A STUDY OF AFFORDABLE CARE ACT COMPETITIVENESS IN MICHIGAN

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Section 1 – State Context

Table 1: Basic State Facts

Michigan Snapshot	
Type of Exchange	State Partnership
Expansion of Medicaid	Yes, with 1115 waiver
Number of Rating Areas	16
Number of Insurers in 2017	10
Net Change in Number of Insurers (2014-2017)	-3
Premium Increase (2016, silver plans)	5% (15th best)
State Population and Rank (July 2015)	9,862,100 (10th)
State Median Household Income and Rank	$54,203 (31st)
Salient Health Facts	Michigan was an early adopter of Medicaid managed care and implemented a statewide managed care program in 1997-1998. Historically, Michigan has had a lower uninsured rate than the national average. Since 2010, both the national and Michigan's uninsured rate have declined. In 2009, 12.2 percent of Michigan residents were uninsured compared with a national average of 15.1 percent. In 2015, 6.1 percent of Michigan residents were uninsured, compared with a national average of 9.4 percent.
Salient Health Policy Information	In 2015, Michigan's Department of Community Health and Department of Human Services merged to become the Department of Health and Human Services (DHHS). Since early 2016, DHHS and other state officials have devoted significant attention and resources toward addressing elevated lead levels in the drinking water supply in Flint, Michigan. As part of the state's response to the Flint water crisis, the state secured a federal waiver to expand Medicaid eligibility to approximately 15,000 Flint residents (pregnant women and children up to age 21) who were served by the Flint water system since April 2014.

EXCHANGE CHARACTERISTICS[1,2]

Michigan operates a state-partnership marketplace.[3,4,5,6,7,8] Under this model, the state of Michigan assumes responsibility for many functions of its exchange but uses the federal HealthCare.gov platform for exchange enrollment activities. The Michigan Department of Insurance and Financial Services (DIFS)

has general regulatory authority over exchange operations. DIFS performs plan management functions for qualified health plans (QHPs) and certifies carriers to participate on the exchange. DIFS also conducts annual rate reviews for plans on the individual market to ensure rates meet requirements of federal and state laws. DIFS contracts with outside actuaries to review carriers' rate change requests. Their analysis of proposed rate changes is based on historical experience, trends, risk adjustment, the carrier's mix of plans, and the expense provisions established by the carrier, including expenses and profits as they relate to medical loss ratio requirements. In addition, DIFS solicits public comment on proposed rate changes as part of its effective rate review process.

Michigan has 16 rating areas for the individual market. Each rating area encompasses anywhere from one to 13 counties, and all counties are fully included in a rating area. Carriers do not have to offer plans across an entire rating area but are generally required to offer exchange plans to an entire county. The boundaries of Michigan's rating areas have not changed since their introduction in 2014. Building off its previous experience regulating regional health maintenance organizations (HMOs), DIFS decided to divide the state into exchange rating areas based off of the boundaries of previously existing HMO service areas. DIFS also solicited input from insurance carriers and consumer groups as it was determining the boundaries of the state's rating areas. The benefit to this approach was that carriers were used to rate based on county lines, and keeping similar boundaries would be easier for consumers to understand.

HEALTH INSURANCE CLIMATE

Individual policies are sold both on and off the state's exchange. Historically, Blue Cross Blue Shield of Michigan (BCBSM) has been the dominant carrier in Michigan's individual health insurance market. Since its founding in the late 1930s, BCBSM has provided coverage with guaranteed issue and guaranteed renewability. BCBSM's status as the "insurer of last resort" for Michigan residents was further affirmed by the Michigan Legislature with the passage of Public Act 350 in 1980. Other health plans in Michigan did not face the same requirements as BCBSM in the individual market. The Michigan regulatory climate, combined with BCBSM's history, resulted in the company's large presence in the individual market prior to the launch of Michigan's exchange. According to data from the National Association of Insurance Commissioners, in 2013 BCBSM and its affiliates had 72 percent of the individual market in Michigan, including both on and off exchange plans. Prior to the passage of the Affordable Care Act (ACA), BCBSM had major financial losses in the individual market. Those losses, combined with the passage of the ACA, convinced Governor Rick Snyder to support changing BCBSM's legal status from a nonprofit health corporation established under Public Act 350 to a nonprofit mutual insurance company. BCBSM restructured as a nonprofit mutual insurer on January 1, 2014.

BCBSM still remains the major carrier in the individual market, though enrollment data from 2014 and 2015 suggests its competitors may be gaining ground. In 2014, BCBSM's individual market share was 66 percent; in 2015, its market share was 59.67 percent. Priority Health, a west Michigan-based carrier, experienced growth in market share, increasing from 7.8 percent in 2014 to 17 percent in 2015, making it the second-largest carrier in the state's individual market.

Section 2 – New Developments Entering the Fourth Open Enrollment Period

In the 2017 open enrollment period, Michigan residents saw fewer carriers offering plans and fewer broad-access preferred provider organization (PPO) plan offerings than in previous years. In addition, average premium increases in 2017 are higher than they have been previously. However, most exchange enrollees in Michigan receive premium tax credits that help shield them from premium increases. In 2016, 87 percent of Michigan's exchange enrollees received these tax credits.

Michigan has had high levels of carrier participation on its exchange. In 2014, Michigan's exchange launched with 13 carriers offering plans. In 2015, three new carriers entered the exchange, bringing participation up to 16. In 2016, two carriers withdrew from the exchange, bringing the number of participating carriers to 14. In 2017, four carriers withdrew from the exchange, leaving 10 carriers in Michigan's individual exchange. The four carriers that withdrew in 2017 are Alliance Health and Life Insurance Co., Harbor Health Co., Priority Health Insurance Co., and UnitedHealthcare Community Plan. These four carriers collectively had 10,000 exchange enrollees in 2016.[9]

In April 2016, UnitedHealthcare announced it would exit Michigan's exchange market in 2017 as part of a broader strategy to scale back exchange participation nationwide.[10] UnitedHealthcare offered HMO plans on the exchange in seven Michigan counties in 2016. Harbor Health—a small local carrier offering exchange plans in Wayne, Oakland, and Macomb counties—withdrew from Michigan's exchange in 2017.[11] In late August, regional carriers Alliance Health and Life Insurance Co. and Priority Health Insurance Co. (PHIC) announced they would pull their PPO plans from the Michigan exchange in 2017. Alliance offered PPO plans in 24 counties in 2016, while PHIC offered PPO plans in 69 counties. The parent companies of Alliance and PHIC, Health Alliance Plan and Priority Health, respectively, continued to sell HMO and point-of-service (POS) plans on the exchange in 2017.[12] The withdrawal of these two PPO companies leaves BCBSM as the only PPO carrier on the individual exchange in 2017. BCBSM is also the only carrier to offer plans in every county of the state. While the majority of enrollment in Michigan's individual market occurs on the exchange, Michigan's off-exchange individual market also experienced some carrier change moving into the 2017 open enrollment period. Humana withdrew its PPO plans from the off-exchange individual market in 2017. However, Humana offered HMO plans on Michigan's exchange in 2016 and continued to do so in 2017.[13]

In addition to changes in the number of carriers offering plans on the exchange, many carriers proposed larger premium increases in 2017 for their exchange plans than in previous years. DIFS approved an average statewide rate increase of 16.7 percent for plans offered in the individual market in 2017.[14] By contrast, in 2016 DIFS approved an average statewide rate increase of 6.5 percent over 2015 rates.[15]

Some of this year's rate increases can be attributed to short-term trends, such as the end of the ACA's reinsurance program at the close of 2016. Carriers may also be correcting for previous underpricing of their products in 2014 and 2015. Some interviewees suggested that premiums had been set low

in the exchange's first two years to initially attract and retain larger numbers of enrollees. However, some interview participants also believed the proposed 2017 rate increases represent the beginning of a multiyear correction for carriers based on their first three years' experience. One interviewee claimed that new exchange enrollees are "definitely higher risk and higher utilization" than anticipated, especially among the population that used special enrollment periods to sign up for coverage. "The pool is sicker than we anticipated," the interviewee said. Another source echoed these remarks, noting that emergency department utilization was "very significant" among their exchange population. With additional years of utilization data available, carriers are now raising premiums to bring them more in line with the costs of providing care to exchange customers. In addition, interview participants believe that rising pharmaceutical costs will be significant drivers of premium increases in the future.

Section 3 – Selection of Local Sites

This report focuses on exchange conditions in five counties in Michigan: Delta, Genesee, Kent, Kalamazoo, and Wayne. Exchange operations and carrier competition vary greatly across geographic regions in Michigan. The selection of these five counties is intended to provide insights on strong urban markets and the experience of a rural county in contrast. Four of these counties—Genesee, Kent, Kalamazoo, and Wayne—include large cities and are some of the state's most heavily populated counties. These counties have multiple carriers offering plans on the exchange and relatively low premiums for exchange plans. The fifth area, rural Delta County, has had the lowest carrier participation and some of the highest premiums in the state.

DELTA COUNTY

Located in Michigan's Upper Peninsula, Delta County is located along Lake Michigan with a population of 36,377 (44th out of 83 counties in the state), a median household income of $42,070 (44th in the state), and an unemployment rate of 6.6 percent.[16,17] Delta County has one 25-bed critical access hospital, OSF Saint Francis Hospital, located in Escanaba. Delta County has had some of the lowest levels of plan competition and highest premiums in the health insurance marketplace in Michigan. However, Delta County experienced an increase in the number of participating carriers and plans offered on the exchange from 2016 to 2017. In 2016, Blue Cross Blue Shield of Michigan was the only issuer in Delta County, offering 13 plans on the exchange. In 2017, Blue Care Network (BCN) entered the exchange in Delta County. BCBSM and BCN are offering 14 plans in 2017.

GENESEE COUNTY

Genesee County, the home of Flint, has a population of 410,849 (5th in the state), a median household income of $41,879 (45th in the state), and an unemployment rate of 6.0 percent.[18,19] Genesee County has three midsize hospitals (Genesys Regional Medical Center, Hurley Medical Center, and McLaren Flint) with over 1,000 combined beds. These hospitals are each part of separate, larger systems. In 2017, Genesee County has eight issuers offering 69 plans on the exchange and some of the lowest marketplace premiums in Michigan.

KALAMAZOO COUNTY

Kalamazoo County, in southwest Michigan, has a population of 260,263 (9th in the state), a median household income of $46,356 (27th in the state), and an unemployment rate of 4.4 percent.[20,21] The city of Kalamazoo is the home of two competing midsize hospitals (Borgess Medical Center and Bronson Methodist Hospital) that have more than 700 beds combined. Kalamazoo County has six issuers offering 57 plans on the exchange in 2017.

KENT COUNTY

Kent County, the home of Grand Rapids, is the largest health care market in western Michigan. With a population of 636,369, Kent County is the state's fourth most populous county, has a median household income of $52,716 (13th in the state), and has an unemployment rate of 3.8 percent.[22,23] Kent County has four short-term acute care hospitals, including Spectrum Health Butterworth Hospital, which is one of the largest teaching hospitals in Michigan. In 2017, Kent County has five issuers offering 54 plans on the exchange. Kent County has some of the lowest marketplace premiums in Michigan.

WAYNE COUNTY

Wayne County, which includes Detroit, is the most populous county in Michigan, with 1,759,335 residents, a median household income of $41,421 (49th in the state), and an unemployment rate of 7.3 percent.[24,25] It has 15 short-term acute care hospitals, including four large health systems that serve southeast Michigan (Henry Ford Health System, Detroit Medical Center, Beaumont Health, and Ascension Health). With 10 issuers and 111 plans in 2016, Wayne County had the most issuers and available plans in Michigan (tied with Oakland and Macomb counties). In 2017, Wayne County has nine issuers and 83 plans on the exchange after the exits of UnitedHealthcare and Harbor Health Plan, but remains one of the counties with the greatest number of participating exchange carriers in the state. Wayne County has some of the lowest marketplace premiums in Michigan.

Section 4 – Methodology

This analysis used two general types of data—quantitative and qualitative. Quantitative data were derived from several publicly available datasets and reports prepared by the state of Michigan, the federal government, and other sources. Qualitative data were collected through discussions with a variety of stakeholders involved in health care and health policy in Michigan.

Data on the number of carriers offering qualified health plans on the Michigan exchange were obtained from publicly available files prepared by the Michigan DIFS. Additional plan and premium data were obtained through marketplace landscape files located at data.healthcare.gov. Enrollment data were obtained from the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

To supplement our data analysis, we also conducted a series of phone and in-person interviews with stakeholders and policymakers involved with and knowledgeable about Michigan's exchange and the broader commercial health insurance industry. We conducted 10 interviews consisting of: two carriers, one

regulatory agency, five hospitals/providers, and two state policy experts. Interview participants represent a range of organizations located in different geographic areas in the state. Efforts were made to ensure participation from as many study areas as possible. Many participants provided a statewide perspective on the questions we asked; some also provided responses that were specific to the geographic regions where they work.

Experts were initially contacted via email. Discussions resulted from these initial emails or from follow-up emails and phone calls. Interviews were conducted over the phone or in person and generally lasted approximately one hour. All participants were assured that their participation was voluntary, that they could refuse to answer a particular question, and that they would not be identified by name or organization. Interviews were recorded and transcribed for accuracy. Some participants requested questions in advance and were provided a set of potential questions via email.

Some questions were standard across all interviews, while others were tailored to the category of expert being interviewed. All interviews began by asking participants to give their general opinion on how well Michigan's exchange has functioned since 2014 and how they perceive competition in this market. Discussions with regulators focused on their processes for annual rate reviews and network adequacy. Discussions with carriers, providers, and policy experts asked for perceptions of factors driving competition in the exchange market, affordability of exchange products for consumers, and potential policy changes to improve stability in the individual market.

Section 5 – Outcomes of Competition and Highlighted Findings for Each Site

Perceptions of competition in Michigan's exchange and overall insurance market varied among interview participants. Some felt that Michigan's exchange was relatively robust, especially compared with other states or national trends. Many of these participants pointed to the success of regional carriers in Michigan compared with national carriers, as well as carriers that had moved from the Medicaid managed care market to the exchange market. Others expressed concern about the stability of Michigan's market in light of premium increases for 2017.

EXCHANGE CONDITIONS

At the end of the 2016 open enrollment period, 345,813 residents had selected a plan through Michigan's exchange. New consumers made up 33 percent of these plan selections, while 67 percent were re-enrollees. Of the re-enrollees, 42 percent chose a new plan in 2016, while 25 percent were automatically re-enrolled into the same plan they held in 2015. By March 31, 2016, Michigan had 313,123 effectuated enrollments (i.e., the number of enrollees who paid premiums) through its exchange. According to the Kaiser Family Foundation, Michigan has enrolled 43 percent of its eligible marketplace population (an estimated 733,000 residents) in coverage through its exchange.[26] This is higher than the national average of 40 percent. Still, interview participants from all sectors agreed that the population of individuals who obtain coverage from the exchange remains a small proportion of the overall health insurance market in Michigan.

The number of effectuated enrollments in the exchange market in 2016 represents only about 3 percent of Michigan's total population. Many providers we interviewed estimated that less than 10 percent of their total patient population had coverage through the exchange. For one provider organization, the expansion of Medicaid through the Healthy Michigan Plan was a bigger influence on its business decisions than the population covered by exchange plans.

CARRIER PARTICIPATION AND PLAN CHOICE

Within the state, there is substantial variation in the number of participating carriers, plan offerings, and premiums across geographic regions. Table 2 shows a summary of enrollment, plans, and premiums for 2016 in each of our five study areas.

Table 2: Exchange Conditions by Study Area, 2017[27,28,29]

County	Number of Plan Selections in 2016	Number of Carriers	Number of Plans	Lowest-Cost Silver Premium (40-year-old)	Second-Lowest Silver Premium (40-year-old)	Highest-Cost Silver Premium (40-year-old)
Delta	1,949	2	14	$397	$436	$557
Genesee	10,931	8	69	$236	$244	$448
Kalamazoo	7,983	6	57	$292	$305	$509
Kent	20,987	5	54	$239	$241	$502
Wayne	46,755	9	83	$233	$237	$465

Michigan's exchange market has seen substantial regional variation in the number of plans offered each year since 2014. All five counties had a significant increase in the number of plans from 2014 to 2015, which may be associated with an increase in the number of carriers participating on Michigan's exchange during that period. Most study areas had decreases in the number of plans available from 2015 to 2016 and from 2016 to 2017. Kalamazoo County was the only study area to have had an increase in the number of plans available from 2015 to 2016. Delta County was the only study area to have had an increase in the number of plans available from 2016 to 2017. Table 3 reports the number of plans offered in each study area from 2014 to 2017.

Table 3: Plan Offerings by Study Area, 2014-2017[30]

County	2014	2015	2016	2017
Delta	5	23	13	14
Genesee	48	92	89	69
Kalamazoo	37	67	74	57
Kent	33	68	62	54
Wayne	55	120	111	83

Michigan appears to have a high level of carrier participation on its exchange compared with other states. However, this participation varies greatly across geographic regions. While the four populous, metropolitan counties in our study have some of the highest carrier participation in the state, many rural counties, particularly in the Upper Peninsula and northern Lower Peninsula, have only one or two carriers participating on the exchange.

Interview participants agreed that Michigan's exchange market, like its overall commercial insurance market, remains dominated by Blue Cross Blue Shield of Michigan and its HMO affiliate, Blue Care Network. However, participants disagreed on the implications of this dominance on Michigan's exchange. One provider felt that BCBSM negotiates provider contracts with far lower payment rates than other carriers, allowing it to set lower premiums for its products. While health systems can negotiate more advantageous rates from competing carriers, higher payment rates for providers can prevent other carriers from competing with BCBSM on the basis of premiums. An executive from a competing carrier echoed this view, claiming that BCBSM's large enrolled population provides a competitive advantage over smaller plans by providing the company the ability to manage risk and to price products accordingly.

Given the prominent role of BCBSM in the state, many interview participants suggested that the exit of national insurers from exchange markets, such as UnitedHealthcare and Aetna, would not have a large impact on the market. One expert with experience in the insurance industry noted that national companies never had a large footprint in Michigan's individual market, and that the performance of regional carriers is a better indicator of the overall strength of Michigan's exchange. Several experts said they would not be surprised if national carriers re-entered exchange markets after a few years of nonparticipation. One participant said, "I really see the whole ACA lineup as being mostly local players.… You may get some national players who come in and try to do well in that marketplace, but I think it'll be always be dominated by locals." This interviewee also believes there is an opening for Medicaid plans to gain a greater share of the exchange market. Another interviewee agreed that Medicaid plans have been successful in this market. This participant was surprised that those plans were not as aggressive initially as expected, but said Medicaid plans had been able to keep their premiums more consistent than commercial carriers' premiums over the last few years.

Consumers Mutual, Michigan's co-op, offered plans on the exchange in 2014 and 2015, but closed at the beginning of the 2016 open enrollment period. The loss of Consumers Mutual impacted consumer choice in the majority of Michigan's 83 counties, as the carrier offered plans in 47 counties in 2014 and 68 counties in 2015. In many of these counties, Consumers Mutual offered the lowest-cost plan at a given metal level. In 2015, Consumers Mutual was the lowest-cost silver option in 14 counties and the second-lowest-cost silver option in 12 counties. It also offered the lowest-cost bronze plan in 10 counties and the lowest-cost gold plan in 19 counties. Within our study areas, the exit of Consumers Mutual has significantly impacted plan choice in Delta County. Consumers Mutual was one of two carriers participating in Delta County in 2015, and offered the lowest-cost bronze, lowest-cost silver, second-lowest-cost silver, and lowest-cost gold plans in that county. After having only BCBSM participating on the exchange in 2016, BCN's entry in 2017 helps restore additional plan choices to Delta County consumers.

PREMIUMS

Premium prices in 2016 varied across regions. Of Michigan's 83 counties, those with the largest populations had some of the lowest premium prices. Four of the five counties with the lowest prices for a 40-year-old purchasing the lowest-cost silver plan in 2016 are the most populous counties in the state and include two of our study areas—Wayne and Kent. Many counties with the highest premiums for the lowest-cost silver plan in 2016 are located in the Upper Peninsula and have some of the smallest populations in the state.

On average, 87 percent of Michigan residents purchasing coverage on the exchange received premium tax credits in 2016 to help pay for their monthly premiums. In Kent and Wayne counties, 80 percent of exchange enrollees received tax credits. In Delta County, where premiums were highest, 95 percent of enrollees received tax credits.

Trends in premium prices from 2014 to 2016 were relatively stable across most of our study regions. In four counties, a 40-year-old choosing the lowest-cost silver plan in 2016 would pay a lower monthly premium than for the lowest-cost silver plan available in that county in 2015. Similarly, in these four counties, a 40-year-old choosing the second-lowest-cost silver plan in 2016 would pay a lower monthly premium than for the second-lowest-cost silver plan in 2015. However, 2017 premiums for the lowest-cost silver plan have risen in 82 of Michigan's 83 counties, including all of our study regions. In all study areas, 2017 premiums for the lowest- and second-lowest-cost silver plan are higher than they were for those plans in 2016.

In many counties, the carrier offering the lowest-cost silver plan and the second-lowest-cost silver plan has changed from year to year. In Delta County, the carrier offering the lowest-cost silver plan in 2015, Consumers Mutual co-op, has since shut down. Tables 4 and 5 report the monthly premium for a 40-year-old purchasing the lowest-cost silver plan and the second-lowest-cost silver plan, respectively, in each of our five study areas from 2014 to 2017. The carrier offering that plan is in parentheses.

Table 4: Premiums for Lowest-Cost Silver Plan by Study Area, 2014-2017[31]

County	2014	2015	2016	2017
Delta	$334 (BCBSM)	$317 (Consumers Mutual co-op)	$392 (BCBSM)	$397 (BCN)
Genesee	$224 (Total Health Care USA)	$243 (Total Health Care USA)	$215 (Meridian)	$236 (Meridian)
Kalamazoo	$255 (BCN)	$280 (BCN)	$254 (Meridian)	$236 (Meridian)
Kent	$200 (BCN)	$219 (BCN)	$206 (Humana)	$239 (Molina)
Wayne	$190 (Humana)	$219 (Humana)	$210 (Humana)	$233 (Meridian)

Table 5: Premiums for Second-Lowest-Cost Silver Plan by Study Area, 2014-2017[32]

County	2014	2015	2016	2017
Delta	$358 (BCBSM Multistate Plan)	$350 (Consumers Mutual co-op)	$424 (BCBSM)	$436 (BCN)
Genesee	$248 (BCN)	$255 (Priority Health)	$230 (Meridian)	$244 (Total Health Care USA)
Kalamazoo	$272 (BCN)	$291 (BCN)	$272 (Meridian)	$305 (Priority Health)
Kent	$254 (BCN)	$227 (BCN)	$226 (BCN)	$241 (Molina)
Wayne	$224 (Total Health Care USA)	$230 (UnitedHealthcare)	$226 (Harbor Health)	$237 (Molina)

Statewide, there have been similar changes in the carrier offering the lowest-cost plan at most metal levels, especially for silver plans. In 2014, BCBSM or its HMO affiliate, Blue Care Network, offered the lowest-cost silver plan in 74 out of 83 counties. In 2015, they offered the lowest-cost silver plan in only 15 counties, as Priority Health became the lowest-cost silver option in 47 counties and Consumers Mutual offered the lowest-cost silver option in 14 counties. In 2016, Consumers Mutual exited the market, leaving BCBSM/BCN as the lowest-cost silver option in 24 counties and Priority Health as the lowest-cost silver option in 43 counties. These trends have remained relatively steady for 2017, with BCBSM/BCN offering the lowest-cost silver plan in 22 counties and Priority Health offering the lowest-cost silver plan in 43 counties.

OUT-OF-POCKET COSTS

Changes in deductibles from 2014 to 2017 varied substantially across study areas as the lowest-cost silver plan changed from year to year. But all study regions have experienced an increase in the deductible for the lowest-cost silver plan when comparing 2014 to 2017. Table 6 shows deductibles for the lowest-cost silver plan in each study area from 2014 to 2017.

Table 6: Deductibles for Lowest-Cost Silver Plan by Study Area, 2014-2017[33]

County	2014	2015	2016	2017
Delta	$1,400	$2,000	$3,500	$4,500
Genesee	$3,000	$3,000	$5,000	$5,400
Kalamazoo	$1,650	$1,650	$5,000	$5,400
Kent	$1,650	$1,650	$3,800	$2,400
Wayne	$4,600	$4,600	$3,800	$5,400

Some providers believed rising deductibles and out-of-pocket costs are a troubling trend that negatively impact consumer perceptions of the value of their coverage. One consultant with experience in the insurance industry concluded that exchange consumers are motivated by premium prices when choosing plans and either do not consider or do not understand the additional out-of-pocket costs of certain plans.

High deductibles and out-of-pocket costs may be impacting exchange consumers' access to care. Health systems and individual providers take different approaches to this issue. Some health systems have strengthened their front-end patient financial services or developed cost estimators to help patients better understand their benefits prior to receiving care. One provider, however, said that certain physicians in their organization refused to accept patients with exchange plans, particularly those with high deductibles and high copayments. This provider indicated that lack of timely payments from these patients was a primary reason why physicians would not accept exchange products.

ENROLLEE INCOME

Michigan's exchange has enrolled a greater proportion of higher-income consumers than many other federally facilitated exchanges. In Michigan, 48 percent of exchange enrollees in 2016 earned annual incomes above 200 percent of the federal poverty level (FPL). This is higher than the average for federally facilitated exchanges in 2016, when only 34 percent of enrollees had incomes greater than 200 percent of the FPL. In our five study areas, the proportion of enrollees with incomes greater than 200 percent of the FPL ranged from 36 percent (Wayne) to 57 percent (Delta). Table 7 reports the income distribution of exchange enrollees in each of our study areas in 2016.

Table 7: Income Distribution of Exchange Enrollees by Study Area, 2016[34]

County	At or below 200% FPL	Above 200% FPL
Delta	37%	57%
Genesee	50%	42%
Kalamazoo	48%	44%
Kent	47%	43%
Wayne	54%	36%

There does not appear to be a clear relationship between the number of plans available and the proportion of exchange enrollees who earn higher incomes. Counties with high levels of carrier participation and a large number of plans would have been expected to attract greater numbers of higher-income enrollees; however, enrollment data from 2016 do not appear to support such a relationship. It is possible that the income distribution of exchange enrollees could be correlated with other demographic or economic conditions in these counties.

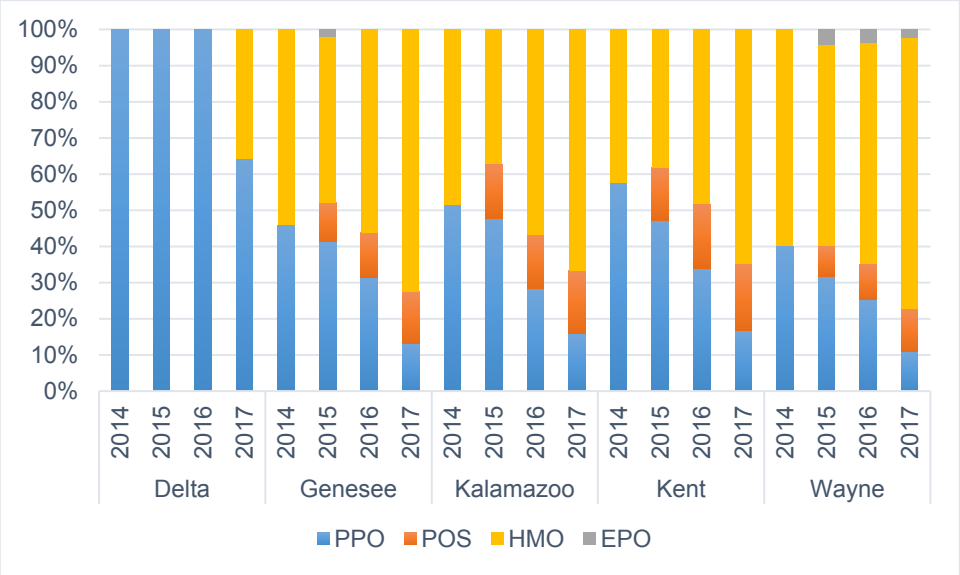
A substantial portion of exchange enrollees in our five study areas and statewide earn incomes that fall between 200 to 250 percent of the FPL. Twenty-one percent of Michigan's exchange enrollees have

incomes within this range compared with 15 percent of all enrollees in federally facilitated exchanges. Within our study areas, the proportion of enrollees with incomes at 200-250 percent of the FPL range from 16 percent of enrollees (Wayne) to 21 percent of enrollees (Delta).

NETWORKS

Since 2014, Michigan has experienced a shift in the types of plans offered on the exchange. In each study area, the share of PPOs relative to other plan types has decreased, while HMOs have become the dominant plan type offered in four of our five study areas. Some carriers also offered point-of-service or exclusive provider organization (EPO) plans beginning in 2015, though the number of these types of plans remains small. Figure 1 illustrates the changes in network types offered in our five study areas since 2014.

Figure 1: Network Composition of Plans Offered in Study Areas, 2014-2017[35]



Michigan's shift from broader-access PPO networks to more narrow HMO and Medicaid-like networks from 2014-2017 could be a result of the financial issues that carriers have experienced on the exchange. Carriers had expected a larger and healthier risk pool for their exchange plans and were surprised by higher-than-expected costs to care for this population. To maintain enrollees in the pool who are price-sensitive, carriers are also looking for ways to deliver affordable products to consumers. The development of narrow networks is an attempt to both maintain affordable prices for the consumer and control utilization, quality, and cost for the carrier. As one interview participant stated, "I think [carriers] are getting out of PPOs because it's a broader-access, higher-price point [that] is not going to be attractive to the people you need to balance the risk pool…that's why you're seeing more of that migration from PPO to HMO, and HMO to extra-HMO, like Medicaid managed care."

Some of the development of narrow networks also appears to be driven by the preferences of consumers in the individual market. One expert contrasted the types of networks individuals want with networks that large employers want: Large group customers, who may have employees living in multiple states,

still seek plans with very broad provider networks to accommodate all of their employees' health care providers. Consumers in the individual market, on the other hand, are motivated to choose plans based on whether or not their own health care providers are in those networks. A participant working for an insurance carrier confirmed the differences between the two markets, saying that as a result the company was "trying to build higher-performing networks within tighter geographic locations."

Lower-cost exchange plans do appear to offer a limited selection of participating providers. An analysis of selected provider participation in the 2016 lowest-cost silver plan shows that consumers in our study areas who chose these plans had a small selection of in-network providers relative to the overall population of providers in their area. We selected several provider types spanning primary care, specialties, and facilities, and analyzed the number of providers participating in the lowest-cost silver plan relative to the total number of providers within a certain number of miles from the most populous ZIP code in each study area. Table 8 shows the proportion of participating providers in the lowest-cost silver plan for each study area in 2016.

Table 8: Selected Provider Participation in Lowest-Cost Silver Plans by Study Area, 2016[36]

Provider Type		Delta	Genesee	Kalamazoo	Kent	Wayne
Primary Care Providers (within 50 miles)	**Not participating**	60 (41%)	8,908 (95%)	2,220 (94%)	1,938 (88%)	7,920 (88%)
	Participating	86 (59%)	472 (5%)	150 (6%)	87 (12%)	1,095 (12%)
	Total	**146**	**9,380**	**2,370**	**2,025**	**9,015**
Psychiatrists (within 50 miles)	**Not participating**	1 (20%)	956 (90%)	227 (87%)	194 (100%)	979 (90%)
	Participating	4 (80%)	111 (10%)	35 (13%)	0 (0%)	106 (10%)
	Total	**5**	**1067**	**262**	**194**	**1085**
Cardiologists (within 50 miles)	**Not participating**	3 (75%)	623 (92%)	154 (94%)	107 (91%)	494 (73%)
	Participating	1 (25%)	56 (8%)	10 (6%)	11 (9%)	187 (27%)
	Total	**4**	**679**	**164**	**118**	**681**
Hospital Facilities (within 100 miles)	**Not participating**	10 (56%)	76 (99%)	61 (95%)	45 (94%)	77 (83%)
	Participating	8 (44%)	1 (1%)	3 (5%)	3 (6%)	16 (17%)
	Total	**18**	**77**	**64**	**48**	**93**

The lowest-cost silver plan in Delta County in 2016 was a PPO and offered some of the highest participation rates for each type of provider across our study areas. The lowest-cost silver plans in the other four study areas in 2016 were HMOs and appeared to offer a much narrower range of providers in each area, though many HMOs allow referrals to out-of-network providers if there are no specialists in their network. An additional factor in provider access is whether or not primary care providers in these networks are accepting new patients, which was not analyzed in this report.

Despite the observed shift in the nature of the network structure of Michigan's exchange plans, some experts, particularly health care providers, believe that narrow networks are still a new phenomenon that have not yet begun to substantially impact competition in the insurance market. However, most participants agreed that the development of narrower networks is a trend that will persist for several years. Many participants also noticed an emerging trend linking quality to networks. Some carriers are experimenting with building narrower networks that contain only the highest-performing primary care providers, hospitals, and specialists. Other experts believe plans that have traditionally operated in the Medicaid managed care market have an opening to build a greater presence in the exchange markets with narrow Medicaid-like network structures.

According to interview participants, consumers shopping on Michigan's exchange would likely benefit from additional education, transparency, and clarity on the types of providers and services included in their plans and networks. Some carriers have developed innovative tools to help consumers identify in-network providers and estimate the costs of common procedures. However, many interview participants, especially providers, expressed concern that consumers remain confused about their levels of coverage. Participants generally felt that consumers shop for plans primarily on the basis of monthly premium costs, and that more could be done to have customers understand the out-of-pocket costs associated with certain exchange plans.

Providers were asked to describe their experiences with patients receiving "surprise" bills for out-of-network services, which can occur when an insured patient unknowingly receives care from a provider who is not in their plan's network. Many providers continue to hear from a small number of patients who receive these surprise bills for out-of-network services, but generally felt that the number of these patients has declined since 2014. However, regulators expressed concern that there could be an increase in patients with surprise bills in 2017 as a result of the Centers for Medicare & Medicaid Services' (CMS) automatic re-enrollment process. With several companies exiting the exchange market this year, there is a possibility that their customers may find themselves in a different plan provided by a different company with a potentially different network structure. During discussions, regulators mentioned they were "debating this issue [with CMS] as we speak.… For various reasons, some legal, we don't think people should be auto-enrolled."

FACTORS AFFECTING COMPETITION IN LOCAL EXCHANGES

POPULATION

Many interview participants said that large populations and concentration of health systems were two primary factors driving competition among carriers in the individual exchange market. Counties like Wayne, Kent, Kalamazoo, and Genesee all contain large metropolitan areas with significant population density. In these areas, carriers are able to contract and partner with multiple large health systems. Conversely, rural areas such as Delta County have neither the population nor the provider density necessary to sustain multiple carriers participating on the exchange. One interviewee pointed to Michigan's past experience in implementing Medicaid managed care as evidence that the Upper Peninsula has long been unable to sustain carrier competition. Another interviewee said it was unrealistic to believe the exchange would drive prices down in all regions. "I think people were

expecting a little bit too much, that competition was going to drive the price down. It does by region; it doesn't necessarily by individual county." From an actuarial perspective, this interviewee said the costs of offering plans in very small counties outweighed the benefits to carriers.

UTILIZATION PATTERNS AND CARRIER COSTS

The affordability of coverage on the exchange appears to be driving enrollment and utilization patterns in ways that impact carriers' costs. Some participants believe that unaffordable coverage has negatively affected the risk pool in Michigan's individual market by driving away healthier people who use fewer services and do not consider their coverage to be valuable enough to maintain year over year given the out-of-pocket costs for using their coverage. One participant believed individuals are able to "game the system" by planning their care and enrolling in coverage through special enrollment rules only when they need services. Using the hepatitis C drug Sovaldi as an example, this participant said, "It's a three-month course of treatment. It's easy to enroll, get cured of hepatitis, and then drop coverage—and the insurers get $1,000 in premiums and pay $80,000 in claims." Other participants highlighted a growing trend of people enrolling and dropping out throughout the year around treatment episodes. Participants would like to see tighter limits on the ability of consumers to take advantage of special enrollment periods. Other participants suggested greater penalties for consumers who choose not to enroll in coverage. Two participants separately mentioned the late enrollment penalty for Medicare Part B as an example of a stronger mechanism to incentivize continuous enrollment.

Concerns about utilization patterns in the exchange population were widespread among interview participants, and the ability to maintain a sustainable underlying cost structure for exchange plans will likely drive future decisions about carrier participation in Michigan's exchange market. Several participants argued that competition among carriers in the first few years of the exchange had pushed premium prices too low to sustain the underlying cost of care. As one participant explained, "There was an extremely wide range of prices, and pretty quickly they condensed down to lower prices. So I think the increased competition…forced people to do corrections to market prices over 2015, 2016, and…2017. The challenge now is they're not actually able to manage the underlying cost at the market price unless they are Medicaid managed care products."

STATE ROLE

Many interview participants agreed that the overall insurance market in Michigan was not heavily regulated, but the state responds well to comments and problems. One interviewee noted that DIFS is increasingly focused on enforcing network adequacy requirements for plans offered on the individual market, particularly regarding access to a broad range of specialists. However, some interviewees believed DIFS's ability to maintain a strong exchange market is often limited to enforcing existing laws and regulations. One participant wondered if a state-based marketplace would have been a better fit for Michigan's health insurance environment than a federally facilitated marketplace. Regulators noted a need for better communication between CMS, states, and carriers.

Section 6 – Analysis

Throughout the course of our interviews, it was clear there is no single predominant opinion on the level of competition in Michigan's exchange market. Interview participants expressed a wide range of views on the strength of Michigan's exchange and its prospects for stability going forward. Even within the same category of participant (e.g., among providers), interviewees provided different opinions on a variety of questions, such as whether the exchange had been functioning well and the level of state regulation over exchange operations. Many participants discussed trends in carrier and provider competition within the context of the entire commercial health insurance climate in Michigan and often did not distinguish between the individual and group markets. This is likely because the individual market still comprises a small proportion of the state's population, even after the launch of the exchange.

Despite differing opinions among interview participants, they said Michigan's exchange experience in its first three years of operation appears to have been generally positive compared with other states. The state started out with a substantial number of carriers willing to participate on the exchange. Even in light of some carrier exits in 2016 and 2017, 10 carriers remain on Michigan's exchange. Residents in many counties will be able to select plans from a variety of carriers, though the number of plans varies significantly across the state. In 2017, only one county (Schoolcraft County, located in the Upper Peninsula) will have just one carrier offering plans on the exchange. Residents in many counties in the Upper Peninsula, including Delta County, will be able to benefit from BCN's entry in 2017. Compared with other states struggling with low numbers of carrier participation, Michigan appears to have encouraged continued carrier participation each year. The breadth of carriers in Michigan may be due, in part, to the strong history in Michigan of local and regional HMO organizations that resulted from the embrace of managed care by the state Medicaid program in the mid-1990s, along with the dominance of a local Blue Cross and Blue Shield plan. The for-profit national carriers have never had a strong presence in Michigan.

LOOKING AHEAD

Prior to the 2016 elections, interviewees offered opinions on the future stability of the exchanges under the assumption that the Affordable Care Act would remain in place, with the potential for some, but not major, changes to the law. As stakeholders looked to the next several years through that lens, they expressed concerns about rising premiums, deductibles, and out-of-pocket costs for consumers. These trends are troubling not just from a consumer perspective, but for carriers as well. If prices continue to rise, some healthier enrollees who use few health care services may decide to drop coverage if they do not see the value in maintaining their plans. This issue is compounded by a general lack of consumer assistance and education on the costs associated with using coverage purchased on the exchange. Participants feared that healthier consumers will drop coverage and destabilize the individual market risk pool further, as people with ongoing health needs remain enrolled and continue to use health care services at high levels. As one participant described it, 2017 is an "inflection point" for many carriers in the state that are still grappling with understanding the health status and cost of caring for the exchange population. At this point in the exchange experience, carriers are developing strategies to control utilization and maintain the underlying cost of care for the exchange population, including the development of narrower networks.

Many participants anticipated more growth in narrow networks over the next several years as carriers continue to find ways to control their costs.

Many interviewees felt that the relative success of Michigan's exchange since 2014 would not be sustained without specific policy changes to stabilize the exchange market. The most common change participants felt needed to be made at the federal level was to tighten the ability of consumers to enroll in coverage through special enrollment periods (SEPs) outside of annual open enrollment, including through upfront verification of consumers' eligibility to enroll through SEPs. Several participants also expressed a desire to improve the risk adjustment payment process. Additionally, one participant supported the continuation of some form of a reinsurance program modeled after similar programs in the auto insurance industry.

Even if some of these policies were enacted, it is unclear whether or not they would draw additional carriers into the exchange market, particularly in rural areas of the state. Carrier participation on the exchange seems to be driven, at least in part, by population density and the existence of several health systems in one geographic area. Nearly all interview participants cited population as a major factor driving the variation in carrier competition across the state. This phenomenon predates the ACA and influenced carrier decisionmaking when Michigan implemented Medicaid managed care in the mid-1990s. It seems unlikely that the ACA has dramatically changed the role that population plays in determining where carriers choose to offer plans across the state. Many rural counties, such as Delta County, may not have sufficient residents or providers for additional carriers to justify entering the exchange market there. While DIFS can continue to ensure access to plans for residents in rural areas, it is unclear whether or not more carriers would be able to offer exchange plans there in the future. BCBSM may continue to be the only carrier offering exchange plans statewide in the near future.

The outcome of the 2016 presidential election has made the future viability of the health insurance marketplace more uncertain. President Donald Trump and a Republican-controlled Senate and House of Representatives have indicated that repeal of the ACA will be a top priority in 2017, though many details remain unknown. While some Republicans have expressed support for parts of the law, such as protections for individuals with pre-existing conditions, the repeal of some major provisions would likely cause instability in the marketplace. Without the individual mandate to purchase health coverage and tax credits to make coverage affordable, fewer healthy individuals may enroll in exchange plans. This would compound concerns that many participants expressed about the risk pool for the individual market, and could potentially lead to further premium increases or additional carrier exits in the individual market.

The 2016 elections have also eliminated the possibility of creating a public option in areas that lack substantial competition in their exchange market. Prior to the election, stakeholders we interviewed had not given much consideration to the idea of developing a public option on Michigan's exchange. One interviewee identified Section 1332 waivers as an opportunity for states to develop alternative coverage systems, including a public option. The public option is probably not a viable idea now, but these waivers may still present an opportunity for states to pursue other changes to their individual markets. These innovation waivers, established under Section 1332 of the ACA, give states the authority to develop alternative ways to access coverage for residents, as long as that coverage is comparable with what is currently offered under the ACA. State officials would need to have enough support to pass legislation

to create an alternative coverage system under the waiver. In addition, because programs implemented under these waivers are not allowed to increase the federal deficit, the state would need to find ways to offset the program's costs. Finally, CMS would have to approve the waiver application submitted by the state, and it is unknown whether or not the Trump administration would embrace the use of 1332 waivers or approve states' applications.

The future of the exchanges is uncertain until more details are known about Republican plans to change the ACA. Even if an exchange-type structure continues to exist, if other key provisions of the law are no longer in place, there is no guarantee that carriers will continue to participate in a system in which they could experience considerable financial burdens. Prior to the ACA, Michigan felt the impact of a requirement for guaranteed issue with no mandate to purchase coverage when BCBSM served as the insurer of last resort in the state. It is unlikely that any carrier would be willing to return to that environment, given the significant financial losses and potential for a risk spiral that they could face. Unless an ACA replacement design can avoid these adverse selection issues, the individual market is at significant risk of collapse.

If major provisions of the ACA are repealed in 2017, we could expect to see a return to pre-ACA coverage trends in the individual market. Without the individual mandate or subsidies to make coverage affordable, we could see a rise in the uninsured rate in Michigan and nationwide, particularly among individuals with lower incomes. While Trump has suggested making health insurance premiums tax deductible, such a tax deduction would likely only benefit higher-income individuals. Carriers would still face cost pressures that would contribute to continuing increases in premiums and deductibles. These trends could be compounded as healthier individuals lose incentives to maintain coverage, and the individual market could face a "death spiral" if only individuals with significant health needs and high utilization patterns remain enrolled in coverage. Cost pressures and risk pool concerns would persist even if no structural changes are made to the ACA in 2017, and a partial repeal of the law will likely exacerbate them. ACA replacement proposals will likely continue to rely on infrastructures similar to the health insurance marketplace. As policymakers consider options to adjust, repeal, or replace the ACA, they should work to address the issues that have led to instability and adopt practices from states that have contributed to well-functioning exchange markets.

Endnotes

1. In Michigan, carriers must establish a separate company to write PPO business. Michigan's Department of Insurance and Financial Services considers the PPO affiliate of an HMO carrier to be a separate carrier when it reports the number of carriers participating on the state's exchange. We follow DIFS's convention in this report.

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