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BILL ANALYSIS

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Senate Bill 693 (as introduced 9-22-11)
Sponsor: Senator Jim Marleau
Committee: Health Policy

Date Completed: 10-6-11

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.**
- **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.**
- **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.**

"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 Board would consist of seven voting members, as well as the OFIR Commissioner, who would serve as a nonvoting ex officio member.

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 of Representatives 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. A Board member could not serve more than two consecutive terms of office.

A Board member could not be employed, directly or indirectly, by a health carrier, producer, health care provider, or any other entity, affiliate, or subsidiary of a health benefit plan.

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 board minutes could be inspected by the public. 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 could establish committees as it considered appropriate 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 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 the management and operation of the marketplace.
-- To make contracts; give guarantees; incur liabilities; borrow money; issue its notes, bonds, and other obligations; and secure any of its obligations by mortgage or pledge of any of its property or an interest in the property.
-- To adopt, amend, or repeal bylaws relating to the Marketplace's purpose, the conduct of its affairs, its rights and powers, and the rights and powers of its Board members, directors, or officers.
-- To elect or appoint officers, employees, and other agents of the Marketplace, prescribe their duties, fix their compensation and the compensation of directors, and indemnify corporate directors, officers, employees, and agents.
-- To cease its corporate activities and dissolve pursuant to the Nonprofit Corporation Act and the Affordable Care Act.

Upon dissolution of the Marketplace, 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.

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 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.
-- Is eligible to participate in the MiHealth Marketplace based upon its policies and procedures.

"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 would have to be counted, including part-time employees and those who were not eligible for coverage through the employer.
-- If an employer were not in existence for the entire preceding calendar year, the determination of whether that employer was a small employer would have to be based on the average number of employees that it was reasonably expected the employer would employ on business days in the current calendar year.
-- 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. ("Federal Act" would mean the Federal Patient Protection and Affordable Care Act, as amended by the Federal Health Care and Education Reconciliation Act, and other Federal acts, and any regulations promulgated under those acts.)

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 an entity subject to the insurance laws and regulations of this State, or subject to the OFIR Commissioner's jurisdiction, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a health insurer, health maintenance organization, Blue Cross Blue Shield of Michigan, and any other entity providing a plan of health insurance, health benefits, or health services.)

Marketplace Duties

The Marketplace would have to do all of the following:

-- Perform all duties and obligations of an exchange required by Federal law, State law, and the purposes of the proposed Act.
-- Implement procedures consistent with the Act for the certification, recertification, and decertification of health benefit plans as qualified health plans.
-- Make available in the Marketplace all qualified health plans consistent with the Act.
-- Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.
-- Provide for enrollment periods, as provided under the Federal Act.

-- 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).
-- Inform individuals of eligibility requirements for Medicaid, MIChild, or any applicable health subsidy program pursuant to the Federal Act.

If, through screening of an application, the Marketplace determined that an individual potentially was eligible for a health subsidy program, the Marketplace would have to give the person information about the program. 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.

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

-- 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.
-- Establish a small business health options program through which qualified employers could gain access to coverage for their employees.
-- Notify employees using the SHOP of potential eligibility for Medicaid or MIChild.

The Marketplace also 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.)

The Marketplace also would have to contract with OFIR to certify health benefit plans as qualified health plans consistent with the proposed Act and transfer to the U.S. Secretary of the Treasury all data and information required to be transferred under regulations promulgated under the Federal Act.

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.

In addition, the Marketplace would have to perform duties required of it by the Secretary of the U.S. Department of Health and Human Services (HHS) or the Federal Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

Also, the Marketplace would have to select entities qualified to serve as navigators pursuant to the Federal Act and standards developed by the HHS Secretary, 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.
-- Facilitate enrollment in qualified 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.

The Marketplace would have to permit insurance producers to serve as navigators; receive grants from the Marketplace; 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.

The Marketplace would have to consult with stakeholders relevant to carrying out the activities required under the proposed Act, including 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 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 the Marketplace 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 meet certain financial integrity requirements. Specifically, it would have to keep an accurate accounting of all activities, receipts, and expenditures and annually submit a report concerning those accountings to the HHS Secretary, the Governor, the OFIR Commissioner, and the Senate and House of Representatives Appropriations Committees and standing committees on insurance issues. 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. 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.
-- As determined by the Commissioner, the requirements of the Federal Act changed substantially after the 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, the HHS Secretary, 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 as determined appropriate by the HHS Secretary.

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 amount 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 the furnishing of a specific item or service by a participating provider.

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 by the HHS Secretary under the Federal Act, and any other dental benefits specified by the Secretary or the Board. Carriers jointly could 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 expenditure of any State money by the Marketplace. The Marketplace could charge assessments or user fees to health carriers or otherwise could generate funding necessary to support its operations. 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.

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 Medicaid.

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.

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

Senate Bill 693 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, which the bill would charge the Board with establishing, 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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