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BILL ANALYSIS

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Senate Bill 693 (Substitute S-2 as passed by the Senate)
Sponsor: Senator Jim Marleau
Committee: Health Policy

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RATIONALE

For many years, health care reform has been a subject of significant nationwide discussion. One aspect that has received considerable attention is insurance coverage, particularly with regard to accessibility, scope, and cost. The Federal Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, (referred to as "the Federal Act") was enacted in 2010. The Act requires all individuals to maintain minimal essential health care coverage or pay a tax penalty; includes tax credits for qualifying small businesses and individuals and families meeting certain income criteria to cover a percentage of their health care costs; and provides for the creation of state-based exchanges through which qualifying individuals and small businesses may purchase health insurance policies meeting prescribed standards. In addition, the Act requires employers with more than 50 full-time employees to offer affordable coverage to workers or pay a penalty for employees who receive tax credits for insurance through an exchange. The Act also expands Medicaid eligibility and creates new regulations for private insurers, including guaranteed policy renewal and the prohibition of pre-existing condition exclusions and annual and lifetime limits on the dollar value of coverage.

Under the Act, each state must design and implement its exchange by January 1, 2014, or default to an exchange designed by the Federal government. It has been suggested that Michigan should move toward the establishment of its own exchange to meet the deadline and avoid participation in a Federal exchange.

In a related matter, the Federal Act is the subject of pending litigation brought by a number of states, including Michigan, based on concerns that it violates the U.S. Constitution. The U.S. Supreme Court recently agreed to review the issue and is expected to deliver a ruling sometime in 2012. In light of the uncertainty surrounding implementation of the Act, it has been suggested that a body should be established to review its implications for Michigan's efforts to create its own exchange and provide for action at the State level should the Federal Act, or certain parts of it, be declared unconstitutional.

CONTENT

The bill would create the "MiHealth Marketplace Act" to provide for the establishment of the MiHealth Marketplace, a nonexclusive clearinghouse for health benefit plans. Specifically, the bill would do the following:

- **-- Require the Marketplace to foster a competitive market for health insurance in Michigan.**
- **-- Require the Marketplace to serve as a market facilitator to promote the purchase and sale of qualified health plans and disseminate information regarding those plans to consumers.**
- **-- Create the MiHealth Marketplace Board to organize and govern the Marketplace.**

-- Require the Board to establish the Marketplace as a nonprofit corporation.
-- Require the Board to appoint an executive director to manage the Marketplace.
-- Require the Marketplace to make "qualified health plans" available for purchase and enrollment by qualified individuals and employers by January 1, 2014.
-- Require the Marketplace to establish a small business health options program (SHOP) through which qualified employers could provide coverage for their employees and federally recognized Indian tribes could provide coverage for their tribal members.
-- Prescribe financial integrity requirements for the Marketplace.
-- Require the Marketplace to contract with the Office of Financial and Insurance Regulation (OFIR) to certify health benefit plans as qualified health plans that could be offered through the Marketplace.
-- Specify that the Act would not authorize the Marketplace to spend State funds.
-- Authorize the Marketplace to charge assessments or user fees to health carriers to support its operations.

In addition, the bill would do the following:

-- Require the Senate Majority Leader and the Speaker of the House to establish a joint committee to review the Federal Patient Protection and Affordable Care Act, as amended, and its implications with regard to the MiHealth Marketplace Act.
-- Require the joint committee to report its findings to the Legislature by January 1, 2014, or within 30 days after any part of the Federal Act was declared unconstitutional, repealed, or otherwise altered, whichever was earlier.
-- Require the OFIR Commissioner to order the suspension of the operation of the SHOP if the part of the Federal Act requiring the SHOP's establishment were declared unconstitutional or repealed.

Federal Act; Joint Committee

The bill specifies that a reference in the proposed Act to the Federal Act would include other provisions of the laws of the United States relating to health care coverage, and provides that nothing in the proposed Act should be construed or implied to recognize the constitutionality of the Federal Act. ("Federal Act" would mean the Federal Patient Protection and Affordable Care Act, as amended by the Federal Health Care and Education Reconciliation Act, and any regulations promulgated under those Acts.)

The bill would require the Senate Majority Leader and the Speaker of the House of Representatives to establish a joint committee to review the Federal law, if any provisions remained, and the implications with regard to the MiHealth Marketplace Act. The committee would have to report its findings to the Legislature by January 1, 2014, or within 30 days after all or any part of the Federal Act was declared unconstitutional, repealed, or otherwise altered in a manner that would affect the implementation or administration of the MiHealth Marketplace Act, whichever date was earlier. The report would have to include the committee's recommendations regarding amendments to the proposed Act or other State law.

If the part of the Federal Act that requires establishment of a small business health options program (described below) were declared unconstitutional or repealed, the OFIR Commissioner would have to issue an order requiring the Marketplace to suspend the operation of the SHOP, and the Marketplace immediately would have to comply. Upon suspension, federally recognized Indian tribes would have to be allowed to pay premiums for qualified health plans on behalf of tribal members as allowed under the proposed Act.

"Qualified Health Plan"

A qualified health plan would be a health benefit plan that had been certified by OFIR under the proposed Act (as described below).

"Health benefit plan" would mean a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver,

arrange for, pay for, or reimburse any of the costs of health care services. The term would not include any of the following:

-- Coverage only for accident or disability income insurance, or any combination of those coverages.
-- Coverage issued as a supplement to liability insurance.
-- Liability insurance, including general liability insurance and automobile liability insurance.
-- Worker's compensation or similar insurance.
-- Automobile medical payment insurance.
-- Credit-only insurance.
-- Coverage for on-site medical clinics.
-- Other similar insurance coverage, specified in Federal regulations issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA), under which benefits for health care services are secondary or incidental to other insurance benefits.

In addition, the term would exclude a plan that provides the following benefits if they are provided under a separate policy, certificate, or contract or are otherwise not an integral part of the plan:

-- Limited scope dental or vision benefits.
-- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits.
-- Other similar, limited benefits specified in HIPAA.

The term also would exclude a plan that provides coverage for only a specified disease or illness, or hospital indemnity or other fixed indemnity insurance, if those benefits are provided under a separate policy, certificate, or contract of insurance, and there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether they are provided with respect to the event under any group health benefit plan maintained by the same plan sponsor.

Additionally, the term would exclude any of the following if offered as a separate policy, certificate, or contract:

-- A Medicare supplemental policy.
-- Coverage supplemental to the coverage provided by the TRICARE program.
-- Similar coverage supplemental to coverage provided under a group health plan.

MiHealth Marketplace Board

The MiHealth Marketplace Board would be created to organize and govern the Marketplace and would be the incorporator of the Marketplace for the purposes of the Nonprofit Corporation Act. The bill provides that the Board would be created to support health care consumers, including employers, in Michigan. The Board would consist of seven voting members, as well as the OFIR Commissioner, who would serve as a nonvoting ex officio member. A majority of the voting members would have to represent the interests of health care consumers.

The Governor would have to appoint five of the initial voting members with the advice and consent of the Senate. The Senate Majority Leader and the Speaker of the House each would have to appoint one of the initial voting members. Except as otherwise provided, a Board vacancy after the initial appointment would have to be filled in the manner specified in the Marketplace's articles of incorporation or bylaws. The appointment of a Board member after the initial appointment would have to be with the advice and consent of the Senate. The articles of incorporation and bylaws would have to include provisions that ensured that the majority of the voting members at all times represented the interests of health care consumers. A Board member could not serve more than two consecutive terms of office.

A Board member could not currently or within the preceding 12 months be employed, directly or indirectly, by a health carrier, producer, health care provider, or third-party administrator or by an affiliate or subsidiary of any of those entities or be otherwise engaged by an entity that received more than 50% of its revenue from a carrier, producer, health care provider, or third-party administrator.

The members first appointed to the Board would have to be appointed within 30 days after the proposed Act took effect. Except

as otherwise provided, an appointed member would serve for a term of four years or until a successor was appointed, whichever was later. Of the members appointed by the Governor, one would serve for one year, one for two years, two for three years, and one for four years. The member appointed by the Senate Majority Leader would serve for four years, and the member appointed by the Speaker of the House would serve for two years.

The OFIR Commissioner would have to call the first Board meeting, at which a chairperson would have to be elected. The Board then would have to meet at least quarterly, or more frequently at the call of the chairperson or if requested by at least four members.

Four members would constitute a quorum for the transaction of business at a meeting. An affirmative vote of four members would be necessary for official Board action.

The Board's business would have to be conducted at a meeting that was held in Michigan, open to the public, and in a place that was available to the general public. The Board could establish reasonable rules and regulations, however, to minimize disruption of a Board meeting. At least 10 days but not more than 60 days before a meeting, the Board would have to give public notice at its principal office and on its internet website. The Board would have to include in the notice the address where the public could inspect Board minutes. The Board could meet in a closed session for any of the following purposes:

-- To consider the hiring, dismissal, suspension, or disciplining of Board members, employees, or agents.
-- To consult with its attorney.
-- To comply with State or Federal law, rules, or regulations regarding privacy or confidentiality.

Board members would serve without compensation, but could be reimbursed for their actual and necessary expenses incurred in the performance of their official duties as Board members.

The Board would have to adopt a code of ethics for its members, employees, and agents and for the directors, officers, and employees of the Marketplace pursuant to Federal law, State law, and the standard of practice applicable to nonprofit corporations. The Board would have to include in the code policies and procedures requiring the disclosure of relationships that could give rise to a conflict of interest.

In addition to complying with the code of ethics, a member would have to declare any conflicts of interest. The Board would have to require that any member with a direct or indirect interest in any matter before the Marketplace disclose that interest before the Board took action on the matter. If a Board member or a member of his or her immediate family, organizationally or individually, would derive direct and specific benefit from a Board decision, that member would have to recuse himself or herself from the discussion and vote on the issue.

The Board would have to establish committees to obtain recommendations concerning the operation and implementation of the Marketplace in Michigan. Committees would have to be given a specific charge and could include individuals who were not Board members, including representatives of consumers, carriers, and health care providers and other health industry representatives.

There would be no liability on the part of, and no cause of action could arise against, any Board member for any lawful action he or she took in the performance of his or her powers and duties under the proposed Act.

MiHealth Marketplace

The initial Board would have to organize a nonprofit corporation on a nonstock, directorship basis under the Nonprofit Corporation Act. The corporation would have to be known as the MiHealth Marketplace. It would have to be organized to provide both an individual and SHOP marketplace for qualified health plans in Michigan.

The Marketplace would have specified powers and duties as a nonprofit corporation, including the following:

-- To contract with others, public or private, for the provision of all or a portion of services necessary for its management and operation.

-- To borrow money and issue its notes, bonds, and other obligations.
-- To adopt, amend, or repeal bylaws.
-- To elect or appoint officers, employees, and other agents of the Marketplace.
-- To cease its corporate activities and dissolve pursuant to the proposed Act, the Nonprofit Corporation Act, and the Federal Act.

The Marketplace would have to submit its plan of dissolution to the OFIR Commissioner and to the Senate and House standing committees on health policy at least 60 business days, including at least seven legislative session days, before it planned to dissolve. Upon dissolution, all of its liabilities would have to be paid and discharged. Remaining assets would have to be distributed as provided in a plan of action developed and adopted by the Board and approved by the Commissioner.

The Marketplace could not guarantee or become surety upon a bond or other undertaking securing the deposit of public money. Also, the Marketplace could not establish and carry out pension or retirement benefit plans.

Other than certain powers and duties specified in Section 261 of the Nonprofit Corporation Act, the Marketplace would have the powers and duties of a nonprofit corporation under that Act. The provisions of the MiHealth Marketplace Act prescribing the Marketplace's powers and duties would control in lieu of the Section 261. If a conflict between a power or duty of the Marketplace under the proposed Act conflicted with a power or duty under other State law, the proposed Act would control.

Beginning on the Act's effective date, an entity could not incorporate, file, register, or otherwise form in Michigan using a name that was the same as or deceptively or confusingly similar to the name "MiHealth Marketplace".

Qualified Health Plan Criteria

The Board would have to develop criteria for rating each qualified health plan offered through the Marketplace based on relative value and quality. The criteria would have to comply with Federal and State law and the proposed Act's purposes. The Board would have to consult with the OFIR Commissioner and the Medical Services Administration for the Department of Community Health (DCH) on the development of the rating criteria. The Board would have to ensure that the methods used to develop the criteria were included in the minutes open to the public, and that they were applied uniformly to all qualified health plans.

Marketplace Executive Director

The Board would have to appoint an executive director to manage the Marketplace. The executive director would have to be independent and have no material relationship with the Marketplace. He or she could appoint staff as necessary.

The executive director could contract with others, public or private, to provide all or a portion of the services necessary to manage and operate the Marketplace.

To ensure efficient operation of the Marketplace, the executive director could seek assistance and support as required in the performance of his or her duties from appropriate State departments, agencies, and offices. Upon the executive director's request, the State department, agency, or office could provide assistance and support to him or her.

The executive director would have to display on the Marketplace internet website information relevant to the public, as defined by the Board, concerning the Marketplace's operations and efficiencies, as well as the Board's assessments of those activities.

Qualified Health Plan Availability

The Marketplace would have to make qualified health plans available through its internet website and toll-free telephone hotline for review, purchase, and enrollment by qualified individuals and qualified employers beginning on or before January 1, 2014, or as otherwise provided for by Federal law, rule, or regulation.

"Qualified individual" would mean an individual, including a minor, who meets all of the following requirements:

-- Is seeking to enroll in a qualified health plan offered to individuals through the Marketplace.
-- Resides in Michigan.
-- At the time of enrollment, is not incarcerated, except pending the disposition of charges.
-- Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the U.S. or an alien lawfully present in the U.S.

"Qualified employer" would mean a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP and, at the option of the employer, some or all of its part-time employees, provided that the employer meets all of the following:

-- Has its principal place of business in Michigan and elects to provide coverage through the SHOP to all of its eligible employees, wherever employed.
-- Elects to provide coverage through the SHOP to all of its eligible employees who are employed principally in Michigan.

Until January 1, 2016, "small employer" would mean both a sole proprietor and small employer as those terms are defined in Section 3701 of the Insurance Code. (Under that section, "small employer" means any person, firm, corporation, partnership, limited liability company, or association actively engaged in business that, on at least 50% of its working days during the preceding and current calendar years, employed at least two but not more than 50 eligible employees (i.e., full-time employees with a normal work week of at least 30 hours, or, if the employer chooses, 17.5 to 30 hours). "Sole proprietor" means an individual who is a sole proprietor or sole shareholder in a trade or business through which he or she earns at least 50% of his or her taxable income, excluding investment income, and for which he or she has filed the appropriate Internal Revenue Service form 1040, Schedule C or F, for the previous taxable year; who is a Michigan resident; and who is actively employed in the operation of the business, working at least 30 hours per week in at least 40 weeks out of the calendar year.)

Effective January 1, 2016, "small employer" would mean an employer that employed an average of not more than 100 employees during the preceding calendar year. Beginning on that date, all of the following would apply to an employer to determine if it were a small employer under the proposed Act:

-- All people treated as a single employer under specific provisions of the Internal Revenue Code (26 USC 414) would have to be treated as a single employer.
-- An employer and any predecessor employer would have to be treated as a single employer.
-- All employees, including part-time employees and those who were not eligible for coverage through the employer, would have to be counted.
-- If an employer were not in existence for the entire preceding calendar year, the determination would have to be based on the average number of employees that the employer was reasonably expected to employ on business days in the current calendar year.

Also, effective January 1, 2016, an employer that made enrollment in qualified health plans available to its employees through the SHOP, and would cease to be a small employer because of an increase in the number of its employees, would have to continue to be treated as a small employer for the Act's purposes as long as it continuously made enrollment through the SHOP available.

The Marketplace could not make available any health benefit plan that was not a qualified health plan. The Marketplace, however, would have to allow a health carrier to offer a plan that provided limited scope dental benefits meeting requirements of the Internal Revenue Code (26 USC 9832), through the Marketplace, either separately or in conjunction with a qualified health plan, if the plan provided pediatric dental benefits meeting requirements of the Federal Act.

The Marketplace, or a carrier offering health benefit plans through the Marketplace, could not charge an individual a fee or penalty for termination of coverage if the individual enrolled in another type of minimum essential coverage because he or she had become newly eligible for that coverage or because the individual's employer-sponsored coverage had become affordable under the standards of the Internal Revenue Code.

("Health carrier" would mean any of the following entities subject to the insurance laws and regulations of this State, or otherwise to the OFIR Commissioner's jurisdiction:

-- A health insurer.
-- A health maintenance organization.
-- Blue Cross Blue Shield of Michigan.
-- A nonprofit dental care corporation.
-- Any other entity providing a plan of health insurance, health benefits, or health services.)

Marketplace Duties

General Responsibilities. The Marketplace would have to perform all duties and obligations of an exchange required by Federal law, State law, and the purposes of the proposed Act. Consistent with its role as a market facilitator, with respect to the establishment of premium rates, the Marketplace could not negotiate rates, require competitive bidding, or engage in other purchaser-related activities.

In addition, the Marketplace would have to do all of the following:

-- Implement procedures consistent with the Act for the certification, recertification, and decertification of health benefit plans as qualified health plans.
-- Contract with OFIR to certify plans (as described below).
-- Make available in the Marketplace all qualified health plans and dental plans consistent with the Act.
-- Provide for the operation of a toll-free telephone hotline to respond to requests for assistance in a manner that was linguistically appropriate to the needs of the population being served by the hotline.
-- Provide at least an annual enrollment period from October 15 through December 7, and, if enrollment periods were provided on a more frequent basis, provide them in a manner that reduced the likelihood of adverse selection.
-- Maintain an internet website through which enrollees and prospective enrollees of qualified health plans could obtain standardized comparative information on the plans.
-- Assign a rating to each qualified health plan offered through the Marketplace pursuant to the rating criteria developed by the Board.
-- Use a standardized format for presenting health benefit options in the Marketplace, including the use of the uniform outline of coverage established under the Public Health Service Act (42 USC 300gg-5).
-- Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under the Internal Revenue Code (26 USC 36B) and any cost-sharing reduction under the Federal Act.

The Marketplace also would have to adopt an annual operating revenue and expense budget before the start of each fiscal year and make the budget available on its website; and transfer all data and information required to be transferred in compliance with Federal law, State law, and the proposed Act's purposes.

In addition, the Marketplace would have to perform duties required of it in compliance with State and Federal law and the proposed Act's purposes related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

Subject to terms and conditions determined by the Marketplace, it would have to allow a federally recognized Indian tribe to pay premiums on behalf of tribal members who were qualified individuals enrolled in a qualified health plan.

At least monthly, the Marketplace would have to give carriers all enrollment and disenrollment information in an electronic format, and remit to carriers any premiums received from qualified employees.

Medical Assistance. The Marketplace would have to inform individuals of eligibility requirements for a State medical assistance program (i.e., Medicaid or MIChild) or any applicable health subsidy program pursuant to the Federal Act.

If, through screening an application, the Marketplace determined that an individual potentially was eligible for a State medical assistance program or other applicable health subsidy program, the Marketplace would have to give the person information

about the program and, if applicable, the ability to enroll in that program through the Marketplace. Upon an individual's request, the Marketplace would have to enroll him or her in the program, if applicable, or direct him or her to the appropriate authority for final eligibility determination and enrollment.

SHOP. The Marketplace would have to establish a small business health options program through which qualified employers could gain access to coverage for their employees and federally recognized Indian tribes could gain access to coverage for their tribal members. The SHOP would have to be established to enable any qualified employer or federally recognized tribe to specify a level of coverage so that any of its employees or tribal members could enroll in any qualified health plan offered through the SHOP at that coverage level. In addition, the SHOP would have to provide a qualified employer or tribe with the opportunity to establish a defined contribution arrangement for its employees or members to purchase a health benefit plan.

The Marketplace would have to notify employees using the SHOP of potential eligibility for a State medical assistance program.

Individual Responsibility Requirement or Penalty. The Marketplace would have to grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code (IRC), an individual was exempt from the individual responsibility requirement or from the penalty because of either of the following:

-- There was no affordable qualified health plan available through the Marketplace, or the individual's employer, covering the individual.
-- The individual met the requirements for any other exemption from the individual responsibility requirement or penalty.

(Section 5000A of the IRC requires an individual to ensure that he or she and any dependents are covered under minimum essential coverage on a monthly basis, beginning in 2014. A person who fails to comply with this requirement will be subject to a tax penalty.)

Employee Information. The Marketplace would have to give an employer the name of each employee who ceased coverage under a qualified health plan during a plan year and the effective date of the cessation. For this purpose, "employer" would include both of the following:

-- An employer that did not provide minimum essential coverage.
-- An employer that provided the minimum essential coverage, but the coverage was determined under the IRC either to be unaffordable to the employee or not to provide the required minimum actuarial value.

Navigators. The Marketplace would have to select entities qualified to serve as navigators in compliance with Federal and State law and the proposed Act's purposes, and award grants to enable navigators to do all of the following:

-- Conduct public education activities to raise awareness of the availability of qualified health plans.
-- Distribute fair, accurate, and impartial information concerning qualified health plans and acknowledge other health plans.
-- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman program established under the Public Health Service Act (42 USC 300gg-93), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan or coverage or a determination under that plan or coverage.
-- Provide information in a manner that was culturally and linguistically appropriate to the needs of the population being served by the Marketplace.
-- Review the rate of premium growth within and outside the Marketplace and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers.
-- Facilitate enrollment in qualified health plans.

("Facilitate enrollment" would mean to perform an act that is only indirectly related to the sale, solicitation, or negotiation of a

health benefit plan and is to inform an individual of his or her eligibility for public assistance or to inform an individual that he or she could purchase a benefit plan through a producer, the Marketplace, a carrier offering a qualified health plan, or other source. The act would have to be in compliance with State and Federal law and the proposed Act's purposes.)

Insurance Producers. The Marketplace would have to permit insurance producers to: receive commissions or other remuneration from a carrier for enrolling consumers in a qualified health plan; enroll qualified individuals, qualified employers, and qualified employees in any qualified health plan; and assist individuals in applying for advanced payments of premium tax credits and cost-sharing reductions. Upon enrollment by a producer, the Marketplace would have to verify that enrollment with the respective individual or employer. These provisions would not require a qualified individual, employer, or employee to use a producer for any of the specified services. An individual, employer, or employee, however, could not be penalized, either by premium cost or coverage under a benefit plan, for choosing to use a producer's services.

Stakeholders. The Marketplace would have to consult with stakeholders relevant to carrying out the activities required under the proposed Act. Stakeholders would include the following:

-- Educated health care consumers who were enrollees in qualified health plans.
-- Individuals and entities with experience in facilitating enrollment in qualified health plans.
-- Representatives of small businesses and self-employed individuals.
-- The Medical Services Administration of the DCH.
-- Advocates for enrolling hard-to-reach populations.
-- Federally recognized Indian tribes.

("Educated health care consumer" would mean an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters.)

Marketplace Financial Integrity

The Board would have to appoint an audit committee, which would have to contract with an external auditor for the preparation of at least one audit of the Marketplace's financial statements in every fiscal year. The committee would have to be independent of the Marketplace and could not have contractual relationships with it or the external auditor other than for the Marketplace audit.

The executive director would have to review and certify the external auditor's reports, and make them available to the Board and the general public.

The Marketplace would have to keep an accurate accounting of all activities, receipts, and expenditures, and annually submit a report concerning those accountings to the Governor, the OFIR Commissioner, and the Senate and House Appropriations Committees and standing committees on health policy. The Marketplace would have to cooperate fully with any investigation conducted by the State or a Federal agency pursuant to authority under Federal or State law to do any of the following:

-- Investigate the Marketplace's affairs.
-- Examine the Marketplace's property and records.
-- Require periodic reports in relation to activities undertaken by the Marketplace.

In carrying out its activities, the Marketplace could not use any money intended for its administrative and operational expenses for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

Health Benefit Plan Certification

The Marketplace would have to contract with OFIR to certify health benefit plans. To the extent possible under the Federal Act, the criteria used by the Commissioner could not duplicate existing requirements of State law. The Commissioner would have to certify a health benefit plan as a qualified health plan if either of the following requirements were met:

-- The plan met the requirements of Federal law, State law, and the proposed Act's purposes.
-- The requirements of the Federal Act changed substantially after the proposed Act took effect, and the plan was offered by a carrier that was licensed or had a certificate of authority under Michigan law and was in good standing to offer the plan to all Michigan residents

The Commissioner could not certify a plan as a qualified health plan unless he or she had approved the premium rates and contract language.

The Commissioner could not exclude a health benefit plan as a qualified health plan on the basis that it was a fee-for-service plan; through the imposition of premium price controls in the Marketplace; or on the basis that the plan provided treatments necessary to prevent patients' deaths in circumstances the Commissioner determined were inappropriate or too costly.

The Commissioner would have to require each carrier seeking certification of a health benefit plan as a qualified health plan to submit a justification for any premium increase before implementing it. The Commissioner would have to take this information into consideration when determining whether to allow the carrier to make plans available through the Marketplace. In addition, the Commissioner would have to require the carrier to make available to the public, in plain language, and submit to the Marketplace and the Commissioner accurate and timely disclosure of all of the following:

-- Claims payment policies and practices.
-- Periodic financial disclosures.
-- Data on enrollment and disenrollment, the number of claims that were denied, and rating practices.
-- Information on cost-sharing and payments with respect to any out-of-network coverage.
-- Information on enrollee and participant rights under the Federal Act.
-- Other information required to be in compliance with Federal and State law and the proposed Act's purposes.

Also, the Commissioner would have to require a carrier seeking certification of a plan to permit an individual to determine, in a timely manner upon the individual's request, the level of cost-sharing, including deductibles, copayments, and coinsurance, under the plan or coverage that he or she would be responsible for paying with respect to a participating provider's furnishing of a specific item or service.

Qualified Dental Plans

The proposed Act's provisions that were applicable to qualified health plans would apply to the extent relevant to qualified dental plans except as modified under the Act or by the Board as permitted by the Federal Act. ("Qualified dental plan" would mean a limited scope dental plan certified under the Act.)

A carrier offering a qualified dental plan would have to be licensed to offer dental coverage, but would not have to be licensed to offer other health benefits. The qualified dental plan would have to be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage. At a minimum, the plan would have to include the essential pediatric dental benefits prescribed under the Federal Act, and any other dental benefits in compliance with Federal and State law and the proposed Act's purposes.

Carriers could jointly offer a comprehensive plan through the Marketplace in which the dental benefits were provided through a qualified dental plan and the other benefits were provided through a qualified health plan, if the plans were priced separately and also made available for purchase separately at the same price.

Marketplace Funding

The proposed Act would not authorize the Marketplace to spend any State money. The Marketplace could charge assessments or user fees to health carriers eligible to offer qualified health plans in the Marketplace or otherwise could generate funding necessary to support its operations. The Marketplace could charge an assessment or user fee to a carrier based only upon that carrier's participation in the Marketplace. An assessment or user fee would be considered a licensing or regulatory fee for the purpose of determining compliance with the medical loss ratio requirements of the Federal Act.

The Marketplace would have to publish the average costs of fees and any other payments it required, as well as its administrative costs, on its website. The Marketplace also would have to include information on money lost to waste, fraud, and abuse.

Before implementing or increasing an assessment or user fee, the Marketplace would have to submit its proposal and a justification for it to the OFIR Commissioner and the Senate and House standing committees on health policy. The justification would have to include the reason for the implementation or increase of the assessment or fee, the amount to be collected, and the potential impact on consumers and carriers. Within 60 days after a proposal was submitted, the Commissioner could reject it as unreasonable or unnecessary. In that case, the proposal would not take effect.

The Marketplace also could generate revenue in compliance with Federal law, State law, and the purposes of the MiHealth Marketplace Act, including raising revenue through advertising on its website. With regard to advertising, the Marketplace would have to comply with all conflict of interest safeguards established by the Board.

Insurance Regulation

The proposed Act would not preempt or supersede the OFIR Commissioner's authority to regulate the business of insurance in Michigan or of the "single state agency" (the DCH) to administer a State medical assistance program.

Except as expressly provided to the contrary in the Act, all carriers offering qualified health plans in Michigan would have to comply fully with all applicable State health insurance laws, and rules and orders promulgated by the Commissioner.

Any standard or requirement adopted by the Marketplace under the Federal Act or the MiHealth Marketplace Act would have to be applied uniformly to all carriers and health benefit plans in each insurance market to which the standard or requirement applied.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

Under the Federal Act, each state's health insurance exchange must be operational by January 1, 2014. States that cannot or choose not to meet that deadline will have to accept a one-size-fits-all exchange designed by the Federal government. It would be preferable for Michigan to create its own exchange for a number of reasons. To date, few details are available regarding the Federal exchange, resulting in uncertainty as to how it will function. It is clear, however, that the State would cede a significant amount of control over its Medicaid budget to the Federal government if it defaulted to the Federal exchange. The design and implementation of an exchange structure specific to Michigan would enable the State to maintain a certain level of authority and be flexible in addressing the needs of its residents.

In order to meet the 2014 deadline, the State must begin working on the exchange as soon as possible. Important decisions must be made, and the State must act quickly to secure services from the best vendors, the demand for which will increase as other states move to create their exchanges.

Federal funding for the exchanges is available to states in several phases. Michigan has applied for Level 1 funding to continue planning and development of the State's exchange. Currently, the Department of Licensing and Regulatory Affairs serves as the proposed exchange's incubator; eventually, however, the exchange must exist and operate outside of State government. Once granted, the Level 1 funding will be used to help determine the exchange's needs with regard to information technology, procurement, and staffing to administer requests for proposals and review contracts. Enabling legislation at the State level is required for Michigan to apply for millions of dollars in Level 2 funding, which is essential to the exchange's continued development, to ensure that it is functioning before Federal certification begins.

Supporting Argument

Rather than adding to existing government bureaucracy, the proposed MiHealth Marketplace would provide a market-driven platform for the purchase of health insurance. In its role as a facilitator, rather than an active purchaser, the proposed exchange would serve as an equitable playing field on which all licensed carriers could compete in terms of innovation, quality, and price. Policy rates would be driven by consumers, not dictated by the exchange. No consumer, either an individual or a small business, would be required to purchase coverage through the exchange. Like other market-driven ventures, the exchange would have to survive based on its own merits, and would go out of business if it were not used. In addition, the exchange would not rely on tax dollars to operate, but instead would be funded by fees imposed on participating carriers, implemented in a way that prevented adverse selection by carriers outside the exchange.

Response: The exchange should have some authority as an active purchaser. This would enable it to use a considerable amount of market power in selecting plans available for purchase, allowing only those of high value to participate. The bill's language prohibiting the exchange from requiring competitive bidding and engaging in other purchaser-related activities could tie the hands of the Marketplace and limit its flexibility in determining how to best meet its mission.

In addition, the same rules should apply to plans both inside and outside the Marketplace, to prevent carriers on the outside from cherry-picking the healthiest consumers and turning the exchange into a high-risk pool with unaffordable premiums. The bill should include stronger safeguards to thwart adverse selection. Similarly, fees should be imposed on all carriers both inside and outside the exchange so those outside were not given an unfair financial advantage.

Supporting Argument

The bill, which is based on model legislation developed by the National Association of Insurance Commissioners, would empower individuals and small businesses in purchasing health insurance by providing a convenient, consumer-friendly portal to allow for comparison shopping. The competition spurred by the exchange would help to spread risk among the pool to be insured and keep premium increases in check. Overall, the proposed exchange would facilitate greater access, affordability, and transparency in both the individual and small group insurance markets.

The placement of all insurance plans in a standard format on one website, each rated in terms of its relative value, would enable consumers to compare policies quickly and make informed choices. The bill's requirement that the MiHealth Board consist primarily of consumers, with industry experts serving in an advisory capacity, would ensure that consumer well-being remained the exchange's main focus. In addition, the conflict of interest and ethics policy provisions would foster transparency.

The bill would further aid consumers in their insurance purchases by requiring that information be provided through culturally and linguistically appropriate means, and providing for navigators to guide potential enrollees.

Also, the bill would require that individuals shopping through the exchange be screened for Medicaid and MIChild eligibility, essentially creating a "no wrong door" approach to both public and private insurance coverage.

Response: As required by the Federal Act, the MiHealth Board should have final authority over all Marketplace decisions, including the certification and rating of participating health plans. The bill's requirement that the exchange contract with OFIR for these services is appropriate; ultimately, however, the Board should have the authority to accept or reject OFIR's recommendations.

While the bill contains requirements aimed at promoting transparency, the MiHealth Board should be subject to the Open Meetings Act and the Freedom of Information Act specifically.

With regard to exchange navigators, the bill should define their role as enrollment facilitators more clearly. Currently, the facilitation of enrollment is the purview of insurance agents, who are trained and licensed to provide appropriate counsel in the complex field of health insurance. If navigators were to perform functions that

have traditionally belonged to insurance agents, it is important that they be subject to the same rigorous standards and not erode the insurance agent's role.

Also, the bill should authorize community-based organizations, such as nonprofit organizations, schools, churches, and health centers, to serve as navigators within the exchange. Such entities typically are trusted in the communities they serve and could play a significant role in outreach and education.

While consumers would benefit from the Medicaid and MIChild screening provisions, the exchange should provide a more seamless enrollment mechanism for people who are eligible, as required by the Federal Act. Some people using the exchange would be likely to move between private insurance and public medical assistance programs due to income fluctuations, so it is important that rules allow for the coordination of plans, benefits, and provider networks to prevent gaps in coverage.

Opposing Argument

The bill would facilitate further implementation of the Federal Act, which is not based on true free market concepts. Government efforts to address access and affordability issues should focus on improving the efficiency of public programs, such as Medicaid; the private sector is the most appropriate venue for health insurance comparison shopping. Rather than creating an entity to certify private plans, assist in enrollment, and otherwise act as an intermediary for insurance transactions, legislation should define data exchange standards that would allow consumers to make apples-to-apples comparisons of policies through private exchanges.

Furthermore, there is a great deal of uncertainty surrounding the Federal Act's future, as well as the structure of the proposed exchange and its associated costs. The existence of so many unknowns would hinder the design and implementation of an effective, efficient exchange that would comply with all legal requirements. Through the bill, the Legislature would be granting statutory authority to apply for and allocate an unspecified amount of Federal funding without a clear idea of the objectives that should be met and how the money would be spent.

Response: While there is a significant amount of ambiguity regarding health care reform, the Federal Act explicitly requires each state to have a functional exchange by January 1, 2014. The State cannot predict the outcome of legal challenges to the Federal Act, but must comply with it as it stands currently. The bill would position Michigan to respond in a timely manner should all or part of the Federal Act be upheld. Additionally, even if the Federal Act ultimately does not pass constitutional muster, the proposed exchange would benefit Michigan consumers.

Also, the State will use the Federal Level 1 funding to help formulate a more concrete plan for the exchange's functionality and costs, which would lay the groundwork for the specific uses of the Level 2 funding.

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

The bill would result in unknown, higher costs to the Department of Licensing and Regulatory Affairs. These costs would be covered by Federal grants until 2015, and user fees charged to health carriers thereafter. The bill does not specify the level of these fees, nor is it known at this time how much these fees would be required to raise to support the operations of the MiHealth Marketplace.

Members of the proposed MiHealth Marketplace Board would serve without compensation, but could be reimbursed for necessary and actual expenses incurred. These costs would likely be related to travel and would be borne by existing Department resources. The MiHealth Marketplace would cost an unknown amount. Other states have already begun implementing health insurance exchanges and have received Federal grants to do so. All costs associated with the creation of the MiHealth Marketplace would be covered by Federal grants through 2014, after which states are expected to find a funding mechanism for their exchanges. The bill would provide ongoing funding for the exchange through unspecified user fees charged to health carriers.

The Department applied for the first round of Federal grants on September 30, 2011, requesting $9.8 million for its Level 1

Exchange Establishment Grants. It is likely that additional funding will be requested going forward. For purposes of comparison, Oregon has reported receiving $9.0 million for its Level 1 Exchange Establishment Grants, and California has reported receiving $39.0 million for its Level 1 grants.

Fiscal Analyst: Josh Sefton

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