Senate Fiscal Agency
P.O. Box 30036
Lansing, Michigan 48909-7536

BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986

Senate Bill 633 (Substitute S-7 as passed by the Senate)
Senate Bills 634 and 638 (as passed by the Senate)
Senate Bills 635 and 636 (Substitute S-1 as passed by the Senate)
Senate Bill 637 (Substitute S-2 as passed by the Senate)
Sponsor: Senator Kevin Hertel (S.B. 633 & 636)
Senator Sylvia Santana (S.B. 634)
Senator Erika Geiss (S.B. 635)
Senator Darrin Camilleri (S.B. 637)
Senator Veronica Klinefelt (S.B. 638)
Committee: Health Policy

Date Completed: 9-4-24

RATIONALE

The Federal Affordable Care Act (ACA) introduced health insurance marketplaces, also known as exchanges, that are designed to allow individuals and families to shop for private health insurance plans or dental insurance coverage. The ACA established a federally-facilitated exchange (FFE) that Michigan and 28 other states use but allows states to establish their own exchanges, known as a state-based insurance exchange (SBE).[1] According to testimony before the Senate Committee on Health Policy, switching to an SBE from the FFE would offer Michigan residents the same healthcare plan options while improving the exchange's outreach to and function for Michigan residents. Accordingly, it has been suggested that the State establish an SBE.

CONTENT

Senate Bill 633 (S-7) would enact the "Michigan Health Insurance Exchange Act" to do the following:

- **Create a 12-member Board to govern the Exchange.**
- **Require the initial Exchange Board to organize a nonprofit corporation within 60 days of the Board's first meeting to provide an individual marketplace for qualified health plans in the State.**
- **Allow the Board to create committees for recommendations concerning the operation and implementation of the Exchange.**
- **Prescribe the powers of the Exchange.**
- **Require the Exchange to make qualified health plans available through its website and hotline beginning on or before January 1, 2026.**
- **Require the Director of the Department of Insurance and Financial Services (DIFS) to certify a health benefit plan if the plan met the requirements of Federal law, State law, and the provisions of the Act.**
- **Require the Exchange to implement an enhanced direct enrollment by the first open enrollment period in which the Exchange's State-based platform was operational.**
- **Require the Exchange to allow health insurance carriers or web brokers to provide for automatic re-enrollment in a qualified health plan.**

[1] "State-based Exchanges", cms.gov. Retrieved 8-27-24.

-- Prohibit the Exchange or a carrier offering health benefit plans through the marketplace from charging an individual a fee or penalty for termination of coverage.
-- Require the Board to establish an audit committee to contract an external auditor to provide at least one audit of the financial statements of the Exchange in each fiscal year, among other things.
-- Require the Exchange to charge assessment or user fees to health carriers to cover its operational costs.
-- Require the Exchange to keep an accurate accounting of all activities, receipts, and expenditures and annually submit a report concerning those accountings to the Governor, DIFS Director, and the Senate and the House of Representatives.
-- Create the Exchange Fund within the State Treasury.
-- Specify that provisions of the Act that were applicable to qualified health plans also would apply to dental plans unless the dental plan were specifically modified otherwise.

Senate Bill 634 would amend Section 1261 of the Insurance Code to modify definitions in accordance with provisions of Senate Bill 633 (S-7).

Senate Bill 635 (S-1) would add Section 3406mm to the Insurance Code to require the DIFS Director to contract with the Exchange to certify qualified health and dental plans.

Senate Bill 636 (S-1) would amend Section 2212a of the Insurance Code to specify that a health insurer would have to provide to insureds upon enrollment in clear, complete, and accurate manner, any information required by the Exchange created under Senate Bill 633 (S-7), as directed by DIFS.

Senate Bill 637 (S-2) would add Section 3406nn to the Insurance Code to require DIFS to apply for a State Insurance Waiver to implement a State-Based Reinsurance Program and report to the Senate and House appropriations committees on money necessary to fund the Program.

Senate Bill 638 would repeal Section 3406w, which generally allows an insurer that delivers or renews a health insurance policy that provides coverage for prescription drugs to provide coverage for emergency and early refills that meet specified requirements until March 31, 2021.

Every bill except Senate Bill 638 is tie-barred to Senate Bill 633. Senate Bill 633 is tie-barred to Senate Bill 637.

Senate Bill 633 (S-7)

Exchange Board

The Michigan Health Insurance Exchange Act would create a 12-member Board to organize and govern the Exchange. The Board would be the incorporator of the Exchange for the purposes of the Nonprofit Corporation Act. The Director of DIFS (Director) and the Director of the DHHS would serve as voting ex officio members of the Board. The Governor would appoint the remaining 10 members, subject to advice and consent of the Senate, as follows:

-- One member from among the insurers that offered health insurance policies through the Exchange that were a hospital plan corporation, a professional health service plan

corporation, or a parent affiliate, subsidiary, or other associated entity or successor of a hospital plan corporation or a professional health services plan.

-- One member from among the carriers that offered health insurance policy through the Exchange that *were not* a hospital plan corporation, a professional health service plan corporation, or a parent, affiliate, subsidiary, or other associated entity or successor of a hospital plan corporation, or a professional health services plan.
-- One member with experience in health care public education and consumer assistance activities.
-- Two members who were consumer representatives.
-- One member from a list of three candidates provided by the Senate Majority Leader who had relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.
-- One member from a list of three candidates provided by the Senate Minority Leader who had relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.
-- One member appointed from a list of three candidates provided by the Speaker of the House of Representatives who had relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.
-- One member appointed from a list of three candidates provided by the Minority Leader of the House of Representatives, who had relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.
-- One member, subject to advice and consent of the Senate, representing a nonprofit mutual disability insurer formed under Chapter 58 (General Mutual Insurers (Domestic)) of the Insurance Code.

"Health insurance policy" would mean an expense-incurred hospital, medical, or surgical policy, certificate, or contract. The term would not include a policy that provided coverage only for excepted benefits as described in 42 USC 300gg-91. Generally, "Excepted Benefits under 42 USC 300gg-91 specifies benefits subject to certain requirements, not subject to requirements if offered separately, or benefits not subject to requirements if offered as independent nonacoordinate benefits.

(Generally, the Nonprofit Corporation Act governs the formation, operation, and dissolution of nonprofit corporations. The Act specifies the requirements for incorporating a nonprofit, including specifying the corporate structure, purpose and activities, duties and responsibilities, membership, and record keeping of a nonprofit in the State.)

The Governor would have to consider the cultural, ethnic, economic, and geographical diversity of the State so that the Board's composition reflected the communities of the State. Except as otherwise provided, an appointed Board member would serve for a term of four years or until a successor was appointed, whichever were later. Of the initial appointed members, five members would be appointed for three-year terms and two members would be appointed for four-year terms. The length of the initial term of each initial member would be determined by the Governor at the time of appointment.

Exchange Board Conflict of Interest

A majority of the voting members of the Board would be prohibited from having a conflict of

interest as set forth in Section 1321 of the Federal Patient Protection and Affordable Care Act (ACA) and the regulations promulgated under Section 1321. Excluding the Director, the Director of the DHHS, and the nonprofit mutual disability insurer, voting members would be prohibited from having a conflict of interest.

(Generally, Section 1321 provides authority for the establishment of standards and regulations to implement statutory standards for Exchanges, qualified health plans and other identified standards.)

"Conflict of Interest" would mean that by taking any action or making any decision or recommendation on a matter within the authority of the board, or an immediate family member, or entity with which the member, or immediate family member, would receive a pecuniary benefit or detriment unless the pecuniary benefit or detriment would apply to the same degree to a class consisting of all persons within the particular class in the State. "Immediate family" would mean any relation by blood or affinity to the third degree.

Each member of the Board would have to meet the requirements of the proposed Act, the ACA, and all applicable State and Federal laws and regulations, to serve the public interest as well as interests of the individuals and small businesses seeking health care coverage through the Exchange, and to ensure the operational well-being and fiscal solvency of the Exchange.

The Governor would have to appoint an Executive Director to manage the Exchange. The Executive Director would have to be independent and have no material relationship with the Exchange.

Exchange Board Meetings

Under the Act, the Executive Director would attend meetings of the Board but could not be a member, vote, or be counted for purposes of establishing a quorum. The Director would call the first meeting of the Board. Additionally, the Director or Director's designee would serve as the chairperson of the Board. After the first meeting, the Board would have to meet at least quarterly, or more frequently at the call of the chairperson, or if requested by four or more members. Six members of the Board would constitute a quorum for the transaction of business at a meeting of the Board. An affirmative vote of six board members would be necessary for official action of the Board. Meetings of the Board would be subject to the Open Meetings Act. If there were a conflict between the provisions of the Act and the Open Meetings Act, the provisions of the Open Meetings Act would control.

Board members would have to serve without compensation. Members could be reimbursed for their actual and necessary expenses incurred in the performance of their official duties as board members. The Exchange would have to pay for the reimbursements of the Board Members.

The Board would have to adopt a code of ethics for its members and for the officers and employees of the Exchange that included policies and procedures that required the disclosure of relationships that could give rise to a conflict of interest. A Board member would have to comply with the code of ethics and declare any conflict of interest. The Board would have to require that any Board member with a direct conflict of interest in any matter before the Exchange disclose the member's interests to the Board prior to Board taking any action on the matter. If a Board member or member of the Board member's immediate family, organizationally or individually, would derive direct and specific benefit from a decision of the Board, that member would have to recuse himself or herself from the discussion and vote on the issue.

The Board could establish committees to obtain recommendations concerning the operation and implementation the Exchange in the State. The committees would have to be given specific charge and could include individuals who were not Board members, including representatives of health care consumers, carriers, and health care providers and other health industry representatives.

The bill would specify that there would be no liability on the part of, and no cause of action could arise against, any Board member for any lawful action taken by the member in performance of the member's powers and duties of the Act.

Nonprofit Corporation

The initial Board would have to organize a nonprofit corporation, on a nonstock directorship basis, under the Nonprofit Corporation Act. The nonprofit corporation would have to be organized within 60 days after the first Board meeting to provide an individual marketplace for qualified health plans in the State. Before formation of the Exchange, the Director could take any action necessary to affect a timely transition from a Federally administered Exchange to the Exchange established under the Act, including taking steps that were necessary to facilitate an SBE on the Federal platform that would operate until the Director determined that the Exchange was adequately prepared to operate on the marketplace.

"Marketplace" would mean the platform operated by the Exchange. "Qualified health plan" would mean a health benefit plant that had been certified by the Exchange.

Exchange Duties and Powers

The Exchange would have to exercise all the powers and duties necessary and appropriate to provide a marketplace for qualified health plans in the State including, without limitation, the following:

-- To contract with others, public or private, for the provision of all or portion of services necessary for the management and operation of the Exchange.
-- To enter contracts, give guarantees, incur liabilities, borrow money at rates of interest as the Exchange could determine, issue its notes, bonds, and other obligations, and secure any of its obligations by mortgage or pledge of any if its property or an interest in the property, wherever situated.
-- To sue and be sued in all courts 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 alter the seal, and to use the seal by causing it or a facsimile to be affixed, impressed, or reproduced in any other manner.
-- To adopt, amend, or repeal bylaws, including emergency bylaws, relating to the purposes of the Exchange, the conduct of its affairs, its rights and powers, and the rights and powers its board members, corporate directors, or officers.
-- To elect or appoint officers, employees, and other agents of the Exchange, to prescribe their duties, to fix their compensation and the compensation of the corporate directors and to indemnify corporate directors, officers, employees, and agents.
-- To apply for, solicit, purchase, receive, take by grant, gift, devise, bequest, or otherwise, lease, or otherwise acquire, and to own, hold, improve, employ, use, and otherwise deal in and with, real or personal property, or an interest in real or personal property, wherever situated, either 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, pledge, or create a security interest in, any of its property, or an interest in the property, wherever situated.

-- To invest and reinvest its money, and take and hold real personal property as security for the payment of money loaned or invested.
-- To purchase, receive, take, or otherwise acquire, to own, hold, sell, lend, exchange, transfer, and otherwise dispose of, and to pledge, use, and otherwise deal in and with its bonds and other securities.
-- To conduct its affairs, carry on its operations, and have offices and exercise the powers granted by the Act in any jurisdiction of business, the receipt and payment of money, to transact business, receive, collect, and disburse money, and to engage in other incidental business matters as were naturally or properly within the scope of its articles of incorporation.

Additionally, the Exchange would have the power to purchase, take, receive, subscribe for, or otherwise acquire, to own, hold, vote, or employ, to sell, lend, lease, exchange, transfer, or otherwise dispose of, and to mortgage, pledge, use, and otherwise deal in and with bonds and other obligations and share or other securities, interests, memberships issued by others, whether engaged in similar or different businesses, governmental, or other activities, including baking corporations or trust companies. The Exchange could not guarantee or become a surety on a bond or other undertaking securing the deposit of public money.

The Exchange also would have the power to establish and carry out savings, thrift, and other incentive and benefit plans, trusts, and provisions for any of its corporate directors, officers, and employees. The marketplace could not establish and carry out pension plans.

The Act would specify that the marketplace would have the power to cease its corporate activities and dissolve under the Nonprofit Corporation and Act and the ACA. Between 12 to 15 months after publication of the public notice by the Board, the Exchange would have to initiate steps to cease operation of the marketplace and would have to cease operations. On dissolution, the assets of the Exchange would have to be distributed as follows:

-- All liabilities would have to be paid and discharged.
-- Assets that remained after all liabilities were paid and discharged would be fulfilled and would have to be distributed as provided in a plan of action developed and adopted by the Board and approved by the Director.

Other than a power and duty under Section 261 of the Nonprofit Corporation Act, the Exchange would have the powers and duties of a nonprofit corporation under the Nonprofit Corporation Act. If a conflict regarding the powers and duties of the Exchange under the Act conflicted with a power or duty under Section 261 of the Nonprofit Corporation Act or other State law, the proposed Act would control. (Section 261 of the Nonprofit Corporation Act specifies the limitations and powers of corporations.)

Beginning on the Act's effective date, an entity would be prohibited from incorporating, filing, registering, or otherwise forming in the State using a name that is the same or deceptively or confusingly similar to the name of the Exchange.

Health Plans and the Exchange

The Exchange 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, 2025. The Exchange would have to implement an enhanced direct enrollment by the first open enrollment period in which the Exchange's state-based platform was operational.

"Enhanced direct enrollment" would mean a process by which an entity approved by the director could provide a comprehensive consumer experience including the eligibility application, exchange enrollment, and pre-enrollment year-round customer service capabilities for consumer and producers working on behalf of consumer, directly on the entity's own website.

"Producer" would mean a person required to be licensed in the State to sell, solicit, or negotiate insurance.

"Qualified employer" would mean a small employer that elected to make its full-time employees eligible for one or more qualified health plans offered through the small business health options program (SHOP) and, at the option of the employer, some or all of its part-time employees, if the employer met any of the following:

-- Had its principal place of business in the State and elected to provide coverage through the SHOP to all its eligible employees, wherever employed.
-- Elected to provide coverage though the SHOP to all its eligible employees who are principally employed in the State.

"Small employer" would mean any person actively engaged in business that employed an average of at least one but no more than 50 full-time employees on the first day of the plan year.

"Qualified individual" would mean with respect to an Exchange, an individual is seeking to enroll in a qualified health plan in the individual market offered through the Exchange and resides in the State that established that Exchange.

The Exchange would have to allow health insurance carriers or web brokers to provide for automatic re-enrollment in a qualified health plan. Health insurance carriers or web brokers, as applicable, would have to make a reasonable effort to notify enrollees before automatic re-enrollment. Auto-enrollees could choose a different qualified health plan during open enrollment but would have until December 15 to choose a different qualified health plan with no interruption in coverage.

Subject to the provisions listed above, the Exchange would have to allow producers to do the following:

-- Receive commissions or other remuneration from a carrier for enrolling consumers in a qualified health plan.
-- Enroll qualified individuals and qualified employers in any qualified health plan; however, upon enrollment by a producer, the Exchange would have to verify that enrollment with the individual enrolled.
-- Assist individuals in applying of advance payment of premium tax credits under Section 36B of the Internal Revenue Code and cost-sharing reductions under Sections 1402 of the ACA.

Under the bill, a qualified individual or qualified employer would not be required to use a producer for any of the services described above. A qualified individual or qualified employer could not be penalized, either by premium cost or coverage under a health benefit plan, for choosing to use the services of a producer.

(Section 36B of the Internal Revenue Code specifies the process for an applicable taxpayer to receive a premium assistance tax credit. Section 1402 of the ACA prescribes the requirements for an individual enrolled in a qualified health plan in the silver level of coverage and whose

household income exceeds 100% but does not exceed 400% of the poverty line for a family of the size involved to be enrolled in a reduction of cost-sharing.)

The Exchange could not make a health benefit plan available if the plan were not a qualified health plan. The Exchange would have to allow a health carrier to offer a qualified dental plan that provided limited scope dental benefits meeting the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code through the marketplace, either separately or in conjunction with a qualified health plan, if the plan provided pediatric dental benefits meeting the requirements of Section 1302b(1)(J) of the ACA. Also, the Exchange would have to allow an individual to purchase a qualified dental plan independently without that individual needing to purchase a qualified health plan.

(Section 9832(c)(2)(A) of the Internal Revenue Code specifies that a limited scope dental or vision benefits plan would be a benefit not subject to certain requirements if offered separately. Section 1302b(1)(J) of the ACA specifies that pediatric services, including oral and vision care, are essential health benefit categories.)

"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 jurisdiction of the Director:

-- 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 Public Act 125 of 1963, which provides for the incorporation supervision, and regulation of nonprofit dental care corporations.
-- Any other entity providing a plant of health insurance, health benefits, or health services.

The Exchange or a carrier offering health benefit plans and qualified dental plans through the marketplace could not charge an individual a fee or penalty for termination of coverage. This provision would not prohibit the Exchange or a carrier from refusing to re-enroll an individual whose coverage had been terminated for nonpayment of premiums if the individual premium was at least 90 days past due.

A carrier could not offer in any service area more than four nonstandardized plan options per any of the following:

-- Network type.
-- Metal level other than catastrophic plans.
-- Inclusion of dental benefit coverage, vision benefit coverage, or both.

The Exchange would have to do all the following:

-- Perform all duties and obligations of an Exchange required by Federal law, State law, and the purposes of the Act.
-- Make available in the marketplace qualified health plans and all qualified dental plans consistent with the provisions of the Act.
-- Provide for the operation of a toll-free telephone hotline, postal address, email address, or other means of communication to accept complaints and grievances and respond to requests for assistance in a manner that was linguistically appropriate to the needs of the population being served; the Exchange would have to work with carriers to establish a system to track complaints and grievances.
-- Maintain an internet website through which enrollees and prospective enrollees of qualified health plans could obtain standardized, comparative information on plans, and, at the

direction of the Board, include information relative to individual health and wellness on the website; the Exchange could not modify the website information relative to individual health and wellness more than quarterly and during an open enrollment period.

-- Assign a rating under the ACA to each qualified health plan offered through the marketplace.
-- Use a standard format for presenting health benefit options in the marketplace, including the use of the uniform outline of coverage established under Section 2715 of the Public Health Services Act.
-- Provide one standard application for insurance coverage to all individuals applying for insurance coverage.
-- Determine each individual applicant's eligibility for any applicable health subsidy program, assess each individual applicant's potential eligibility to enroll in a state medical assistance program, and inform the applicant of the determination and assessment.
-- Share application enrollment information with a State medical assistance program or any applicable health subsidy program under the ACA and State law.
-- Establish and make electronically available a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code and any cost-sharing reduction under Section 1402 of the ACA.
-- Adopt an annual operating revenue and expense budget before the start of each fiscal year and make the budget available on its website.
-- Transfer all data and information required to be transferred in compliance with Federal and State law.
-- Perform duties required of the Exchange in compliance with Federal and State law relating to determining eligibility for premium tax credits or reduced cost-sharing.
-- Select entities qualified to serve as navigators in compliance with applicable law and award grants to enable navigators to perform the duties established in Section 1262(3) of the Insurance Code.
-- Enroll individuals in qualified health plans and coordinate with the DHHS to refer individuals to State medical assistance programs.
-- Subject to terms and conditions determined by the Exchange, allow a Federally recognized Indian Tribe to pay premiums for qualified health plans on behalf of tribal members who were qualified individuals enrolled in a qualified health plan.
-- Match, to the extent reasonably practicable, the reconciliation standards established by the Centers for Medicare and Medicaid Services for a health insurance exchange website operated by the Federal government.
-- Educate consumers, including through outreach, a navigator program and post-enrollment support.
-- If the Exchange established a SHOP, notify employees using the SHOP of potential eligibility for a State medical assistance program.
-- Ensure that all enrollee information possessed by any person associated with the Exchange is protected as required by the Health Insurance Portability and Accountability Act (HIPAA).
-- Protect personally identifiable health and financial information in accordance with all applicable Federal and State laws and regulations, including any rules that the Director could promulgate to implement the Act.

The Exchange could establish a SHOP through which qualified employers could access coverage for their employees and Federally recognized Indian Tribes could access coverage for their tribal members. If established the SHOP must do all the following:

-- Enable any qualified employer or Federally recognized Indian Tribe to specify a level of coverage so that its employees or Tribal members could enroll in any qualified health plan offered through the SHOP at the specified level of coverage.

-- Provide a qualified employers or Federally recognized Indian Tribe with the opportunity to establish a defined contribution arrangement for the shop's employees or tribal members to purchase a health benefit plan.

"Federally recognized Indian Tribe" would mean any of the following:

-- Any Indian or Alaska Native Tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian Tribe.
-- Any Indian Tribe, band, nation, or other organized group or community including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.
-- An Indian Tribe an Indian or Alaska Native Tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledged to exist as an Indian Tribe pursuant to the Federally Recognized Indian Tribe List Act.

"State medical assistance program" would mean the Medicaid or State Children's Health Insurance Program.

The Exchange would have to notify employees using the SHOP of any potential eligibility for a State medical assistance program.

(Section 2715 of the Public Health Services Act sets the requirements for the development of standards for use by a group health plan and a health insurance issuer offering a group or individual health insurance coverage and specifies that the plan must have a summary of the benefits of coverage. Section 1262(3) of the Internal Revenue Code specifies that any application for an award or other document related to an application has to be filed and served in the same manner as other pleadings in the proceeding.)

In addition to the requirements above, the Exchange also would have to implement procedures consistent with the Act for the certification, recertification, and decertification of qualified health plans. The Exchange would have to do the following:

-- Contract with DIFS to certify health benefit plans as qualified health plans consistent with those requirements.
-- Contract with qualified vendors to provide technology, implementation, maintenance, and enhancement services needed to operate the Exchange and coordinate as necessary with the DHHS to meet this requirement.

In addition to the requirements above, the Exchange would have to provide any of the following for an enrollment period:

-- Provide at the least an annual enrollment period beginning on November 1 and ending on January 15.
-- Provide a special enrollment period in accordance with 42 USC 18031, and any regulations promulgated under that Section.[2]
-- If the Governor declared a state of emergency or state of disaster under the Emergency Management Act, provide an enrollment period that a majority of the Board determined necessary as a result of the declaration of a state of emergency or state of disaster.
-- By a 75% vote of the Board members then serving, provide for not more than one 45-day enrollment period in addition to those required above in a calendar year.

[2] Generally, 42 USC 18031 governs assistance to states for establishing health benefit exchanges.

Under the Act, the Exchange would have to consult with stakeholders relevant to carrying out certain activities. Stakeholders would include the following:

-- Consumer representatives.
-- Individuals and entities with experience in facilitating enrollment in qualified health plans.
-- Representatives of small businesses and self-employed individuals.
-- The medical services administration of the DHHS.
-- Advocates for enrolling hard-to-reach populations.
-- Federally recognized Indian Tribes.
-- Federally recognized qualified health centers.

"Facilities enrollment" would mean to perform an act that is only indirectly related to the sale, solicitation or negotiation of a health insurance policy and is to inform and individual of the individual's eligibility for public assistance or to inform an individual that the individual can purchase a health insurance policy through a producer, the marketplace, a carrier offering a qualified health plan, or other source, which act is in compliance with Federal law, State law, and the purposes of the Act.

Audit Committee

The Board would have to appoint from its members an audit committee. The audit committee would have to contract with an external auditor for the preparation of at least one audit of the financial statements of the Exchange in each fiscal year. The audit committee members could not have contractional relationships with the external auditor other than for the Exchange audit.

The audit committee would have to review the reports of the external auditor and make the external auditor reports available to the Board and the public. Additionally, the Exchange would have to meet the following financial integrity requirements:

-- Keep an accurate accounting of all activities, receipts, and expenditures and annually submit a report concerning those accountings to the Governor, Director, and the Senate and the House of Representatives appropriations committees and standing committees on health policy.
-- Fully cooperate with any investigation conducted by the State or any Federal agency so long as the authority met certain conditions.

An investigation conducted by the State or Federal Agency would have to be pursuant to authority under Federal or State law to do any of the following:

-- Investigate the affairs of the marketplace.
-- Examine the properties and records of the Exchange.
-- Require periodic reports in relation to activities undertaken by the Exchange.

Health Benefit Plan Certification

The Exchange would have to contract with DIFS to certify health insurance policies. The Director would have to certify a health insurance policy as a qualified health plan in the health benefit plan met the requirements of Federal law, State law, and the purposes of the Act. The Director could not certify a health insurance policy as a qualified health plan unless the premium rates and contract language had been approved by the Director.

The Director would have to require each carrier seeking certification of a health insurance policy as a qualified health plan to permit determination in a timely manner on the request of

the individual, the level of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, that information would have to be made available to the individual through a website and through other means for individuals without access to the internet. Additionally, the Director would have to require each carrier seeking certification to make available to the public, in plain language, and submit to the Exchange and the Director accurate and timely disclosure of the following:

-- Claims payment policies and practices.
-- Periodic financial disclosures.
-- Data on enrollment and disenrollment.
-- Data on the number of claims that were denied.
-- Data on rating practices.
-- Information on cost-sharing and payment with respect to any out-of-network coverage.
-- Information on enrollee and participant rights under Title I of the ACA.
-- Other information as required to comply with Federal law, State law, and purposes of the Act.

Certification of Dental Plans

The Act specifies that provisions applicable to qualified health plans would apply to the extent relevant to qualified dental plans except as modified below or by the Board as permitted by the ACA. A carrier that offered a qualified dental plan would have to be licensed to offer dental coverage but would not need 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 least the essential pediatric dental benefits required under Section 1302(b)(1)(J) of the ACA and any other dental benefits specified in compliance with Federal Law, State Law, and the purposes of the Act.

"Qualified dental plan" would mean a limited scope dental plan that had been certified as described above.

Carriers could jointly offer a comprehensive plan through the marketplace in which the dental benefits were provided by a carrier through a qualified dental plan and the other benefits were provided by a carrier through a qualified health plan if the plans were priced separately and were also made available for purchase separately at the same price.

The Exchange Fund

The Exchange Fund would be created within the State Treasury.

The State Treasurer could receive money or other assets from any source for deposit into the Fund. The State Treasurer would have to direct the investment of the Fund. The State Treasurer would have to credit to the Fund interest and earnings from Fund investments.

Money in the Fund at the close of the fiscal year would have to remain in the Fund and could not lapse into the General Fund.

The Department of Insurance and Financial Services would be the administrator of the Fund for auditing purposes and would have to spend money from the Fund to do either of the following:

-- Operate the exchange.
-- On appropriation and from money, other than money received from fees under the Act, assist health carriers for transition costs in the first year the exchange operated.

Fees and Implementation

The Act would allow the Director to promulgate rules that the Director determined were necessary to implement the Act. Subject to the Director's rules, the Exchange would have to charge assessments or user fees and collect fees from carriers to support the operation of the Exchange under the Act and the reinsurance program established under Section 3406nn of the Insurance Code (see Senate Bill 637), except that the Exchange could not assess or collect any form of obligation other than an exchange user fee on total monthly premiums for exchange policies and unless approved by unanimous consent of the Board, the fee could not exceed the user fee for the federally facilitated marketplace plus or minus 1% of total monthly premiums for on-exchange policies. By majority vote, the Board could decrease the fee. By a 75% vote, the Board could increase the fee. The Exchange could generate funding necessary to support its operations. An assessment or user fee charged to carriers would be considered a licensing and regulatory fee for the purpose of determining compliance with the medical loss ratio requirements of the ACA. An assessment of a user fee could only be used for the purposes directly related to the operation of the Exchange or any reinsurance program established under State law.

(Under the ACA, medical loss ratio requirements are the share of total health care premiums spent on medical claims and efforts to improve the quality of care. The ACA sets minimum medical loss ratios for different markets.)

The Exchange would have to publish on its website the financial information as required under the ACA. The Board would have to approve any assessment or fee by majority vote.

The provisions of the Act could not preempt or supersede the authority of the Director to regulate the business of insurance in the State or of the Director of the DHHS to administer a State medical assistance program. Except as otherwise provided, all carriers that offered a qualified health plan in the State would have to comply with all applicable health insurance laws in the State and with rules promulged and orders issued by the Director. Additionally, any standard or requirement adopted under the ACA or the proposed Act would have to be applied uniformly to all carriers and health benefit plans in each insurance market to which the standard or requirement applied.

A carrier aggrieved by an action or decision of the Exchange could appeal to the Director within 30 days after the action or decision. After a hearing held on at least 10 days' written notice to the aggrieved carrier and the Exchange, the Director would have to issue an order approving the action or decision, disapproving the action or decision, or directing the Exchange to consider further the matter. Proceedings of this kind would be subject to judicial review under the Administrative Procedures Act.

Senate Bill 634

Under the Insurance Code, "exchange" means an American health benefits exchange established or operating under the ACA. Under the bill, that term would mean a marketplace as the term was defined in the proposed Michigan Health Insurance Exchange Act (see Senate Bill 633).

The Code specifies that a certified navigator cannot recommend a particular *health benefit plan* or provide any information or services related to insurance regulated under the Code

other than a *health benefit plan* or other products offered in the Exchange. In addition, under the bill, a certified navigator could not recommend a particular *health insurance policy* or provide any information or services related to insurance regulated under the Code other than a *health insurance policy* or other products offered in the Exchange.

Senate Bill 635 (S-1)

The bill would amend the Insurance Code to require the Director of DIFS to contract with the Exchange established by the proposed Michigan Health Insurance Exchange Act, (see Senate Bill 633 (S-7)) to certify qualified health plans and qualified dental plans. The Director would have to establish criteria by rule for certifying qualified plans under Federal law. The bill would not limit the authority of the Director to regulate the business of insurance within the State or to exempt qualified plans from compliance with applicable provisions of Federal and State law.

Senate Bill 636 (S-1)

Under the Insurance Code, an insurer that delivers, issues for delivery, or renews in this State a health insurance policy must provide a written summary of the health insurance policy in plain English to insureds. The written summary must provide a clear, complete, and accurate description of all the following, as applicable:

-- Uniform definitions of standard insurance terms and medical terms so that a consumer may compare health coverage and understand the terms of, or exceptions to, the consumer's coverage, in accordance with the most recent guidance issued by the United States Department of Health and Human Services.
-- A description of the coverage, including cost sharing, for each category of benefits in the most recent guidance issued by the United States Department of Health and Human Services.
-- The exceptions, reductions, and limitations of the health insurance policy.
-- The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations.
-- The renewability and continuation of coverage provisions.
-- Coverage examples.
-- A statement about whether the health insurance policy provides minimum essential coverage as defined under section 5000A of the Internal Revenue Code and whether the health insurance policy's share of the total allowed costs of benefits provided under the health insurance policy meets applicable requirements.
-- A statement that the summary is only a summary and that the health insurance policy should be consulted to determine the governing contractual provisions of the coverage.
-- Contact information for questions.
-- An internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.
-- For insurers that maintain one or more networks of providers, instructions for obtaining a list of network providers. For insurers that use a formulary in providing prescription drug coverage, instructions for obtaining information on prescription drug coverage.
-- Instructions for obtaining the uniform glossary and a contact telephone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

Under the bill, the form also would have to include any information that was required by the Exchange created under the proposed Michigan Health Insurance Exchange Act (see Senate Bill 633 (S-7)) as directed by DIFS.

Senate Bill 637 (S-2)

The bill would amend the Insurance Code to require DIFS to apply to the United States Secretary of Health and Human Services under Section 1332 of the ACA for a State innovation waiver to do any of the following:

-- Waive any applicable provisions of the ACA with respect to health insurance coverage.
-- Establish a reinsurance program in accordance with any approved waiver.
-- Maximize Federal funding for the reinsurance program for plan years beginning on or after implementation of the program.

Under the bill, within 180 days after the bill's effective date, DIFS would have to do the following:

-- Make a draft application available for a 30-day public review and comment period and consider any comments on its final submitted application.
-- Provide the draft application to the standing committees of the Senate and House of Representatives that primarily consider health and insurance matters.

Additionally, the bill would allow DIFS to amend the waiver application at any time as necessary to carry out the provisions of the proposed Michigan Health Insurance Exchange Act (see Senate Bill 633 (S-7)). On approval of the application for an innovation waiver, DIFS would have to implement a reinsurance program. The Department of Insurance and Financial Services would have to report to the Senate and House Appropriation Committees on money necessary to fund the reinsurance program and suggested sources of the money, including any money necessary to be appropriated by the Legislature from the General Fund.

MCL 500.1261 et al. (S.B. 634)
Proposed MCL 500.3406mm (S.B. 635)
MCL 500.2212a (S.B. 636)
Proposed MCL 500.3406nn (S.B. 637)
MCL 500.3406o (S.B. 638)

BACKGROUND

The ACA is a comprehensive healthcare reform law that was enacted in March 2010 under President Obama's Administration. Among other provisions, the ACA introduced health insurance marketplaces, also known as exchanges. The exchange platforms were designed to allow individuals and families to shop for private health insurance plans or dental insurance coverage. The ACA required such exchanges to be established in every state. The operational phase of initial exchanges began in October 2013 to allow consumers to shop for plans that took effect as early as January 1, 2014. The Federal government created an FFE which is a centralized online platform where residents of states may enroll in ACA-compliant health insurance plans. States were granted the choice to adopt the FFE or to create their own health insurance exchange platforms, known as SBEs, which are generally tailored to local healthcare needs and regulations. Additionally, a state may adopt an SBE using a Federal platform (SBE-FP), in which that state oversees the exchange but uses the federally-facilitated information technology platform.

An exchange can be designated as individual exchange or SHOP exchange, each catering to the nongroup and small-group segments of the private health insurance market, respectively. Each exchange is required to fulfill certain functions such as providing a way for consumers and small businesses to compare and purchase health plans options through participating insurers. Exchanges are responsible for certifying the plans that will be offered in their

marketplace and collecting and reporting data to the United States Department of Health and Human Services (USDHHS), the Federal Treasury, and applicable state insurance departments.

States can apply to the USDHHS and the United States Department of Treasury for a State Innovation Waiver to waive certain requirements of the ACA, including requirements pertaining to qualified health plans, health insurance exchanges, premium tax credits, cost-sharing subsidies, and individual or employer mandates. With an approved Waiver, a state is expected to implement a plan to meet certain minimum requirements. States can operate a state-based reinsurance program by waiving the single pool risk requirement for individuals and small group health insurance markets. The single pool risk requirement merges all enrollees into a unified risk pool, which prevents segregation by level of health. Specifically, State Innovation Waivers can secure funding for state-based reinsurance programs which are designed to reduce health insurance premiums in the market by reimbursing insurers for high-cost claims incurred by beneficiaries with complex medical needs. The programs are typically funded through a combination of state and Federal resources in which states receive Federal pass-through funding based on savings in premium funding sourced from assessments on insurers and providers or state general funds.[3]

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

An SBE would increase coordination across State departments and help Michigan residents to find their ideal healthcare more quickly. According to testimony before the Senate Committee on Health Policy, if a person applied for Medicaid but made too much money to qualify, the Exchange would be better than the FFE at informing the person of other qualifying subsidies and what plans may be most affordable in the marketplace. Similarly, if a person who would otherwise qualify for Medicaid sought health insurance on the Exchange, the Exchange could direct the person more effectively than the FFE toward applying for those benefits. Testimony also indicates that the current FFE is intended to be a template for states' own exchange websites and that the FFE is not capable of the same level of customization or user-friendliness as an SBE. Further, the Exchange's customizable nature would enable the State to gather better data related to Michigan residents' healthcare for Michigan. Gathering health data is important to establishing good healthcare policy. The Exchange would be a more effective tool for helping Michigan residents find appropriate healthcare and so it should be created and used instead of the FFE.

Supporting Argument

Currently, the revenue generated by the user fee for the FFE (healthcare.gov) in Michigan goes to the Federal government. Instead, with an SBE, Michigan could capture this revenue and use it to employ Michigan residents to run the Exchange. According to testimony before the Senate Committee on Health Policy, in eight other states that transitioned to their own SBEs, about half of the money collected by the Federal government went toward the operation of their FFEs. Assuming the Federal government was spending half the money collected from Michigan's fee on operation of its FFE, the other half of the money could be used to do outreach to underinsured communities, to upgrade the Exchange, or reduce premium costs for residents of Michigan. By creating the Exchange, the money Michigan residents use on the FFE would instead go to helping Michigan residents.

Legislative Analyst: Alex Krabill

[3] National Conference of State Legislatures, "*State Roles Using 1332 Health Waivers*", Retrieved on 8-5-24.

FISCAL IMPACT

Senate Bills 633 (S-7) & 637 (S-2)

The bills would have an indeterminate but significant fiscal impact on State government and an indeterminate fiscal impact on local units of government.

Senate Bill 633 (S-7) would require DIFS to implement a reinsurance program upon approval of a State Innovation Waiver. The impact to the State would include start-up costs and ongoing operational costs. In addition to DIFS, it is likely that other State departments would incur costs due to responsibilities associated with launching and operating the Exchange system. These responsibilities could include legal assistance and representation, information technology, and administrative assistance.

Estimates of annual costs of a reinsurance program in Michigan included in a 2022 actuarial study ranged from $71.0 million to $232.3 million, depending on the exact parameters of the program and the number of claims submitted. If the program successfully resulted in savings compared to the Federal exchange, Michigan would receive a significant amount of Federal pass-through dollars each year. Based on the experience of other states in operating reinsurance programs, it is likely that these Federal funds would be sufficient to cover a substantial portion of the costs of running the program. The 2022 study suggested that approximately 65% to 70% of reinsurance costs would be paid through Federal pass-through funds. The State-based portion of any reinsurance program likely would be funded in part by assessments on the group health insurance market, user fees, and/or by a specific tax on providers or businesses. Based on the figures above, the State-based portion of the program likely would range from about $30.0 to $40.0 million over the first few years. This figure is similar to current costs for the State of Pennsylvania's exchange.

The exact costs of running a program would be significant but highly dependent on the details of the program. Start-up costs could potentially be amortized over a period of several fiscal years. Additionally, due to the non-profit structure and independent authority granted under the bill, it is possible that some funding would not be reflected in annual State appropriations. Under Senate Bill 633 (S-7), members of the Board would not receive a salary, benefits, or other compensation but could be reimbursed for actual and necessary expenses. Current appropriations to DIFS likely would be sufficient to cover certification duties.

A one-time appropriation of $250,000 General Fund/General Purpose was included in the Fiscal Year 2020-21 budget to contract with a third-party for the actuarial cited above. The analyses included in the study would form part of the application for a waiver and likely would not need to be repeated. Other costs of completing an application likely would be sufficiently funded by existing appropriations; however, it is possible that data collection for the application and start-up period could require a contract with a third-party entity.

The Board would be required to contract with an external audit each fiscal year. While an exact estimate is unavailable at this time, the 2022 actuarial study estimated the cost of an annual audit of claim submissions and assessments by an external vendor at $10,000 per audit. The cost of auditing the financial statements of the exchange could be higher in initial years.

Senate Bills 634 & 636 (S-1)

The bills would have no fiscal impact on State or local government.

Senate Bill 635 (S-1)

The bill likely would not have a significant fiscal impact on State or local units of government. The costs of contracting with the exchange for certification likely would be covered by existing appropriations to DIFS. Additional costs likely would be paid from the overall appropriations made for the establishment of the State exchange.

Senate Bill 638

The bill would have no fiscal impact on the Department of Health and Human Services. The expiration of the temporary requirement for health insurers to allow early and emergency refills of prescriptions under the Insurance Code expired on March 31, 2021. Any indeterminate cost increase resulting from the expiration of allowing early and emergency refills that lasted longer than the original scripts (60 to 90 days) would have been incurred at that time.

Fiscal Analysts: John P. Maxwell
Elizabeth Raczkowski