HB 1229

Department of Legislative Services

Maryland General Assembly
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FISCAL AND POLICY NOTE

House Bill 1229 (Delegate Hough, *et al.*)
Health and Government Operations

Maryland Health Benefit Exchange - Repeal - Transfer of Enrollees to Federal Health Insurance Marketplace

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This emergency bill repeals the Maryland Health Benefit Exchange (MHBE), including the MHBE Fund, the Individual Exchange, and the Small Business Health Options (SHOP) Exchange and instead expresses the intent of the General Assembly that individuals who are enrolled in MHBE will be transferred to and enrolled in the federal health insurance marketplace. The Insurance Commissioner must adopt regulations to facilitate the transfer of enrollees.

Fiscal Summary

State Effect: Repeal of MHBE and transfer of enrollees into the federal health insurance marketplace have a significant fiscal and operational impact on MHBE. MHBE expenditures (general, federal, and special funds), positions, and federal fund revenues decline by an indeterminate amount beginning in FY 2015. Given the complexity of such a transition, the specific impact cannot be reliably estimated at this time, as discussed below. The Governor's proposed FY 2015 budget includes $72.0 million and 72 positions for MHBE. Any change in expenditures will depend on what level of State operations will be necessary to supplement the federal health insurance marketplace. Regulations to facilitate the transfer of enrollees can be adopted using existing Maryland Insurance Administration (MIA) resources.

Local Effect: To the extent connector entities are impacted under the bill, Montgomery and Worcester County health departments are affected.

Small Business Effect: Minimal.

Analysis

Bill Summary: The bill repeals funding of MHBE through the health insurance premium tax. Revenues to the Maryland Health Insurance Plan (MHIP) fund may continue to be used to subsidize health insurance coverage for medically uninsurable individuals and bridge-eligible individuals; however, authorization to use MHIP fund revenue to fund the State Reinsurance Program is repealed.

The bill repeals the provision of Chapter 1 of 2014 that terminates the enrollment of a bridge-eligible individual in MHIP on the effective date of the individual's enrollment in a qualified health plan (QHP) in MHBE. MHIP must provide members with notice that they may be eligible to purchase a health benefit plan offered in the federal health insurance marketplace rather than MHBE.

The bill also preserves several studies required by Chapter 159 of 2013 regarding continuity of care, the impact of tobacco use ratings, pediatric dental benefits, and the captive producer program, but it removes participation in the studies by MHBE.

Current Law: Chapters 1 and 2 of 2011, the Maryland Health Benefit Exchange Act of 2011, established the governance, structure, and funding of MHBE, the primary function of which is to certify and make available QHPs and qualified dental plans to individuals and businesses and to serve as a gateway to an expanded Medicaid program as provided under the federal Patient Protection and Affordable Care Act (ACA). Chapters 1 and 2 established the MHBE Board of Trustees, the MHBE Fund, and qualifications for carriers to offer QHPs.

Chapter 152 of 2012, the Maryland Health Benefit Exchange Act of 2012, expanded the operating structure of MHBE by, among other things, authorizing the exchange to contract with health insurance carriers in a certain manner, establishing the framework for the Small Business Health Options Program (SHOP) Exchange, and establishing navigator programs for the SHOP and Individual exchanges. Chapter 152 required SHOP Exchange navigators to be licensed, Individual Exchange navigators to be certified, and insurance producers to be authorized to sell QHPs in the SHOP and/or Individual exchanges. Chapter 152 also established requirements for insurance carriers to participate in the individual and small group health insurance markets, with separate provisions for grandfathered and nongrandfathered health plans. Carriers with at least $10.0 million in total aggregate annual earned premium may not offer individual health benefit plans in the State unless they also offer QHPs in the Individual Exchange. Medicaid managed care organizations (MCOs) may not be required to offer qualified plans in the exchange.

Chapter 159 of 2013, the Maryland Health Progress Act of 2013, further modified State law to implement ACA by expanding Medicaid eligibility, establishing a dedicated funding stream for MHBE from the insurance premium tax on health insurers, providing for the transition of MHIP enrollees into MHBE, establishing a State Reinsurance Program, and establishing continuity-of-care requirements.

Beginning January 1, 2015, a portion of the insurance premium tax must be distributed annually to the MHBE Fund to fund the operation and administration of MHBE. Funds must be allocated from the premium tax paid by health insurers, excluding MCOs and for-profit health maintenance organizations (HMOs). Beginning in fiscal 2015, the amount distributed to the fund must be sufficient to fully fund the operation and administration of MHBE. MHBE operating expenses must be charged to non-State funds before State funds where possible.

Under Chapter 159, MHBE and MIA must conduct four studies and report their findings and recommendations to the Governor and the General Assembly on (1) the impact of ACA's allowance of a tobacco use rating of 1.5 to 1 and the options that may be available to the State to address any adverse consequences, due September 1, 2014; (2) the impact of federal regulations governing the manner in which pediatric dental benefits must be offered and the options that may be available to the State to address any adverse consequences, due December 1, 2014; (3) the captive producer program, due December 1, 2015; and (4) the implementation and efficacy of the bill's continuity-of-care provisions, which must be conducted with the Department of Health and Mental Hygiene and the Maryland Health Care Commission, and is due December 1, 2017.

Title 6 of the Insurance Article imposes a 2% premium tax on each authorized insurance company, surplus lines broker, or unauthorized insurance company that sells, or an individual who independently procures, *any type* of insurance coverage upon a risk that is located in the State. Revenues accrue to the general fund. For-profit HMOs and Medicaid MCOs are also subject to the tax. Since fiscal 2007, revenues from the tax imposed on for-profit HMOs and MCOs are distributed to the Maryland Health Care Provider Rate Stabilization Fund. Historically, money in the fund was used to pay authorized medical professional liability insurance premium subsidies and to fund Medicaid. In recent years, revenues have been used solely to support Medicaid operations. Revenues from the premium tax on all insurers are projected to be $315.2 million in fiscal 2014.

Background: Under ACA, states can elect to build a fully state-based marketplace, enter into a state-federal partnership marketplace, or default into a federally facilitated marketplace. The Secretary of Health and Human Services must establish and operate a federally facilitated marketplace in any state that is not able or willing to establish a

state-based marketplace. In a federally facilitated marketplace, the U.S. Department of Health and Human Services (HHS) will perform all marketplace functions. States entering into a partnership marketplace may administer plan management functions, in-person consumer assistance functions, or both, and HHS will perform the remaining functions. There are 17 state-based health insurance marketplaces (including Maryland and the District of Columbia), 7 partnership marketplaces (including Delaware and West Virginia), and 27 federally facilitated marketplaces (including Pennsylvania and Virginia).

State Fiscal Effect: Repeal of MHBE and transfer of enrollees into the federal health insurance marketplace have a significant fiscal and operational impact on MHBE. MHBE expenditures (general, federal, and special funds), positions, and federal fund revenues decline by an indeterminate amount beginning in fiscal 2015. Given the complexity of such a transition, the specific impact cannot be reliably estimated at this time. The amount of reduction in expenditures and positions depends on what level of State operations, if any, are necessary to supplement the federal health insurance marketplace and what information technology (IT) infrastructure is required. Despite the bill's emergency status, the bill likely has no impact in fiscal 2014 because a transition plan would be needed and contracts are already in place for the year.

In some states with federally facilitated exchanges such as Pennsylvania, the federal government assumes full responsibility for running the health insurance exchange. However, in other states, such as Virginia, states have received federal grant funds to perform significant plan management activities including collecting and analyzing information on plan rates, benefits, and cost-sharing; ensuring continued plan compliance; managing consumer complaints; and providing technical assistance. It is also unclear what additional costs might be incurred to transition to the federal health insurance marketplace. For example, in states with federally facilitated exchanges, a monthly user fee of 3.5% of the monthly premium charged by the issuer is assessed in order to fund operations of the marketplace.

The Governor's proposed fiscal 2015 budget includes $72.0 million in total funds for MHBE and 72 positions (28 of which were vacant as of December 31, 2013). This includes $43.5 million in federal funds ($25.1 million in grants and $18.4 million in federal Medicaid matching funds), $15.5 million in general funds, and $13.0 million in special funds from premium tax revenues. Fiscal 2015 operational expenditures are estimated to be $40.0 million, including $10.6 million for the call center and consumer assistance, $8.6 million for navigator grants, $8.5 million for assister grants, $6.9 million for personnel, $3.5 million for other expenditures, and $1.9 million for advertising. The remaining $32.0 million in MHBE funding is earmarked for IT contract expenditures. Total spending on MHBE for fiscal 2011 through 2015 will equal $116.5 million for operations and $186.2 million for IT development.

The bill impacts two revenue sources that will no longer be earmarked for specific purposes. First, the bill repeals authorization to use MHIP funds for a State Reinsurance Program. The program, which is intended to mitigate the impact of high-risk individuals on rates in the individual market both inside and outside MHBE, is not yet operational and no specific proposal for the program has been adopted. According to MIA, the MHIP fund balance is anticipated to be $149.6 million at the end of fiscal 2014. A portion of these funds would have been used for a State Reinsurance Program. Second, the bill repeals the requirement that, beginning in fiscal 2015, funding be provided to MHBE from the premium tax on health insurers sufficient to fully fund the operation and administration of MHBE. In fiscal 2015, the mandated appropriation for MHBE must be no less than $10 million. The Governor's proposed fiscal 2015 budget includes $13.0 million in special funds for MHBE. In subsequent years, the mandated appropriation must be no less than $35.0 million annually. If not used for MHBE, these revenues would accrue to the general fund.

Additional Comments: MHBE has faced significant difficulties with the MHBE Eligibility System (HIX), which was intended to replace current eligibility systems for Medicaid and other social service programs with a single system that serves those programs and MHBE. While MHBE will continue using HIX through the end of the current open enrollment period (March 31), the Administration has acknowledged that a significant decision regarding the future of HIX must be taken. Five options are currently under consideration: (1) remediating the current system; (2) developing a new system; (3) adopting a technology successfully used in another state; (4) joining a multistate consortium; and (5) using the federal marketplace, which could involve using the federal capability in terms of eligibility determinations but maintaining a Maryland portal.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Henry J. Kaiser Family Foundation, U.S. Centers for Medicare and Medicaid Services, Department of Budget and Management, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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