MEMORANDUM

HOUSE FISCAL AGENCY

DATE: January 24, 2013

TO: Interested Parties

FROM: Paul Holland, Fiscal Analyst

RE: Health Insurance Exchanges and Federal Funding--REVISED

Background

This memo provides a preliminary overview of the various types of Health Insurance Exchanges under the Affordable Care Act and Patient Protection Act of 2010 (ACA), and rules promulgated by the U.S. Department of Health and Human Services (US HHS) pursuant to the ACA, by describing the divergent administrative responsibilities of the state and federal government in operational functions for each type of Health Insurance Exchange and how these administrative responsibilities would be financially supported through federal grants and monthly user fees.

The information provided in this memo is based on rules promulgated by and general guidance propagated by the US HHS and is subject to change. Additional information pertaining to the federal grant awarded on January 17, 2013 was provided by the Department of Licensing and Regulatory Affairs (LARA) as HFA was not able to review the grant application.

Types of Health Insurance Exchanges

A Health Insurance Exchange is a regulated virtual marketplace (i.e. internet portal and call center) through which eligible individuals and small employers will be able to compare, purchase, and enroll in Qualified Health Plans and determine their eligibility for federal and state health programs, federal premium tax credits, and cost-sharing reductions. In addition to the website and call center, there will be consumer assistance offered throughout the state (i.e. Navigators and In-Person Assistance) for individuals and small employers who prefer to work with a physical person to interact with the Health Insurance Exchange.

The ACA requires a Health Insurance Exchange to offer Qualified Health Plans within each state by January 1, 2014 and to begin open enrollment by October 1, 2013. There are three types of Health Insurance Exchanges under the ACA and rules promulgated by US HHS pursuant to the ACA. See the table, *Types of Health Insurance Exchanges*, attached at the end of this memo for an overview of the information presented in the following pages.

<u>State-Based Exchange</u>

Under a State-Based Exchange, the State would operate all functions of the Health Insurance Exchange consistent with the ACA and rules promulgated by US HHS pursuant to the ACA. The State would be able to assess user fees on insurers offering Qualified Health Plans within the Health Insurance Exchange to support operational expenses.

Timeline: The extended deadline for the State to submit a formal Declaration Letter requesting approval from US HHS to operate a State-Based Exchange was December 14, 2012. The State did not submit the Declaration Letter. Under the ACA, the State was required to demonstrate operational

capacity and receive approval, or conditional approval, by January 1, 2013 from US HHS in order to operate a State-Based Exchange. The State did not obtain the approval, or conditional approval, from US HHS.

Federally-Facilitated Exchange

Under a Federally-Facilitated Exchange, US HHS would operate all functions of the Health Insurance Exchange within the state. US HHS will assess user fees on insurers offering Qualified Health Plans within the Health Insurance Exchange to support operational expenses. The State is still required to interface its Medicaid and CHIP programs' IT systems with the Health Insurance Exchange under a Federally-Facilitated Exchange.

US HHS' role and authority relating to Plan Management functions are limited to the certification and management of Qualified Health Plans within the Health Insurance Exchange and does not extend beyond the Health Insurance Exchange or affect otherwise applicable state laws governing health insurance products sold in the individual and small group markets. US HHS will require that health insurance providers desiring to offer Qualified Health Plans through the Health Insurance Exchange satisfy all applicable state laws.

Timeline: None. If the State takes no action pertaining to the Health Insurance Exchange, US HHS will operate the Health Insurance Exchange by default.

State Partnership Model

Under the State Partnership Model, the federal US HHS would operate the Health Insurance Exchange within the state, but the State would administer Plan Management and/or Consumer Assistance functions pertaining to the Health Insurance Exchange. US HHS will assess user fees on insurers offering Qualified Health Plans within the Health Insurance Exchange to support operational expenses.

The State Partnership Model is fundamentally a Federally-Facilitated Exchange as US HHS operates the Health Insurance Exchange itself, yet under the State partnership Model the State assumes the primary administrative responsibility over Plan Management and/or Consumer Assistance functions.[1] US HHS anticipates reimbursing the State for functions performed on behalf of the Health Insurance Exchange after Level One Exchange Establishment grant opportunities have expired.

Timeline: The State is required to submit a formal Declaration Letter and Exchange Blueprint by February 15, 2013 requesting approval from US HHS to administer State Partnership Model functions. On January 22, 2013, the Governor sent such a Declaration Letter requesting US HHS' approval to administer Plan Management and Consumer Assistance functions of the Health Insurance Exchange subject to the availability of federal funding and appointed LARA as the lead state agency concerning the Health Insurance Exchange.

Transitioning between Types of Health Insurance Exchanges

The State is permitted to transition into different types of Health Insurance Exchanges in future years. For instance, the State may initially opt for US HHS to operate a Federally-Facilitated Exchange through 2014, administer Plan Management and/or Consumer Assistance functions under the State Partnership Model during 2015, and choose to expand its administrative role and transition into a

[1] In areas where the law prohibits US HHS from completely delegating responsibility to a state, US HHS will work with states to agree upon processes that maximize the probability that US HHS will accept state recommendations without the need for duplicative reviews from US HHS.

State-Based Exchange for 2016 onwards. However, federal Level One Exchange Establishment grant opportunities are scheduled to expire on December 31, 2014.

Level One Exchange Establishment Grant for a State Partnership Model

On November 15, 2012, the State applied for a Level One Exchange Establishment Grant (Grant) under the *Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges* which included a Work Plan detailing milestones and timelines pertaining to activities for which the State is seeking funding; specifically, the administration of Plan Management and Consumer Assistance functions under the State Partnership Model, in addition to developing and implementing the IT system interface between the State's Medicaid and CHIP programs and the Health Insurance Exchange.

On January 17, 2013 US HHS awarded the State of Michigan a Grant in the amount of $30,667,944 which is available for expenditure for up to one year, until January 17, 2014.[2]

If the Legislature appropriates the Grant, the State would escalate implementation activities related to the State Partnership Model, specifically the administration of Plan Management and Consumer Assistance functions pertaining to the Health Insurance Exchange, in addition to the development and implementation of the IT system interface between the State's Medicaid and CHIP programs and the Health Insurance Exchange.

If the Legislature does not appropriate the Grant, US HHS could operate the Health Insurance Exchange as a Federally-Facilitated Exchange within the state, including the administration of Plan Management and Consumer Assistance functions, and the State could be required to financially support the development and implementation of the IT system interface between its Medicaid and CHIP programs and the Health Insurance Exchange.

State Functions under a State Partnership Model

If the Grant is appropriated, the State would proceed with the development and implementation of the following functions under a State Partnership Model.

Plan Management

The Department of Insurance and Financial Services (DIFS)[3] is responsible for regulating health insurance providers and the health insurance market and for reviewing and approving health insurance rates and forms within the State.[4] Under the State Partnership Model, DIFS would retain regulatory authority over Qualified Health Plans offered within the Health Insurance Exchange consistent with the ACA, rules promulgated by US HHS pursuant to the ACA, and state laws. DIFS would develop and implement processes and standards for Qualified Health Plan certification, recertification, and decertification; including review of licensure and good standing, service area, network adequacy, essential community providers, marketing oversight, accreditation status, essential health benefits standards, actuarial value standards, discriminatory benefit design, new and increased rates in compliance with market rating reforms.

[2] The previous Level One Establishment Grant, awarded to the State on November 29, 2011, has expired and is no longer available for expenditure. Level Two Establishment Grants are only available to states establishing a State-Based Exchange, thus the State is not eligible to receive Level Two Establishment Grants..

[3] Formerly, the Office of Financial and Insurance Regulation (OFIR).

[4] Section 200 of the Insurance Code provides DIFS with authority to execute state and federal laws pertaining to the insurance industry (MCL 500.200).

DIFS would be responsible for administering the following Plan Management functions:

1) Certification Process: issuing Qualified Health Plan applications, collecting Qualified Health Plan issuer and plan data, submitting rate review determinations to US HHS, verifying Qualified Health Plan issuer compliance with actuarial values and cost-sharing reduction plan variation standards, submitting recommendations to US HHS regarding Qualified Health Plan certification, transmitting timely and standardized Qualified Health Plan issuer and plan data to US HHS.

2) Account Management: managing Qualified Health Plan issuer accounts, serving as a point of contract for Qualified Health Plan issuers, managing communications with Qualified Health Plan issuers, resolving, tracking, and coordinating consumer complaints with US HHS.

3) Oversight & Monitoring: ensuring compliance with Qualified Health Plan certification standards, taking compliance actions against Qualified Health Plan issuers for violations of state laws and informing US HHS, recommending Health Insurance Exchange compliance actions for Qualified Health Plans to US HHS and coordinating state and Health Insurance Exchange law enforcement, coordinating with US HHS on Health Insurance Exchange operational oversight.

4) Quality & Data: coordinating with US HHS on data collection requirements related to quality and accreditation, conducting other quality or performance monitoring, providing an internet link to additional quality data for the Health Insurance Exchange website.

Timeline: DIFS would need to begin the certification process for Qualified Health Plans by early spring of 2013 as state law stipulates 60 or 90 days for the rate review and approval process. The State would be required to certify Qualified Health Plans prior to being loaded into the Health Insurance Exchange which will begin open enrollment on October 1, 2013.

Consumer Assistance

US HHS will operate a website and call center through which consumers will obtain information and interact with the Health Insurance Exchange to determine various eligibilities and purchase Qualified Health Plans. However, under the State Partnership Model, the State would administer the following education and outreach functions.

1) US HHS would develop and establish conflict of interest, cultural competency, and training standards pertaining to the Navigator Program in which it awards grants to public or private entities to act as Navigators.[5] Navigators will engage in locally-focused work by conducting public education targeting eligible populations, assisting consumers in an impartial and accurate manner with the selection of Qualified Health Plans, providing information on federal premium tax credits and cost-sharing reductions, referring consumers to applicable consumer assistance programs, and performing all of the above in a culturally and linguistically appropriate manner accessible to persons with disabilities. While US HHS will develop and operate Navigator training and examination programs, the State would be able to develop and operate additional training modules and licensing or certification requirements.[6] The State would also manage the day-to-day administration of the Navigator Program, including monitoring of Navigator activities, providing technical assistance to Navigators, and ensuring that Navigators are adhering to US HHS, and potential state, standards. Entities selected to act as Navigators will be funded through federal

[5] Including community- or consumer-focused nonprofit groups; trade, industry, or professional associations; commercial fishing, ranching, or farming organizations; chambers of commerce, labor unions, resource partners of the Small Business Administration, licensed insurance agents or brokers, other public or private entities or individuals that meet federal requirements (e.g. Indian tribes or organizations and State or local human service agencies).

[6] However, the State cannot require that Navigators be licensed as insurance agents or brokers.

grants and US HHS will retain ultimate authority over the Navigator grant process, including selecting Navigator grantees, awarding Navigator grants, and approving Navigator grantee activities and budgets.

2) The State would have broad authority, subject to guidance from US HHS, to develop, implement, and manage In-person Assistance Programs, separate and distinct from the Navigator Program, throughout the state as an additional mechanism to educate consumers about the Health Insurance Exchange and insurance affordability programs so to encourage participation with the Health Insurance Exchange. Consumers could be referred to the in-person assistance program which is required to provide information to applicants and enrollees in plain language and in a manner that is accessible and timely to individuals living with disabilities and whose English proficiency is limited. US HHS training standards and programs that apply to Navigators will also apply to in-persons assistants.

3) The State could develop and operate additional outreach and education programs.

Timeline: The State must submit its Outreach and Education Plan to US HHS for approval by March 29, 2013 and should implement In-person Assistance Programs by summer of 2013.

IT System Interface with Medicaid and CHIP Programs

A portion of the Grant is allocated to develop and implement the IT system interface between the Health Insurance Exchange and the State's Medicaid and CHIP programs. The State's Medicaid and CHIP programs will be required to transfer information to and accept information from the Health Insurance Exchange for eligibility determinations pertaining to Medicaid, CHIP, and federal premium tax credits as individuals who are eligible for Medicaid or CHIP are not eligible for federal premium tax credits. The expenses related to developing and implementing the IT system interface between the Medicaid and CHIP programs and the Health Insurance Exchange will be shared between the Health Insurance Exchange (via federal grants or other funding mechanisms) and the Medicaid and CHIP programs (via federal cost allocation rules).[7]

US HHS, through the Grant, has provided 100% federal funding to the State for the development and implementation of the Health Insurance Exchange portion of the IT system interface between Medicaid and CHIP programs and the Health Insurance Exchange. The Medicaid and CHIP portion of the IT system interface will be supported by current cost allocation rules (90/10 federal/state split). The IT system interface is required under the ACA regardless of whether the State opts for a Federally-Facilitated Exchange or the State Partnership Model. If the Grant is not appropriated, the State would still be required to financially support the development and implementation of the IT system interface through yet unspecified funding mechanisms.

Timeline: The State must develop and implement the IT system interface between the Health Insurance Exchange and its Medicaid and CHIP programs by October 1, 2013 (the date at which the Health Insurance Exchange begins open enrollment). If the IT system interface is not operational by the time the Health Insurance Exchange begins open enrollment, the State could be in violation of the ACA.

[7] The share of expenses for the IT system interface borne by the State's Medicaid and CHIP programs was appropriated for in Section 107 of the FY 2012-13 General Government budget within the Enterprise Information Technology Investments line item and Section 234 of boilerplate.

Future Funding for the Health Insurance Exchange

The Health Insurance Exchange must be financially self-sustaining by January 1, 2015. However, multiple Level One Exchange Establishment grants may be awarded until December 31, 2014 for US HHS approved activities to expand, establish, test, and improve functions that the State performs in support of the Health Insurance Exchange during the first year and after December 31, 2014 (including activities to transition to a State-Based Exchange).

US HHS has proposed that the monthly user fee for insurance providers offering Qualified Health Plans within the Health Insurance Exchange will be 3.5% of premiums.[8] The revenue generated by the user fees will be collected by the federal government and, under either a Federally-Facilitated Exchange or State Partnership Model, used to support the operation of the Health Insurance Exchange. If the State opts to administer Plan Management and/or Consumer Assistance functions under a State Partnership Model, US HHS anticipates the development of an alternative funding vehicle with which it would reimburse the State for functions performed on behalf of the Health Insurance Exchange after Level One Exchange Establishment grant opportunities have expired. However, US HHS has not yet promulgated final rules and procedures for user fees or potential reimbursements.

Future IT system interface costs will be borne by the Health Insurance Exchange (via federal reimbursement or state user fees) and the State's Medicaid and CHIP programs (via federal cost allocation rules).

[8] Under a State-Based Exchange, the State has the authority to determine and assess user fees or develop other funding mechanisms.

Types of Health Insurance Exchanges

	State-Based Exchange	Federally-Facilitated Exchange	State Partnership Model
Functions	The State operates all Exchange functions. The State may utilize federal government services for: • Federal premium tax credit and cost-sharing reduction determinations • Exemptions • Risk Adjustment Program • Reinsurance Program	The federal government operates all Exchange functions. The State may elect to perform or may utilize federal government services for: • Reinsurance Program • Medicaid and CHIP eligibility assessment or determination	The federal government operates Exchange functions. The State would operate: • Plan Management functions • Consumer Assistance functions • Both of the above The State may elect to perform or can use federal government services for: • Reinsurance Program • Medicaid and CHIP eligibility assessment or determination
Funding	Federal grants for the establishment of the Exchange until 2015. The State would determine and assess user fees or develop other funding mechanisms for the operation of the Exchange.	The federal government would determine and assess user fees (3.5% of premiums within the Exchange).	Federal grants for the establishment of Exchange functions administer by the State. The federal government would determine and assess user fees (3.5% of premiums within the Exchange) for the operation of the Exchange. The federal government anticipates reimbursing the State for functions performed on behalf of the Exchange after grant funding opportunities have expired.
Timeline	The State was required to submit a formal Declaration Letter requesting federal government approval to operate a State-Based Exchange by December 14, 2012. The State did not submit the Declaration Letter, thus the State did not obtain approval.	None. if the State takes no action pertaining to the Health Insurance Exchange, the federal government will operate the Exchange by default.	The State is required to submit a formal Declaration Letter by February 15, 2013 requesting federal government approval to administer State Partnership Model functions. On January 22, 2013, the Governor sent a Declaration Letter requesting approval to administer Plan Management and Consumer Assistance functions subject to the availability of federal funding.
State Actions*	California, Colorado, Connecticut, D.C., Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Mississippi, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, Washington	Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, Wisconsin, Wyoming	Arkansas, Delaware, Illinois, Iowa, Michigan, North Carolina, West Virginia
IT System Interface	The federal government, through grant awards, will provide 100% federal funding to states for the development and implementation of the Exchange portion of the IT system interfacing between Medicaid and CHIP programs and the Exchange. The Medicaid and CHIP portion of the IT system interface will be supported by current cost allocation rules (90/10 federal/state split). The IT system interface is required under the ACA regardless of the type of Exchange states opt for. If federal grants are not utilized, states would be required to financially support the IT system interface.		

* As of January 4, 2012. States have until February 15, 2013 to declare their intention to administer a State Partnership Model.