Department of Legislative Services

Maryland General Assembly
2011 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 182 (The President, *et al.*) (By Request - Administration)
Finance and Budget and Taxation Health and Government Operations

Maryland Health Benefit Exchange Act of 2011

This Administration bill establishes the governance, structure, and funding of the Maryland Health Benefit Exchange, a public corporation and independent unit of government created to (1) reduce the number of uninsured; (2) facilitate the purchase and sale of qualified health plans (QHPs) in the individual market; (3) assist qualified employers facilitating the enrollment of their employees in QHPs in the small group market and in accessing small business tax credits; (4) assist individuals in accessing public programs, premium tax credits, and cost-sharing reductions; and (5) supplement the individual and small group insurance markets outside of the exchange. The exchange will be governed by a Board of Trustees and funded through specified fees or assessments. The bill also establishes a Maryland Health Benefit Exchange Fund.

The exchange must study and report on specified functions and is prohibited from implementing those functions until the Governor and General Assembly enact additional legislation.

The bill takes effect June 1, 2011.

Fiscal Summary

State Effect: Significant increase in federal fund revenues and expenditures beginning in FY 2013, including personnel costs associated with establishing the exchange. The Department of Health and Mental Hygiene (DHMH) has received $997,227 in federal grant funding for FY 2011 and 2012 to begin implementation of an exchange. Legal authority to establish and operate an exchange, such as provided in the bill, will help to secure additional federal funding through December 31, 2014. The exchange must be financially self-sustaining by January 1, 2015. Thus, revenues and expenditures attributable to exchange operations are anticipated to be covered with special funds by

FY 2015. The bill's reporting requirements can be handled with existing budgeted resources, given the availability of the federal funding.

Local Effect: None.

Small Business Effect: The Administration has determined that this bill has a meaningful impact on small business (attached). Legislative Services concurs with this assessment. (The attached assessment does not reflect amendments to the bill.)

Analysis

Bill Summary:

Functions of the Exchange: The primary function of the exchange will be to certify and make available QHPs to individuals and small businesses and to serve as a gateway to an expanded Medicaid program. By January 1, 2014, the exchange must:

- make QHPs available to qualified individuals and employers;
- allow carriers to offer a qualified dental plan (QDP) that provides limited dental benefits with or separate from QHPs;
- implement QHP certification procedures;
- operate a toll-free telephone hotline;
- provide for enrollment periods;
- maintain a website with standardized, comparative information on QHPs and QDPs;
- assign ratings for and determine each QHP's level of coverage;
- present QHPs in a standardized format;
- provide information and make eligibility determinations for Medicaid and the Maryland Children's Health Program (MCHP);
- facilitate enrollment in Medicaid or MCHP;
- establish an electronic calculator to determine QHP and QDP costs after the application of any premium tax credit;
- establish a Small Business Health Options Program (SHOP) exchange through which qualified employers may access coverage for their employees and meet standards for the federal qualified employer tax credit;
- implement a certification process for individuals exempt from the individual responsibility requirement and penalty;
- implement a process to notify the federal government of individuals who are exempt from the individual responsibility requirement;

- provide notice to employers of employees who cease coverage under a QHP during a plan year;
- determine eligibility for premium tax credits, reduced cost-sharing, and individual responsibility exemptions;
- establish a Navigator Program for the individual and SHOP exchanges;
- establish a process for crediting the amount of free choice vouchers to premiums of QHPs and QDPs and collect the amount credited from employers;
- carry out a plan to provide assistance for consumers seeking to purchase products through the exchange; and
- carry out a public relations and advertising campaign to promote the exchange.

The exchange may not carry out any function that is not authorized by the federal Patient Protection and Affordable Care Act (ACA).

Qualified Health Benefit Plans and Qualified Dental Plans: To offer a QHP, a carrier must be licensed and in good standing to offer health insurance; offer at least one QHP at both silver and gold levels outside the exchange if participating in the individual exchange; offer at least one QHP at both silver and gold levels in the small group market outside the exchange if participating in the SHOP exchange; and charge the same premiums for plans offered inside and outside the exchange. The exchange must certify health benefit plans as QHPs. To be certified, a plan must provide the essential benefits package required under ACA; obtain prior approval of premium rates and contract language from the Insurance Commissioner; provide at least a bronze level of coverage; and ensure that cost-sharing requirements do not exceed the limits established under ACA. A QHP is required to provide at least a bronze level of coverage if the QHP is certified as a qualified catastrophic plan.

A QDP must meet all QHP requirements except that dental plan carriers need not be licensed to offer other health benefits. Plans must be limited to dental/oral health benefits and include essential pediatric dental benefits and other dental benefits required by the Secretary of Health and Human Services or the exchange. Carriers may offer health and dental plans jointly under certain circumstances.

Framework and Governance of the Exchange: The exchange will be governed by a nine-member Board of Trustees of the Exchange (the board) consisting of the Secretary of Health and Mental Hygiene, the Insurance Commissioner, the Executive Director of the Maryland Health Care Commission, and six members appointed by the Governor with the advice and consent of the Senate. Appointed members serve four-year terms and may not serve more than two consecutive terms. Board members are entitled to reimbursement for expenses. Members of the board must disclose certain relationships and adhere strictly to conflict of interest provisions.

Among other powers and duties, the board may sue and be sued; adopt bylaws, rules, and policies; adopt regulations; maintain an office; enter into agreements, contracts, or memoranda of understanding; apply for and receive grants, contracts, or other funding; and enter into information-sharing agreements with federal and State agencies and other state health insurance exchanges. While not subject to most State procurement laws, the board must establish an open and transparent procurement process. The board must create and consult with advisory committees and appoint to the advisory committees representatives of specified organizations.

The board must appoint an executive director of the exchange. The executive director serves at the pleasure of the board and is authorized to hire staff who are not subject to State actions governing compensation, including furloughs, pay cuts, or any other general fund cost savings measure.

The exchange is subject to numerous State laws including adoption of regulations under the Administrative Procedure Act, access to public records, open meetings, immunity and liability of State personnel, public ethics, procurement laws for minority business participation and policies for exempt units, and whistleblower and other provisions of State personnel law. The exchange is exempt from State or local taxation and specified provisions of procurement and State personnel law.

Funding and the Maryland Health Benefit Exchange Fund: Beginning January 1, 2014, the exchange may impose user fees, licensing, or other regulatory fees or assessments that do not exceed reasonable projections regarding the amount necessary to support the operations of the exchange or otherwise generate funding to support its operations. Any funding mechanisms must be transparent and broad based. Before imposing or altering any fee or assessment, the exchange must adopt regulations specifying who is subject to the fee or assessment, the amount of the fee or assessment, and the manner in which the fee or assessment will be collected. Funds collected must be deposited in the Maryland Health Benefit Exchange Fund. This special, nonlapsing fund will consist of any user fees or assessments, income from investments, interest income, and other specified sources. The exchange is prohibited from imposing fees or assessments that would provide a competitive disadvantage to health benefit plans outside of the exchange. The exchange must publish on its website the average amounts of any fees or assessments, the administrative costs of the exchange, and the amount of funds known to be lost through waste, fraud, and abuse.

Studies, Recommendations, and Annual Reporting: The exchange must study and make recommendations regarding the feasibility and desirability of the exchange engaging in selective contracting and multistate or regional contracting; the rules under which health benefit plans should be offered inside and outside of the exchange; the design and operation of the exchange's Navigator Program; the design and function of the SHOP

Exchange; how the exchange can be self-sustaining by 2015; and how the exchange should conduct its public relations and advertising campaign. The exchange must submit its findings and recommendations to the Governor and the General Assembly by December 23, 2011.

By December 1, 2015, the exchange must conduct a study and report its findings and recommendations to the Governor and the General Assembly on whether the exchange should remain an independent public body or should become a nongovernmental, nonprofit entity. Uncodified language states that it is the intent of the General Assembly that the exchange should not take any action that would inhibit the potential transformation of the exchange into a nongovernmental, nonprofit or quasi-governmental entity.

By December 1 of each year, the exchange must submit an annual report to the Secretary of Health and Human Services, the Governor, and the General Assembly.

Legislative Authority to Implement Further Powers, Duties, and Functions

Uncodified language prohibits the exchange from exercising the following powers, duties, and functions until it has submitted specified recommendations and the Governor and the General Assembly authorize the exercise of those powers, duties, and functions through legislation during the 2012 session:

- make QHPs available to qualified individuals and employers;
- assign ratings for and determine each QHP's level of coverage;
- establish a SHOP exchange;
- establish a Navigator Program;
- carry out a plan to provide assistance for consumers seeking to purchase products through the exchange;
- carry out a public relations and advertising campaign to promote the exchange;
- certify health benefit plans as QHPs; and
- impose fees or other assessments to support the operations of the exchange.

Uncodified language also prohibits the exchange from implementing any functions that require further guidance from the Secretary of Health and Human Services, until the guidance is received.

Current Law: None.

Background:

Federal Health Care Reform – the Affordable Care Act: In March 2010, major federal health care reform legislation, ACA, was enacted to expand health care coverage, control health care costs, and improve the health care delivery system. Under ACA, each state must establish a health benefit exchange that facilitates the individual purchase of QHPs. Initial structure and governance must be established by March 23, 2012. If a state fails to act, the federal government will step in to establish an exchange by January 1, 2013. By January 1, 2014, exchanges must become operational and offer consumers a choice of plans, establish common rules regarding the offering and pricing of plans, and provide information to help consumers better understand the coverage options available to them. By January 1, 2015, exchanges must be financially self-sustaining. ACA requires that an exchange perform the following core functions:

- certification, recertification, and decertification of plans;
- operation of a toll-free hotline;
- maintenance of a website for providing information on plans to current and prospective enrollees;
- assignment of a price and quality rating to plans;
- presentation of plan benefit options in a standardized format;
- provision of information on Medicaid and Children's Health Insurance Program eligibility and determination of eligibility for individuals in these programs;
- provision of an electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost-sharing reductions;
- certification of individuals exempt from the individual responsibility requirement;
- provision of information on certain individuals and to employers; and
- establishment of a Navigator program that provides grants to entities assisting consumers.

Additional functions required of the exchange include presentation of enrollee satisfaction survey results, provision of open enrollment periods, consultation with stakeholders, and publication of data on the administrative costs of the exchange.

While federal law and regulations define many elements, each state may design significant aspects of the operation and financing of its exchange. States must determine:

- governance and operation of the exchange (must be run by a government agency or a nonprofit entity);

- how many exchanges to establish (*i.e.*, combine individuals and small businesses, consider regional and multistate exchanges);
- functions of the exchange (*i.e.*, ensure that the state exchange meets federal requirements such as certifying qualified plans);
- market considerations (*i.e.*, should the state require carriers to participate, regulate plans inside and outside the exchange differently, collect premiums from small businesses, and direct the contributions to the insurance plans chosen by employers?);
- participation by small businesses (whether to allow employers with up to 50 or up to 100 employees to participate); and
- required benefits (whether or not to mandate benefits beyond the federally defined essential health benefits for insurance plans sold through the exchange and how to defray the extra cost of those benefits).

The National Association of Insurance Commissioners (NAIC), as directed under ACA, created the American Health Benefit Exchange Model Act to establish standards for the exchanges. This bill largely adopts the model act.

Implementation of Health Care Reform in Maryland: The Health Care Reform Coordinating Council (HCRCC) was established by executive order in 2010 to facilitate implementation of ACA in Maryland. The council issued its final report and recommendations in January 2011. The first recommendation was to establish the basic structure and governance of Maryland's Health Benefit Exchange, a "required building block of reform." HCRCC recommended that the enabling statute create an independent public entity, establish a board and governing principles for transparency and accountability, ensure sufficient flexibility with respect to procurement and personnel practices, and confer authority to begin some federally mandated implementation activities immediately while developing recommendations for the Governor and the General Assembly on others.

HCRCC noted the exchange must be "competitive and nimble in its hiring and procurement practices as well as nonpartisan in its administration and development of policy." HCRCC noted that, while an initial public entity is ideal, the exchange may evolve into a nonprofit later on. Therefore, HCRCC recommended that the exchange study and report to the Governor and the General Assembly by 2015 its findings and recommendations on whether it should be transformed into a nonprofit or remain a public entity.

Exchange Activity in Other States: In 2006, Massachusetts enacted landmark health reform legislation, which created the first health insurance exchange. The Massachusetts Connector sets standards for the health insurance that Massachusetts residents must have,

provides waivers of the individual mandate for those who cannot afford coverage, helps individuals and employers access coverage, provides subsidized or no-cost health insurance through the Commonwealth Care program, and provides the Commonwealth Choice program. Commonwealth Choice is an unsubsidized offering of six private health plans, selected by competitive bidding, and available through the Connector to individuals, families, and small employers (2 to 50 employees). The private plans have received the Connector's "Seal of Approval" to offer a range of benefits options, grouped by level of benefits and cost-sharing at the bronze, silver, and gold levels. There is also a special, lower-priced Young Adults Plan offering from the same six carriers, exclusively for individuals between the ages of 18 and 26. The Connector is funded through retention of 3.75% of Commonwealth Care premiums and 4.5% of Commonwealth Choice premiums. In fiscal 2010, revenues were $30.7 million ($26.9 million for the 165,000 Commonwealth Care enrollees and $3.8 million for the 24,500 Commonwealth Choice enrollees).

Utah established the Utah Health Exchange in 2009. The exchange is an Internet-based information portal that connects consumers to information about available health plans and facilitates the electronic purchase of and enrollment in such plans. The exchange was set up as a public agency in the Utah Office of Consumer Health Services with an initial appropriation of $600,000; ongoing funding is provided through budget appropriations and technology fees.

At least 21 states, including Maryland, have pending legislation to establish a health insurance exchange. In 2010, California became the first state to enact legislation to establish a health benefit exchange in response to ACA. The California Health Benefit Exchange will be run by an independent state agency governed by a five-member board appointed by the governor and legislature. The exchange will include a website that provides standardized comparison information on QHPs, a calculator for applicants to compare costs across plan options, a web-based eligibility portal to help link individuals to health coverage options available to them, and a toll-free consumer hotline. Participating carriers must offer at least one product within each of the five levels of coverage inside and outside of the exchange. Carriers not participating in the exchange are prohibited from selling the catastrophic plan. The California Health Facilities Financing Authority is authorized to loan up to $5 million for initial exchange operations, and the exchange is authorized to impose an assessment limited to one year's approved operating budget.

State Fiscal Effect: In September 2010, DHMH received a $997,227 planning and implementation grant from the U.S. Department of Health and Human Services to:

- create an information infrastructure plan;
- develop an outreach and communications strategy;

- fund Maryland-specific studies of insurance coverage and health care expenditures to determine whether to merge the individual and small group markets and whether to provide additional protection against adverse selection;
- assess current public-sector technological capabilities;
- determine whether the existing public or private-sector capacity could be adapted for online public access; and
- develop a request for proposal for eligibility system expansion or acquisition.

A portion of these funds will be expended in fiscal 2011, with the remainder in fiscal 2012. If progress is made under the exchange planning grant, Maryland will qualify for a level one establishment grant to fund the exchange in federal fiscal 2012.

Once states meet certain federal requirements, they become eligible for level two establishment grants to provide exchange funding through December 31, 2014. To be eligible for this grant, a state must have legal authority to establish and operate an exchange that complies with federal requirements; a governance structure for the exchange; a budget and initial plan for financial sustainability by 2015; a plan outlining steps to prevent fraud, waste, and abuse; and a plan describing how consumer assistance capacity in the state will be created, continued, and/or expanded, including provision for a call center. This bill helps Maryland meet some of these eligibility criteria.

Under the bill, once the exchange is operational and self-sufficient, special fund revenues and expenditures will increase by fiscal 2015.

Establishment and operation of a health benefit exchange will require significant expenditures for information technology, personnel, and administrative costs. The amount and timing of such expenditures cannot be reliably estimated at this time. *For illustrative purposes only*, initial funding for the Massachusetts Connector was approximately $25 million and the Connector employs about 45 personnel. Exchange expenditures are anticipated to be fully funded through federal grant money through December 31, 2014 and, thereafter, special fund revenues generated by the exchange.

Additional Comments: Two important functions of the exchange will be to provide information and make eligibility determinations for Medicaid and MCHP and to facilitate enrollment in those programs. This will require significant information technology infrastructure. The Governor's proposed fiscal 2012 budget includes $10.0 million related to information technology under federal health care reform: $9.0 million to help DHMH establish a secure website sufficient for allowing eligibility determination via a single application and $1.0 million to help the Department of Human Resources implement changes to the CARES and SAIL information systems.

Additional Information

Prior Introductions: None.

Cross File: HB 166 (The Speaker, *et al.*) (By Request - Administration) - Health and Government Operations.

Information Source(s): *A Health Insurance Exchange for Maryland? Comparing Massachusetts and Maryland,* Maryland Association of Health Underwriters and the National Association of Insurance and Financial Advisors of Maryland, 2010; *Final Report and Recommendations,* Maryland Health Care Reform Coordinating Council, January 1, 2011; National Association of Insurance Commissioners; National Academy of Social Insurance; National Conference of State Legislatures; Massachusetts Connector; Utah Health Exchange; Department of Budget and Management; Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - February 14, 2011
mlm/mwc Revised - Senate Third Reader - April 6, 2011

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ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: **Maryland Health Benefit Exchange Act of 2011**

BILL NUMBER: Senate Bill 182/House Bill 166

PREPARED BY: Department of Health and Mental Hygiene and
Governor's Legislative Office

PART A. ECONOMIC IMPACT RATING

This agency estimates that the proposed bill:

____ WILL HAVE MINIMAL OR NO ECONOMIC IMPACT ON MARYLAND SMALL BUSINESS

OR

__X__ WILL HAVE MEANINGFUL ECONOMIC IMPACT ON MARYLAND SMALL BUSINESSES

PART B. ECONOMIC IMPACT ANALYSIS

"The Exchange will facilitate small employers' purchase of insurance by creating a new, transparent market which will foster competition among insurers and highlight the value of policies to provide more meaningful, affordable choices for employers and their employees. In addition, beginning in 2014, a small business health insurance tax credit for up to 50% of the employer's share of employee health insurance premiums will only be available through the exchange. Employers with up to 25 employees (counted using "full-time equivalents" and excluding owners) and with average employee wages of under $50,000 will be eligible for two years of tax credits. The maximum tax credit is available for firms of up to 10 employees with average employee wages up to $25,000."