D78Y01
Maryland Health Benefit Exchange

Operating Budget Data

($ in Thousands)

	FY 16 Actual	FY 17 Working	FY 18 Allowance	FY 17-18 Change	% Change Prior Year
General Fund	$10,596	$0	$0	$0	
Adjusted General Fund	**$10,596**	**$0**	**$0**	**$0**	
Special Fund	30,466	75,120	56,300	-18,820	-25.1%
Adjustments	0	0	-16	-16	
Adjusted Special Fund	**$30,466**	**$75,120**	**$56,284**	**-$18,836**	**-25.1%**
Federal Fund	57,204	47,366	47,473	108	0.2%
Adjustments	0	0	-12	-12	
Adjusted Federal Fund	**$57,204**	**$47,366**	**$47,461**	**$95**	**0.2%**
Adjusted Grand Total	**$98,265**	**$122,486**	**$103,745**	**-$18,741**	**-15.3%**

Note: Includes targeted reversions, deficiencies, and contingent reductions.

- The $18.8 million decrease in special funds is primarily due to a decrease in funds for reinsurance payments of $18.7 million. Other than this change, the fiscal 2018 budget is essentially flat compared to fiscal 2017.

Note: Numbers may not sum to total due to rounding.

For further information contact: Lindsey B. Holthaus Phone: (410) 946-5530

Personnel Data

	FY 16 Actual	FY 17 Working	FY 18 Allowance	FY 17-18 Change
Regular Positions	74.00	67.00	67.00	0.00
Contractual FTEs	0.00	0.00	0.00	0.00
Total Personnel	**74.00**	**67.00**	**67.00**	**0.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	1.67	2.49%
Positions and Percentage Vacant as of 12/31/16	8.00	11.94%

- The fiscal 2017 working appropriation undercounts the personnel complement by 1.0 full-time equivalent (FTE). As a result, the fiscal 2018 allowance in fact decreases by 1.0 FTE over the fiscal 2017 working appropriation. An assistant Attorney General position was abolished in fiscal 2018.

- The agency's vacancy rate is 11.94%, more than enough to meet budgeted turnover.

Analysis in Brief

Major Trends

More Marylanders Are Enrolled in a Qualified Health Plan: After the fourth open enrollment period, 151,000 consumers were enrolled in a Qualified Health Plan (QHP), the highest to date. The silver metal level QHP was the most selected metal plan in calendar 2016.

Uninsured Rate Continues to Decrease: The uninsured rate dropped to a low of 6.6% in fiscal 2015 from 7.9% in fiscal 2014. The uninsured rate in Maryland continues to trend below the national rate of 9.4% in fiscal 2015.

Latinos and Younger Marylanders Have the Highest Uninsured Rate: While the uninsured rate decreased for all Marylanders, the rate for Hispanic/Latino adults (33%) and adults aged 26 to 34 (13%) remains high.

Premiums for All Participating Carriers Increased: For the fourth open enrollment period, all carriers offering a plan on the exchange increased rates ranging from 20% to 30%. Carriers had more information on actual experience available to set rates for the 2017 plan year. The increases are due partially to higher hospital and pharmaceutical costs.

Issues

Impact of Potential Changes at the Federal Level to the Affordable Care Act on the Maryland Health Benefit Exchange: While details remain uncertain, repeal or substantial amendment of the Affordable Care Act and/or the adoption of alternative reforms could have a significant impact on Maryland and will likely require the General Assembly to consider financial and policy decisions.

Access to Qualified Health Plans: Although the State's uninsured rate dropped to 6.6% in fiscal 2015 from 10.2% in fiscal 2013, some State residents remain ineligible due to citizenship status. This issue will discuss the options available to those State residents who are ineligible for QHPs through the exchange.

Premium Increases and Market Competitiveness: The Maryland Insurance Administration approved premium increases of 20% to 30% for insurers selling 2017 plans. Additionally, UnitedHealthcare, which previously comprised 10% of the market, decided to no longer participate in the exchange while Evergreen was not allowed to participate in the exchange while awaiting acquisition to convert to a for-profit company. This issue will discuss affordability of QHPs after premium increases and the competitiveness of the exchange.

Recommended Actions

		Funds
1.	Reduce funds for information technology enhancements.	$ 250,000
	Total Reductions	**$ 250,000**

Updates

Progress Report on the Maryland Health Benefit Exchange: The second and third open enrollment, after the switch to a new information technology platform and additional enhancements, were generally successful. The fourth open enrollment included additional user-focused enhancements.

D78Y01
Maryland Health Benefit Exchange

Operating Budget Analysis

Program Description

The Maryland Health Benefit Exchange (MHBE) was created during the 2011 session in response to the federal Patient Protection and Affordable Care Act (ACA) of 2010. MHBE is intended to provide a marketplace for individuals and small businesses to purchase affordable health coverage.

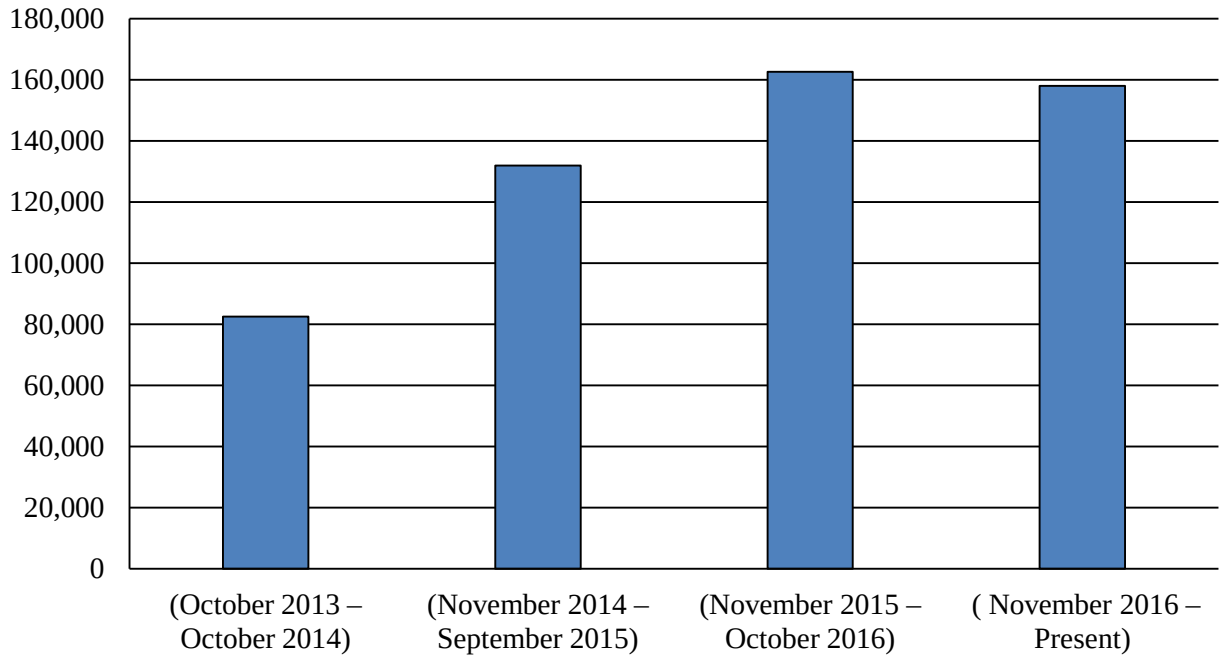
Through the Maryland Health Connection (MHC), Maryland residents can shop for health insurance plans, compare rates, and determine their eligibility for tax credits, cost-sharing reductions, and public assistance programs such as Medicaid. Once an individual, family, or small business selects a Qualified Health Plan (QHP) or available program, they enroll in that program directly through MHC. Under the ACA, to be certified as a QHP, an insurance plan must meet certain requirements including providing at least 10 essential benefits with no lifetime maximums and follow established limits on cost sharing (deductibles, copayments, and out-of-pocket maximum amounts). The same rules apply to plans sold both in and out of the exchange, but in order to be sold in the exchange, a health plan must also be certified by the exchange as a QHP. Premium subsidies and cost-sharing reductions are only available to plans purchased in the exchange by eligible individuals.

Performance Analysis: Managing for Results

1. More Marylanders Are Enrolled in a Qualified Health Plan

As of February 1, 2017, 158,000 individuals enrolled in a QHP through MHBE. As shown in **Exhibit 1**, QHP enrollment increased significantly during the second open enrollment period (November 2014 through September 2015), with 131,974 individuals enrolled in coverage. Enrollment then experienced modest growth during the third open enrollment period (November 2015 through October 2016), with 162,652 individuals enrolled in a QHP. Of those enrolled during the third open enrollment period 51,195 were new. Enrollment declined slightly during the fourth open enrollment period (November 2016 through February 2017). Higher premiums for the fourth open enrollment may be a contributing factor to the decrease. Of those enrolled during the fourth open enrollment period, 64,000 were new. More than two-thirds (77%) of individuals purchasing QHPs received an advanced premium tax credit (APTC) in the fourth open enrollment.

Exhibit 1
Qualified Health Plan Enrollment
First Open Enrollment through Fourth Open Enrollment Period



APTC: advanced premium tax credit

Source: Centers for Medicare and Medicaid Services; Maryland Health Benefit Exchange

In calendar 2015 and 2016, MHBE asked the State Health Access Data Assistance Center (SHADAC) to analyze the geographic distribution of Maryland's remaining eligible population. The research excluded estimates of unauthorized immigrants and of uninsured workers who declined qualified health coverage from their employer – individuals who would not be eligible for financial assistance under the ACA. As of calendar 2016, an estimated 240,000 additional Marylanders are eligible for private qualified health insurance through the marketplace. **Exhibit 2** shows the areas that SHADAC identified with the most eligible population remaining.

In calendar 2016, MHBE conducted a large-scale survey of Marylanders to assess awareness and opinions about the health insurance marketplace and analyze challenges that remain to enrolling the uninsured. Results from the survey helped guide marketing and outreach strategies for the 2017 open enrollment.

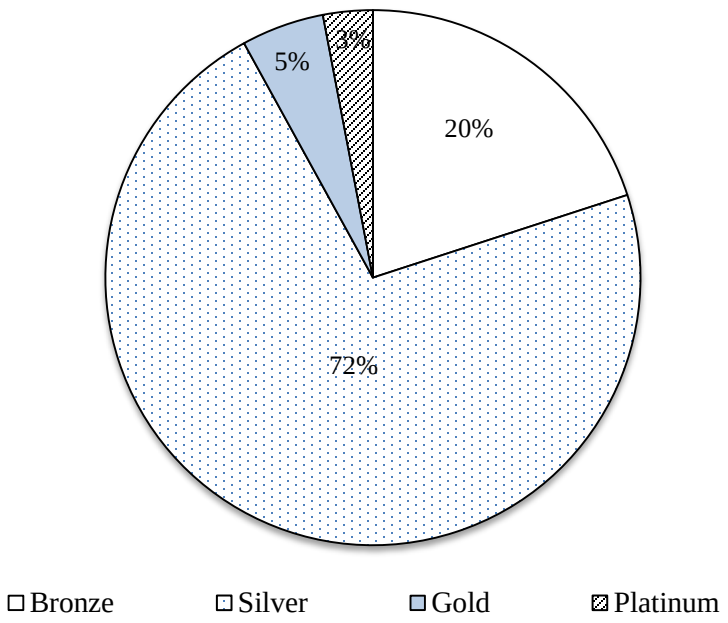
Exhibit 2
Areas with Most Eligible Population Remaining
Public Use Microdata Area
Calendar 2016

Public Use Microdata Area	By Number of Population Remaining Eligible	Public Use Microdata Area	Percent of Eligible Population Not Enrolled
St. Mary's and Calvert counties	9,539	St. Mary's and Calvert counties	75%
Howard County (East) – Columbia (East), Ellicott City (Southeast), and Elkridge	9,456	Cecil County	72%
Queen Anne's, Talbot, Caroline, Dorchester, and Kent counties	9,002	Harford County (South and East) – Aberdeen and Havre de Grace	71%
Montgomery County (South) – Bethesda, Potomac, and North Bethesda	8,854	Carroll County	70%
Montgomery County (West Central) – Germantown, and Montgomery Village	8,780	Baltimore City – Inner Harbor, Canton, and Bayview	70%

Source: Maryland Health Benefit Exchange

In terms of QHP plan selection, in calendar 2016, the silver metal level was the most selected level by consumers for the third year. **Exhibit 3** shows the percentage of QHP consumers choosing this plan in calendar 2016 (as of January 2017), 72%, increasing from 62% in calendar 2015. Plans with a higher metal level typically have higher premiums and lower out-of-pocket costs. Plan levels include bronze, silver, gold, and platinum. For example, in a silver metal plan, on average, the issuer pays 70% of health care costs while the insured pays 30% out-of-pocket. Consumers chose fewer bronze, gold, and platinum plans. Silver plans are the only plans where an individual under 250% of the federal poverty level can qualify for cost-sharing reductions. People under the age of 30 and some people with limited incomes may buy an alternative kind of coverage called a "catastrophic" health plan.

Exhibit 3
Qualified Health Plan Enrollment by Metal Level
January 2017

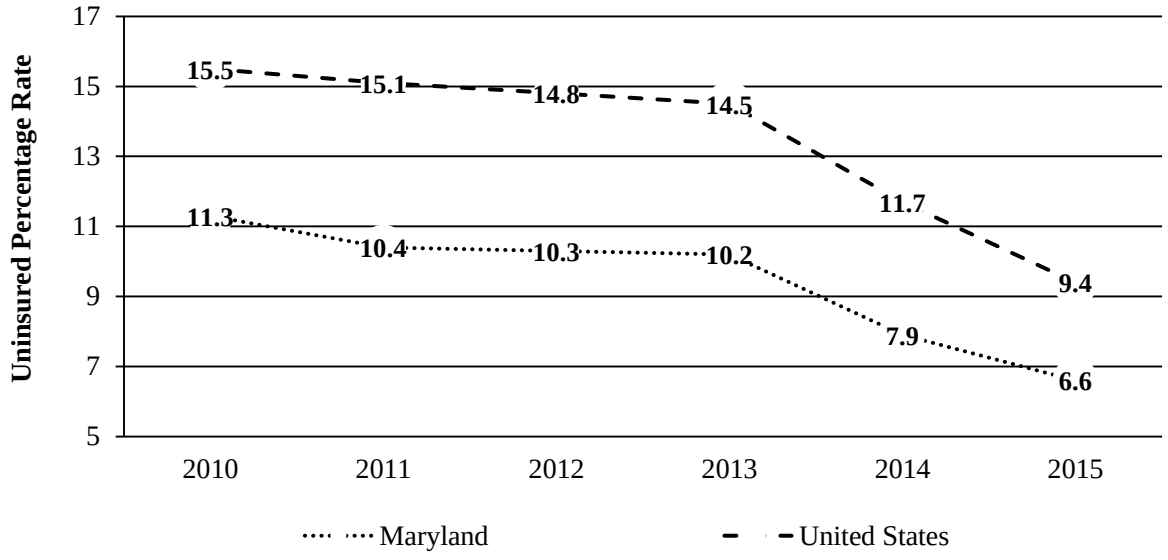


Source: Maryland Health Benefit Exchange

2. Uninsured Rate Continues to Decrease

Maryland has experienced a significant decrease in the number of uninsured residents since calendar 2010, when the first ACA reforms went into effect. As shown in **Exhibit 4**, the uninsured rate in the State has dropped from 11.3% (641,000) in calendar 2010 to 6.6% (389,000) in calendar 2015 based on data reported by the U.S. Census Bureau. The most significant drop occurred in calendar 2014 and 2015, the first two years of full ACA implementation, including MHBE and the Medicaid expansion. Nationwide, the uninsured rate fell from 15.5% in calendar 2010 to 9.4% in calendar 2015.

Exhibit 4
Uninsured Rate: United States and Maryland
Calendar 2010-2015 (All Ages)



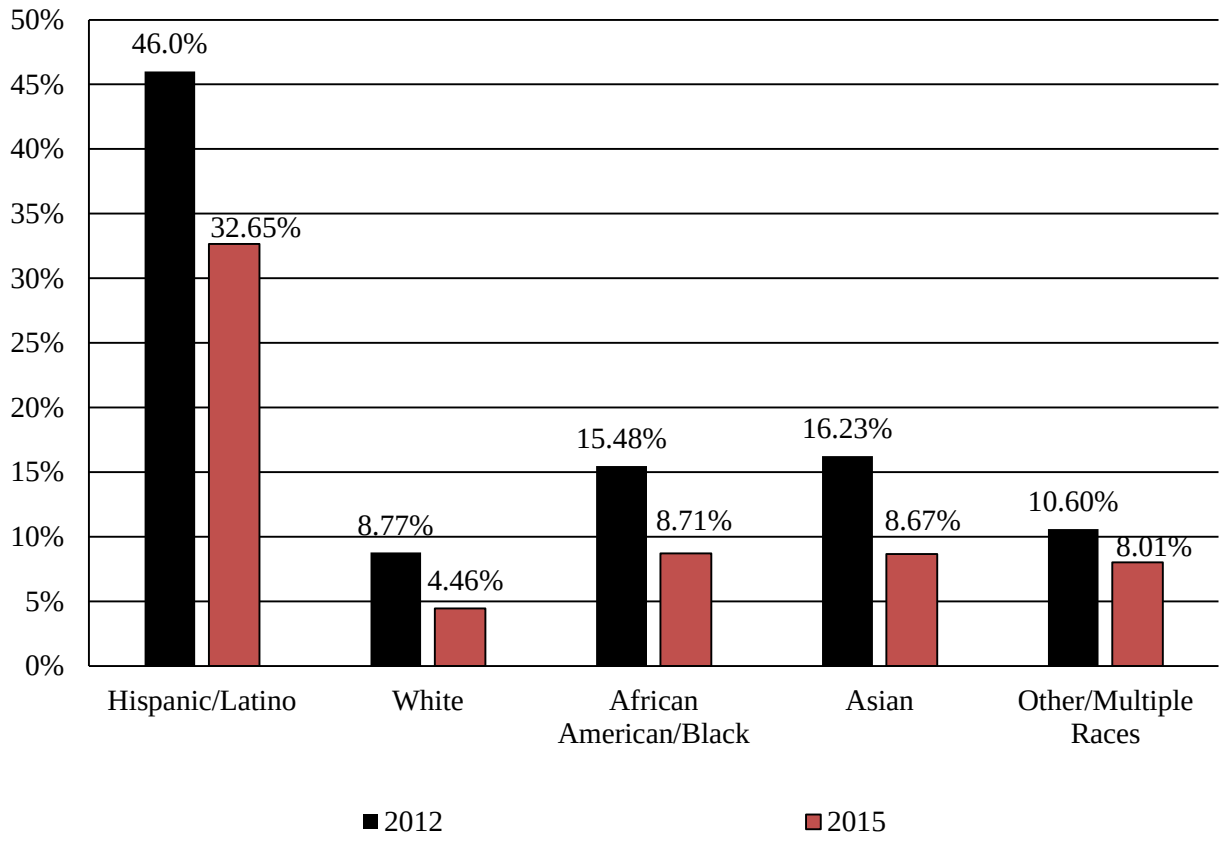
Source: U.S. Census Bureau, *American Community Survey*

Maryland's uninsured rate of 6.6% in calendar 2015, as reported by the U.S. Census Bureau, is somewhat lower than the average uninsured rate of 7.2% for states that expanded Medicaid eligibility and substantially lower than the average uninsured rate of 12.3% for states that did not expand Medicaid eligibility.

3. Latinos and Younger Marylanders Have the Highest Uninsured Rate

As shown in **Exhibit 5,** the uninsured rate by race/ethnicity for Maryland adults is much higher for the Hispanic/Latino population, with 32.65% of the Hispanic/Latino (18- to 64-year olds) population uninsured in calendar 2015. The rate is also nearly twice as high for African Americans and Asians than for Whites, although progress was made for both with rates nearly cut in half from calendar 2012 to 2015.

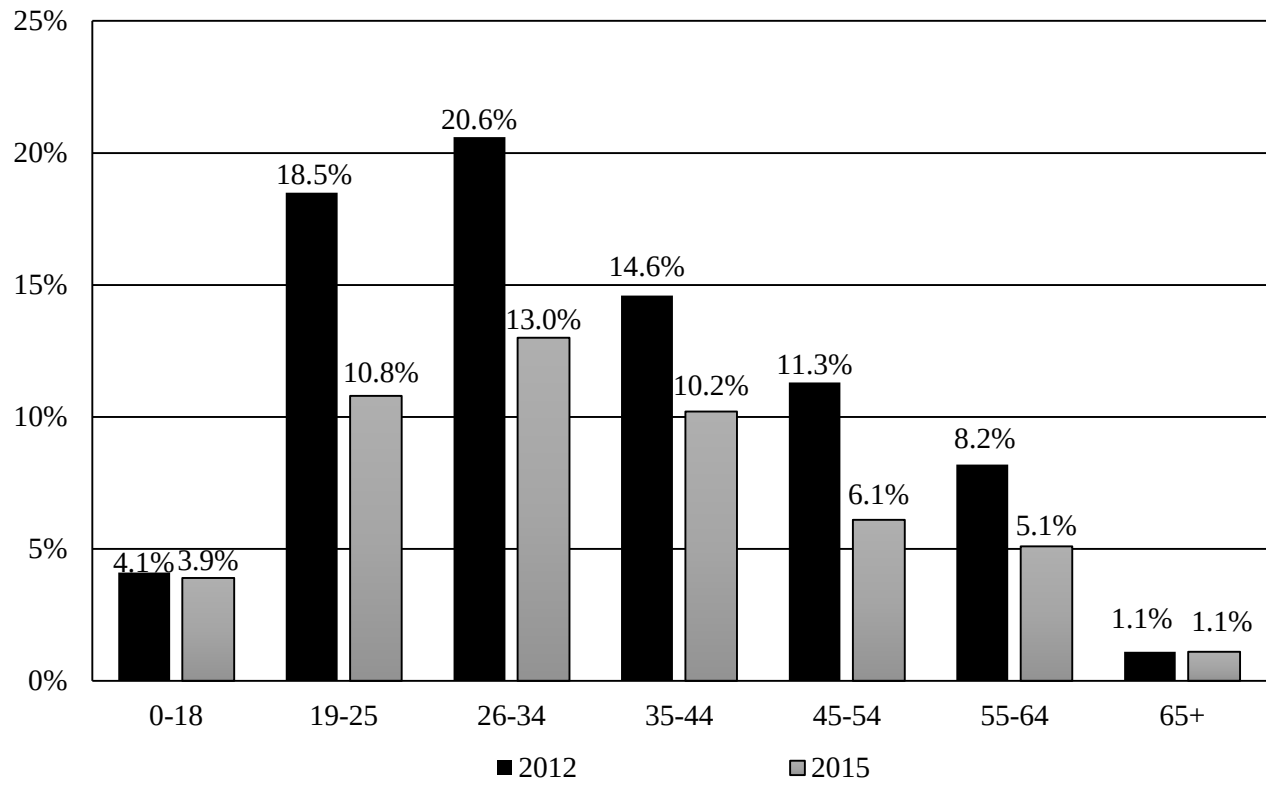
Exhibit 5
Maryland's Uninsured Rate by Race/Ethnicity (Ages 18 to 64)
Calendar 2012 vs. 2015



Source: U.S. Census Bureau, *American Community Survey*; Department of Legislative Services

From calendar 2012 to 2015, the uninsured rate decreased for all age groups. As shown in **Exhibit 6**, the uninsured rate remains highest among ages 26 to 34. The ACA provision, permitting dependents to remain on their parents' insurance plan until their twenty-sixth birthday, is a potential factor contributing to the higher rates for this group, as young adults phase out of their parent's coverage. Additionally, as this age group is younger, more individuals may be healthier and opt out of buying coverage until needed. Children and individuals older than age 65 are insured at a higher rate due to the Maryland Children's Health Program, which insures children up to 300% federal poverty guidelines (FPG) (compared to Medicaid for adults which effectively covers up to 138% FPG), and Medicare, which is available to most individuals age 65 and older.

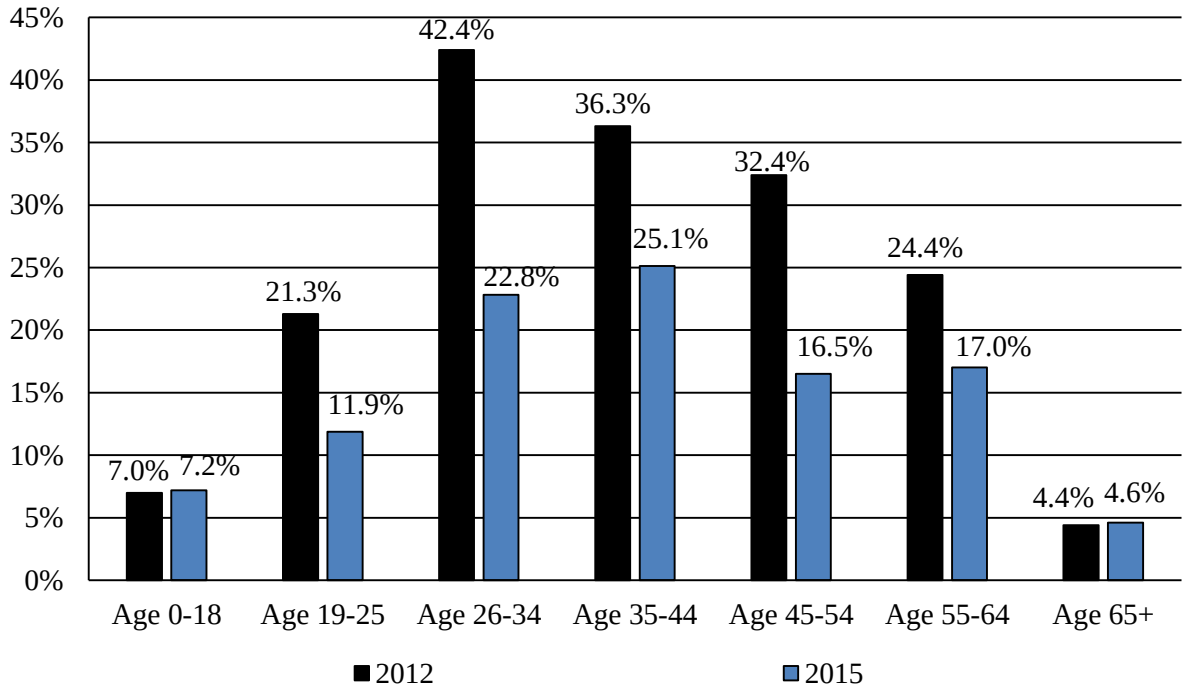
Exhibit 6
Maryland's Uninsured Rate by Age (All Ages)
Calendar 2012 vs. 2015



Source: U.S. Census Bureau, *American Community Survey*; Department of Legislative Services

Exhibit 7 shows the uninsured rate by age category for individuals with household incomes up to 138% FPG. Given the expansion of Medicaid eligibility to 138% FPG (based on calculation of modified adjusted gross income), it is not surprising that the uninsured rate declined significantly for adults at this income level (children were already generally eligible for coverage). For ages 35 to 44 at this income level, 25.1% remained uninsured in calendar 2015.

Exhibit 7
Maryland's Uninsured Rate for Individuals with Household Incomes Less Than 138% of Federal Poverty Guidelines by Age
Calendar 2012 vs. 2015

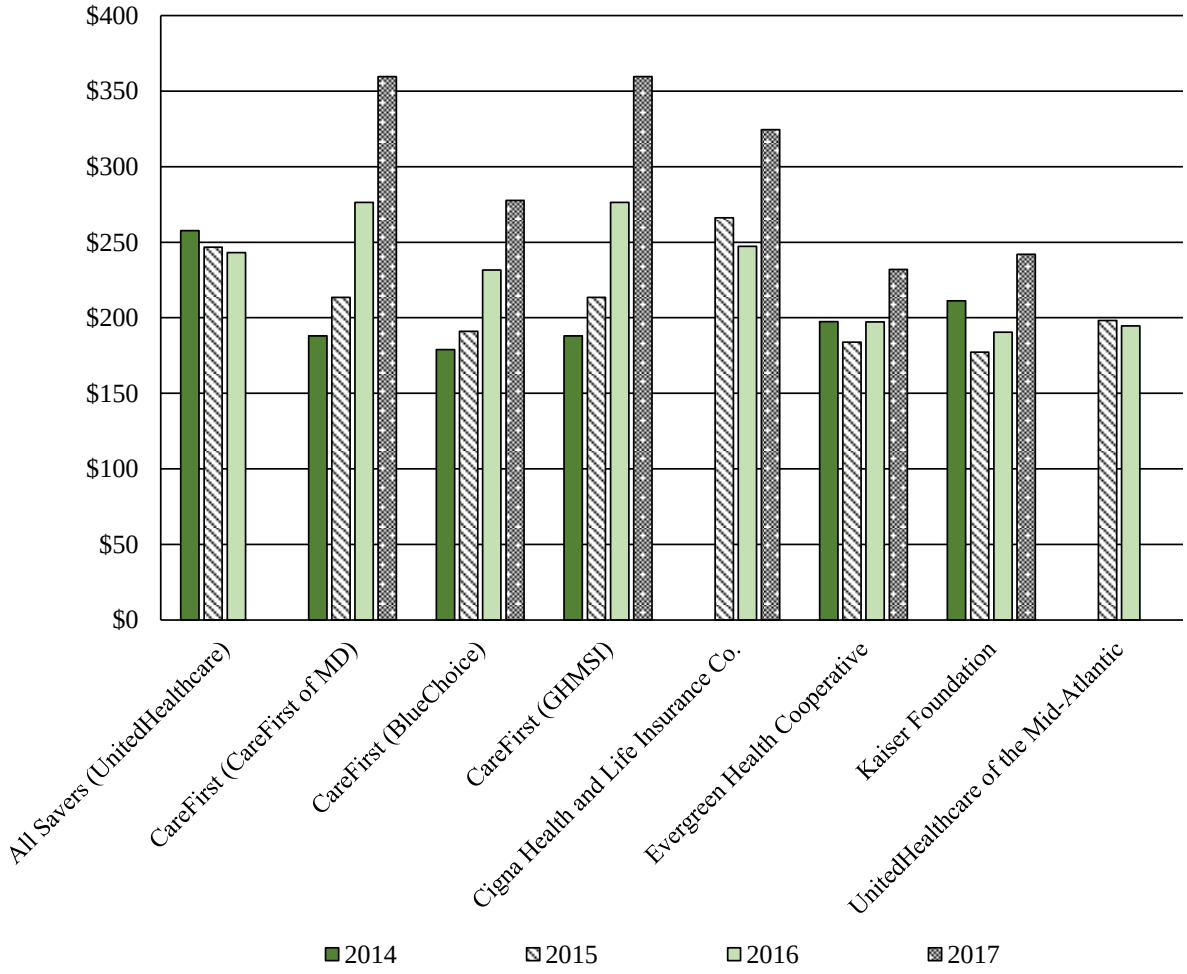


Source: State Health Access Data Assistance Center, Analysis of the *American Community Survey*

4. Premiums for All Participating Carriers Increased

Instability in Maryland's individual insurance market has required consumers to shop carefully for a health plan that meets both their health care needs and budget. The number of carriers participating in the individual market has fluctuated from six in 2014 to eight in calendar 2015 and 2016 and down to five in calendar 2017. Three of these carriers are under the CareFirst umbrella. As shown in **Exhibit 8**, the lowest-cost silver plan for a 21-year-old individual offered by each carrier in the Baltimore metropolitan area has increased in price for all carriers. Although Evergreen Health Cooperative Inc., had the lowest approved rates for calendar 2017, the Maryland Insurance Administration (MIA) announced on December 8, 2016, that Evergreen plans will not be available in the individual market for the 2017 plan year. As a result, Kaiser has the lowest-priced silver plan among the five remaining carriers.

Exhibit 8
Baltimore Metropolitan Area Approved Monthly Rate Examples
Lowest-priced Silver Plan – Age 21
Calendar 2014-2017



MD: Maryland
GHMSI: Group Hospitalization and Medical Services, Inc.

Note: Despite approved rates, Evergreen plans are not available in 2017.

Source: Maryland Insurance Administration

While premiums have increased across carriers, the APTC also increases at the same rate when an individual enrolls in the second lowest-cost silver plan.

Fiscal 2017 Actions

Section 20 Position Abolitions

The fiscal 2017 budget bill contained a section that directed the Executive Branch to abolish 657 positions and achieve a savings of $25 million, including $20 million in general funds and $5 million in special funds. This agency's share of the reduction is 1 position and approximately $69,202 in special funds for 1 administrative officer.

Proposed Budget

As shown in **Exhibit 9**, the Governor's fiscal 2018 allowance falls by $18.7 million (15.3%) over the fiscal 2017 working appropriation, primarily due to a reduction in special funds for reinsurance payments ($18.7 million).

Exhibit 9
Proposed Budget
Maryland Health Benefit Exchange
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Total
Fiscal 2016 Actual	$10,596	$30,466	$57,204	$98,265
Fiscal 2017 Working Appropriation	0	75,120	47,366	122,486
Fiscal 2018 Allowance	0	56,284	47,461	103,745
Fiscal 2017-2018 Amount Change	$0	-$18,836	$95	-$18,741
Fiscal 2017-2018 Percent Change		-25.1%	0.2%	-15.3%

Where It Goes:	
Personnel Expenses	
Turnover adjustments	$97
Other fringe benefit adjustments	-2
Employee and retiree health insurance	-44
Regular earnings and adjustments	-64
Program Direction	
Call center contract transition	1,893
Office relocation (current lease expires December 2017)	150
Customer support	120

Where It Goes:	
Customer relationship management licenses	75
Software maintenance (align to actual)	50
Rent	28
Subscription dues	-13
Salesforce training	-18
Contractual audit services	-45
University of Maryland Baltimore County/Hilltop studies	-100
Quality and disparity data collection – MHCC	-139
Printing and fulfillment	-1,000
Other	-9
Major Information Technology Projects	
Software	15
Major Information Technology Projects	-952
Reinsurance Program	
Costs associated with the Maryland Health Insurance Plan	-89
Reinsurance Fund	-18,700
Total	**-$18,747**

MHCC: Maryland Health Care Commission

Note: Numbers may not sum to total due to rounding.

Across-the-board Reductions

The fiscal 2018 budget bill includes a $54.5 million (all funds) across-the-board contingent reduction for a supplemental pension payment. Annual payments are mandated for fiscal 2017 through 2020 if the Unassigned General Fund balance exceeds a certain amount at the close of the fiscal year. This agency's share of these reductions is $16,000 in special funds, and $12,000 in federal funds. This action is tied to a provision in the Budget Reconciliation and Financing Act of 2017.

Personnel Expenses

Personnel expenses decrease the MHBE budget by $13,000. There was an increase of $97,000 to reduce turnover expectancy and a decrease of $64,000 in regular earnings and other salary adjustments due to the abolition of 1 position in fiscal 2018. Additionally, there was a decrease of $44,000 in employee and retiree health insurance.

Program Direction

Program Direction Expenses increase by $1 million in the fiscal 2018 allowance, primarily in special projects. Of the increase in special projects, $1.9 million was due to an increase in the consolidated service center (call center), offset by a $1.0 million reduction in printing/fulfillment services. Both of these services are currently provided by Maximus. The total fiscal 2018 funding for the call center is $26.0 million, approximately $1.9 million greater than the fiscal 2017 appropriation. Actual funding in fiscal 2016 totaled $33.0 million. However, that reflected a higher call volume due to an increase in Medicaid redeterminations through MHBE. The current call center contract ends on December 31, 2017, and funds are needed to transition to the new contract. The new contract, which will separate from fulfillment services and become a stand-alone contract, will include a managed care organization selection, primary care physician selection, and health assessment for Medicaid. The new contract will also include Medicaid enrollment packet distribution. MHBE is proposing a three-year contract with options and will provide for a transition period to be complete before open enrollment begins on November 1, 2017. In addition to special projects, which total $33.2 million in fiscal 2018, rent increases by $28,000 to pay for the current space and new space concurrently during the move.

Major Information Technology Projects

The budget for major information technology (IT) projects falls in fiscal 2018 by $937,000 over the fiscal 2017 appropriation to $30.6 million. As the MHBE matures, fewer IT enhancements and website improvements are needed. Of the $937,000, there is a decrease of $300,000 for the Small Business Health Options Program (SHOP) development, $560,000 for document processing, $50,000 for software monitoring, and $265,000 to the Chesapeake Regional Information System for our Patients (CRISP) for provider information management partially offset by a $190,000 increase to CRISP for the all-payer claims database updates. Additionally, software enhancements increase the fiscal 2018 allowance by $15,000 for timekeeping software used for the Project Management Office (PMO) staff.

MHBE serves both Medicaid enrollees and QHP consumers. However, MHBE no longer receives federal funding for IT projects that would serve solely the QHP population. Instead, MHBE receives a federal match from 75% to 90% for IT activities related to the Medicaid population. The projects proposed for the current fiscal 2018 budget include a mix of projects for both the Medicaid and QHP population. Given the current uncertainty surrounding the future of QHPs, it may not be appropriate to invest heavily in IT improvements and enhancements solely for the QHP population at MHBE. It is important to note that while MHBE is solely funded with special and federal funds, special funds not expended return to the General Fund. **Therefore, the Department of Legislative Services recommends reducing the special fund appropriation for IT by $250,000.**

Reinsurance Program

Payments through the Reinsurance Program decrease the agency's budget by $18.7 million in special funds. In fiscal 2017, the budget included $40.0 million in special funds to pay for calendar 2015 claims. Calendar 2016 claims will be paid out of the fiscal 2018 budget, which includes $21.3 million, an $18.7 million decrease. Fiscal 2018 is the last year reinsurance is expected to be paid.

Issues

1. Impact of Potential Changes at the Federal Level to the Affordable Care Act on the Maryland Health Benefit Exchange

Consequences for the State from Repeal and Replacement

Since the passage of the ACA, Maryland has moved to fully implement the health reforms ushered in by the law by enacting legislation establishing MHBE, expanding Medicaid eligibility, conforming State health insurance law to federal law, and requiring health insurance carriers to follow specific provisions of the ACA, in effect, allowing the Insurance Commissioner to enforce those provisions in the State. Legislation enacted to implement the ACA also closed enrollment in the Maryland Health Insurance Plan (MHIP) and provided for the transition of MHIP enrollees into MHBE. While details remain uncertain, repeal or substantial amendment of the ACA and/or the adoption of alternative reforms could have a significant impact on Maryland and will likely require the General Assembly to consider financial and policy decisions, which are outlined below.

Maryland Health Benefit Exchange

Legislation enacted in 2011 and 2012, established MHBE with a primary function of certifying and making available QHPs to individuals and businesses and to serve as a gateway to an expanded Medicaid program under the ACA. A number of MHBE statutory functions, such as determining consumer eligibility for tax credits and facilitating enrollment in QHPs, are founded on the ACA.

If the ACA is repealed without replacement, Marylanders are at risk of losing both the APTC and cost-sharing reductions (CSR). In tax year 2014, an APTC was claimed on 26,230 Maryland tax returns for a total value of $63.9 million. Estimates for tax year 2016 project that the average monthly APTC in Maryland was $243, with 100,844 individuals receiving credits for a total value of $294.1 million. CSR are paid for by carriers who are then reimbursed from the federal government. If the federal government no longer subsidized insurers for cost sharing, they would either stop offering CSR or raise premiums to offset the costs.

On the other side of the equation, a principal feature of the ACA is the individual mandate. Most U.S. citizens and legal residents must have qualifying health coverage each month, qualify for an exemption, or pay a tax penalty (known as the health care individual responsibility payment) when they file their federal tax return. The purpose of the mandate is to incentivize all individuals to purchase health insurance coverage in order to guarantee a broad pool of insured individuals. Internal Revenue Service data shows that in tax year 2014 (the most recent data available), 104,340 Maryland tax returns were subject to the health care individual responsibility payment. The value of these payments was $23.6 million, an average of $226 per return. The penalty increased in subsequent years. Repeal of the ACA would eliminate the penalty.

As shown in Exhibit 9, in fiscal 2018, MHBE is estimated to be funded with a total of $104.0 million ($47.5 million in federal funds and $56.3 million in special funds). The special funds include $35.0 million in special funds from the State premium tax and $21.3 million in former MHIP funds for the State Reinsurance Program (that is not planned to continue after fiscal 2018). State law mandates an annual appropriation of at least $35.0 million to support MHBE.

Although MHBE is currently funded with special and federal funds and, therefore, could be financed after an ACA repeal, both consumers and insurers will be affected by a repeal. Some insurance companies may drop out of the ACA exchanges as soon as 2018. Insurance companies technically have until March 2017 to decide if they will offer coverage in Maryland in 2018, when they must declare to MIA. For those that decide to stay, a report by the Congressional Budget Office estimates an increase for premiums of an additional 20% to 25% on top of normal increases. If the APTC and CSR are lost, there will likely be a large drop in enrollment, leaving a pool of sicker, costly consumers.

It is also important to note that all income-based enrollment in Medicaid is done via the exchange's eligibility system. This function will not disappear regardless of actions at the federal level. **The agency should comment on how it intends to plan for the next round of open enrollment given uncertainty at the federal level.**

2. Access to Qualified Health Plans

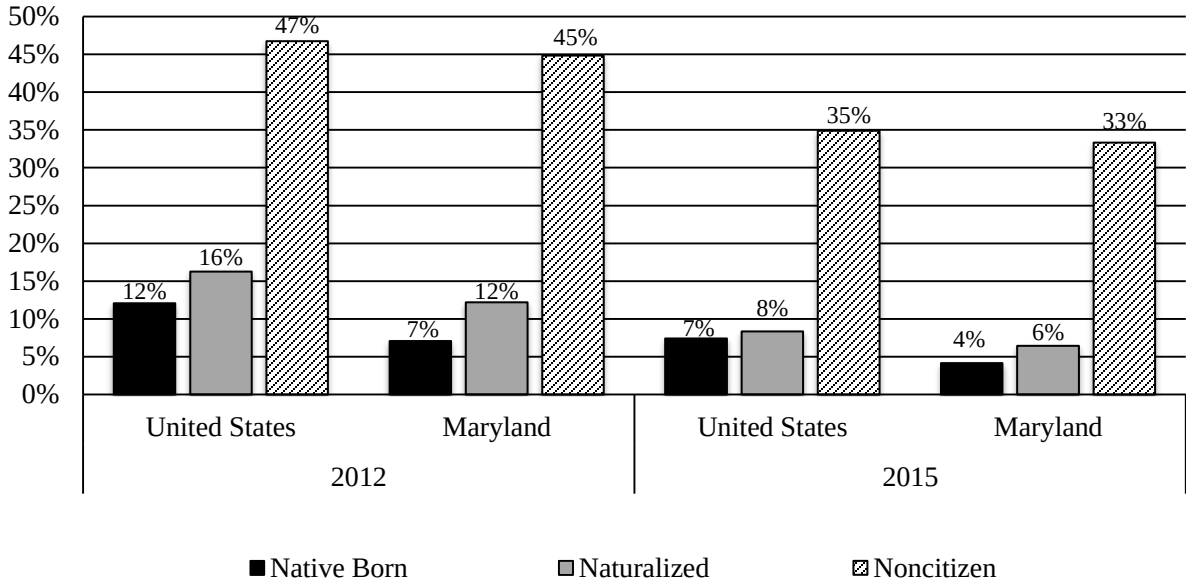
Although the State's uninsured rate dropped to 6.6% in 2015 from 10.2% in 2013, some State residents remain ineligible. Noncitizens, in particular, may lack access to purchasing a QHP. Noncitizens include both legal residents (documented noncitizens) and undocumented immigrants. A legal resident includes those with a green card, visa, or other legal status who have not become a naturalized citizen, which consists of being a permanent legal resident for at least five years (three years if a spouse of a U.S. citizen) or having a qualifying service in the U.S. Armed Forces and meeting other eligibility requirements.

Uninsured Rate by Citizenship Status

As shown in **Exhibit 10**, insurance coverage for immigrants differs by citizenship status. The exhibit shows that native born citizens were more likely to be insured than naturalized citizens, and naturalized citizens were more likely to be insured than noncitizens.

From calendar 2012 to 2015, the uninsured rate decreased from 7% to 4% for native born citizens and from 12% to 6% for naturalized citizens. The uninsured rate among noncitizens fell, but only from 45% to 33%. Since the noncitizen population contains both undocumented immigrants and legal residents, it is likely that the uninsured rate is higher for noncitizens due to their ineligibility for Medicaid (most naturalized citizens will qualify for Medicaid if they have been a permanent resident for five years). Noncitizens may be more likely to have characteristics related to being uninsured, including being male, young, single, and having lower education and income. They may also work in jobs that do not provide health insurance coverage.

Exhibit 10
Maryland's Uninsured Rate by Citizenship Status (All Ages)
Calendar 2012 vs. 2015



Source: State Health Access Data Assistance Center, Analysis of the *American Community Survey*

Health Insurance Options for Noncitizens

Noncitizens are largely limited to purchasing private coverage outside of MHBE if they do not have an immigration status that qualifies an individual to purchase through MHBE including: lawful permanent resident (green card holder), asylees, refugees, Cuban/Haitian entrants paroled into the United States, battered spouse/child/parent, temporary protected status, deferred enforced departure, nonimmigrant status (such as H-1B, H-2A, H-2B), student visas, U visa, and T visa. Undocumented immigrants without one of the qualifying statuses are unable to purchase a QHP through MHBE.

Noncitizens are also not eligible for Medicaid but may receive Emergency Medicaid, which includes labor and delivery services. Once an individual becomes a legal resident, there is a five-year waiting period to receive Medicaid. Individuals residing in Maryland on student or temporary work visas are not eligible for Medicaid. During this five-year waiting period, however, legal residents can buy a QHP through MHBE and may qualify for financial assistance based on their income. Undocumented immigrants are ineligible for Medicaid and ineligible to purchase a QHP through MHBE.

Geographic Location of the Uninsured and Noncitizens

As shown in **Exhibit 11**, the uninsured rate in Maryland varies by geographic area, from a low of 1.8% in parts of Harford County (north and west) – Bel Air Town, Fallston, and Jarrettsville – to a high of 22.8% in parts of Prince George's County (northwest) – College Park and Langley Park. This high rate is likely attributable to the large Hispanic population and the number of noncitizens, particularly in Langley Park. As discussed, these populations are both more likely to be uninsured. According to the U.S. Census Bureau, in Langley Park, 76.6% of the population are Hispanic, 58.5% are noncitizens, and 53.8% are uninsured. In College Park, only 7.9% of residents are uninsured.

Low-income, uninsured adults who, because of immigration status, may not qualify for Medicaid or a QHP, may have access to a safety-net clinic, such as Montgomery Cares that provides primary health care services. **The agency should comment on future plans to provide health insurance options for those currently ineligible to purchase a QHP offered through MHBE.**

Exhibit 11
Uninsured Rate in Maryland by Public Use Microdata Area
Calendar 2015 (All Ages)

Note: A Public Use Microdata Area (PUMA) is a geographic unit used by the U.S. Census Bureau. Each PUMA contains at least 100,000 people. PUMAs do not overlap. There are 2,378 PUMAs in Maryland based on the 2010 census.

Source: U.S. Census Bureau (*American Community Survey*)

3. Premium Increases and Market Competitiveness

The large rate increase in 2017 for CareFirst in the individual market, as well as other carriers, is due to carriers aligning premiums with actual costs. Insurer premiums in the first years were low relative to the marketwide risk profile. Now that carriers have received actual claims, more information is available to accurately price insurance.

In addition to knowing actual claims, two mechanisms created under the ACA that were intended to stabilize premiums in the earlier years of the ACA implementation were temporary programs. Reinsurance that provided payments to plans that enroll higher cost individuals and Risk Corridors that provided payments to plans with higher than expected claims, both ended after 2016. The ACA created a third mechanism – Risk Adjustment – intended to protect against the negative effects of adverse selection by redistributing funds from plans with lower risk enrollees to plans with higher risk enrollees. This is a permanent program under the ACA.

Advanced Premium Tax Credits and Cost-sharing Reductions

Individuals who purchase an insurance plan through MHBE may be eligible for financial assistance, reducing premiums and out-of-pocket expenses compared to purchasing the plan outside of MHBE. Through the ACA, consumers who purchase a QHP through MHBE may be eligible for an APTC, which can be used by individuals earning up to 400% FPG to help pay monthly health insurance premiums. An individual will qualify for the APTC in 2017 if their income is less than approximately $48,240.

In addition to the APTC, an individual enrolled in a silver plan may qualify for a CSR. The CSR lowers the amount that individuals pay out-of-pocket for essential health benefits and may include lower copays or deductibles.

Exhibit 12 shows an example of income levels for subsidy eligibility for a 40-year-old nonsmoker in the Baltimore metropolitan area. With an income of greater than $48,240 (400% FPG), the individual pays the full premium and out-of-pocket maximum. From $30,000 to $48,240, the individual would qualify for a small APTC to decrease the cost of their premium. From $17,000 to $30,000, an individual would qualify for both an APTC to lower premiums and an APTC to lower out-of-pocket costs.

Exhibit 12
Income Levels for Subsidy Eligibility
Sample for Blue Choice HMO Silver $3,500

Income Range	Subsidy Eligibility	Full Cost of Monthly Premium	Member Monthly Premium	Member Annual Premium		Member Out-of-pocket Maximum	Potential Annual Cost (Annual Premium + Out-of-pocket Maximum)
>$48,240	No Subsidy	$355	$355	$4,260	+	$6,850 =	$11,110
~$30,000-$48,240	APTC Only		$349-$355	$3,000-$4,260	+	$6,850 =	$9,850-$11,110
~$24,000-$30,000	CSR and APTC		$173-$249	$2,100-$3,000	+	$5,700 =	$7,800-$8,700
~$17,000-$24,000	CSR and APTC		$93-$173	$1,100-$2,100	+	$2,250 =	$3,360-$4,350

APTC: advanced premium tax credit
CSR: cost-sharing reductions
HMO: health maintenance organizations

Note: All premium rates are for 40-year-old individual, nonsmokers in the Baltimore metropolitan area.

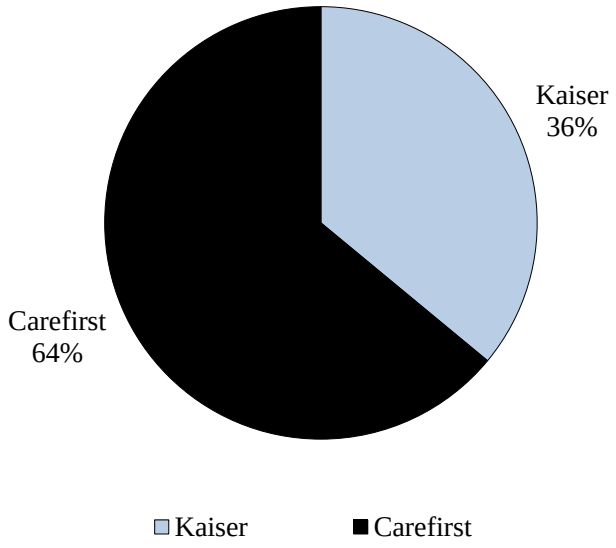
Source: CareFirst Testimony to the Health and Government Operations Committee, January 19, 2017

The 2018 Plan Certification Standard proposed a standardized option for a plan offered on MHBE. Under this plan, all carriers would offer a plan that charges the same rate for out-of-pocket costs so that consumers can compare plans based on characteristics, such as the quality of the doctors. For example, with this standard, a consumer would pay the same co-payment for a visit to a primary care or specialty doctor across all carriers.

Lack of Carrier Participation Decreases Market Competition

In fiscal 2017, Marylanders enrolling in commercial plans selected from 31 plans offered by three carriers. As of January 14, 2017, a significant majority of enrollees, 64%, are enrolled in CareFirst, similar to the 65% market share in fiscal 2016. This market share is lower than when 79% of enrollees were enrolled in CareFirst in fiscal 2015 and 90% in fiscal 2014. In fiscal 2016, MHBE attributed this change to the changes made by carriers to the different plans they offer. MHBE also rolled out "anonymous browsing," allowing consumers to shop plans prior to creating an account. However, market share has become concentrated between two carriers, as shown in **Exhibit 13**.

Exhibit 13
Enrollment by Carrier
January 3, 2017



Note: Cigna enrollees represented <1 % of market share.

Source: Maryland Health Benefit Exchange; Department of Legislative Services

For the third open enrollment period, UnitedHealthcare, which had a 7% market share in fiscal 2016, made the decision not to participate in the market. Additionally, MIA announced on December 8, 2016, that Evergreen plans would not be available in the individual market for the 2017 plan year. Evergreen, which made up 5% of the market share in fiscal 2016, suffered financial difficulties and has been acquired by investors to convert from a nonprofit to a for-profit insurer. Although Cigna also participated in the individual market, their market share was less than 1%. The agency notes that Cigna's low market share may be a result of higher prices. Participation of carriers is particularly important when it comes to choice for individuals in rural areas. Currently, individuals in rural areas have the option of both CareFirst and Cigna, as those are both statewide programs. However, as noted, few choose Cigna. **Although there are currently at least two carriers statewide, the agency should comment on how it intends to increase carrier participation for fiscal 2018 to allow consumers more choice.**

Recommended Actions

		Amount Reduction	
1.	Reduce the appropriation of the Maryland Health Benefit Exchange Information Technology (IT) program by $250,000 in special funds for IT enhancements to Qualified Health Plan-related activities.	$ 250,000	SF
	Total Special Fund Reductions	**$ 250,000**	

Updates

1. Progress Report on the Maryland Health Benefit Exchange

MHBE launched in October of 2013. The initial open enrollment period was marred by IT problems. Following the problems of the initial open enrollment period, in April 2014, MHBE upgraded to the Connecticut IT platform. This option allowed for rapid implementation of a proven IT solution, was feasible given the timeline for the upcoming 2014 open enrollment period, and maximized use of existing software licenses and hardware components. All major milestones for the development of the new MHBE IT platform were completed on time, and the new platform went live with no issues at the start of the second open enrollment period on November 15, 2014.

Second and Third Open Enrollment Periods Generally Successful

During the second open enrollment period, no major system issues were observed until the final week, when some users had difficulty accessing the system. These issues were relatively minor (particularly, compared to the significant issues with the system in the last open enrollment period), but open enrollment was consequently extended from February 20 to February 28, 2015. Additionally, IT management responsibilities that had previously been handled by the Secretary of Information Technology were handed off to the MHBE PMO as MHBE transitioned from an implementation phase to an ongoing operations phase. By December 2014, 62,539 individuals had enrolled in a QHP through the exchange, increasing to 114,559 individuals by March 2015.

After a generally successful second open enrollment, the call center experienced high call volumes as Medicaid consumers who were initially provided enrollment through the State's Client Automated Resource and Eligibility System and the Exchange Eligibility System were directed to enroll through the new exchange eligibility system for continuation of coverage. This added pressure on the call center and resulted in longer wait times and higher abandonment rates for calls.

For the third open enrollment period, to reduce pressure on the call center, MHBE piloted the Broker Assistance Transfer (BAT) program to have licensed insurance brokers embedded in the call center prior to the start of open enrollment. After call center representatives determined consumers eligible for qualified health plan enrollment, a broker joined the call through phone software installed on their computer and took over assistance. The BATphone pilot resulted in more than 2,000 enrollments. In addition to the BAT program, MHBE developed passive renewals and Form 1095-A and -B automation in time for the 2016 open enrollment. The IT team also added functionality to enable consumers to reset their own passwords and cancel policies online, which reduced volume and operational burdens on the call center. As more consumers are in the new system, MHBE expects auto renewals to increase, reducing call volume. By March 2016, 135,208 individuals had enrolled in a QHP through MHBE.

Fourth Open Enrollment Period Focused on Consumer Upgrades

For the fourth open enrollment period, special attention was paid to application to improve usability for consumers and reduce frustration. MHBE surveyed users to identify and refine trouble areas, such as who to include as members of a household when applying. In September, 2016, MHBE introduced a new mobile application that allowed Marylanders to enroll in coverage on MHC directly from their smartphone or tablet. The Enroll MHC application is available free in the App Store (iOS) and the Google Play Store (Android). The application allows consumers to apply, compare prices and ratings of various plans, log in to view their notices, and even upload documents for verification through the camera on their device. The Department of Health and Mental Hygiene is providing funding for maintenance of the mobile application in 2017, which will serve enrollees in both Medicaid and private health insurance plans. As of January 2017, approximately 151,000 individuals had enrolled in a QHP, and 315,000 had enrolled in Medicaid through MHBE.

In fiscal 2016, MHBE added Stand-Alone Dental Plans (SADP). Consumers may enroll in health and dental coverage at the same time. MHBE offers family and child-only dental plans – 18 plans in all from six participating dental insurers. In January 2016, 4,122 individuals were enrolled in a SADP, while others enrolled in dental coverage in conjunction with a private health plan. Almost half of consumers (44%) enrolled in a SADP from carrier Dominion Dental, and 21% enrolled in CareFirst. As of January 16, 2017, 10,307 individuals enrolled in a SADP.

Status of the Small Business Health Options Program Exchange

Maryland is among 17 states that elected to operate their own SHOP exchange through which small businesses with 50 or fewer employees may enroll in QHPs. Small businesses that employ 25 or fewer employees and have an average annual salary of $50,000 or less qualify for a federal tax credit to offset the cost of purchasing coverage for any two consecutive tax years beginning in 2014. Small businesses are able to deduct premium costs not covered by the tax credit. Enrollment in QHPs offered on the SHOP exchange has been low for the first three years of operation, a trend observed in other states.

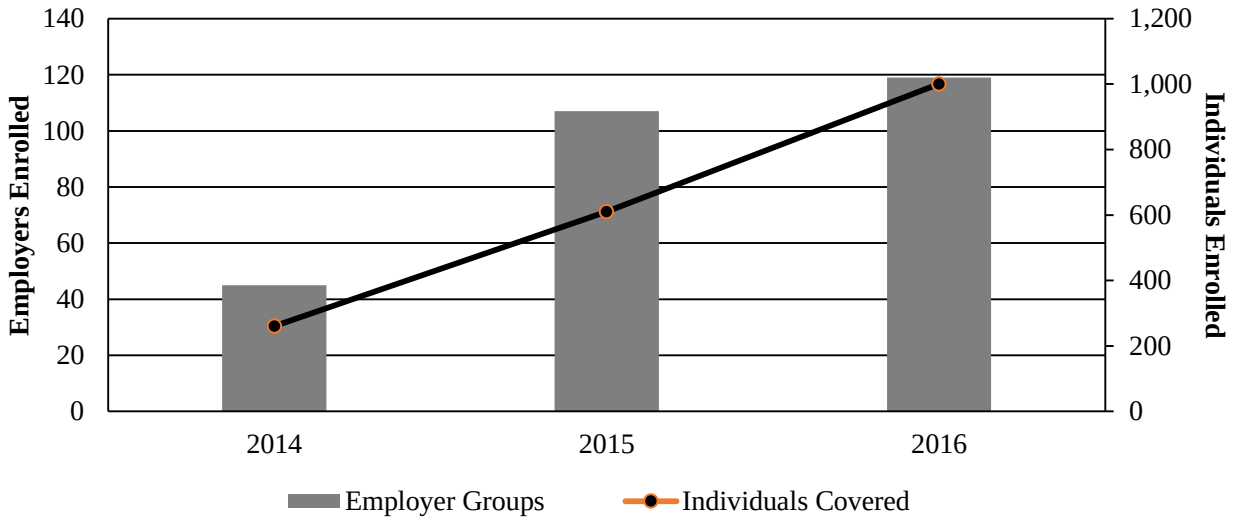
MHBE launched SHOP in April 2014, allowing small businesses to enroll through a paper-based process. Beginning in January 2015, MHBE partnered with three selected third-party administrators (TPA) to allow employers and employees to access their enrollment application and account information through a website. The functionality of SHOP expanded further in August 2015, with the introduction of an employee choice option for plan selection. An employer has two options for plan selection. Under the employer choice option, the employer picks one insurance company and employees can choose any plan offered by that insurer. Under the employee choice option, the employer picks the metal level that will be open to employees, and employees can then choose a plan at that metal level from any insurer that will be open to employees. The MHBE 2018 Plan Certification Standard has proposed an expansion of the employee choice option, allowing employers to select up to two consecutive metal levels, in which employers can then choose a plan at either metal level from any insurer on the exchange. This will be optional for 2018. The 2018 Plan Certification Standard also proposed employer choice composite rating. Currently, each employee's premium corresponds with

their age. With composite rating, the ages of all employees under one employer will merge into a composite with one premium rate for all employees.

In July 2016, MHBE selected Benefit Mall to serve as the sole administrator of SHOP, a decision that establishes just one online portal for SHOP enrollment instead of the three separate portals that had been maintained by the three TPAs. In 2017, 11 carriers will offer QHPs through SHOP.

The Hilltop Institute at the University of Maryland Baltimore County had projected that more than 8,000 employees of small businesses would enroll in QHPs through SHOP in its first year. However, as shown in **Exhibit 14**, only 45 employers enrolled in 2014, covering about 260 individuals. Enrollment grew modestly in the subsequent years of operation; with 107 employers enrolled in 2015, covering about 610 individuals; and 119 employers enrolled in 2016, covering about 1,000 individuals. Eighty-three percent of the groups enrolled in June 2016 had fewer than 10 employees and 12% had fewer than 20 employees. Low enrollment in SHOP is not unique to Maryland. Nationally, SHOP enrollment amounts to less than 1% of the small group insurance market.

Exhibit 14
Enrollment in the Small Business Health Options Program
December 2014, October 2015, and June 2016



Source: Maryland Health Benefit Exchange

Appendix 1
Current and Prior Year Budgets
Maryland Health Benefit Exchange
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2016					
Legislative Appropriation	$0	$36,592	$42,838	$0	$79,430
Deficiency Appropriation	10,887	0	6,391	0	17,278
Budget Amendments	0	65	11,565	0	11,630
Reversions and Cancellations	-291	-6,191	-3,590	0	-10,073
Actual Expenditures	**$10,596**	**$30,466**	**$57,204**	**$0**	**$98,265**
Fiscal 2017					
Legislative Appropriation	$0	$75,027	$47,366	$0	$122,393
Budget Amendments	0	93	0	0	93
Working Appropriation	**$0**	**$75,120**	**$47,366**	**$0**	**$122,486**

Note: Does not include targeted reversions, deficiencies, and contingent reductions. Numbers may not sum to total due to rounding.

Fiscal 2016

The fiscal 2016 budget for the Maryland Health Benefit Exchange (MHBE) closed $18.8 million above the legislative appropriation. Deficiency appropriations increased general funds by $10.9 million and federal funds by $6.4 million to supplement existing funding for the call center ($12.1 million – $5.7 million in general funds and $6.4 million in federal funds), retain outside legal counsel ($3.6 million in general funds), and to cover fiscal 2015 expenses for the call center and legal services ($1.6 million in general funds). Of the $12.1 million in call center expenditures, $11.2 million of this amount was to assist with issues surrounding Medicaid redeterminations.

Budget amendments added an additional $11.6 million in federal funds to cover the cost of call center activities ($8.1 million), Medicaid-related activities ($3.2 million), a procurement consultant ($130,000), and an assessment study ($190,000). The $65,000 in special fund amendments reflects the restoration of the 2% pay reduction.

Cancellations totaled $3.6 million in federal funds and $6.2 million in special funds. Reversions totaled $291,000 in general funds. Of this amount, $4.1 million in special funds and $900,000 in federal funds were canceled due to overestimates of program spending for the Maryland Health Insurance Plan and the Affordable Care Act's federal high-risk pool. The remaining cancellations of $2.1 million in special funds, $2.7 million in federal funds, and the reversion of $291,000 in general funds were primarily due to reduced call center and enrollment support expenses.

Fiscal 2017

To date, the fiscal 2017 legislative appropriation for MHBE has been increased by $92,958 in special funds related to the centrally budgeted fiscal 2017 salary increments.

Appendix 2
Object/Fund Difference Report
Maryland Health Benefit Exchange

Object/Fund	FY 16 Actual	FY 17 Working Appropriation	FY 18 Allowance	FY 17 - FY 18 Amount Change	Percent Change
Positions					
01 Regular	74.00	67.00	67.00	0.00	0%
Total Positions	**74.00**	**67.00**	**67.00**	**0.00**	**0%**
Objects					
01 Salaries and Wages	$ 7,308,143	$ 7,723,911	$ 7,739,104	$ 15,193	0.2%
02 Technical and Spec. Fees	49,778	59,172	10,921	-48,251	-81.5%
03 Communication	102,377	75,988	76,884	896	1.2%
04 Travel	21,320	23,897	19,360	-4,537	-19.0%
07 Motor Vehicles	2,647	0	0	0	0.0%
08 Contractual Services	78,079,643	103,801,804	85,106,180	-18,695,624	-18.0%
09 Supplies and Materials	47,207	44,346	43,818	-528	-1.2%
10 Equipment – Replacement	77,727	0	0	0	0.0%
11 Equipment – Additional	18,225	6,900	0	-6,900	-100.0%
12 Grants, Subsidies, and Contributions	11,854,472	10,000,000	10,000,000	0	0%
13 Fixed Charges	703,640	749,594	777,092	27,498	3.7%
Total Objects	**$ 98,265,179**	**$ 122,485,612**	**$ 103,773,359**	**-$ 18,712,253**	**-15.3%**
Funds					
01 General Fund	$ 10,595,822	$ 0	$ 0	$ 0	0.0%
03 Special Fund	30,465,671	75,119,872	56,300,000	-18,819,872	-25.1%
05 Federal Fund	57,203,686	47,365,740	47,473,359	107,619	0.2%
Total Funds	**$ 98,265,179**	**$ 122,485,612**	**$ 103,773,359**	**-$ 18,712,253**	**-15.3%**

Note: Does not include targeted reversions, deficiencies, and contingent reductions.

Appendix 3
Fiscal Summary
Maryland Health Benefit Exchange

Program/Unit	FY 16 Actual	FY 17 Wrk Approp	FY 18 Allowance	Change	FY 17 - FY 18 % Change
01 Maryland Health Benefit Exchange	$ 69,808,703	$ 50,857,618	$ 51,872,355	$ 1,014,737	2.0%
02 Major Information Technology Development Projects	31,593,205	31,537,994	30,601,004	-936,990	-3.0%
03 Maryland Health Insurance Program	0	40,090,000	21,300,000	-18,790,000	-46.9%
01 Maryland Health Insurance Program	-3,136,729	0	0	0	0%
Total Expenditures	**$ 98,265,179**	**$ 122,485,612**	**$ 103,773,359**	**-$ 18,712,253**	**-15.3%**
General Fund	$ 10,595,822	$ 0	$ 0	$ 0	0.0%
Special Fund	30,465,671	75,119,872	56,300,000	-18,819,872	-25.1%
Federal Fund	57,203,686	47,365,740	47,473,359	107,619	0.2%
Total Appropriations	**$ 98,265,179**	**$ 122,485,612**	**$ 103,773,359**	**-$ 18,712,253**	**-15.3%**

Note: Does not include targeted reversions, deficiencies, and contingent reductions.