HOUSE FISCAL AGENCY

MEMORANDUM

DATE: 11/07/2011

TO: Members of the House Appropriation Subcommittee for LARA

FROM: Paul Holland, Fiscal Analyst

RE: State Health Insurance Exchanges

In response to the requirements pertaining to the establishment of a state health insurance exchange stipulated in the federal Patient Protection and Affordable Care Act (ACA), SB 693 has been introduced. SB 693 would create the "MIHealth Marketplace." In addition, HB 5014 was amended within the Senate to include a supplemental appropriation authorizing the state to accept a federal grant for planning and development of the MIHealth Marketplace. This memo provides background on the requirements of the ACA pertaining to state health insurance exchanges, as well as the provisions of SB 693 and implications of HB 5014.

What is a state health insurance exchange (i.e. "American Health Benefit Exchange")?

An American Health Benefit Exchange (AHBE) is a regulated virtual marketplace/clearinghouse (i.e. internet portal & call center) developed by states through which individuals and families would be able to compare, purchase, and enroll in qualified health insurance plans. AHBEs are nonexclusive, meaning that health insurance carriers would not be required to participate in an AHBE. AHBEs will provide information about health insurance plans offered through an AHBE to health insurance consumers.

What is a "Small Business Health Options Program"?

A Small Business Health Options Program (SHOP) is a program through which businesses with fewer than 100 employees would be able to compare and purchase qualified health insurance plans to offer to their employees (states may limit access to the SHOP to businesses with less than 50 employees until on January 1, 2016). The SHOP may be a separate "small group" exchange or may be merged within the AHBE.

What are the major federal requirements for AHBEs?

Under the ACA[1], states may develop and implement AHBEs and provide oversight of health insurance plans, ensuring that they meet ACA and US Health and Human Services (HHS) regulations[2]. States may determine how AHBEs will be administered; either by an existing or independent governmental agency or a nonprofit entity established by states. States may develop and permit more than one subsidiary AHBEs to operate within their state providing each AHBE serves a distinct geographical area. States may enter into agreements with one or more other states to form regional exchanges or permit health insurance carriers to offer qualified health insurance plans across state lines. AHBEs may operate either as an "active purchaser" using its market power as leverage to negotiate coverage and costs with health insurance carriers and determine what health insurance plans are offered or as an "open marketplace" open to all qualified health insurance plans offered by health insurance carriers.

[1] Full text of the ACA is available at http://www.healthcare.gov/law/full/index.html as of 10/20/2011.
[2] Updated HHS regulations are available at http://cciio.cms.gov/resources/regulations/index.html#hie as of 10/20/2011.

AHBEs will be responsible for certifying, recertifying, and decertifying whether a health insurance plan is "qualified" (based on criteria determined by the ACA and HHS) and is in the interest of health insurance consumers. AHBEs must require health insurance carriers to provide justification of any premium increases prior to implementation and post this justification on the internet portal. AHBEs must assign a "metallic" rating to qualified plans based on quality and price criteria determined by HHS (see side panel) "Qualified" health insurance plans offered by health insurance carriers on AHBEs would be required to comply with various regulations and report standardized coverage and cost information which would be available on AHBEs.

AHBEs must maintain an internet portal that provides standardized comparative information including a unified outline of coverage and costs of qualified health insurance plans and a standardized enrollment application process. The internet portal must include a calculator to determine the *actual cost of coverage* for consumers. AHBEs must operate a toll-free hotline to assist health insurance consumers.

AHBEs must provide information about and determine eligibility for ACA premium tax credits and ACA cost-sharing subsidies (see panel on next page), as well as Medicaid, SCHIP, and other public programs for health insurance consumers. AHBEs must coordinate seamless enrollment procedures with state Medicaid and SCHIP programs and develop a simple, streamlined enrollment form.[3]

AHBEs must require health insurance carriers to submit and publicly disclose various data and information as required by the ACA and HHS and report this information on AHBEs and to HHS. This information will be consulted to accomplish reinsurance and risk adjustment, oversight, and transparency objectives as determined by HHS.

AHBEs must fund and establish a program to award grants to "navigators". Navigators are entities (individuals or organizations, for- or non-profit) that would engage in outreach to, education for, and facilitate enrollment of health insurance consumers.[4] Navigators are not permitted to receive direct or indirect "consideration" from health insurance carriers.

What is a "qualified health plan"?

To be a "qualified" health plan, all health insurance plans offered through AHBEs and through individual and small group markets outside AHBEs must include the services provided in the "essential benefits package" as determined by the ACA and HHS. These qualified plans are rated as one of four (4) "metallic" categories depending on the level of coverage for essential benefits available:

"Bronze" plan is the minimum coverage available for a qualified plan and covers 60% of benefits cost with out-of-pocket limits equal to those set in § 223 of the Internal Revenue Code for health savings accounts ($6,050 for individuals and $12,100 for families in 2012).

"Silver" plan covers 70% of benefits cost with out-of-pocket limits equal to those set in § 223 of the Internal Revenue Code.

"Gold" plan covers 80% of benefits cost with out-of-pocket limits equal to those set in § 223 of the Internal Revenue Code.

"Platinum" plan covers 90% of benefits cost with out-of-pocket limits equal to those set in § 223 of the Internal Revenue Code.

In addition to the above four categories, a "catastrophic" plan would be available to those less than 30 years of age who are exempt from the mandate to purchase health insurance. Covers catastrophic claims at levels defined by § 223 of the Internal Revenue Code in addition to preventative benefits and three primary care visits.

Individuals and families with incomes between 100% and 400% of the federal poverty level purchasing health insurance through AHBEs would be eligible for reductions of the out-of-pocket limits equal to those set in § 223 of the Internal Revenue Code.

Qualified health insurance plans offered through AHBEs must additionally satisfy various marketing, provider network, community service, clinical accreditation, quality improvement strategy, uniform enrollment forms, standard formatting for plan options, quality measurement information, and annual reporting requirements.

[3] The American Recovery and Reinvestment Act (ARRA) includes the Health Information Technology for Economic and Clinical Health Act (HITECH) which authorizes increasing federal matching of state Medicaid administration to 90% for expenditures related to Electronic Health Records Incentive Programs. The Center for Medicare & Medicaid Services (CMS) determined that these expenditures may include one-time costs of incorporating Medicaid enrollment into AHBEs.

[4] The ACA lists the following as potential Navigators: "trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers

The ACA places new Medicaid Maintenance of Effort (MOE) requirements on the state. *Until the AHBE is determined operational by the Secretary of HHS*, the state is prohibited from reducing eligibility levels for adults covered under Medicaid. The state is prohibited from implementing cuts to eligibility levels, increasing premiums or enrollment fees, or any more restrictive enrollment policies and must maintain the enrollment policies and procedures in effect on March 23, 2010.[5] If the state does not satisfy the MOE requirements, it will lose all federal Medicaid match until the MOE is satisfied.

Who is eligible for tax credits and subsidies through AHBEs?

Individuals and families with incomes between 133% and 400% of the federal poverty level (FPL) will be eligible for refundable and advanceable premium tax credits to purchase qualified health insurance plans through AHBEs. Additional cost-sharing subsidies will be available for individuals and families with income between 100% and 400% of FPL. The amount of premium tax credits and cost-sharing subsidies are tied to the second lowest cost "silver" plan and derived based on modified adjusted gross income levels.

States could opt to establish a "Basic Health Plan" that meets "essential benefits" coverage and various cost requirements for uninsured individuals with incomes between 133% and 200% of FPL who would otherwise be eligible to receive tax credits or subsidies. Those subsidies would accrue to the states.

Individual and families with incomes under 133% will automatically be eligible for enrollment in state Medicaid programs.

Businesses with fewer than 25 employees and average annual wages less than $50,000 are eligible for a phased tax credit if they purchase coverage through AHBEs and contribute at least 50% of the total premium cost. Businesses with fewer than 10 employees and less than $25,000 would be eligible for the full credit of 50%. Tax-exempt businesses would also be eligible for tax credits up to 35%. The credit will be available for two years.

How will AHBEs be financially supported?

Until January 1, 2015, the costs of developing and implementing AHBEs will be supported through federal grant awards (i.e. "Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges"). AHBEs must be financially self-sufficient by January 1, 2015. States are responsible for determining how AHBEs will be financed (user fees, assessments, general funds, etc.).

By what date(s) does the ACA require states to implement an AHBE?

January 1, 2013: the AHBE plan must be certified by HHS.

States would submit to HHS an "Exchange Plan" and undergo a "readiness assessment" to demonstrate operation capacity. The Secretary of HHS will determine if an AHBE can perform required functions and open for enrollment on October 1, 2013. If the Secretary determines that an AHBE *will* be ready, the plan will be approved. If the Secretary determines that an AHBE *is likely* to be ready, (s)he will issue a conditional approval and HHS will conduct additional assessments to determine operational readiness.

October 1, 2013: an AHBE must begin open enrollment.

January 1, 2014: an AHBE must be fully operational as determined by the Secretary of HHS.

January 1, 2015: an AHBE must be financially self-sustaining.

What occurs if the state does not implement an AHBE by the deadline?

The federal government will facilitate AHBEs within states. Services for AHBEs may be provided by private sector contractors hired by HHS. Specifically, Title 1, Part 2, Section 1321, Subsection (c) of

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of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers, and other entities that..." are capable, meet standards, and provide information as described by the ACA.

[5] States can qualify for an exemption of the Medicaid MOE for non-pregnant, non-disabled adults with incomes greater than 133% of the federal poverty level if it certifies to the Secretary of HHS that it is facing a budget deficit for the current or following succeeding fiscal year.

the ACA stipulates that if a state does not implement an AHBE or if the Secretary determines that the AHBE will not be operational by January 1, 2014, "the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements."

How does SB 693 affect the development and implementation of an AHBE?

SB 693, as introduced, creates the "MIHealth Marketplace" (Marketplace) which would operate as Michigan AHBE. The Marketplace would be a nonexclusive health insurance clearinghouse incorporated as a nonprofit corporation by an independent board of directors (Board) that is organized to provide both an individual and SHOP exchange.

The Board

SB 693 authorizes the creation of the Board which would consist of seven voting members and the Commissioner of the Office of Financial and Insurance Regulation (Commissioner), who would serve as a nonvoting ex-officio member. The Governor would appoint five of the initial board members with the advice and consent of the Senate. The Senate Majority Leader and Speaker of the House of Representatives would each appoint one initial board member. Subsequent vacancies on the Board would be filled in a manner specified in the Marketplace's articles of incorporation or bylaws. Board members, subsequent to initial appointees, would serve for four years and would not be able to serve more than two consecutive terms. Board members would not be compensated for serving and would not be permitted to be employed, directly or indirectly, by a health insurance carrier or producer, or a health care provider. The Board would have to hold meetings at least quarterly which would be publicized and open to the public. The Board would develop criteria, in compliance with federal and state law and in consultation with the Commissioner and DCH, for rating qualified health plans offered through the Marketplace based on relative value and quality. The Board would appoint an Executive Director (Director) to manage the Marketplace and an audit committee to contract with an external auditor.

The Marketplace

Section 209 of SB 693 requires the Marketplace to "make qualified health plans available through its internet website for review, purchase, and enrollment by qualified individuals and qualified employers on or before January 1, 2014." Specifically, Section 211 of SB 693 requires the Marketplace to "perform all duties and obligations of an exchange required by federal law, state law, and the purposes of this act" and explicitly lists the AHBE requirements stipulated by the ACA (see above, under "federal mandates").

Qualified Health Benefit Plans

Section 215 of SB 693 would require the Marketplace to contract with the Office of Financial and Insurance Regulation (OFIR) and the Commissioner to certify qualified health benefit plans. The Commissioner would certify a plan as a qualified health benefit plan if it met the requirements of federal law[6] and s(he) approved the premium rates and contract language. Health carriers seeking certification for qualified health benefit plans offered through the Marketplace would be required to submit and publicize justifications for any premium increases, publicize various information required by the ACA and HHS, and provide coverage and costs information to individuals.

Financing

Section 217 of SB 693 explicitly stipulates that the bill does not authorize the expending of state money by the Marketplace and authorizes the Marketplace to charge assessments or user fees to

[6] If the requirements of the ACA have substantially changed since the effective date of SB 693, the Commissioner would certify plans offered by licensed health carriers in good standing to all residents.

health carriers or otherwise generate necessary funding. SB 693 does not contain language stipulating that the Marketplace be financially self-sustaining by January 1, 2015.

SB 693, as introduced, contains many provisions consistent with current federal requirements of the ACA and HHS and would authorize the creation of an AHBE within Michigan.

How does HB 5014 affect the development and implementation of an AHBE?

The supplemental appropriation[7] included in HB 5014 would authorize the Department of Licensing and Regulatory Affairs (LARA) to expend $9,850,000 of a "Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges" (CASE-SOHIE) Level One Establishment federal grant to support an expansion of the state's planning and development for the establishment of the MIHealth Marketplace as required by the ACA and HHS. Specifically, the expenditure of federal funds authorized by this supplemental would support LARA in analysis of the impacts within the state of MIHealth Marketplace; contracting with service providers to assist with legal requirements, technology planning, education and outreach activities, and financial matters; and provide for initial start-up and staffing costs for the MIHealth Marketplace. The state's performance period for the Level One Establishment grant is up to one year after the date of award (expected November 15, 2012). The state can apply for additional federal funds to support the AHBE once "sufficient progress has been made" as determined by HHS.

In FY 2009-10 (2010 PA 182), the state accepted $1,000,000 in initial federal funds that supported, through the Department of Community Health, preliminary planning for an AHBE.

What are the requirements attached to accepting the federal funds?

The announcement for the CASE-SOHIE federal grant[8], stipulates that states "applying for funding will be required to develop and submit a Work Plan that includes milestones...." These milestones "must be completed in the timeframe provided" by HHS. Level One Establishment grants must complete milestones by the end of the performance period (expected November 15, 2012). HHS organizes milestones into 11 "Core Areas" listed within the adjacent panel. The specific milestones and timeframes required by HHS in the CASE-SOHIE federal grant announcement are attached.

Milestone Core Areas

- Background Research
- Stakeholder Consultation
- Legislative and Regulatory Action
- Governance
- Program Integration
- Exchange IT Systems
- Financial Management
- Oversight and Program Integrity
- Health Insurance Market Reforms
- Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints
- Business Operations of the Exchange (numerous subareas)

Title 1, Part 2, Section 1311, subsection (a)(3) of the ACA stipulates that "a state shall use amounts awarded...for activities (including planning activities) related to establishing an [AHBE]...." Subsection a(4)(A) empowers the Secretary to renew a grant award if the grantee "is making progress, as determined by the Secretary, toward...establishing an exchange...implementing [insurance] reforms...[and] meeting such other benchmarks as the Secretary may establish." It is unclear whether the ACA empowers the HHS to restrict or rescind federal funds already awarded under a grant if the Secretary determines that the grantee is not making progress. However, the grant announcement conditions the funding so that "if the grantee does not show progress on the required milestones, HHS may restrict funds for those activities until milestones are met." Furthermore, that HHS "will work closely with each State to evaluate its progress against its Exchange Work Plan and may condition funding quarterly based on this progress and adherence to Federal guidelines and Exchange requirements."

[7] Reflects SR 2012-4, dated October 17, 2011, which requested a supplemental amendment to 2011 PA 63.
[8] The grant announcement is available at http://cciio.cms.gov/resources/fundingopportunities/foa_exchange_establishment.pdf as of 10/20/2011.

By accepting the federal funds is the state committing to establish an AHBE?

Not according to the grant announcement. By accepting the federal funds the state is committing to meet the required milestones included in the Work Plan submitted within LARA's CASE-SOHIE federal grant application. Those milestones are essential steps in the establishment of an AHBE but do not, in and of themselves, commit the state to the establishment of an AHBE.

Does the Legislature have to pass legislation to establish an AHBE (i.e. the MIHealth Marketplace specified in SB 396) in order to accept the federal funds?

Not according to the grant announcement. However, before the state applies for a Level Two Establishment CASE-SOHIE federal grant, the necessary legal authority to establish and operate an AHBE that complies with federal requirements must be available.

By what date does the state have to accept the federal funds?

There is no formal acceptance of the CASE-SOHIE federal grant award. Once the state expends funds from the award, HHS considers the award accepted. The state cannot expend funds from the award without approval from the Legislature.

Attachment: CASE-SOHIE Milestones and Timeframes