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BILL ANALYSIS

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Senate Bill 595 (as introduced 9-7-11)
Sponsor: Senator Roger Kahn, M.D.
Committee: Health Policy

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**CONTENT**

**The bill would create the "Michigan Basic Health Program Act" to require the Department of Community Health (DCH) to establish, implement, and administer a Basic Health Program through which an eligible individual could enroll in a standard health plan. Specifically, the bill would do the following:**

- **Prescribe eligibility criteria for enrollment, including a household income between 133% and 200% of the Federal poverty line.**
- **Require a standard health plan to provide at least the essential health benefits described in the Federal Patient Protection and Affordable Care Act.**
- **Require the administrator (the DCH Director) to select three standard health plans in each service area with a mandatory participation population under 100,000, and four plans in each service area with such a population of 100,000 or more.**
- **Require the administrator to establish a uniform procedure for negotiating with health maintenance organizations (HMOs) regarding the selection of plans for participation in the Program.**
- **Provide that only plans that had an active Medicaid contract with the DCH would be eligible to participate.**
- **Prescribe procedures for enrollment, disenrollment, and changing plans under the Program.**
- **Prescribe the administrator's duties, including coordinating the Program with other health coverage programs and seeking Federal approval to use Federal funds and premiums to administer the Program.**
- **Create the "Basic Health Program Trust Fund" for the purposes of reducing premiums and cost-sharing and providing additional benefits under the Program.**

Eligibility

"Eligible individual" would mean an individual who meets all of the following criteria:

- Is a resident (i.e., an individual who lives voluntarily in Michigan with the intention of making his or her home in Michigan and not for a temporary purpose, and who is not receiving public assistance from another state).
- Is not eligible to enroll in Medicaid, Medicare, or the State Children's Health Insurance Program for benefits that at a minimum consist of the essential health benefits as described in the Patient Protection and Affordable Care Act (ACA).
- Has household income that exceeds 133% of the Federal poverty line (FPL) but does not exceed 200% of the FPL for the size of the family involved.
- Is not eligible for minimum essential coverage, as defined in Section 5000A(f) of the Internal Revenue Code (IRC), or is eligible for an employer-sponsored plan that is not affordable coverage as determined under Section 5000A(e)(2) of the IRC.

-- Has not attained age 65 as of the beginning of the plan year.

(The Patient Protection and Affordable Care Act requires a health benefits package offered through a state exchange to include coverage for "essential health benefits", which include at least the following general categories:

-- Ambulatory patient services.
-- Emergency services.
-- Hospitalization.
-- Maternity and newborn care.
-- Mental health and substance abuse disorder services.
-- Prescription drugs.
-- Rehabilitative and habilitative services and devices.
-- Laboratory services.
-- Preventive and wellness services and chronic disease management.
-- Pediatric services, including oral and vision care.

Beginning in 2014, Section 5000A of the IRC requires an individual to maintain "minimum essential coverage" for himself or herself and any dependents, and imposes a tax penalty for every month that a person fails to meet this requirement. Under Section 5000A(f), "minimum essential coverage" means any of the following:

-- With regard to government-sponsored programs, coverage under Medicare, Medicaid, or the Children's Health Insurance Program; an Armed Forces medical coverage program; a veterans' health care program; a Peace Corps program; and the Nonappropriated Fund Health Benefits Program of the Department of Defense.
-- Coverage under an eligible employer-sponsored plan.
-- Coverage under a health plan offered in the individual market.
-- Coverage under a grandfathered health plan.
-- Other health benefits coverage, such as a state health benefits risk pool.

Section 5000A(e)(2) provides that no penalty may be imposed with respect to an individual whose household income is below the tax filing threshold.)

Basic Health Program & Standard Health Plans

The bill would require the DCH to establish, implement, and administer a Basic Health Program in compliance with the proposed Act and Section 1331 of the ACA. (Section 1331 provides for the establishment of a basic health program under which a state may enter into contracts to offer standard health plans providing essential health benefits to eligible individuals in lieu of offering them coverage through an exchange.)

In negotiating with a licensed HMO regarding its managed care health plans for participation in the Program as a standard health plan, the administrator would have to adopt a uniform procedure that included a request for proposals (RFP). The RFP would have to include standards regarding the following:

-- The quality of services to be provided under the managed care health plan that were at least as rigid as those currently required of managed care health plans participating in the State Medicaid program.
-- The financial integrity of managed care health plans sponsored by responding HMOs.
-- History and experience of responding HMOs in addressing the health care needs of, and providing quality health care services to, low-income residents.

The RFP also would have to include standards for minimum provider network development to ensure that the managed care health plan's network for each service area within which it would participate had a sufficient number, mix, and geographic distribution to meet the target populations' needs and to ensure adequate service availability.

("Standard health plan" would mean a managed care health plan with which Michigan contracted as part of the Program that met all of the following requirements:

-- Enrolled only eligible individuals.
-- Provided at least the essential health benefits described in ACA.
-- Had and maintained a medical loss ratio of at least 85% as provided in ACA.

"Service area" would mean the geographic area approved by the administrator within which a standard health plan met the administrator's requirements for the minimum provider network development.)

Only managed health care plans that were provided by licensed HMOs in Michigan and that had an active Medicaid contract with the DCH at the time of the RFP release would be eligible to participate in the Program.

The administrator would have to select three standard health plans in each service area within the State that had mandatory participant populations of less than 100,000 and four standard plans in each service area that had mandatory participant populations of at least 100,000. The administrator could select a plan for participation in more than one service area.

In selecting standard health plans, the administrator would have to give preference to licensed HMOs that were under a Medicaid contract with the DCH currently and that had meaningful and proven chronic care, disease management, and preventive care programs.

An individual who was a qualified individual under Section 1312 of ACA and who was eligible for enrollment in a qualified health plan offered through the exchange would not be an eligible individual under the proposed Act and could not be enrolled in a standard health plan.

("Exchange" would mean an American health benefit exchange established by the State pursuant to ACA. Under Section 3312 of that Act, "qualified individual" means an individual who is seeking to enroll in a qualified health plan in the individual market offered through the exchange, and who resides in the state that established the exchange.)

Enrollment

Upon enrollment, an eligible individual would have 15 days to choose a standard health plan in his or her service area. The administration would have to enroll an eligible individual who did not choose a plan during the 15-day period in a standard health plan through the automatic assignment protocol. ("Automatic assignment protocol" would mean the protocol for assigning individuals to standard health plans as used currently by the DCH for Medicaid managed care plans and as modified by the administrator to promote the availability and affordability of health coverage in Michigan consistent with the ACA.)

An individual enrolled in a standard health plan could request disenrollment at any time, without cause, during the first 90 days of enrollment.

The administrator would have to establish an annual, 30-day open enrollment period during which an eligible individual could disenroll from one standard health plan and enroll in another plan participating in his or her service area.

Basic Health Program Trust Fund

The Basic Health Program Trust Fund would be created within the Department of Treasury. The State Treasurer could receive money or other assets from any source other than General Fund State funds for deposit into the proposed Fund. The State Treasurer would have to direct the investment of the Fund, and credit to it any interest and earnings. Money in the Fund at the close of the fiscal year would remain in the Fund and would not lapse to the General Fund. The DCH would be the Fund administrator for auditing purposes.

The administrator would have to spend Fund money without further appropriation for the purposes of reducing the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans in the Basic Health Program.

Administrator Duties

The administrator would have to do all of the following:

-- Ensure that the participating standard health plans provided essential health benefits as described in the ACA.
-- Evaluate performance measures as determined by the administrator.
-- Contract with standard health plans as provided in the proposed Act.
-- To the extent possible, coordinate the Medicaid Managed Care Program, the

Basic Health Program, and the exchange.

In addition, the administrator would have to seek approval from the U.S. Secretary of Health and Human Services to use a portion of the Federal funds to be provided to the State under the Program, or a portion of premiums paid by eligible individuals, to fund administration of the Program.

The administrator also would have to perform any other activity necessary to fulfill his or her duties under the proposed Act.

The administrator could promulgate rules that he or she considered necessary to implement the Act.

Legislative Analyst: Julie Cassidy

**FISCAL IMPACT**

The implementation of the Basic Health Program (BHP) outlined in Senate Bill 595 would have an indeterminate fiscal impact on State government. There are numerous factors that could affect State expenditures. Some of these factors can be estimated, some are impossible to estimate accurately, and the most important factor depends on a decision by the Federal government that has yet to be made.

Under the Federal Patient Protection and Affordable Care Act (ACA), the statutory name of what is commonly known as "Federal health reform", uninsured individuals with incomes under 400% of the Federal Poverty Level (FPL) will receive Federal premium tax credits to support the purchase of insurance from health insurance exchanges, if the ACA is upheld by the United States Supreme Court. Individuals with incomes under 250% of the FPL will receive Federal subsidies to support cost sharing expenses. These provisions, along with the expansion of Medicaid to cover all adults under 133% of the FPL, are scheduled to take effect on January 1, 2014.

Under the ACA, assuming that it is upheld, states will have the option to create a "Basic Health Program" for uninsured individuals under 200% of the FPL to provide health insurance for that population. If a state opts to create a BHP, these individuals will not purchase insurance from the exchange or receive the premium tax credits and cost sharing subsidies. Instead, 95% of the estimated premium tax credit revenue and 100% of the cost sharing subsidies for these individuals will be transferred to the state to support the costs of the BHP.

Senate Bill 595 would direct that BHP services be provided by licensed health maintenance organizations (HMOs) that participate in Medicaid and are not subject to Section 9010 of the ACA (which imposes a fee on health insurers, subject to certain exceptions). This would appear to limit the eligible HMOs to six for-profit HMOs. The eight nonprofit HMOs that participate in Medicaid would appear not to be eligible due to the Section 9010 provision.

The amount of tax credit and subsidy funding that would be transferred to the State would depend on the Federal government's estimates. The intent is to transfer an amount based on the estimated cost of coverage for the population. However, it is not clear at this point what benchmark the Federal government will use, whether it will be the cost of individual policies, small group policies, or some other measure. These costs vary considerably and, because there has been no Federal determination at this point, it is not possible to provide an estimate of the revenue that would be made available to the State to fund the BHP.

Because the revenue amount cannot be estimated as it would be based on a Federal decision that has not yet been made, it is impossible to estimate a fiscal impact for the legislation. However, it is possible to discuss some of the general fiscal issues, including the factors that could lead to greater or lesser costs.

The general belief is that about 250,000 Michigan residents would be eligible for coverage by the BHP. Under any reasonable estimate of the cost of insurance, this would lead to the State's receiving at least $1.0 billion (and likely much more) to cover individuals through the BHP.

Assuming full implementation of the ACA, the State would be faced with a choice between allowing those between 133% and 200% of the FPL to seek insurance through the exchanges or placing those individuals in the BHP. There are fiscal advantages and disadvantages to each option.

Many people move on and off Medicaid over any period of time. The BHP HMOs would be partially aligned with Medicaid HMOs; therefore, a person could, if his or her income increased or decreased, remain with the same HMO. Furthermore, while a low income person with income over 133% of the FPL would generally not be Medicaid eligible, his or her child typically would be. Instituting a BHP would allow that person to be in the same HMO as the child. On the other hand, the legislation, as written, appears to exclude most Medicaid HMOs from the BHP. Therefore, a majority of Medicaid clients would not be able to stay with the same HMO if their income increased, and the smoothness of transition would be significantly affected.

The limitation of the proposal to for-profit HMOs also would reduce the choices BHP enrollees would have and would likely reduce the amount of competition among the HMOs, which could lead to greater costs.

Advocates note, with reason, that the BHP could offer insurance products that would have lower out of pocket costs than exchange products, and note that individuals would be more likely to participate if their out of pocket costs were lower. This could lead to greater participation but also greater cost.

Opponents have noted that moving 250,000 individuals out of the exchanges into the BHP, especially given the belief that these individuals generally would be younger and healthier than the average population, could increase the average cost of insurance for the exchange population. Also, younger and healthier individuals may be less likely to purchase products from the exchange. This is because the community rating provisions of the ACA (requiring that no insurance policy cost more than three times the cheapest policy based on age) may lead them to choose not to purchase insurance.

There are also some who note that some Medicaid recipients could be shifted from Medicaid (funded presently at 34% State funding) to the BHP (funded with 0% State funding). The number who would benefit from this appears to be quite limited. Other states, such as New York, with far more generous Medicaid coverage, would appear to see a much greater windfall.

As noted above, the uncertainties are significant. The Federal decision on the amount that would be transferred to the State is the most important. Second, there is no statement in the bill as to the reimbursement rates for providers in the BHP. Because the largest component of the revenue used to support the program would be tied to a Federal decision and the largest factor in expenditures, the provider reimbursement rates, has yet to be set, a definite fiscal impact estimate is not possible at this time.

Participation rates are subject to individual choices. Because the ACA has yet to be implemented anywhere, it is unknown how many people would choose to participate in the exchanges or participate in the BHP if that option were made available. There is also uncertainty on how many individuals would lose their coverage from employer-based coverage and shift into the exchanges or BHP. Again, until there is experience with the implementation of the ACA, any estimate on the impact is guesswork.

There also would be relatively minor costs tied to administrative expenses. It is not clear whether the transferred Federal funding could be used to administer the BHP, though administrative costs would be much smaller than the health care expenditures.

Finally, there is the issue of marginal costs. To the extent that the costs of the BHP exceeded the revenue, the excess costs would be covered by the State. Adjustments in the reimbursement rates could help limit any excess. If the costs were less than the revenue, then the money would accrue to the Basic Health Program Fund established in the legislation and would be available to cover possible future cost overruns.

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