Michigan Exchange Planning Advances and Insights

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PRACTICE AREAS
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This article supplements my earlier article on the subject of the emerging Michigan Health Insurance Exchange. When it has been appropriately implemented, the Michigan Exchange will play a vital role in opening health care access and insurance coverage for hundreds of thousands of Michigan citizens and their families. Since my prior article was published, the Michigan stakeholder workgroup issued its final report on June 17, 2011. This article summarizes the recommendations given in the report and provides several insights to the workgroup process as a whole.

BACKGROUND

The Michigan stakeholder workgroup was responsible for making in-depth recommendations regarding the projected Michigan Exchange (also referred to in this article as the "Exchange"). The workgroup was divided into five separate sub-workgroups. After careful consideration, each sub-workgroup provided input regarding the formation and operation of the Michigan Exchange, according to their respective areas of focus. These sub-workgroups included (1) Governance; (2) Business Operations; (3) Finance, Reporting, and Evaluation; (4) Technology; and (5) Regulatory and Policy Action.

SUB-WORKGROUP RECOMMENDATIONS

Not surprisingly, the discussions held in each sub-workgroup were similar and led to common recommendations. The overlap of recommendations highlighted the fact that there are a number of important issues and concerns common to all of the sub-workgroups, despite their distinct focus area assignments. The individual sub-workgroup recommendations are discussed below.

1. **Governance**. The Governance sub-workgroup was charged with developing recommendations on how the Exchange should be created as well as proposals on how it should be structured and governed. After the discussions and voting had ended, the sub-workgroup made the following recommendations, among others:

a. A Michigan-specific exchange should be established as opposed to other options, such as partnering with other states (or regions) or deferring to the Federal Government.

b. A single Exchange should be established as an independent public authority, which would later seek non-profit status.

c. A thirteen person board should be appointed and consist of both state agency members and diversified stakeholders with representation from healthcare consumers, small employers (defined as having between one to 100 employees), laborers, the health insurance industry and health insurance providers. The board should also include three ex-officio state government members, who would have voting rights, and the Insurance Commissioner, who sit on the board in a non-voting capacity. Appointments to the board should be made by the Governor, and a strict conflict of interest policy would be imposed. The board would appoint an executive director for the Exchange.

d. The Exchange should exist for both individuals and small businesses, and the Exchange board would oversee both functions.

e. The Board should also be subject to the state Open Meetings Act ("OMA") and Freedom of Information Act ("FOIA"). Flexibility, transparency and diversity should be hallmarks of the Exchange.

2. **Business Operations**. The Business Operations sub-workgroup was given the responsibility of providing recommendations on how the Exchange should be operated as a whole. Its recommendations, among others, were as follows:

a. A number of qualified health plans may be certified as participants in the Exchange. The Exchange should have restrictions consistent with those imposed on other insurers in Michigan and also meet the requirements of the Patient Protection and Affordable Care Act ("PPACA"). The number of plans participating should be limited in a rational manner.

b. The Exchange should be viable and sustainable with careful budgeting; assistance from outside sources, such as foundations; and a clear educational purpose.

3. **Finance, Reporting, and Evaluation**. This sub-workgroup was tasked with presenting recommendations on transparent operations, accounting and auditing standards, and self-sustaining financial strategies for the Exchange. Several important recommendations are as follows:

a. Federal funds, as well as funding from foundations, should be sought to support start-up costs for the Exchange. If Medicaid is included in the Exchange, it should bear its fair share of the start-up costs, including the cost of a Medicaid eligibility determination system.

b. Plans should pay a reasonable fee for participation in the Exchange, with maximum federal matching funds for Medicaid costs in the on-going operation of the Exchange.

c. The Exchange should be allowed to seek entrepreneurial opportunities related to its mission that do not present conflicts of interest.

d. Costs should be spread over the widest base possible.

e. Annual audits should be conducted, and the public should be apprised of the Exchange's financial affairs and potential conflicts of interest.

f. Michigan should collaborate with other states on the development and implementation of evaluation and monitoring activities for the Exchange.

g. The Exchange should exercise best practices.

4. **Technology**. The Technology sub-workgroup was asked to provide recommendations on how to make the Exchange user-friendly, but it also provided advice on the Exchange's interoperability with current state systems. It provided the following feedback:

   a. A single individual or entity should bear responsibility for outreach education and enrollment.

   b. Determinations of eligibility can be the subject of interoperative activity between the Exchange and existing state systems.

   c. Representatives of various systems made presentations to the sub-workgroup and workgroup leaders identified certain systems as most applicable to the Exchange.

5. **Regulatory and Policy Action sub-workgroup.** This sub-workgroup was basically charged with the development of a state statute that would be termed the *Michigan Health Benefit Exchange Act.* Not surprisingly, this sub-workgroup seemed to have the most overlap with other groups, since its proposed legislation was intended to reflect the other groups' recommendations. A few of the significant concerns included the following:

   a. Important definitions should be incorporated from the Federal Model Act including "health benefit plan" and its various exclusions.

   b. Qualifications should be consistent between the Federal and State Acts.

   c. Board composition should be diverse, and appointments should be made by the Governor.

   d. The OMA and FOIA should be followed to ensure transparency in the board's activities.

PRACTICAL INSIGHTS

Through my work with the Regulatory and Policy Action sub-workgroup, I was able to discover common themes in the discussions between all the sub-workgroups. Similar concerns and proposed remedies were introduced with regard to plan participation, individual involvement, oversight and financial implications with regard to the Exchange. These are outlined below.

1. **Plan Participation.** Any carrier that meets the requirements of PPACA should be allowed to provide its plans in the Exchange. To that end, the Regulatory sub-workgroup specifically approved language that PPACA's criteria for a qualified health plan's certification must be followed. Additionally, the Department of Health and Human Services' guidelines for certification, re-certification, and decertification of qualified health plans will be implemented. There will be limitations, however, as the Exchange board will determine, in a non-discriminatory manner, a reasonable limit to the number of plans that shall be offered through the Exchange.

2. **Individual Involvement.** Qualified health plans must be made available to qualified individuals and employers on or before January 1, 2014. Dental benefits may also be offered through the Exchange. For assistance with an individual's decision in participating, the Regulatory sub-workgroup voted to make an electronic calculator available for use in determining the actual cost of coverage after application of any premium tax credit. For assistance with businesses, a Small Business Health Insurance Option Program, through which qualified employers may access coverage for their employees, may be offered through the Exchange as well at the specified level of coverage.

   There were also recommendations made concerning an individual's involvement and termination with the Exchange. Individual patients should confirm that a provider is accepting new patients however, and not automatically assume that is the case. The Regulatory sub-workgroup determined this was the patient's responsibility rather than that of the Exchange. When an individual terminates coverage, because he or she becomes eligible for new coverage or where coverage becomes more affordable, no fees or penalties shall attach.

3. **Oversight.** Oversight of plans will primarily be the work of the Exchange. The duties involved in overseeing the plans, however, may be shared with the Insurance Commissioner, who should be given such authority by adding operative language to the Insurance Code. The specific responsibilities will depend upon the statutory language as written, which must be in compliance with the health insurance laws of the state and regulations and orders issued by the Insurance Commissioner. PPACA will remain controlling, and it is not the intent of the state statute to pre-empt federal action under PPACA unless permission is given by the federal government.

   The Regulatory sub-workgroup also reviewed the involvement of "navigators." Navigators will provide information and tools to assist Exchange participants in making an assessment of plans. They will not have the expertise to "counsel" Exchange participants in plan selection and transition procedures, which will generally be done by insurance agents or brokers. Navigators most likely will not need to be certified, as a majority of the Regulatory sub-workgroup voted against such certification.

4. **Financial Implications.** The Exchange shall work jointly with state Medicaid and the Children's Health Insurance Program ("CHIP"), to assist people who are likely to move between Medicaid and Exchange plans. The Regulatory sub-workgroup endorsed the exchange of data between the Exchange, Medicaid and CHIP, and the Business Operations sub-workgroup supported this idea of the Exchange as a market facilitator. If Medicaid is included in the Exchange, it is advisable the state should seek federal matching funds for Medicaid costs associated with the start-up and continuing operations of the Exchange. Insurance carriers having certified health plans within the Exchange should also be expected to pay a reasonable fee to help defray the costs of the Exchange.

CONCLUSION

The discussion above outlines recommendations of the state workgroup in formulating a vision for a model statute governing the Exchange. It is likely that much what appears in the workgroup report will become a part of Michigan's state statute for setting up and operating the Michigan Exchange. It is hoped that this article, which addresses many facets of the proposed Michigan Exchange, will assist readers with at least a

summary of what the stakeholder sub-workgroups have proposed.