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MIHEALTH MARKETPLACE ACT

House Bill 6112 as introduced
Sponsor: Rep. Mark A. Tisdel
Committee: Health Policy
Complete to 5-25-22

SUMMARY:

House Bill 6112 would create a new act, the MIHealth Marketplace Act, which would provide for the creation of the MIHealth Marketplace as a nonprofit corporation, create the MIHealth Marketplace Board and provide for its powers and duties, allow for certain user fees and other assessments, require the Department of Insurance and Financial Services (DIFS) to certify qualified health plans to be made available through the marketplace, and provide for the powers, duties, and procedures of the marketplace. The bill describes the marketplace as a nonexclusive health insurance clearinghouse that would have to foster a competitive market for health insurance in Michigan and serve as a market facilitator to promote the purchase and sale of qualified health plans and disseminate health insurance information regarding qualified health plans to health benefit plan consumers.

MIHealth Marketplace Board

The bill would create the MIHealth Marketplace Board to organize and govern the MIHealth Marketplace and to support health care consumers, including employers, in Michigan.

Board members

The MIHealth Marketplace Board would consist of seven voting members, a majority of whom would have to represent the interests of health care consumers in Michigan. The director of the Department of Insurance and Financial Services (DIFS) would serve as a nonvoting ex officio member of the board. The board would be the incorporator of the marketplace for the purposes of the Nonprofit Corporation Act. A board member could not currently or within the immediately preceding 12 months be employed by, be employed by an affiliate or subsidiary of, or be otherwise engaged by an entity that receives more than 50% of its revenues from, a ***health carrier***, ***producer***, health care provider, or third party administrator.

Health carrier or ***carrier*** would mean any of the following entities that are subject to the insurance laws and regulations of the state or otherwise subject to the jurisdiction of the director of DIFS:

- A health insurer operating under the Insurance Code.
- A health maintenance organization operating under the Insurance Code.
- A health care corporation operating under the Nonprofit Health Care Corporation Reform Act.
- A nonprofit dental care corporation operating under 1963 PA 125.
- Any other entity providing a plan of health insurance, health benefits, or health services.

Producer would mean a person required to be licensed under state law to sell, solicit, or negotiate insurance.

The governor would appoint five of the initial voting members of the board, with the advice and consent of the Senate, and the Speaker of the House and Senate Majority Leader would each appoint one initial voting member. The initial members would have to be appointed within 30 days after the bill's effective date. An appointed board member would serve a term of four years or until a successor is appointed, whichever is later, except that the terms of members initially appointed would be staggered in length. A board member could not serve more than two consecutive terms. After the initial appointments, members would be appointed with the advice and consent of the Senate.

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

A vacancy on the board would have to be filled as specified in the marketplace's articles of incorporation or bylaws, which also would have to ensure that a majority of the board's voting members represent the interests of health care consumers at all times.

Board meetings

The director of DIFS would call the first meeting of the board, at which a chairperson would have to be elected. After the first meeting, the board would have to meet at least quarterly, but could meet more frequently at the call of the chairperson or if requested by four or more members.

Four members of the board would constitute a quorum for the transaction of business at a meeting of the board, and an affirmative vote of four board members would be required for official action of the board.

The board's business would have to be conducted at a meeting that is held in Michigan, open to the public, and held in a place available to the general public. The board could establish reasonable rules and regulations to minimize disruptions. At least 10 but not more than 60 days before a meeting, the board would have to provide public notice of the meeting at its principal office and on its website. The notice would have to include the address where board minutes may be inspected by the public. The board could meet in a closed session for 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.

The board would have to keep minutes of each meeting, which would have to be open to public inspection, with copies available for the reasonable estimated cost of printing. The minutes would have to include all of the following:

- The date, time, and place of the meeting.
- Board members present and absent.
- Board decisions made at a meeting open to the public.
- All roll call votes taken.

Code of ethics

The board would have to adopt a code of ethics for its members, employees, and agents and for the corporate directors, officers, and employees of the marketplace pursuant to federal and state law and the standard of practice applicable to nonprofit corporations. The code of ethics would have to include policies and procedures requiring disclosure of relationships that may give rise to a conflict of interest. A board member with a direct or indirect interest in any matter before the marketplace would have to disclose that interest before any board action on the matter. Board members would have to recuse themselves from the discussion and vote if they or a member of their immediate family would derive direct and specific benefit from a board decision on an issue.

Other provisions concerning the board

The board would have to establish committees with a specific charge concerning the operation and implementation of the marketplace. The committees could include individuals who are not board members, such as representatives of health care consumers, health carriers, and health care providers and other health industry representatives.

There would be no liability of, or cause of action against, a board member for any lawful action taken in the performance of the member's powers and duties under the bill.

The board also would have other duties related to the marketplace as described below.

MIHealth Marketplace

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

> ***SHOP*** would mean the Small Business Health Options Program established by the marketplace as described below.
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> ***Qualified health plan*** would mean a health benefit plan that has been certified as described below.
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> ***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. Health benefit plan would not include any of the following:
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> - Coverage only for accident or disability income insurance or a 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 under the Health Insurance Portability and Accountability Act, under which benefits for health care services are secondary or incidental to other insurance benefits.
- A plan that provides the following benefits if they are provided under a separate policy, certificate, or contract of insurance 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 federal regulations issued under the Health Insurance Portability and Accountability Act.
- A plan that provides the following benefits if they are provided under a separate policy, certificate, or contract of insurance, if there is no coordination between their provision and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor, and if they are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health benefit plan maintained by the same plan sponsor:
    - Coverage only for a specified disease or illness.
    - Hospital indemnity or other fixed indemnity insurance.
    - Any of the following if offered as a separate policy, certificate, or contract of insurance:
    - A Medicare supplemental policy as defined in the Social Security Act.
    - Coverage supplemental to the coverage provided by the TRICARE Program.
    - Similar coverage supplemental to coverage provided under a group health plan.

Powers and duties as a nonprofit corporation

The marketplace would have only the following powers and duties as a nonprofit corporation:

- To contract with others to provide services necessary for its management and operation.
- To make contracts, give guarantees, incur liabilities, borrow money, and secure obligations by mortgage or pledge.
- To sue and be sued and participate in actions and proceedings judicial, administrative, arbitrative, or otherwise in the same manner as a natural person.
- To have a corporate seal.
- To adopt, amend, or repeal bylaws relating to the purposes of the marketplace, the conduct of its affairs, its rights and powers, and the rights and powers of its board members, corporate directors, or officers.
- To elect or appoint officers, employees, and other agents of the marketplace, to prescribe their duties, to fix their compensation and the compensation of corporate directors, and to indemnify corporate directors, officers, employees, and agents.
- To purchase, receive, take by grant, gift, devise, bequest, or otherwise, lease, or otherwise acquire, and to own, improve, use, and otherwise deal in and with, real or personal property, absolutely or in trust and without limitation as to amount or value.
- To sell, convey, lease, exchange, transfer, or otherwise dispose of, or to mortgage or create a security interest in, any of its property or an interest in the property.

- To purchase, take, receive, subscribe for, or acquire, own, and hold bonds and other obligations and shares or other securities issued by others. However, the marketplace could not guarantee or become a surety upon a bond or other undertaking securing the deposit of public money.
- To invest and reinvest its money, and take and hold real and personal property as security for the payment of money loaned or invested.
- To establish savings, thrift, and other incentive and benefit plans, trusts, and provisions for its corporate directors, officers, and employees. The marketplace could not establish and carry out pensions.
- To purchase, receive, acquire, own, hold, sell, lend, exchange, transfer, dispose of, and use its bonds and other securities.
- To cease its corporate activities and dissolve under the bill's provisions, the Nonprofit Corporation Act, and the federal Affordable Care Act (ACA).[1] The marketplace would have to submit its plan to cease its corporate activities and dissolve to the director of DIFS and the House and Senate standing committees on health policy 60 or more business days (including at least seven legislative session days) before it plans to dissolve. Upon dissolution, the assets of the marketplace would have to be distributed as follows:
    - All liabilities would have to be paid and discharged.
    - Assets remaining after the above would have to be distributed as provided in a plan of action developed and adopted by the MIHealth Marketplace Board and approved by the director of DIFS.
- To conduct its affairs, carry on its operations, and engage in other incidental business matters as are naturally or properly within the scope of its articles of incorporation.

The marketplace would have the powers and duties of a nonprofit corporation under the Nonprofit Corporation Act—except for a power or duty under section 261 of that act, instead of which the above list of powers and duties would control regarding the powers and duties of the marketplace. The bill also would control if a power or duty of the marketplace under the bill conflicted with a power or duty under other state law.

Executive director

The MIHealth Marketplace Board would have to appoint an executive director to manage the marketplace, who would have to be independent of the marketplace and have no material relationship with it. The executive director could appoint staff as necessary and contract with others to provide the services necessary to operate the marketplace. The executive director also could seek assistance and support from appropriate state departments, agencies, and offices, which could provide that assistance upon request.

The executive director would have to display on the marketplace's website information relevant to the public concerning the marketplace's operations and efficiencies.

[1] The bill here uses the term ***federal act***, which it defines as the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and any regulations promulgated under those acts. The bill also states that a reference to the ***federal act*** includes other provisions of the laws of the United States relating to health care coverage. For ease of reference, this summary will use "ACA" where the bill uses the term ***federal act***.

Availability of qualified health plans

The marketplace would have to make qualified health plans available through its website and its toll-free telephone hotline for review, purchase, and enrollment by ***qualified individuals*** and ***qualified employers*** beginning on or before January 1, 2023, 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, other than incarceration pending the disposition of charges.
- Is, and is reasonably expected to be, for the entire period of enrollment, a citizen or national of, or an alien lawfully present in, the United States.

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 either 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 principally employed in Michigan.

Small employer would mean that term as defined in section 3701 of the Insurance Code.

The marketplace could not make available any health benefit plan that is not a qualified health plan. However, a health carrier could offer a limited scope dental plan meeting IRS requirements, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of the ACA.

A fee or penalty for termination of coverage could not be charged if the individual enrolled in another type of minimum essential coverage because the individual became newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the IRS standards.

Rating criteria for qualified health plans

The MIHealth Marketplace Board would have to develop criteria for rating each qualified health plan offered through the marketplace based on relative value and quality, with criteria compliant with federal and state law and the purposes of the bill. The board would have to consult with the director of DIFS and the Medical Services Administration for the Department of Health and Human Services (DHHS) on the development of the rating criteria. The methods used to develop the criteria would have to be included in minutes open to the public, and the criteria would have to be uniformly applied to all qualified health plans.

Requirements of the marketplace

The marketplace would have to do all of the following:

- Perform all duties and obligations of an exchange required by federal and state law and the purposes of the bill. This would not include negotiating rates, requiring competitive bidding, or engaging in other purchaser-related activities with respect to the establishment of premium rates.
- Implement procedures as described below for the certification, recertification, and decertification of health benefit plans as qualified health plans, including contracting with DIFS to certify qualified health plans as described below.
- Make all qualified health plans and all ***qualified dental plans*** available in the marketplace as described below.
- Provide for the operation of a toll-free telephone hotline in a manner linguistically appropriate to the needs of the population being served by the hotline.
- Provide at least the annual enrollment period beginning on November 1 and ending on December 15. If enrollment periods were offered more frequently, it would have to be done in a manner that reduces the likelihood of adverse selection.
- Maintain a website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on the plans.
- Assign a rating to each qualified health plan offered, using the rating criteria developed by the MIHealth Marketplace Board, and use a standardized format for presenting health benefit options.
- Inform individuals of eligibility requirements for a ***state medical assistance program*** or any applicable health subsidy program under the ACA and provide potentially eligible individuals with information about the program and the ability to enroll in it.
- Establish and make available by electronic means a calculator to determine the actual cost of coverage after applying any premium tax credit under the Internal Revenue Code and any cost-sharing reduction under the ACA.
- Establish a small business health options program (***SHOP***) through which qualified employers may access coverage for their employees and ***federally recognized Indian tribes*** may access coverage for their tribal members. The SHOP would have to be established to do both of the following:
    - Enable a qualified employer or federally recognized Indian tribe to specify a level of coverage so any of its employees or tribal members may enroll in any qualified health plan offered through the SHOP at the specified level of coverage.
    - Provide a qualified employer or federally recognized Indian tribe the opportunity to establish a defined contribution arrangement for its employees or tribal members to purchase a health benefit plan.
- Notify employees using the SHOP of potential eligibility for a state medical assistance program.
- Grant a certification attesting that an individual is exempt from the Internal Revenue Code individual responsibility requirement or penalty under certain conditions.
- Adopt an annual operating revenue and expense budget before the start of each fiscal year and make it available on its website.
- Transfer all data and information required to be transferred in compliance with federal and state law and the purposes of the bill.
- Provide the name of each employee of an employer described in the bill who ceases coverage under a qualified health plan during a plan year and the date of the cessation.

- Perform duties required of the marketplace in compliance with federal and state law and the purposes of the bill related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.
- Select entities qualified to serve as navigators in compliance with federal and state law and the purposes of the bill and award grants to enable navigators to do all of the following:
    - Conduct public education activities on the availability of qualified health plans.
    - Distribute fair, accurate, and impartial information concerning qualified health plans and acknowledge other health plans.
    - Provide appropriate referrals to enrollees with a grievance, complaint, or question regarding their health benefit plan or coverage or a determination under that plan or coverage.
    - Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served.
    - Facilitate enrollment in qualified health plans by informing individuals of their eligibility for public assistance or that they can purchase a health benefit plan through a producer, the MIHealth marketplace, a health carrier offering a qualified health plan, or another source.
- 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.
- Allow producers to do all of the following:
    - Enroll qualified individuals, qualified employers, and qualified employees in a qualified health plan.
    - Receive remuneration from a health carrier for enrolling consumers in a qualified health plan.
    - Assist individuals in applying for advance payments of premium tax credits under the Internal Revenue Code and cost-sharing reductions under the ACA.
- Subject to terms and conditions determined by the marketplace, allow a federally recognized Indian tribe to pay premiums for qualified health plans on behalf of tribal members who are qualified individuals enrolled in a qualified health plan.
- Consult with specified stakeholders.
- Provide all enrollment and disenrollment information to health carriers daily in an electronic format.
- At least monthly, remit to health carriers any premiums received from qualified employees.

Federally recognized Indian tribe would mean an Indian tribe as that term is defined in 25 USC 5130 or in 25 USC 1603 or an Indian tribe, tribal organization, or inter-tribal consortium as those terms are defined in 25 USC 5301 to 5423.

Qualified dental plan would mean a limited scope dental plan that has been certified as described below.

State medical assistance program would mean a program established in Michigan under Title XIX or Title XXI of the Social Security Act.

Audit committee

The MIHealth Marketplace Board would have to appoint an audit committee, which would have to contract with an external auditor for at least one audit of the marketplace's financial statements in each fiscal year. The audit committee 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 MIHealth Marketplace Board and the general public.

Financial integrity requirements

The marketplace would have to meet all of the following financial integrity requirements:

- Keep an accurate accounting of all activities, receipts, and expenditures and annually submit a report on those accountings to the governor, director of DIFS, and House and Senate appropriations committees and standing committees on health policy.
- Fully cooperate with any investigation conducted by the state or a federal agency to do any of the following:
    - Investigate the affairs of the marketplace.
    - Examine the properties and records of the marketplace.
    - Require periodic reports in relation to the activities undertaken by the marketplace.
- In carrying out its activities under the bill, not use any money intended for the administrative and operational expenses of the marketplace for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications.

Certification of health benefit plans

As described above, the marketplace would have to contract with DIFS to certify health benefit plans. The certification criteria used could not, to the extent possible under the ACA, duplicate existing requirements of state law. A health benefit plan could not be certified as a qualified health plan unless the premium rates and contract language were approved by the director of DIFS. Otherwise, the director of DIFS would have to certify a health benefit plan as a qualified health plan if either of the following requirements were met:

- The health benefit plan meets the requirements of federal and state law and the purposes of the bill.
- The director determines that the requirements of the ACA have changed substantially after the bill's effective date, and the plan is offered by a health carrier that is licensed or has a certificate of authority in Michigan and is in good standing.

A plan could not be excluded on the basis that it is a fee-for-service plan, through the imposition of premium price controls in the marketplace, or on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the director of DIFS determines are inappropriate or too costly.

The director of DIFS would have to require each health carrier seeking certification of a health benefit plan as a qualified health plan to do certain things as prescribed in the bill, such as submitting a justification for any premium increase before increasing the premium.

Qualified dental plans

The provisions of the bill that apply to qualified health plans would apply, to the extent relevant, to qualified dental plans except as described below or as modified by the MIHealth Marketplace Board as allowed by the ACA. A health 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, and would have to include, at a minimum, the essential pediatric dental benefits required under the ACA, and any other dental benefits specified in compliance with federal and state law and the purposes of the bill. Health carriers could jointly offer a comprehensive plan through the marketplace in which the dental benefits are provided by a health carrier through a qualified dental plan and the other benefits are provided by a health carrier through a qualified health plan, if the plans were priced separately and also made available for purchase separately at the same price.

Assessments or user fees

The marketplace could charge assessments or user fees to health carriers eligible to offer qualified health plans in the marketplace or otherwise generate funding necessary to support its operations. The marketplace could only charge an assessment or user fee to a health carrier based on that health carrier's participation in the marketplace. An assessment or user fee charged to health carriers would be considered a licensing or regulatory fee for the purpose of determining compliance with the medical loss ratio requirements of the ACA.

Before implementing or increasing an assessment or user fee, the marketplace would have to submit its proposal and its justification for that proposal to the director of DIFS and the House and Senate standing committees on health policy. Within 60 days after submission of a proposal, the director of DIFS could reject the proposal as unreasonable or unnecessary. A rejected assessment or user fee would not take effect.

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

Joint committee

The bill would require the Speaker of the House and the Senate Majority Leader to establish a joint committee to review the ACA, if any provisions remain, and the implications with regard to the bill. The joint committee would have to report its findings to the legislature by January 1, 2024, or within 30 days after all or any part of the ACA is declared unconstitutional, repealed, or otherwise altered in a way that affects the implementation or administration of the bill, whichever date is earlier. The report would have to include recommendations regarding amendments to the new act or to other state law.

Should the part of the ACA that requires the establishment of a small business health options program (SHOP) be declared unconstitutional or repealed, the director of DIFS would have to issue an order requiring the suspension of the SHOP. Upon issuance of such an order, the marketplace would have to immediately suspend the operation of the SHOP. Upon that suspension, federally recognized Indian tribes would have to be allowed to pay premiums for qualified health plans on behalf of tribal members as described above.

Other provisions

The bill provides that it does not recognize the constitutionality of the ACA.

The bill provides that it does not authorize the expending of state money by the marketplace.

The bill would not preempt or supersede the authority of the director of DIFS to regulate the business of insurance in Michigan or of DHHS to administer a state medical assistance program.

All health carriers offering qualified health plans in Michigan would have to comply fully with all applicable state health insurance laws and departmental rules and orders, except as otherwise expressly provided in the bill.

Any standard or requirement adopted by the marketplace pursuant to the ACA or the bill would have to be applied uniformly to all health carriers and health benefit plans in each insurance market to which the standard or requirement applies.

Beginning on the bill's effective date, an entity would be prohibited from incorporating, filing, registering, or otherwise forming in Michigan using a name that is the same as, or is deceptively or confusingly similar to, "MIHealth Marketplace."

FISCAL IMPACT:

House Bill 6112 would not be anticipated to have a significant fiscal impact on the Department of Insurance and Financial Services, on the Department of Health and Human Services, or on other units of state or local government.

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