scheduled to collect $8 billion from health insurers. The fee will increase to $11.3 billion in 2015 and gradually further to $14.3 billion in 2018, after which it will be indexed to the rate of premium growth. The fee is allocated to insurers based on their prior year's premium revenue as a share of total market premium revenue. In general, insurers pass along the fee to enrollees through an increase to the premium. The effect on premiums will depend on the number of enrollees over which the fee is spread—a greater number of enrollees will translate to the fee being a smaller addition to the premium. The increase in health insurer fee collections from 2014 to 2015 will, in most cases, lead to a small increase in 2015 premiums relative to 2014 (See Exchange and Insurance Market Standards for 2015 and Beyond (Final Rule), Federal Register: 79 (101), May 27, 2014. Available at: http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf. |

| | |
|---|---|
| Changes in geographic regions | Within a state, health insurance premiums are allowed to vary across geographic regions established by the state according to federal criteria.<br><br>Changes in the number of geographic regions in the state or how those regions are defined could cause premium changes that would vary across areas. For instance, assuming no other changes, if a lower-cost region and a higher-cost region are combined into one region for premium rating purposes, individuals in the lower-cost area would see premium increases, and individuals in the higher-cost areas would see premium reductions. |
| ***Market Competition*** | |
| Market forces and product positioning | Insurers might withstand short-term losses in order to achieve long-term goals.<br><br>Due to the ACA's uniform rating rules and transparency requirements imposed by regulators, premiums are much easier to compare than before the ACA, and some insurers lowered their premiums after they were able to see competitors' premiums. |