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BILL ANALYSIS

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House Bill 4111 (as passed by the House)
Sponsor: Representative Joe Haveman
House Committee: Appropriations

Date Completed: 3-4-13

CONTENT

The bill would provide supplemental appropriations for fiscal year (FY) 2012-13. The bill includes Adjusted Gross appropriations of $30.7 million in the Department of Licensing and Regulatory Affairs for anticipated costs related to the development of a State-Federal partnership health insurance exchange under the Federal Patient Protection and Affordable Care Act (ACA). Table 1 summarizes the appropriations in the bill.

Table 1

FY 2012-13 Supplemental Appropriations			
Department/Program	**Adjusted Gross**	**Federal**	**GF/GP**
Licensing and Regulatory Affairs – Health Insurance Exchange	$30,670,000	$30,670,000	$0
Total	**$30,670,000**	**$30,670,000**	**$0**

BACKGROUND

The ACA has numerous provisions regarding health care coverage. Among them are provisions that have already taken effect. These include a requirement that insurance policies cover dependents through age 26, a prohibition against the denial of a policy based on pre-existing medical conditions, and other provisions. There are also provisions of the law that have not yet taken effect. Among these are the expansion of State Medicaid programs to cover all individuals with incomes of up to 133% of the Federal poverty level and the creation of State health insurance exchanges. States will at some point have to decide whether to expand their Medicaid programs pursuant to the ACA, but a health insurance exchange will be created in each state regardless of action from its legislature or executive office. Medicaid expansion and health insurance exchanges are two issues that are independent of one another.

Under the ACA, states have essentially three types of State health insurance exchanges to choose from for implementation. A state can elect to run its own state exchange, it can opt for a State-Federal partnership where administration of the exchange is shared by the State and the U.S. Department of Health and Human Services (HHS), or it can opt to have a Federal exchange run entirely by HHS. Table 2 and the paragraphs below provide more detail on the types of exchanges from which states can choose.

Under a state exchange, the State would receive grants for the creation and implementation of an exchange that meets legal requirements of the ACA and guidelines established by HHS. The State would be allowed to charge its own fee structure to support the exchange. At this time, it is not an option for Michigan to opt for a state exchange, as the deadline for the submission of an official Declaration Letter was December 14, 2012.

Under a State-Federal partnership exchange, certain aspects of the exchange would be created and administered by HHS, and certain aspects would be created and administered by the state. Under a partnership exchange, HHS would be responsible for the creation and administration of the exchange itself, and it would levy a fee on users of the exchange to pay for operations. Currently, HHS has indicated that this fee would be 3.5% of premiums paid on health plans issued through the exchange. The State would be responsible for health plan management and consumer assistance functions. Additionally, the State would be responsible for creating an interface between the federally-run exchange and the state's Medicaid eligibility system. This Medicaid piece should not be confused with ACA's Medicaid expansion; an interface between the state Medicaid eligibility system and the state's health insurance exchange will have to exist regardless of which type of exchange a state selects.

Under a Federal exchange, all responsibilities for the exchange with the exception of the creation of Medicaid and Children's Health Insurance Program (CHIP) eligibility interfaces would be undertaken by HHS. The responsibilities of HHS for the exchange in this case would include creation, operation, plan management, and consumer assistance. As with the state-Federal partnership, HHS would levy a fee on health plans issued through the exchange; HHS has indicated that this fee would be 3.5% of premiums.

It should be noted that a state's initial choice is not entirely binding. For instance, a state could elect to begin with a State-Federal partnership exchange, and then a few years down the road take over all administrative functions of the exchange and essentially make a transition to a state exchange.

Table 2

Responsibilities of States and HHS Under the Three Types of Health Insurance Exchanges		
	Responsibilities	
Exchange Type	**HHS**	**State**
State	None/guidance and rule-making only	Exchange creation and administration, plan management, customer service, exchange fee establishment, Medicaid/CHIP eligibility interface
State-Federal Partnership	Exchange creation and administration, exchange fee establishment	Plan management, customer service, Medicaid/CHIP eligibility interface
Federal	Exchange creation and administration, plan management, customer service, exchange fee establishment	Medicaid/CHIP eligibility interface

FISCAL IMPACT

The bill would increase FY 2012-13 Adjusted Gross appropriations by $30.7 million, all of which would be Federal revenue.

Funding for the exchange would come from a grant from the U.S. Department of Health and Human Services; no State funds would be used for the development of the exchange. Specifically, the $30.7 million contained in the bill would be a Level One grant that would be used for the design, development, and implementation of Michigan's functions under a State-Federal partnership agreement. Under current Federal law, health insurance

exchanges of all types (State, State-Federal partnership, and federally-facilitated) are required to be open for enrollment by October 1, 2013, and be fully-operational by January 1, 2014.

Under a State-Federal partnership health care exchange, Michigan would assume the plan management and consumer assistance functions of the exchange, and the Federal government would assume the responsibility of running the exchange itself. Additionally, the State would be responsible for creating the information technology infrastructure required to interface the exchange with Michigan's Medicaid and CHIP, which the appropriation in this bill also would pay for.

In the future, if Michigan wished to assume full responsibility for operating additional or all aspects of the exchange, the ACA allows for that transition to happen. The ACA also requires that the exchange be financially self-supporting by January 1, 2015. Under a State-Federal partnership, HHS has indicated that a 3.5% surcharge on health insurance premiums issued through the exchange would be used to fund the exchange. If Michigan were to accept full responsibility for the exchange in the future, a different funding structure could be adopted.

Long term, the development of a State-Federal partnership health insurance exchange would likely have no ongoing direct fiscal impact on State or local finances, as the operations of the exchange would be paid for by fees paid on premiums offered through the exchange. It should be noted that the exchange, no matter who runs it, cannot provide private insurance to Medicaid-eligible individuals. People who seek health insurance through the exchange and who meet Medicaid eligibility standards must be enrolled in Medicaid. To the extent that people seek insurance through the exchange but are determined to be eligible for "traditional" Medicaid, State costs would increase. Again, this indeterminate cost would occur regardless of who runs the exchange; it is not tied to the question of who runs the exchange, whether to make the appropriations in this bill, or whether to proceed with Medicaid expansion.

Under a State-Federal partnership model, HHS has indicated that a portion of the proceeds from the 3.5% fee would be passed-through to the State for its responsibilities as part of the partnership. Because future exchange enrollment and premiums paid are unknown, it is difficult to estimate how much revenue the 3.5% fee would generate. Massachusetts has a health insurance exchange called the "Connector". It operates with an annual budget of approximately $30.0 million and services approximately 220,000 people, for a cost of about $136 per year, per person. Since Massachusetts operates its exchange on its own, it retains all of the revenue generated from surcharges on premiums.

The appropriation in this bill would provide the Department of Licensing and Regulatory Affairs with the spending authority to begin creation of Michigan's plan management and consumer assistance systems as well as its Medicaid and CHIP eligibility interfaces. Additionally, under a partnership exchange, Michigan would receive some portion of the premium fees collected by HHS to compensate the State for its responsibilities under the partnership. Michigan would not receive the total revenue generated by fees on its exchange since the Federal government would be using a portion to fund its share of the administration of Michigan's exchange.

Boilerplate Language Sections

Sec. 201. General. Lists total State spending as $0, and payments to local units of government as $0.

Sec. 202. General. Requires that appropriations in the bill be subject to the Management and Budget Act.

Sec. 301. Work Project Language. Establishes the amounts appropriated in Part 1 as a work project, subject to the Management and Budget Act.

Sec. 302. Insurer/HMO Non-Exclusivity. States that insurers and health maintenance organizations are not required to offer products exclusively through a health insurance exchange.

Sec. 303. Spending Report. Requires a detailed expenditure report on funds spent from the appropriation for the partnership exchange.

Sec. 304. Michigan-Based Consumer Assistance/LARA Oversight of Navigators. Requires the Department to use Michigan-based resources, including insurance producers, to assist Michigan residents with health care decisions. Also requires the Department to ensure that navigators only facilitate enrollment in qualified health plans.

Sec. 305. Ensure Michigan Insurance Producers Can Sell on Exchange. Requires the Department to ensure that licensed Michigan insurance producers can offer products offered on the exchange.

Sec. 306. Federal Navigator Liability. Requires the Department to ensure that Federal navigators carry insurance or have other safeguards that are similar to what Michigan insurance producers carry. Also requires the Department to properly train all parties engaged in consumer assistance activities.

Sec. 307. Federal Financing for IT Upgrades. Requires the Department to seek Federal financing for information technology upgrades for the purposes of effective communication with the exchange and consumer protection.

Sec. 308. Navigator Complaint Process. Requires the Department to provide a consumer complaint process for residents that seek to report practices by navigators.

Sec. 309. Criminal Background Checks. Requires all navigators and in-person assistors to undergo a criminal and regulatory background check.

Sec. 310. Privacy Protection. Requires the Department to work to ensure that the privacy of individual citizens is protected in all aspects of the exchange.

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.