mahp
Michigan Association of Health Plans

MAHP: Your Source for Health Care Information

Objective – Reliable – Resourceful

MAHP: WHO WE ARE & WHY WE'RE HERE TODAY

The Michigan Association of Health Plans (MAHP) represents the most unique and diverse set of state and federal healthcare stakeholders in Lansing that can provide you with meaningful and impactful resources for all your health care discussions.

We represent 11 different non-profit and for-profit state and national health care insurance providers and more than 50 different health-related affiliates, including groups like SBAM, Team Wellness, MSU Institute for Health & Delta Dental.

Our member health plans employ over 8,000 persons throughout the state and provide coverage for more than 3.5 million Michigan citizens – nearly one in every three Michiganders.

I am here today to talk a little about healthcare markets in Michigan and public policies MAHP is happy to help this committee research and explore over the next two years.

mahp
Michigan Association of Health Plans

OUR MISSION

Provide leadership for the promotion and advocacy of high quality, affordable, accessible health care for the citizens of Michigan.

aetna
Aetna Better Health® of Michigan

UnitedHealthcare Community Plan

MOLINA HEALTHCARE

hap

PARAMOUNT
Affiliate of ProMedica

Physicians Health Plan

McLaren HEALTH PLAN

UPHP
UPPER PENINSULA HEALTH PLAN

Priority Health

cca health MICHIGAN

meridian

MAHP IS YOUR RESOURCE

RESEARCH

Finding and deciphering facts, figures and statistics surrounding health care is daunting. MAHP can help you collect objective healthcare data including healthcare costs, funding, and other financial information on any health care subject to assist your healthcare discussions.

EXPERTS

Are you looking for leaders in health care that can talk to you on background? Are you seeking a presenter to talk about a certain health care topic? Do you need a presenter with a national health care perspective? We can help you find reliable experts you're looking for.

CONCEPT PAPERS

Are you looking for information on different health care markets and state of competition in each? Do you have questions about new and innovative provider payment models? If you're seeking background material on certain health care issues, we can formulate resourceful analyses, reports, and concept papers for you.

CONSTITUENT RESPONSES

Do your constituents have questions about their health insurance provider? We can help your office get resourceful answers and responses quickly.

MAHP's pacesetting commitment to working with organizations like the Food Bank Council to find policy solutions for the challenges facing Michigan, like food insecurity, is both commendable and exciting.

- Dr. Philip Knight, Executive Director of the Food Bank Council

MAHP has a talented team of dedicated professionals who conduct research and develop concept papers on important health care issues. They have proven to be a valuable partner and resource for policy making.

- Brian Calley, President & CEO, Small Business Association

The diverse membership of MAHP makes them unique and unlike most health care stakeholders in town – they bring multiple different viewpoints and perspectives on an issue.

- Senate Republican Leader Aric Nesbitt

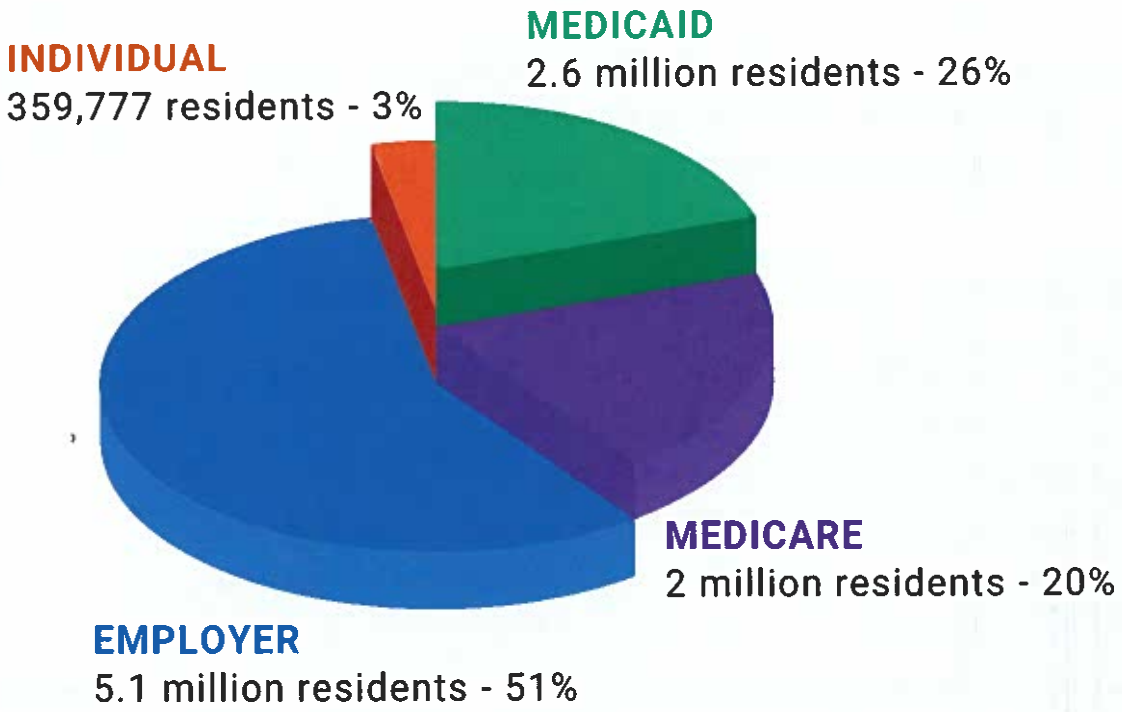
MAHP represents so many different health care stakeholders that they're able to overcome one-sided arguments to help you dig for the truth and find the facts.

- Michigan Speaker of House Joe Tate

HEALTHCARE MARKETS IN MICHIGAN

Background: Michigan has four healthcare markets. There are government-sponsored markets Medicare and Medicaid, a commercial marketplace where Employers provide health insurance to employees, and an Individual marketplace commonly referred to as the federal "exchange" where residents can purchase healthcare.

Fact: Most Michigan residents acquire health insurance through the Employer commercial market, by far the largest market in the state

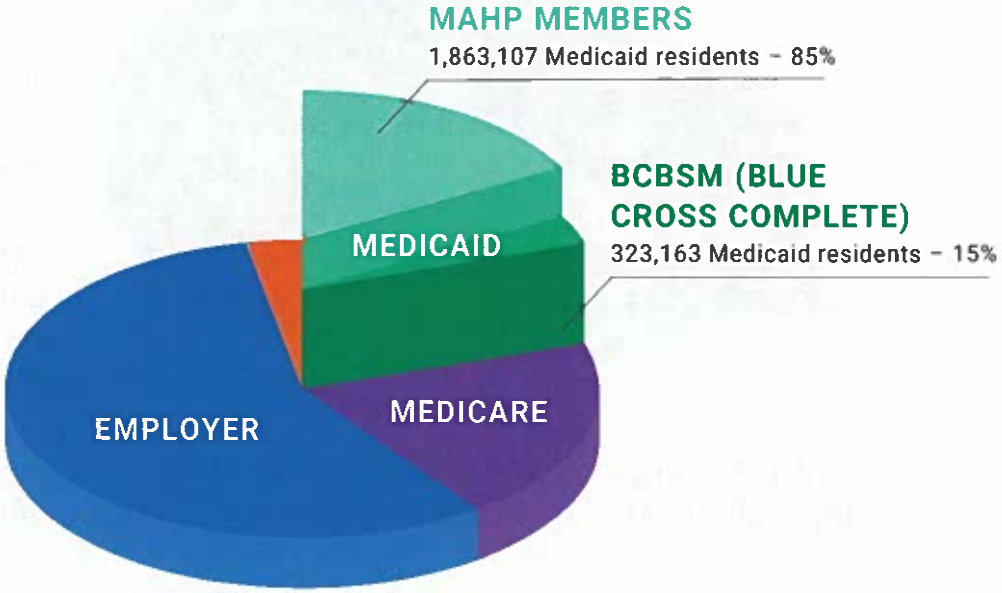


MEDICAID

Government-Sponsored Market

Background: Two million residents choose their Medicaid healthcare coverage from a list of eligible for-profit and non-profit health plans (below). These managed care plans provide comprehensive physical health and mild to moderate mental health services. Michigan Association of Health Plans (MAHP) members provide healthcare to 85% of Michigan's Medicaid population.

Fact: The state has realized nearly $5 billion in savings by moving Medicaid from a government-run fee-for-service model to a free market innovative managed care model, according to independent third-party independent actuary soundness reports



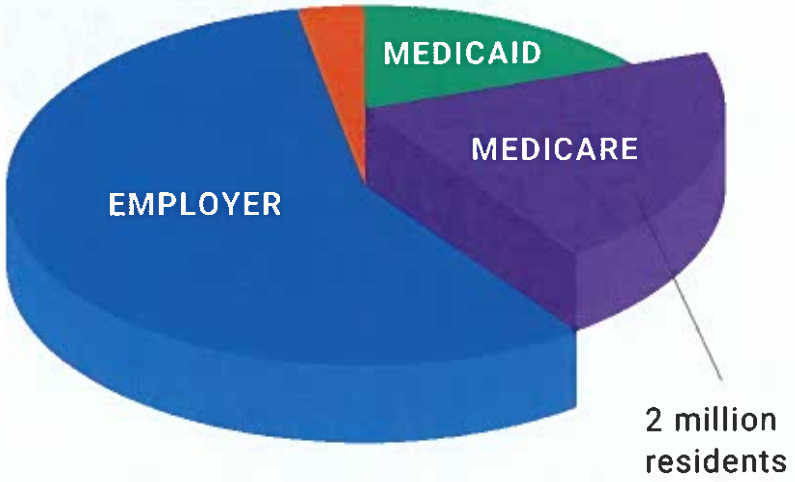
UnitedHealthcare Community Plan · aetna Aetna Better Health of Michigan · Blue Cross complete of Michigan · hap · McLaren HEALTH PLAN · meridian · UPHP UPPER PENINSULA HEALTH PLAN · MOLINA HEALTHCARE · Priority Health

MEDICARE

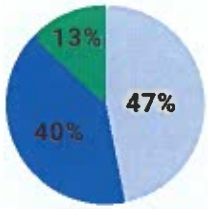
Government-Sponsored Market

Background: Medicare is a health insurance program that administers coverage to roughly two million Michigan residents. Roughly half of these beneficiaries access their covered benefits by self-referring to Medicare participating providers while the other half select a managed care plan (Medicare Advantage) to coordinate and administer their Medicare-covered benefits through a health plan network. Medicare beneficiaries may also choose to acquire additional coverage to help reduce the cost of co-payments and coinsurance costs or access additional benefits through either a supplemental insurance policy or through Medicare Advantage Part C.

Fact: Enrollment in Medicare Advantage offered by managed care plans have double in the past 5 years.



Medicare Advantage Market Share
1 million residents

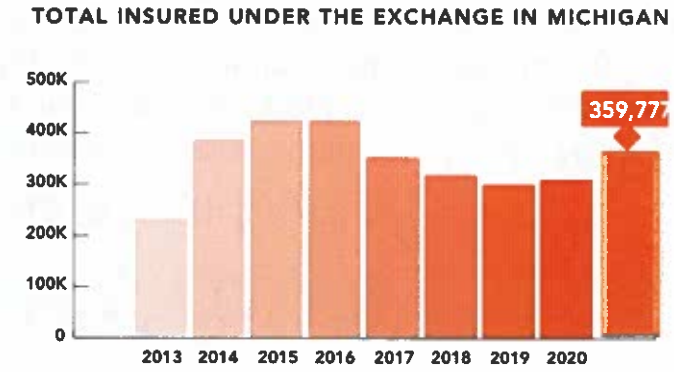


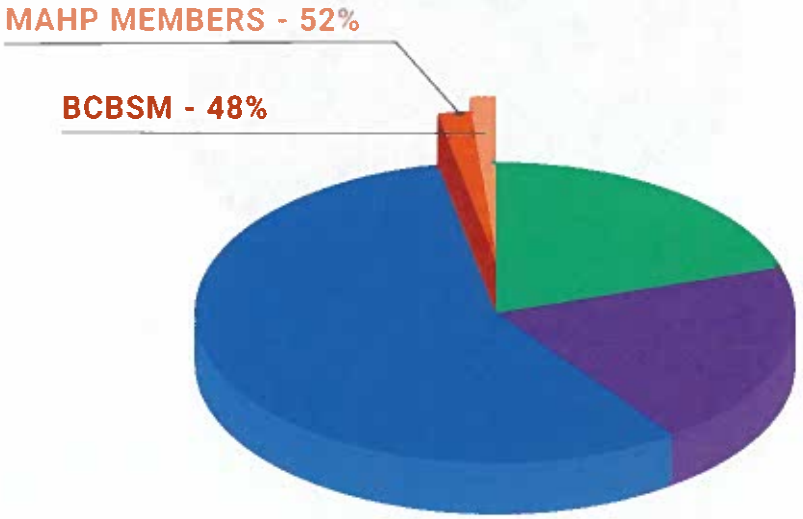
INDIVIDUAL

Federal "Exchange" Market

Background: Michigan's individual market allows consumers to shop freely for healthcare. The federal healthcare exchange began in 2014 after the passage of the Affordable Care Act. More than 350K residents obtain healthcare from the federal exchange. Residents can choose appropriate coverage from different competing health plans on the exchange. Federal subsidies are provided to purchasers based on income levels.

Fact: It's estimated that nearly 50K additional residents have obtained coverage from the individual exchange in the past 18 months

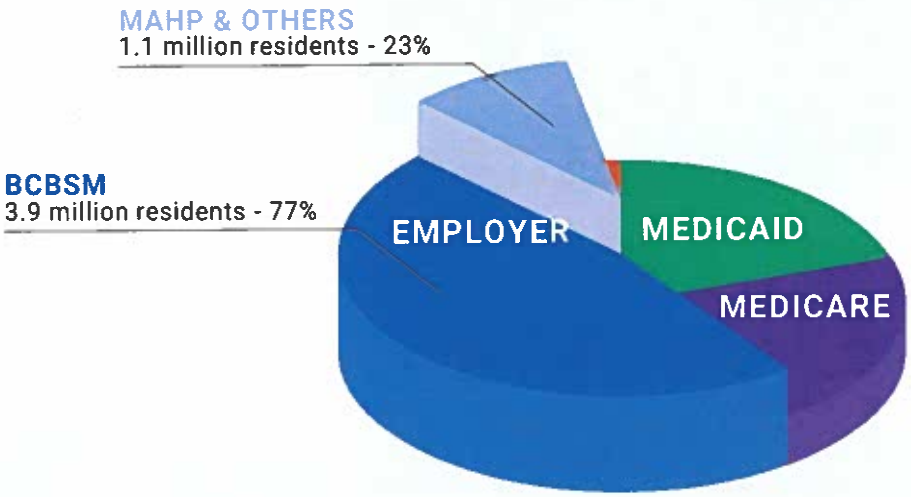




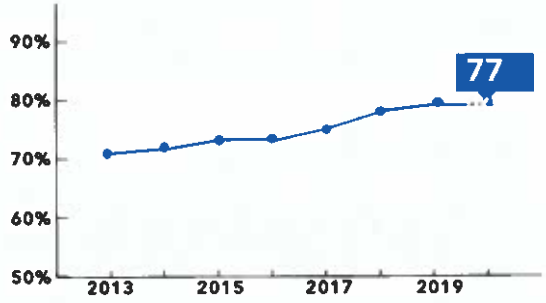
EMPLOYER

Commercial Market

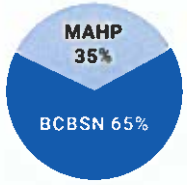
Background: More than half of Michigan residents receive healthcare through their employers. The commercial market is made up of a small group (employers providing coverage to less than 50 employees), a large group (employers providing coverage to more than 50 employees) and a self-insured group (very large employers that bear part or all the financial risk of the plan).



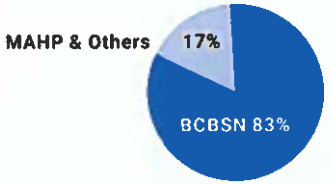
BCBSM MARKET SHARE 77%



EMPLOYER SMALL & LARGE GROUP
1.7 million residents



EMPLOYER SELF-INSURED
3.3 million residents



WHO REGULATES WHICH MARKET(S)

State Laws & Regulations	Markets	Federal Laws & Regulations
✓	Medicaid	✓
✗	Medicare	✓
✓	Employer Small Group	✓
✓	Employer Large Group	✓
✗	Employer Self-Insured Group	✓
✓	Individual Exchange	✓

Fact: State laws only regulate healthcare for 4.7 million residents (47%)

PUBLIC POLICIES

MAHP has identified potential public policy opportunities to explore based on member health plan experiences in other states to help control costs, spur competition and improve health equity.

- **Prescription Drug Spending:** Meaningful drug pricing transparency, insulin drug manufacturing competition, drug affordability review boards, and drug importation options will help lower prescription drug costs.
- **Individual Market:** Based upon experiences in other states, there are opportunities worthy of exploring to help stabilize the Individual Market via a State-Based Exchange & 1332 Innovation Waiver
- **Review Mandates:** State Legislative Mandates increase the costs of insurance. State Mandate Review Commissions give policymakers objective information on the impact mandates have on premiums.

WHERE DOES YOUR HEALTH CARE DOLLAR GO?

Your premium - how much you pay for your health insurance coverage each month - helps cover the costs of the medications and care you receive and improves health care affordability, access and quality for everyone.

Here is where your health care dollar really goes.

Source: AHIP

PRESCRIPTION DRUG SPENDING

U.S. prescription drugs spending rose to $407 billion in 2021; a **12% growth** from previous year.

Newly introduced biosimilar specialty drugs account for **$10 billion** in yearly spending for the past two years.

Spending for specialty drugs now account for 55% of total drug expenditures, **up from 28%** a decade ago.

Over 250 new drugs are expected to launch within the next 5 years and will contribute over $100 billion in new spending.

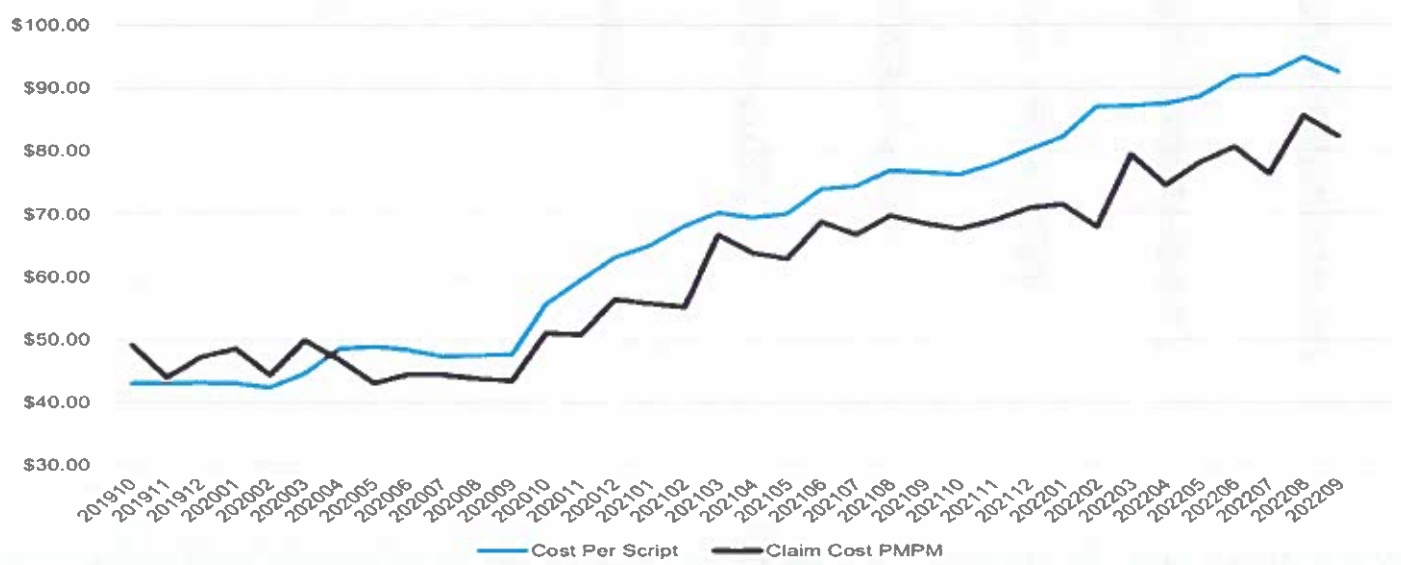
Autoimmune & oncology treatments are the largest driver currently in specialty drug growth, which have tripled in spending over this period.

Prescriptions for **mental health disorders** grew 5.5% in 2021 and 7.6% in 2020, and increase of more than 64 million prescriptions in two years.

IQVIA Institute April 2022: Medicine Use & Spending in the U.S.

PHARMACY TRENDS

SFY2022 Pharmacy Experience

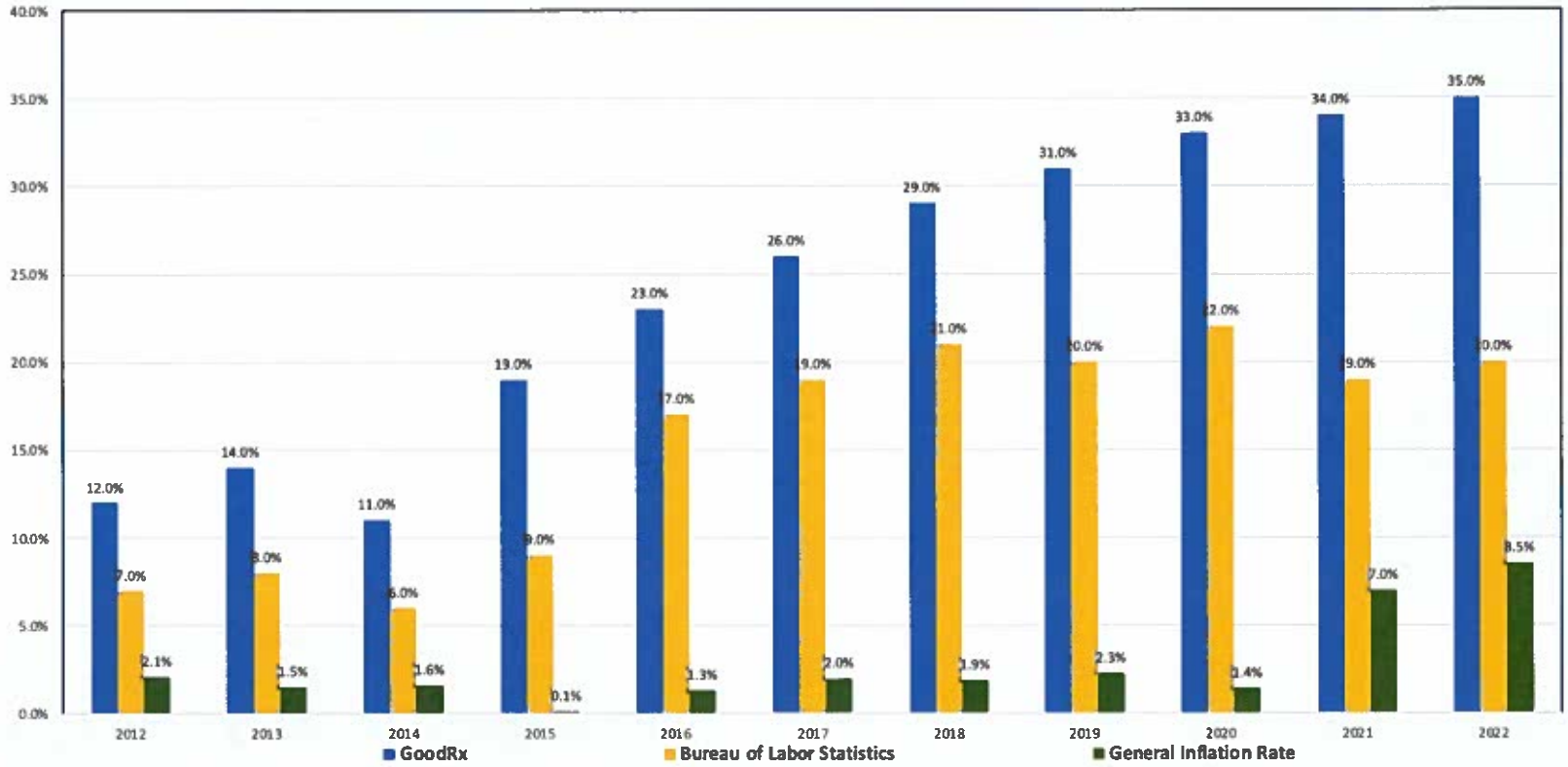


Per Script Cost Trends have **exceeded 20%** over the past year

Pricing trends ranged from **8-9%** for SFY 2023, with **~1%** for utilization

SFY 2022 Avg. PMPM: **$63**
SFY 2023: **$76**

CHANGE IN DRUG COSTS COMPARED TO INFLATION



STATE-BASED EXCHANGE - KEY POLICY ELEMENTS

Background: As part of the Michigan Association of Health Plans (MAHP) 2023 Strategic Plan, the Innovation, Competition, and Exchange (ICE) Committee has been charged with identifying key policy consensus elements to include in a State-Based Exchange (SBE) bill to take an active role in future policy discussions. Based upon input from ICE Committee members, below are the key policy elements that have been identified:

FEDERAL 1332 WAIVER REINSURANCE PROGRAM PREREQUISITE

To optimize the affordability of qualified health plans offered on an SBE, MAHP recommends that the state seek and secure a federal 1332 waiver to run a claims-based state reinsurance program. To ensure the cost-effective transition to an SBE for customers and plans, we recommend that a federal 1332 waiver be considered a prerequisite for creating an SBE and that the bill's effective date be contingent upon a waiver acquisition.

FEES

To successfully operate an SBE, nearly every state charges participating health plans a fee based upon a percentage of premiums collected on the SBE. The federal marketplace fee charged to participating health plans is 2.75% of premiums collected. As such, any SBE fee imposed on participating health plans should be lower than the national fee to ensure an SBE operates more efficiently and cost-effectively for customers.

GOVERNANCE STRUCTURE

Upon review of 18 different SBE governing structures, MAHP recommends that an SBE governance structure be modeled after Pennsylvania, where there is an 11-voting member board with representation from health plans, provider-sponsored health plans, consumers, and individuals that have relevant experience with the individual market. We also recommend an advisory board comprised of all health plans participating in the exchange, employer groups, and medical stakeholders.

TRANSITION COST RECOVERY

To assist with the migration from the federal exchange to an SBE, we recommend that the state consider a small pool of state resources that health plans could seek for administrative cost recovery to ensure the affordability of qualified health plans on the newly established SBE.

ELIMINATE SHOP

Avoid a Small Business Health Options Program (SHOP) from an SBE.

RATING CRITERIA

To ensure predictable, objective, and nationally accepted best practices, MAHP recommends that reasonable guardrails be placed around any criteria established to rate qualified health plans on the exchange. As such, the requirements should be modeled and or reflect either the Star quality rating system administered by CMS for plans on the federal marketplace or quality criteria in place for Medicaid health plans.

DUE PROCESS

If the state creates a separate standalone quasi-government board with administrative authorities independent from specific state departments, MAHP would encourage venues for administrative due diligence by allowing health plans to appeal decisions of the SBE board for review by the Director of DIFS. If a health plan is aggrieved by the final judgment or inaction of the DIFS Director, health plans should be able to seek due process under the administrative procedures act and explore other legal avenues.

LIMITS ON ADMINISTRATIVE AUTHORITY

The statutory administrative authority granted to the SBE governing board or state departments should not be broad and sweeping. Such authority must be carefully delegated, and appropriate administrative and legal due process should be granted to participating health plans.

PROTECTION OF CONFIDENTIAL INFORMATION

Ensure health plan and customer information that may be required under an SBE (such as financial disclosures, claims payment policies, rating practices, payments for out-of-network, etc.) is confidential and protected.

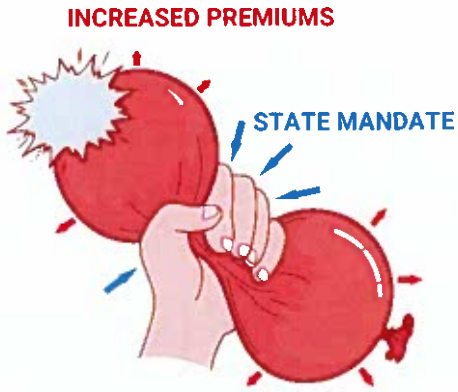
REVIEW MANDATES

Federal Mandate Charges: The federal government sets forth a uniform set of basic health insurance coverage standards known as essential health benefits (EHB). The EHB outlines insurance benefits that all insurers must cover, which are medically necessary and affordable for customers.

State Mandates: Over the past decade, individual states have begun setting up a patchwork of new and additional insurance mandates which exceed the EHB. According to the Journal of Risk and Financial Management, each state has more than 40 unique health insurance mandates above and beyond the EHB. These new state insurance mandates increase health care costs and create a patchwork of benefit coverages for customers.

Mandate Review Commissions: California, Massachusetts, Rhonda Island, New Jersey, Vermont, Maryland, and Washington DC have created mandate review commissions. The mandate review commission in Maryland reviewed the impact of state insurance mandates and found that state mandates contributed 14% of premium costs in the commercial market. Michigan should create a Mandate Review Commission to assist policymakers with objective information on what future state mandates cost taxpayers.

The Goal of Mandate Review Commissions: To provide objective information on state insurance mandates' impact on insurance coverage and premiums.



mahp
Michigan Association of Health Plans

327 Seymour Ave.
Lansing, MI 48933

mahp.org (517) 371-3181

Dominick Pallone
Executive Director
dpallone@mahp.org | (517) 420-6197

Christine Shearer
Deputy Director of Legislation & Advocacy
cshearer@mahp.org | (517) 749-0369

Please don't hesitate to contact Christine Shearer for any questions

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Concept Paper

Your *Source* for Health Care Information

PRESCRIPTION DRUG COSTS

BACKGROUND

For years, policymakers have attempted to control prescription drug costs by imposing customer cost-sharing caps, reducing utilization controls, and mandating coverage of certain prescription drugs on health plans. These efforts have done nothing to stop the ongoing skyrocketing costs of prescription drugs. Instead, these changes have increased the premiums that customers and employers pay for healthcare.

According to the US Department of Health and Human Services, Americans pay higher prices for prescription drugs than in any other country. Prescription drugs are more than 2.5 times higher than in other similar high-income nations. This spending is driven by high-cost brand-name drugs, for which manufacturers freely set prices.

The median launch price of a new drug in the United States increased from $2,115 in 2008 to $180,007 in 2021 — a 20% annual increase each year.

Researchers report that the percentage of drugs that cost more than $150,000 a year increased by 9% in 2008-2013 and then 47% in 2020-2021.

The Centers for Medicare and Medicaid Services (CMS) has reported that prescription drug spending is projected to outpace growth in all other major healthcare sectors, averaging 6.1 percent annually through 2027. Insulin & Epilepsy drugs have increased by staggering margins over the past few years, forcing the Michigan Attorney General to take action against unsubstantiated insulin drug prices.

The trend in drug prices for new drugs outpaces growth in prices for all other healthcare services. According to research conducted by a national healthcare association, nearly a quarter of every premium dollar goes to pay for prescription drugs – an amount higher than any other spending category, more elevated than outpatient and inpatient hospital costs.

WHERE DOES YOUR HEALTH CARE DOLLAR GO?

The Michigan Department of Financial & Insurance Services (DIFS) noted the increase in prescription drug costs that health plans experienced during their most recent rate filings. According to DIFS, **health plans are witnessing higher cost increases in prescription drugs than any other medical service covered under a benefit plan.**

According to the Centers for Medicare and Medicaid Services (CMS), prescription drug spending is projected to outpace growth in all other major healthcare sectors, averaging 6.3 percent annually through 2026.

POLICYMAKERS ARE MISSING THE MARK

Unlike other counties, the United States does not regulate or negotiate the price of prescription drugs. Drug manufacturers freely set drug pricing without government price control or regulation.

To combat the high costs of prescription drugs, policymakers have advanced reforms against health plans and pharmacy benefit managers (PBM). Reforms like cost-sharing caps on certain medications such as insulin, mandatory drug coverages like oral chemotherapy, and elimination of utilization controls like prior authorization and step therapy exacerbate prescription drug costs. Drug manufactures support these reforms and other state insurance mandates because they make prescription drugs easier to access at a higher price.

Drug companies have successfully worked with prescribing physician groups to scale back utilization controls put in place by health plans to control healthcare costs. Recently, drug manufacturers have begun leading the charge for additional regulations and rules on PBMs' to divert attention from themselves. Meanwhile, these policy changes are raising healthcare costs and impacting employers and workers.

DRUG MANUFACTURER REFORMS ARE NEEDED

In recent years, the federal government has opened doors to allowing states to control drug pricing by regulating drug manufacturers. The FDA recently permitted states to create importation programs to help health plans access lower prescription drugs. Previous legal arguments made by drug manufacturers on why they can't be regulated at the state level are finally being called into question. **If policymakers in Michigan want to lower prescription drug costs, advancing the following reforms would help.**

IMPORTATION

Allow for the importing of prescription drugs at a lower cost and cast a light on why other countries that better regulate drug manufacturers have lower prescription drug costs.

TRANSPARENCY

Force drug manufacturers to **provide transparency reports** on drug pricing in Michigan.

COMPETITION

Allow the state of Michigan to manufacture and compete against other higher-cost insulin drug manufacturers.

INFLATIONARY CAPS ON DRUG PRICES

Limit specific drug prices to no greater than inflationary increases.

EARLY WARNING

Require drug manufacturers to **provide an early warning of price increases on prescription drugs.** Doing so would allow health plans, employers, and the state to factor in and prepare for those increases.

RATE APPROVAL & AFFORDABILITY REVIEW

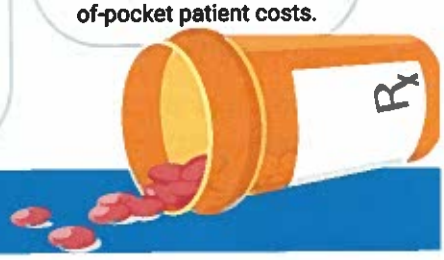
Health plans must **file and seek approval for their premium rates** with state and federal regulatory entities each year; why not drug manufacturers? The creation of a state affordability review board would allow states to review and set rates for certain high-cost prescription drugs.

INTERNATIONAL REFERENCE RATES

Allow state regulators to **establish international reference rates** for the 250 most costly drugs in the state and prohibit state entities, health plans, or employers from purchasing referenced drugs for a cost higher than the referenced rate.

LIMIT MONOPOLY STATUS OF NEW DRUGS

Call on Congress to **change federal prescription drug patent timeframes.** New drugs in the U.S. are typically granted monopoly periods that usually last 12 to 17 years. During this period, drug companies tend to raise list prices each year, which can lead to higher out-of-pocket patient costs.



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The Facts

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HOW DRUG COUPONS INCREASE HEALTH CARE COSTS

DRUG A

Brand-Name Drug with Coupon

Price: $500

Cost to Health Plan	$470
Copay Cost to Patient	$30
Coupon	-$25
Total Copay Cost to Patient	$5
Total cost for the health care system	$480

DRUG B

Generic without coupon

Price: $150

Cost to Health Plan	$140
Copay Cost to Patient	$10
Coupon not Available	$0
Total Copay Cost to Patient	$10
Total cost for the health care system	$160

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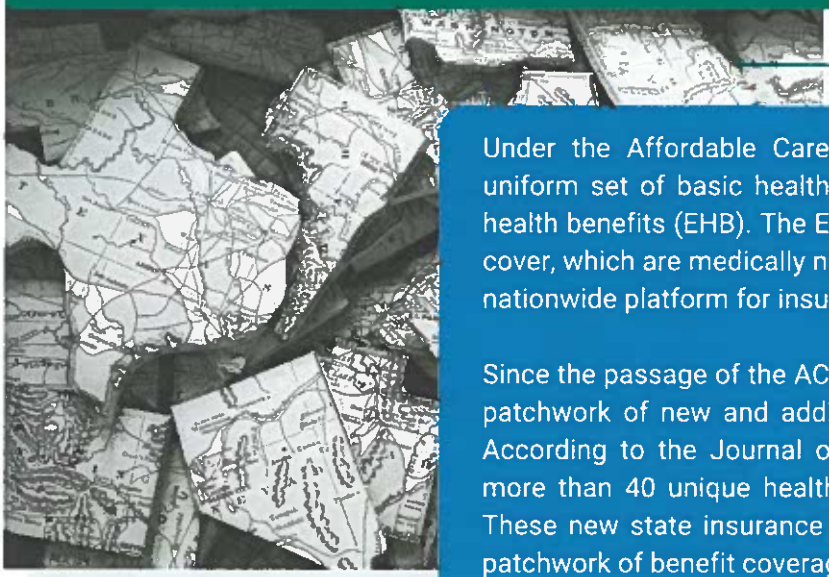
Concept Paper

Your *Source* for Health Care Information

INSURANCE MANDATES



BACKGROUND

Under the Affordable Care Act (ACA), the federal government sets forth a uniform set of basic health insurance coverage standards known as essential health benefits (EHB). The EHB outlines insurance benefits that all insurers must cover, which are medically necessary and affordable for customers. The EHB is a nationwide platform for insurers to deliver uniform healthcare benefits.

Since the passage of the ACA, states across the country have begun setting up a patchwork of new and additional insurance mandates which exceed the EHB. According to the Journal of Risk and Financial Management, each state has more than 40 unique health insurance mandates above and beyond the EHB. These new state insurance mandates increase health care costs and create a patchwork of benefit coverages for customers.

WHAT ARE STATE INSURANCE MANDATE LAWS?

Benefits and coverage mandates imposed by states require health plans to cover specific services, provide access to certain healthcare providers, and supply additional benefits to certain populations. While intended to improve healthcare delivery, state insurance mandates drive up costs, create inconsistencies in coverages, and limit health plans' ability to design benefits that match the preferences and budgets of a diverse set of purchasers.

State insurance mandates vary significantly across the United States. Some states now require broad coverage for dental, vision, or chiropractic care, while others require specific benefits for autism and certain prescription drugs. States also limit cost-sharing benefits designs like co-pays and limit utilization controls like prior authorizations. Some recently proposed or enacted state insurance mandates in Michigan include coverage for Wigs, Prosthetics, Autism, Ambulatory Services, Mid-Wife, Oral Chemotherapy, and other diagnostic services.

APPLICABILITY OF STATE MANDATES

To further complicate the inconsistencies of uniform healthcare coverage, states have minimal jurisdiction to effectuate their health insurance mandates. In Michigan, less than half of the population has health care insurance that is subject to state level regulations. The vast majority of customers who received health insurance through their employer or through Medicare are not subject to state mandates.

Nearly 60% of all Michiganders

get their healthcare from large, self-insured employers. This population is entirely exempt from all state insurance mandates. They're subject to federal health care regulations, not state.

WHO REGULATES WHICH MARKET(S)?

STATE LAWS & REGULATIONS			FEDERAL LAWS & REGULATIONS
✓	Medicaid	2.5 million lives	✓
✗	Medicare	2 million lives	✓
✓	Employer Small Group	.5 million lives	✓
✓	Employer Large Group	1.3 million lives	✓
✗	Employer Self-Insured Group	3.4 million lives	✓
✓	Individual Exchange	.3 million lives	✓

STATE LAWS REGULATE HEALTHCARE

FOR ONLY 4.6 MILLION RESIDENTS

IMPLICATIONS OF STATE INSURANCE MANDATES

The debate over the value and need for state health insurance mandates is taking center stage as healthcare spending, and insurance premiums are increasing faster in recent years than ever. Studies illustrate that customer out-of-pocket spending nationally has generally risen over time as the average number of state mandates increased.

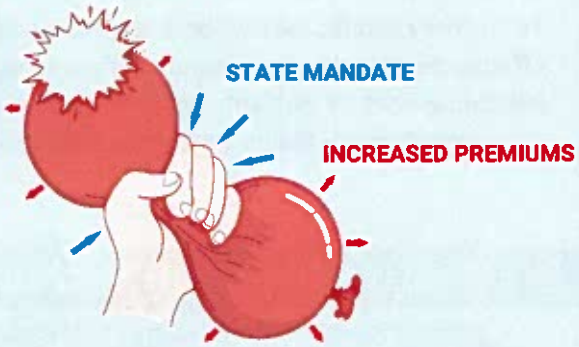
This has resulted in health plans charging higher premiums for individuals and employers looking to purchase insurance. Some small employers are dropping coverage altogether, contributing to a higher uninsurance rate. For the first time since the passage of the ACA, the number of individuals acquiring health insurance from small businesses in Michigan has declined.

Studies have documented that state mandates have contributed to higher insurance costs. In Maryland, the state has established a Health Care Commission to review the impact of state insurance mandates. In a report issued by this Commission in 2019, state insurance mandates contributed 14% of premium costs in the commercial market and 12% in the individual market.

For the first time since the passage of the ACA, the number of individuals acquiring health insurance from small businesses in Michigan has declined.

WHO PAYS FOR STATE INSURANCE MANDATES?

Small employers and individuals who purchase health insurance are paying the price for state health insurance mandates. Costs associated with mandated benefit coverages have a price that is passed on to purchasers. Even mandates with the best intentions to save customers money result in increased premiums. Costs associated with state mandates are a zero-sum game that has inflated health care costs to nearly a popping point.



MAHP'S KEY POLICY ELEMENTS FOR A STATE-BASED EXCHANGE

BACKGROUND

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FEES

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GOVERNANCE STRUCTURE

Upon review of 18 different SBE governing structures, MAHP recommends that an SBE governance structure be modeled after Pennsylvania, where there is an 11-voting member board with representation from health plans, provider-sponsored health plans, consumers, and individuals that have relevant experience with the individual market. We also recommend an advisory board comprised of all health plans participating in the exchange, employer groups, and medical stakeholders.

TRANSITION COST RECOVERY

To assist with the migration from the federal exchange to an SBE, we recommend that the state consider a small pool of state resources that health plans could seek for administrative cost recovery to ensure the affordability of qualified health plans on the newly established SBE.

RATING CRITERIA

To ensure predictable, objective, and nationally accepted best practices, MAHP recommends that reasonable guardrails be placed around any criteria established to rate qualified health plans on the exchange. As such, the requirements should be modeled and or reflect either the Star quality rating system administered by CMS for plans on the federal marketplace or quality criteria in place for Medicaid health plans.

ELIMINATE SHOP

Avoid a Small Business Health Options Program (SHOP) from an SBE.

PROTECTION OF CONFIDENTIAL INFORMATION

Ensure health plan and customer information that may be required under an SBE (such as financial disclosures, claims payment policies, rating practices, payments for out-of-network, etc.) is confidential and protected.

LIMITS ON ADMINISTRATIVE AUTHORITY

The statutory administrative authority granted to the SBE governing board or state departments should not be broad and sweeping. Such authority must be carefully delegated, and appropriate administrative and legal due process should be granted to participating health plans.

DUE PROCESS

If the state creates a separate standalone quasi-government board with administrative authorities independent from specific state departments, MAHP would encourage venues for administrative due diligence by allowing health plans to appeal decisions of the SBE board for review by the Director of DIFS. If a health plan is aggrieved by the final judgment or inaction of the DIFS Director, health plans should be able to seek due process under the administrative procedures act and explore other legal avenues.

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