



Round II: Status of Health Insurance Exchanges in Michigan Michigan Efforts to Establish Health Insurance Exchanges

by Theresamarie Mantese and Gregory Nowakowski
January 5, 2013

A. Introduction

The 2010 Patient Protection and Affordable Care Act (“Affordable Care Act” or “ACA”) sustained a hard-fought court challenge. With that challenge over, the long road to execution of this statute is underway. Now, the task for each State is how to implement its various provisions. One of the goals of the Affordable Care Act is to extend health coverage to more than 30 million uninsured Americans beginning in January 2014. A critical provision in accomplishing this goal is the establishment of health insurance exchanges (“Exchange(s”).

Exchanges are “state or federally run websites that allow consumers to choose a health plan, as well as to compare benefits and costs of each plan. Some states will allow all insurers to participate; others have asked insurers to bid to participate; and some states are creating a list of requirements insurers must meet to participate.”¹ Exchanges permit individuals and small employers to comparison shop for the best plan to meet their needs. Exchanges streamline the process for individuals and small employers to obtain affordable health care insurance based on a user-friendly, easy one-stop information center.

Exchanges are required to be fully operational in every State by January 1, 2014. The readiness of an Exchange to operate will be evaluated by the federal Department of Health and Human Services (“HHS”) one year prior to opening. States planning to operate a state-based Exchange or a state-federal partnership Exchange are required to submit a blueprint for the Exchanges consisting of a declaration letter signed by the Governor and an application to HHS by November 16, 2012. Given these fast approaching deadlines, “states face serious challenges to making the necessary policy and implementation decisions.”²

B. Federal Guidelines in Establishing Exchanges

“Exchanges will allow individuals and small businesses to compare health plans, get answers to questions, find out if they are eligible for tax credits for private insurance or a health program like the Children’s Health Insurance

¹ “States try to innovate with health exchanges,” USA Today, Kelly Kennedy, November 9, 2012.

² “Establishing Health Insurance Exchanges: An Overview of State Efforts,” August 2012, Kaiser Family Foundation at [Affordable Insurance Exchanges | HealthCare.gov](http://www.healthcare.gov/exchanges) at www.healthcare.gov/exchanges.

Program (CHIP), and enroll in a health plan that meets their needs.”³ Section 1311(d) of the Affordable Care Act gives States the option to establish the Exchange as a governmental agency or as a nonprofit entity. The Exchange could be housed within an existing State office or it could be an independent public authority if the Exchange is established as a government agency. Exchanges must be accountable to the public and be transparent.⁴ Moreover, competent leadership must be recruited to meet federal standards for Exchanges.⁵

C. Federal Statutory Requirements

Section 1311 of the Affordable Care Act includes two basic types of federal requirements for Exchanges: core functions and essential health benefits (“EHB”).

Section 1311(d)(4) specifies core functions that an Exchange must meet:⁶

- Certification, recertification and decertification of plans
- Operation of a toll-free hotline
- Maintenance of a website for providing information on plans to current and prospective enrollees
- Assignment of a price and quality rating to plans
- Presentation of plan benefit options in a standardized format
- Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs
- Provision of an electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions
- Certification of individuals exempt from the individual responsibility requirement
- Provision of information on certain individuals identified in Section 1311 (d)(4)(I) to the Treasury Department and to employers
- Establishment of a Navigator program that provides grants to entities assisting consumers as described in Section 1311(i)⁷

³ See, www.healthcare.gov/exchanges.

⁴ “Initial Guidance to States on Exchanges,” November 13, 2012 at

www.healthcare.gov/law/resources/regulations/guidance-to-states-on-exchanges.html.

⁵ *Id.*

⁶ *Id.*

D. Essential Health Benefits

Health insurance plans offered in the small group and individual markets, both on and off the Exchange, must provide EHBs in ten required categories by January 1, 2014.⁸ These ten categories are:

- (1) ambulatory patient services;
- (2) emergency services;
- (3) hospitalization;
- (4) maternity and newborn care;
- (5) mental health and substance use disorder services (including behavioral health treatment);
- (6) prescription drugs;
- (7) rehabilitative and habilitative services and devices;
- (8) laboratory services;
- (9) preventive and wellness services and chronic disease management, and
- (10) pediatric services (including oral and vision care).⁹

Each State is required to select an EHB “benchmark plan.” A benchmark plan will identify the scope of services and the limits under a “typical employer plan” in the State as required by the Affordable Care Act.¹⁰ Benchmark plans will establish EHBs for benefit years beginning in 2014 and 2015.¹¹ The benchmark plan selection process will be reevaluated by the HHS for the benefit year of 2016 and all years thereafter.¹²

E. Federal Regulatory Summary

On July 15, 2011, the Centers for Medicare and Medicaid Services (“CMS”) published proposed regulations for establishing the Exchanges and qualified health plans (“QHP”). After a comment period, CMS finalized the regulations on March 27, 2012. The regulations clarify the standards required for States if they desire to run their own Exchanges, including specific minimum standards for health insurers to participate in the Exchanges. The regulations, subject to further comment, also published interim final rules on the basic standards required for employers to participate in the Small Business Health Options Program, or “SHOP.”¹³

⁷ *Id.*

⁸ ACA § 1302(b)(1)-(2).

⁹ ACA § 1302(b)(1)(A)-(J).

¹⁰ ACA § 1302(b)(2)(A).

¹¹ “Michigan’s Essential Health Benefits Benchmark Plan: Executive Report,” Michigan Office of Financial and Insurance Regulation (OFIR), September 25, 2012, p. 3.

¹² *Id.*

¹³ The proposed regulations and commentary for 45 C.F.R. Parts 155-157 are published at 76 Fed. Reg. 136, 41866-41927 (July 15, 2011), and the final rule is published at 77 Fed. Reg. 59, 18310-18475 (March 27, 2012). A technical correction notice to the final rule was published a few months later on May 29, 2012, at 77 Fed. Reg. 103, 31513-31515.

On August 17, 2011, CMS published its proposed rule on Exchange functions in the Individual Market: Eligibility Exchange Standards for Employers, which further defined the Accountable Care Act's requirements that an Exchange perform eligibility functions in regards to participation. Particularly, "in order to be eligible for enrollment in a QHP, an individual must be a citizen, national, or a non-citizen lawfully present, and be reasonably expected to remain so for the entire period for which enrollment is sought."¹⁴ As proposed, the regulations are designed around the Medicaid eligibility requirements. Moreover, the regulations contain detailed requirements as to eligibility verification:

In general, the verification processes proposed in this subpart would have the Exchange first rely on sources of electronic data and, to the extent that the Exchange is unable to verify information through such sources, follow specific procedures that include requesting documentation from applicants. Data sources described in this section may include the records of the Social Security Administration (SSA), the Department of Homeland Security (DHS), and the Internal Revenue Service (IRS), as well as data sources maintained by other entities.¹⁵

Also on August 17, 2011, CMS published the Medicaid eligibility changes called for under the Affordable Care Act, which coordinate and simplify Medicaid eligibility.¹⁶

On August 17, 2011, CMS further published the standards related to health insurance premium tax credits, which provide a tax credit to participants in the Exchanges who meet eligibility requirements including that "an applicable taxpayer is a taxpayer (1) With household income for the taxable year between 100 percent and 400 percent of the federal poverty line (FPL) for the taxpayer's family size, (2) who may not be claimed as a dependent by another taxpayer, and (3) who files a joint return if married."¹⁷

On March 16, 2012, the Center for Consumer Information & Insurance Oversight published its "[Regulatory Impact Analysis: Establishment of Exchanges and Qualified Health Plans \(CMS-9989-FWP\) and Standards Related to Reinsurance Risk Corridors and Risk Adjustment \(CMS-9975-F\)](#)" which provides the required regulatory impact statement for the named regulations.¹⁸

¹⁴ 76 Fed. Reg. 159, 51202-51237, 51206 (August 17, 2011).

¹⁵ *Id.* at 51210.

¹⁶ *Id.* at 51148-51199, 51148.

¹⁷ *Id.* at 50931-50949, 50933.

¹⁸ Available at: <http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf>, last visited November 20, 2012.

On June 5, 2012, CMS published proposed rules on data collection and support standards related to EHBs. The proposed rules will be important for states that run Exchanges.¹⁹

F. Michigan's Efforts

In August 2012, Governor Rick Snyder initiated efforts to form a state-federal partnership as Michigan's Exchange. Governor Snyder advocated a partnership with the federal government due to Michigan legislative opposition to the implementation of Exchanges and Michigan's inability to meet the federal timetable for state-only implementation. A state that opts for a partnership Exchange can operate plan management functions, consumer assistance functions, or both. The state can also elect to perform Medicaid and CHIP eligibility determinations or rely on the federal government to make those determinations.²⁰

The Michigan Office of Financial and Insurance Regulation ("OFIR") presented Michigan's Essential Health Benefits Benchmark Plan: Executive Report ("Report").²¹ The Report contained OFIR's recommendations to the Governor as to the selection of an EHB benchmark plan. OFIR recommended that "the Priority Health HMO plan be selected as Michigan's benchmark plan. This plan is the lowest-cost benchmark plan option, which will provide an excellent framework for all individual and small group plans offered in Michigan after January 1, 2014. In addition, OFIR recommends that the FEDVIP pediatric vision plan and the MI Child dental plan be selected to supplement the Priority Health HMO benchmark plan."²²

OFIR took into consideration the following in the selection of the Priority Health HMO benchmark plan:

- Consumer and other stakeholder input;
- Potential costs associated with defraying the cost of State-mandated coverage not included in the selected benchmark plan;
- Scope and duration limitations for covered benefits;
- Consumer demand for particular plans;
- Ease of administration of the selected benchmark plan.²³

¹⁹ 77 Fed. Reg. 108, 33133-33142 (June 5, 2012). The CMS website contains additional and ancillary regulatory information relating to health insurance exchanges available at <http://cciio.cms.gov/resources/regulations/index.html#hie>.

²⁰ "Mich. small-business group presses for state-run health exchange," Jay Greene, Crain's Business Detroit, September 6, 2012 at www.modernhealthcare.com/article/20120906/INFO/309069991.

²¹ "Michigan's Essential Health Benefits Benchmark Plan: Executive Report," *supra*.

²² *Id.* at 1.

²³ *Id.* at 16.

Only time will tell whether OFIR's recommendation of the Priority Health HMO benchmark plan will result in the mitigation of rate increases that will result from the implementation of the EHB requirement; reduction of the impact of the EHB on consumers; and provision of a wide array of benefits in the EHB categories.

G. Conclusion

To conclude, the OFIR recommendation will have to be assessed after the Exchange is established in Michigan. Federal regulations must be implemented and other State experiences have to be assessed before any conclusions can be made in connection with the implementation of Exchanges.