D78Y01
Maryland Health Benefit Exchange

Operating Budget Data

($ in Thousands)

	FY 17 Actual	FY 18 Working	FY 19 Allowance	FY 18-19 Change	% Change Prior Year
Special Fund	$72,156	$56,284	$35,000	-$21,284	-37.8%
Adjustments	0	-60	38	98	
Adjusted Special Fund	**$72,156**	**$56,224**	**$35,038**	**-$21,186**	**-37.7%**
Federal Fund	44,726	47,461	48,160	700	1.5%
Adjustments	0	-46	26	72	
Adjusted Federal Fund	**$44,726**	**$47,415**	**$48,187**	**$772**	**1.6%**
Adjusted Grand Total	**$116,882**	**$103,639**	**$83,225**	**-$20,414**	**-19.7%**

Note: FY 18 Working includes targeted reversions, deficiencies, and across-the-board reductions. FY 19 Allowance includes contingent reductions and cost-of-living adjustments.

- The adjusted fiscal 2019 allowance decreases by $20.4 million, or 19.7%, compared to the adjusted fiscal 2018 working appropriation. Fiscal 2018 was the final year of State-funded reinsurance payments and results in a $21.3 million decrease in special funds. An increase in federal funds is largely driven by increases in software and hardware costs in the Information Technology (IT) Center.

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

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Personnel Data

	FY 17 Actual	FY 18 Working	FY 19 Allowance	FY 18-19 Change
Regular Positions	67.00	67.00	67.00	0.00
Contractual FTEs	0.00	0.00	0.00	0.00
Total Personnel	**67.00**	**67.00**	**67.00**	**0.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	2.68	4.00%
Positions and Percentage Vacant as of 12/31/17	8.00	11.94%

- The number of regular positions remains constant in fiscal 2019.

- As of December 31, 2017, the agency had a vacancy rate of 11.94%, 5.32 positions over budgeted turnover.

Analysis in Brief

Major Trends

Enrollment in a Qualified Health Plan Decreased Slightly: Enrollment dropped slightly in the fifth open enrollment period for plan year 2018. Although silver metal level plans were the most selected, enrollment in gold plans increased significantly.

Uninsured Rate Continues to Decrease: The uninsured rate dropped to a low of 6.1% in 2016 from 6.6% in 2015. The uninsured rate in Maryland continues to trend below the national rate of 8.6% in 2016.

Premiums for All Participating Carriers Increased: For the fifth open enrollment period, all carriers offering a plan on the exchange increased rates. Carriers had more information on actual experience available to set rates for plan year 2018, and rates were further impacted by federal action affecting the individual market.

Issues

Findings of the Maryland Health Insurance Coverage Protection Commission and Update on Federal Changes to Health Care Programs: Chapter 17 of 2017 established the Maryland Health Insurance Protection Commission. The 19-member commission was established to (1) monitor potential and actual federal changes to the Patient Protection and Affordable Care Act, Medicaid, Maryland Children's Health Program, Medicare, and the Maryland All-Payer Model; (2) assess the impact of such changes; and (3) provide recommendations for State and local action to protect access to affordable health coverage. This issue discusses findings of the commission in its first year.

Medicaid Managed Care Organization Online Shopping: In 2017, the Maryland Health Benefit Exchange (MHBE) was in the process of implementing a managed care organization (MCO) IT Project. The goal of the project was to fully integrate MCO plan shopping into the Exchange's consumer and worker portals. This issue discusses the status of MCO plan shopping.

Operating Budget Recommended Actions

1. Concur with Governor's allowance.

Updates

Potentially Improper or Fraudulent Enrollments: In a September 2017 report, the Government Accountability Office (GAO) examined three state-based marketplaces, including MHBE, to determine whether individuals were improperly enrolled in insurance plans through the marketplaces in calendar 2015. The GAO report found that there were very few instances of improper or fraudulent enrollment. However, approximately 2% of total enrollees in Maryland and Rhode Island had immigration-related inconsistencies.

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.

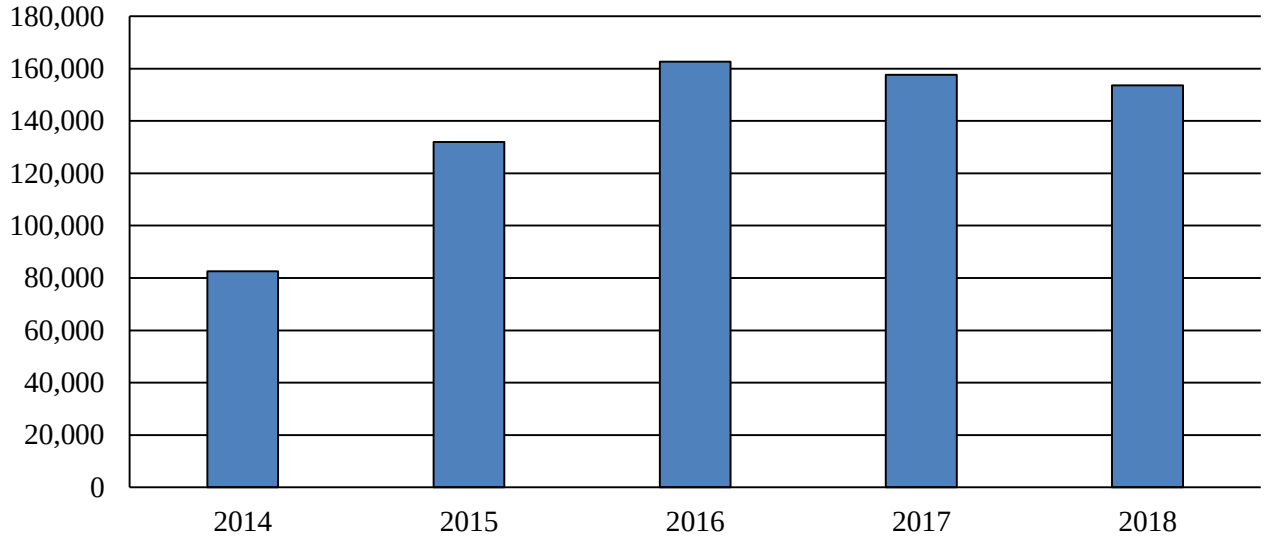
Through the Maryland Health Connection (MHC), Maryland residents can shop for health insurance plans, compare rates, and determine their eligibility for tax credits, cost-sharing reductions, and public assistance programs such as Medicaid. Once an individual or family selects a Qualified Health Plan (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 on 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 on the exchange by eligible individuals.

Performance Analysis: Managing for Results

1. Enrollment in a Qualified Health Plan Decreased Slightly

In open enrollment (OE) for plan year 2018, 153,608 individuals enrolled in a QHP through MHBE. As shown in **Exhibit 1**, this represents a decrease of 4,029 enrollees when compared to OE 2017. Of the total enrolled, 108,009 individuals, or 70%, are returning from the previous year. OE 2018 is the second open enrollment period with declining enrollment compared to the previous year.

Exhibit 1
Open Enrollment
Calendar 2014-2018



Source: Maryland Health Benefit Exchange

Higher premiums may be a contributing factor to the decrease. It is also likely that the improving economy contributes to lower enrollment as more individuals qualify for employer-based insurance. In addition, OE 2018 was nearly half as long as previous open enrollment periods (52 vs. 90 days). MHBE believes that the shortened enrollment period had little impact on enrollment numbers because most enrollees are enrolled early in open enrollment. However, it is possible that some people missed open enrollment who would normally have enrolled later.

More enrollees qualify for Advanced Premium Tax Credits (APTC) in 2018 compared to the 2017 plan year. Qualification for APTCs is dependent on income. Enrollees who are at or below 400% of the federal poverty level (FPL) qualify on a sliding scale for APTCs, which reduce the cost of monthly premiums. In 2018, at least 124,833, or 81% of total enrollees, are at or below 400% of FPL and qualify for APTCs. Only 8,723 of individuals enrolled through the exchange are known to have an income above 400% of FPL and do not qualify for APTCs. As of January 25, 2018, 20,052 of individuals enrolled through the exchange have unknown income levels because they enrolled in a QHP without assistance.

In calendar 2015, 2016, and 2017, 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 2017, an estimated 247,376 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 unenrolled.

Exhibit 2
Areas with the Most Eligible Population Remaining
Calendar 2017

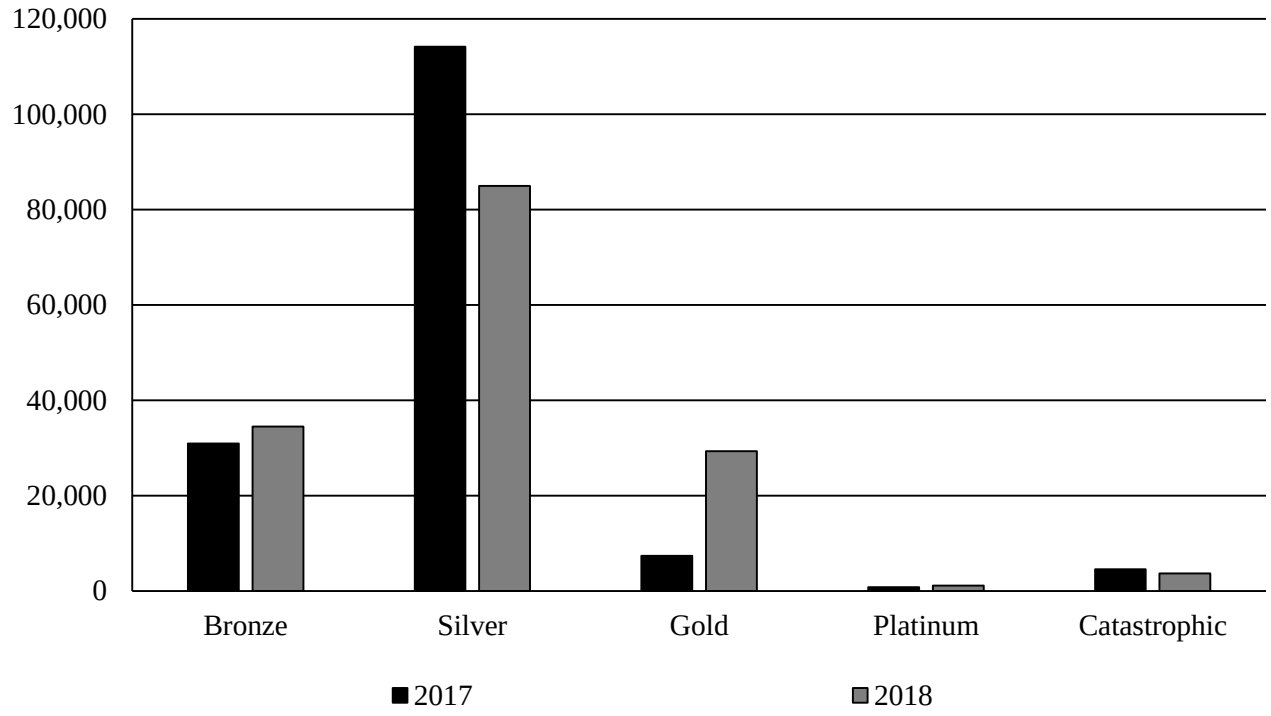
Public Use Microdata Area	Eligible Population Not Enrolled	Public Use Microdata Area	Percent of Eligible Population Not Enrolled
St. Mary's and Calvert Counties	9,701	St. Mary's and Calvert Counties	76%
Howard County (East) – Columbia (East), Ellicott City (Southeast), and Elkridge	9,633	Baltimore City – Inner Harbor, Canton, and Bayview	73%
Queen Anne's, Talbot, Caroline, Dorchester, and Kent Counties	9,255	Cecil County	72%
Wicomico, Worcester, and Somerset Counties – Salisbury City	9,009	Harford County (South and East) – Aberdeen and Havre de Grace Cities	72%
Montgomery County (South) – Bethesda, Potomac, and North Bethesda	8,809	Baltimore City – Irvington, Ten Hills, and Cherry Hill	72%

Source: Maryland Health Benefit Exchange

Although Exhibit 2 only shows areas with the most eligible population remaining, every area in the State, with one exception, has above 40% of the eligible population remaining not enrolled. This is likely not to change in 2018, given the slight overall decrease in enrollment.

In terms of QHP plan selection, in plan year 2018, the silver metal level was the most selected level by consumers for the fourth year. However, as shown in **Exhibit 3,** there is a large drop in silver plan enrollment and a large increase in gold plan enrollment compared to 2017. This is likely due to federal actions affecting the exchange, which will be discussed later in the analysis.

Exhibit 3
Qualified Health Plan by Metal Level
Calendar 2017 and 2018



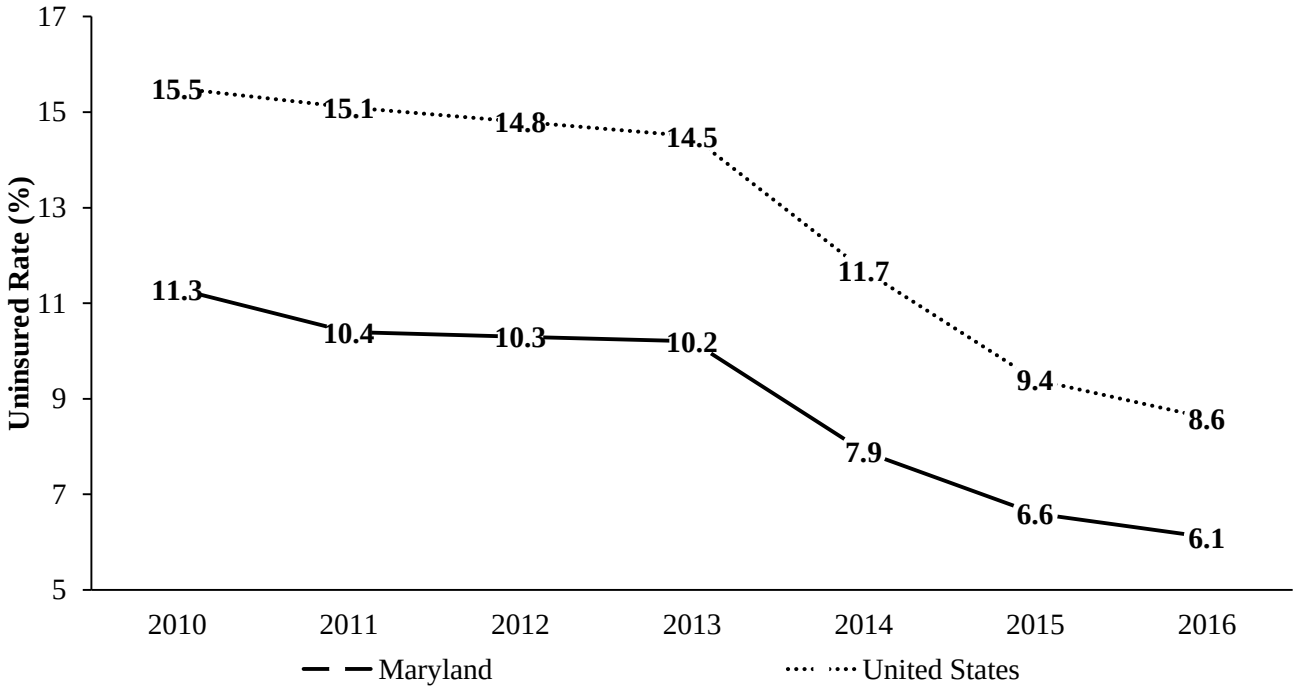
Source: Maryland Health Benefit Exchange

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. (People under the age of 30 and some people with limited incomes may buy an alternative kind of coverage called a "catastrophic" health plan.)

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 6.1% (363,179) in calendar 2016 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 8.6% in calendar 2016.

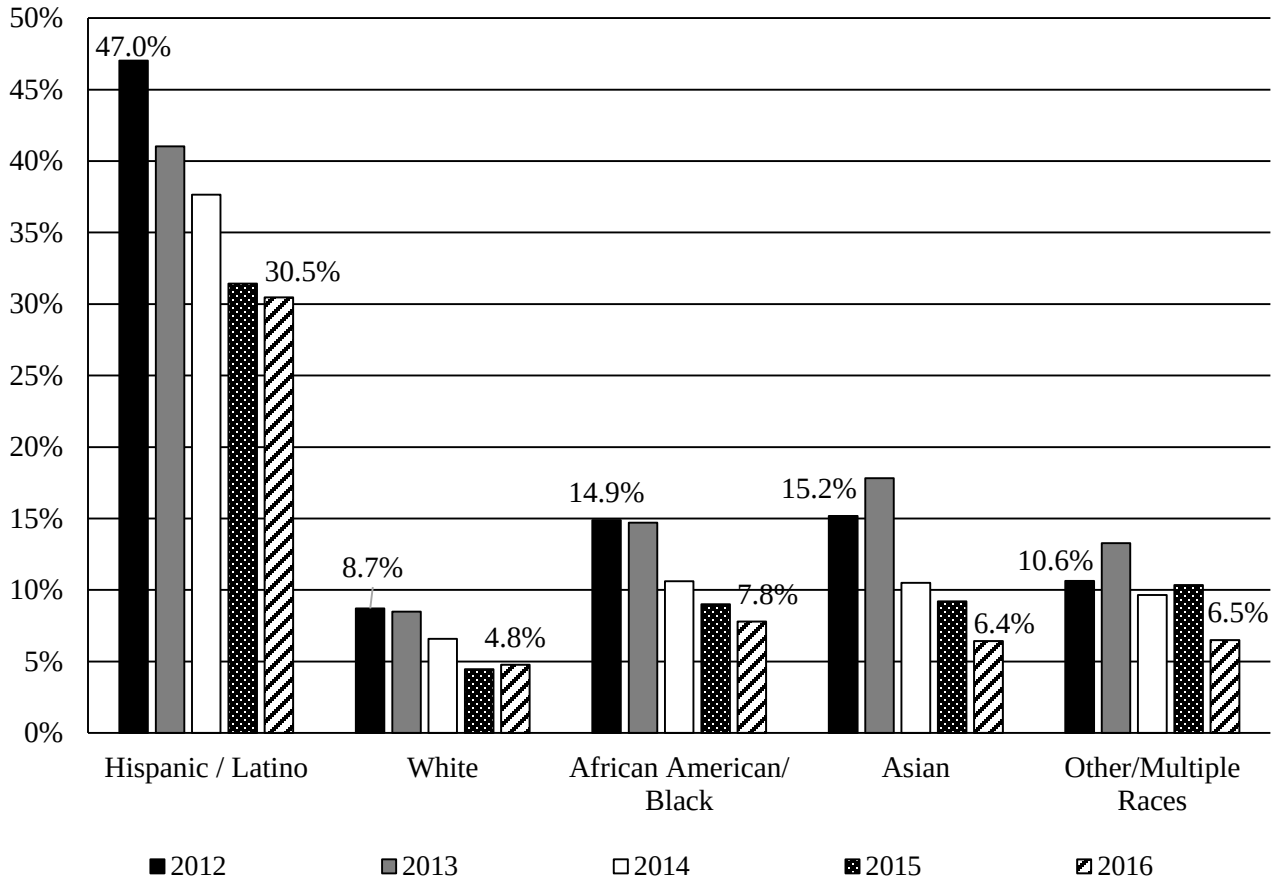
Exhibit 4
Uninsured Rate: United States and Maryland
Calendar 2010-2016



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

As shown in **Exhibit 5,** the uninsured rate by race/ethnicity for Maryland adults is much higher for the Hispanic/Latino population, with 30.5% of the Hispanic/Latino (18- to 64-year olds) population uninsured in calendar 2016. The rate is also higher for African Americans and Asians than for Whites, although progress was made for both groups since 2012.

Exhibit 5
Maryland's Uninsured Rate by Race/Ethnicity (Ages 18 to 64)
Calendar 2012-2016

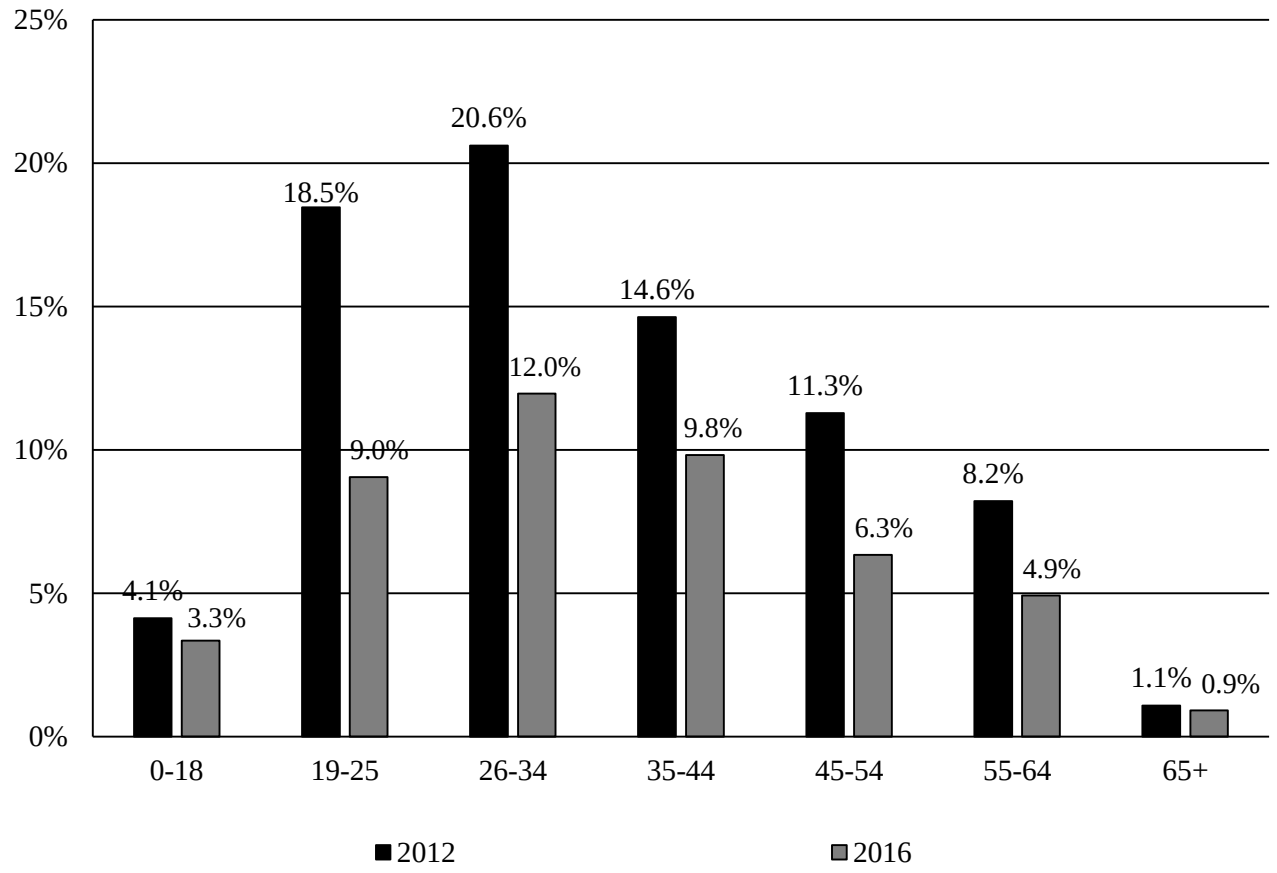


Source: State Health Access Data Assistance Center, Analysis of the *American Community Survey*

Appendix 4 provides the uninsured rate by jurisdiction and race/ethnicity in calendar 2016.

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 almost certainly the major contributing factor to the higher rates for this group, as young adults age 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. Even so, the uninsured rate for this group has fallen sharply since 2012, from 20.6% to 12%. Children and individuals older than age 65 are insured at a higher rate due to the Maryland Children's Health Program (MCHP), which insures children up to 300% federal poverty guidelines (FPG), and Medicare, which is available to most individuals age 65 and older.

Exhibit 6
Uninsured Rate by Age
Calendar 2012 and 2016

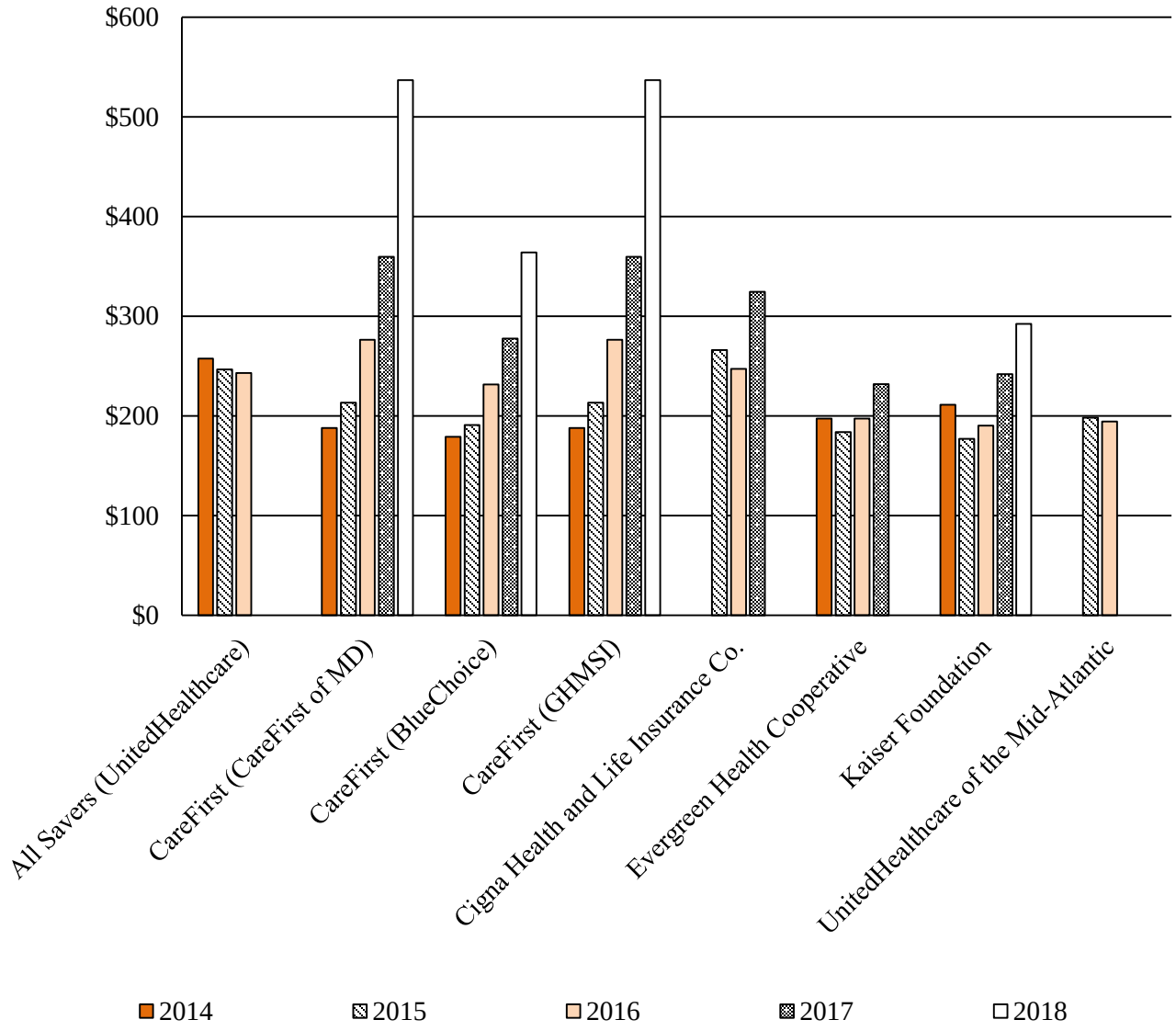


Source: State Health Access Data Assistance Center, Analysis of the *American Community Survey*

3. 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 plans available in the individual market has fluctuated. In calendar 2018, there are four plans offered by two carriers: CareFirst BlueCross BlueShield (CareFirst) and Kaiser Permanente (Kaiser). As shown in **Exhibit 7**, the lowest cost silver plan for a 21-year-old individual offered in the Baltimore metropolitan area has increased in price for all plans.

Exhibit 7
Baltimore Metropolitan Area Approved Monthly Rate Examples
Lowest Priced Silver Plan – Age 21
Calendar 2014-2018



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

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

Source: Maryland Insurance Administration

As shown in Exhibit 7, premiums increased by 31% to 49% in CareFirst plans and 21% in the Kaiser plan. Federal action in 2017, specifically to eliminate cost-sharing reductions (CSR), exacerbated the already high planned increases.

Federal Decision to End Cost-sharing Reductions

The 2017 *Joint Chairmen's Report* (JCR) requested that MHBE submit a report 60 days after the enactment of any legislation at the federal level that impacts the operation of MHBE or QHPs. On October 12, 2017, the U.S. Department of Health and Human Services (HHS) announced that CSR payments would end effective immediately. This decision did not require the enactment of federal legislation. However, recognizing the intent of the narrative, MHBE submitted a report on November 22, 2017, detailing the effect of no CSRs on MHBE and the QHPs.

The ACA requires insurers to reduce cost sharing for QHP enrollees with incomes up to 250% of the FPL and enrolled in a silver-level plan. A silver plan typically has an actuarial value of 70%, meaning that the insurer will typically pay 70% of health care expenses, and the enrolled will pay 30%. For enrollees that qualify for CSRs, the actuarial value is increased, which has the effect of lowering the overall expenses for the enrollee. The federal government makes payments to the insurers to cover the additional cost.

Disagreement arose between the U.S. House of Representatives – believing that CSR payments must be authorized by the U.S. Congress – and the Obama Administration – believing that the CSR payments were permanently authorized through the ACA. The courts did not resolve this issue by the end of the Obama Administration.

On October 11, 2017, the Attorney General of the United States issued a legal opinion concluding that the U.S. Congress must authorize appropriations for CSR payments. Following the legal opinion, HHS made the announcement that CSR payments to insurers must end effective immediately.

Impact on the State (Silver-loading)

At the time of the federal decision, the Maryland Insurance Administration had already approved 2018 individual market health insurance premium rates. Approved rates assumed that federal CSR payments would be made to the insurers. State law requires that rates be adequate and neither excessive nor unfairly discriminatory, which necessitated a rate revision.

Amended rates were issued on October 25, 2017, for silver-level exchange plans only. **Exhibit 8** compares the original approved rates to the amended rates. As shown in the exhibit, amended rates were significantly higher than the original approved rates. The rate increases were necessary despite the loss of CSR payments as the carriers are still required to provide a reduced cost sharing to enrollees with incomes up to 250% of the FPL.

Exhibit 8
Amended Rates Increase for Silver-level Exchange Plans
Calendar 2018

	Original Rate	Amended Rate
CareFirst (CareFirst of Maryland)	52.1%	76.0%
CareFirst (BlueChoice)	31.4%	58.2%
CareFirst (GHMSI)	52.1%	76.0%
Kaiser Foundation	22.7%	43.4%

GHMSI: Group Hospitalization and Medical Services, Inc.

Source: Maryland Health Benefit Exchange

The amended rates led to increased premiums for silver-level individual health insurance plans offered on the exchange, which affects the value of APTCs. Enrollees under 400% of FPL qualify for APTCs regardless of the metal level of the plan. The value of the APTCs is based on the premium cost of the second lowest cost available silver-plan. In practice, this means that enrollees who qualify for APTCs will have lower actual premium costs in 2018. Effectively, there was a large shift in enrollment when comparing OE17 to OE18 from silver-level plans to bronze- and especially gold-level plans.

MHBE estimates that the total value of APTCs in January 2018 will be $63.9 million compared to $29.8 million in January 2017, a 114% increase year over year, or as much as $798 million annually. In calendar 2017, in the scenario presented in Exhibit 7, silver plan premiums were between 77% and 85% of the cost of gold plan premiums. In calendar 2018, in the scenario presented in Exhibit 7, silver plan premiums are between 83% and 90% of the cost of gold plan premiums.

Fiscal 2018 Actions

Across-the-board Employee and Retiree Health Insurance Reduction

The budget bill includes an across-the-board reduction for employee and retiree health insurance in fiscal 2018 to reflect a surplus balance in the fund. This agency's share of this reduction is $60,410 in special funds and $45,913 in federal funds.

Proposed Budget

As shown in **Exhibit 9**, the adjusted fiscal 2019 allowance decreases by $20.4 million, or 19.7%, compared to the adjusted fiscal 2018 working appropriation. Fiscal 2018 marking the final year of reinsurance payments ($21.3 million) drives the decrease in special funds. An increase in

federal funds is largely driven by increases in software and hardware costs in the Information Technology (IT) Center.

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

How Much It Grows:	Special Fund	Federal Fund	Total
Fiscal 2017 Actual	$72,156	$44,726	$116,882
Fiscal 2018 Working Appropriation	56,224	47,415	103,639
Fiscal 2019 Allowance	35,038	48,187	83,225
Fiscal 2018-2019 Amount Change	-$21,186	$772	-$20,414
Fiscal 2018-2019 Percent Change	-37.7%	1.6%	-19.7%

Where It Goes:	
Personnel Expenses	
Employee health insurance, the impact of the fiscal 2018 health insurance deduction holidays	$118
Cost-of-living adjustment	64
Salaries	63
Social Security contributions	8
Turnover adjustments	-103
Program Direction	
OAG charges (align to actual)	130
Legal services (align to actual)	58
DoIT information technology moving charges	50
Advertising	35
Security services (align to actual)	14
Administrative hearings	9
Rent	-169
Other	-2
Information Technology	
Replacement of computers, workstations, and laptops	338
Software	273
Reinsurance	
Reinsurance fund	-21,300
Total	**-$20,414**

DoIT: Department of Information Technology
OAG: Office of the Attorney General

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

Personnel

Personnel costs in the allowance increase by $150,667 compared to the fiscal 2018 working appropriation. This increase is driven by the reduction of health insurance in fiscal 2018 and the general salary increase. The fiscal 2019 allowance includes funds for a 2% general salary increase for all State employees, effective January 1, 2019. These funds are budgeted in the Department of Budget and Management's statewide program and will be distributed to agencies during the fiscal year. This agency's share of the general salary increase is $64,000.

Program Direction and IT

Expenses increase by $735,384 in Program Direction and IT. The largest increases in Program Direction are intended to align expenditures with recent actuals. IT expenses increase for both hardware ($337,500) and software ($273,151). The largest decrease is in rent, which is due to the consolidation of office locations. The main office and the IT center are now both located in the same office, resulting in an overall decrease in rent of $169,065.

Reinsurance Program

Payments through the Reinsurance Program lower the agency's budget by $21.3 million in special funds. In fiscal 2018, the budget included $21.3 million in special funds to pay for calendar 2016 claims. Fiscal 2018 is the last year that State funding was available for reinsurance.

Issues

1. Findings of the Maryland Health Insurance Coverage Protection Commission and Update on Federal Changes to Health Care Programs

Chapter 17 of 2017 established the Maryland Health Insurance Protection Commission. The 19-member commission was established to (1) monitor potential and actual federal changes to the ACA, Medicaid, MCHP, Medicare, and the Maryland All-Payer Model; (2) assess the impact of such changes; and (3) provide recommendations for State and local action to protect access to affordable health coverage.

The commission consists of (1) three members of the Senate; (2) three members of the House of Delegates; (3) the Secretary of Health (or designee); (4) the Maryland Insurance Commissioner (or designee); (5) the Attorney General (or designee); (6) one representative of the Maryland Hospital Association; (7) one representative of a managed care organization (MCO); (8) one consumer of health care services; (9) one representative of a health insurance carrier; (10) one representative who is an employer; (11) one representative of the nursing home industry; (12) one representative of MedChi; (13) one representative of behavioral health care providers; and (14) two members of the public.

The duties of the commission encompass a requirement for a study that includes (1) an assessment of the current and potential adverse effects of the loss of health coverage on the residents, public health, and economy of the State resulting from changes to the ACA, Medicaid, MCHP, Medicare, or the Maryland All-Payer Model; (2) an estimate of the costs of such adverse effects and the resulting loss of health coverage; (3) an examination of measures that may prevent or mitigate such adverse effects and the resulting loss of health coverage; and (4) recommendations for laws that may be warranted to minimize such adverse effects and assist residents in obtaining and maintaining affordable health coverage.

The commission is established for three years and will terminate on June 30, 2020. By December 31 each year, the commission must submit a report on its findings and recommendations. The first report was submitted on December 31, 2017.

Summary of Options Considered By the Commission

The commission met three times over the course of 2017. In each of those meetings, stakeholders, experts, and representatives of various governmental agencies presented the largest issues facing the State's health care landscape at the moment and into the future.

During the December 5, 2017 meeting, the commission considered options presented for stabilizing the individual market in the State, including proposals by CareFirst and Kaiser, reinsurance programs adopted in other states, adopting a State-based individual mandate, the Basic Health Program (BHP) option under the ACA, establishing a pilot program that would combine individual mandate penalty payments and premium tax credits to enroll certain uninsured individuals in insurance coverage,

and establishing a surcharge on silver-level QHPs and using the revenue to enroll uninsured individuals into coverage and improve the risk pool.

State-based Individual Mandate

The federal Tax Cut and Jobs Act of 2017 repealed the federal penalty on individuals for not having qualifying coverage – the individual mandate. One option presented to the commission was the enactment of a State-based individual mandate to replace the repealed federal provision.

CareFirst Proposal

CareFirst proposed that the State obtain a State Innovation Waiver under Section 1332 of the ACA. A waiver as proposed by CareFirst would include five points:

(1) move from multiple insurance options to one standard product in the individual on-exchange market with a $1,000 deductible and $3,500 out-of-pocket maximum;

(2) establish a stop-loss reinsurance limit of $50,000 per person per year above which costs would be split 80% federal government and 20% carriers;

(3) reallocate federal funding for APTC and cost-sharing reduction payments to fund reinsurance and premium subsidies for individuals with incomes up to 400% of FPL

(4) place a stabilization surcharge on the premiums of carriers that do not participate on the exchange; and

(5) include other funding mechanisms, such as an assessment on hospital rates.

The extent to which the CareFirst proposal is still a viable option is unknown given federal action eliminating the CSR payments. However, the amount of total federal funds available for reallocation may be even higher than before elimination of CSRs as it is expected (although not required) that federal funding would be equal to that received in the calendar year of the application. As noted earlier, the extent of APTC dollars has increased sharply so far in 2018.

Reinsurance Programs Adopted In Other States through Section 1332 Waivers

Alaska, Minnesota, and Oregon are implementing reinsurance programs under Section 1332 waivers. All three of these states' reinsurance programs are funded through pass-through federal funding based on the amount of APTCs that would have been paid absent the waiver.

Kaiser Proposal

Kaiser also supports a State-based individual mandate and a State-based reinsurance program under Section 1332 of the ACA. Kaiser's proposal differs in that Kaiser is skeptical of the use of a premium tax on insurers.

BHP

Under the BHP option in Section 1331 of the ACA, Maryland could elect to cover adults with incomes between 138% and 200% FPG through State-administered coverage instead of through QHPs offered by health insurance carriers participating in MHBE. States that implement BHP receive 95% of what the federal government would have spent on APTCs (and until 2017 CSRs) if the BHP enrollees had enrolled in marketplace coverage instead. BHP coverage could be provided through MCOs under contract to Medicaid. Minnesota and New York have implemented BHPs.

Surcharge Silver-level Qualified Health Plans

Funds generated from a surcharge placed on silver-level QHPs could be used to increase coverage and improve the insurance risk pool. The surcharge would likely have no significant effect on insured individuals enrolled in a silver-level QHP because the surcharge would increase APTC levels.

Recommendations

The commission made no specific recommendations for which of the listed options the State should implement. However, the commission did make recommendations in a broad sense for what the State should do going forward to ensure that responsible choices are eventually made:

(1) the State should not delay in acting to stabilize the individual insurance market;

(2) the State should obtain an independent actuarial analysis of the options to stabilize the individual insurance market; and

(3) a workgroup could assist the General Assembly during the 2018 legislative session in working on individual market stabilization legislation.

Many of the options presented to the commission for consideration are not mutually exclusive and can be implemented concurrently. In the case of any option that utilizes APTC pass-through funding, recent federal action may have made the options more viable. Based on 2018 enrollment, APTCs are 214% higher in January 2018 than they were in January 2017. Extending that increase to the entire year, total APTCs to individuals in Maryland in 2018 may total as much as $798 million, $426 million more than in 2017.

There are still many uncertainties to consider, especially at the federal level, in terms of approval of any Section 1332 waiver application and the extent that federal action in calendar 2018 further destabilizes the health insurance market.

MHBE has indicated that, in preparation for the possibility of a Section 1332 waiver application, it has engaged the Hilltop Institute at the University of Maryland Baltimore County and has documented the process and action required to submit a 1332 waiver. MHBE indicates that it is able to file a waiver but needs statutory authority to do so. In addition, a review of Centers for Medicare and Medicaid

Services (CMS) guidance indicates that approval needs to be quite specific in terms of the options being sought. Approval of any waiver would likely take some time, making it imperative to decide on options as soon as possible.

2. Medicaid Managed Care Organization Online Shopping

In 2017, MHBE was in the process of implementing an MCO IT project. The goal of the project was to fully integrate MCO plan shopping into the exchange's consumer and worker portals. This would allow Medicaid enrollees to select an MCO during the application process. Previously, MCO-eligible Medicaid recipients had to wait to receive a packet in the mail to choose an MCO.

The 2017 JCR requested that MHBE submit a report on the status of the MCO IT project. A report was submitted July 25, 2017, detailing the status of the project. The report includes an overview, the anticipated benefits, and the status of the project at that time.

The scope of the project was as follows:

- implement an MCO plan selection option through MHBE;
- increase operational efficiency by providing seamless integration of plan selection and Medicaid enrollment online, thereby significantly reducing the consumer wait time to receive benefits from 15 to 5 days;
- strengthen MHBE's security environment for exchange of data with the Maryland Department of Health, the Department of Human Services, CMS, and the Internal Revenue Service; and
- integrate provider directory with the exchange, removing the dependency on external provider search portal.

This project creates a single point of entry for Medicaid eligibility determination and MCO plan shopping, improves the customer experience through integration and faster service, allows recipients to take advantage of MCOs earlier, and decreases reliance on the fee-for-service program.

As of the submission of the report, this project was on track to finish implementation in September 2017. The project was launched on September 9, 2017. As of February 7, 2018, 1,053,434 individuals received Medicaid coverage through the exchange. Just over half of those individuals receiving coverage attempted to MCO plan shop (555,983) with 554,966 individuals successfully enrolling in an MCO. The fiscal 2019 budget assumes a $4 million total fund savings in Medicaid by requiring MCO enrollees to be automatically assigned to an MCO upon enrollment if they do not opt in to an MCO. These savings are facilitated by the MCO IT project.

Operating Budget Recommended Actions

1. Concur with Governor's allowance.

Updates

1. Potentially Improper or Fraudulent Enrollments

In a September 2017 report, the Government Accountability Office (GAO) examined three state-based marketplaces, including MHBE, to determine whether individuals were improperly enrolled in insurance plans through the marketplaces in calendar 2015. The GAO report found that there were very few instances of improper or fraudulent enrollment. However, approximately 2% of total enrollees in Maryland and Rhode Island had immigration-related inconsistencies.

GAO reviewed 210,000 individual applications across the three states. In Maryland specifically, GAO examined 96,000 applicants who received $180 million in APTCs in 2015. Four areas within the market place processes were analyzed:

(1) applicants whose information, including Social Security Number (SSN), did not match the Social Security Administration's (SSA) records;

(2) applicants who were potentially deceased;

(3) applicants who self-attested to being noncitizens or were identified by the state-based marketplaces as having immigration-related inconsistencies; and

(4) applicants who were identified by the state-based marketplace as potentially incarcerated.

Across the states, 2,000 applications were flagged for having personal information that did not match SSA records. GAO notes that in specific cases, name changes and data-entry errors resulted in inconsistencies.

Across the states, 21 of the 210,000 applicants were flagged for being deceased before the start of the plan year. The majority died after their applications were submitted. An additional 30 applications contained SSNs of deceased individuals with names or birthdays that did not match. GAO notes that there were data-entry errors in the specific cases that were reviewed.

Across the states, 245 of the 210,000 applicants were flagged for being potentially incarcerated. GAO notes that incarceration data presents inherent challenges, including the risk of false positives that could incorrectly terminate coverage.

GAO identified 3,000 applicants (2.4% of applicants across the two states) in Maryland and Rhode Island for which immigration-related data matching inconsistencies were unresolved. More than half of these applicants received coverage for more than six months. GAO notes that both states have since implemented processes to automatically close inconsistencies and terminate coverage after the 90-day period.

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2017					
Legislative Appropriation	$0	$75,027	$47,366	$0	$122,393
Deficiency Appropriation	0	0	0	0	0
Cost Containment	0	0	0	0	0
Budget Amendments	0	93	0	0	93
Reversions and Cancellations	0	-2,964	-2,640	0	-5,604
Actual Expenditures	**$0**	**$72,156**	**$44,726**	**$0**	**$116,882**
Fiscal 2018					
Legislative Appropriation	$0	$56,284	$47,461	$0	$103,745
Cost Containment	0	0	0	0	0
Budget Amendments	0	0	0	0	0
Working Appropriation	**$0**	**$56,284**	**$47,461**	**$0**	**$103,745**

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. Numbers may not sum to total due to rounding.

Fiscal 2017

The fiscal 2017 legislative appropriation for the Maryland Health Benefit Exchange (MHBE) decreased by $5.5 million. The MHBE budget increased by $92,958 in special funds related to centrally budgeted fiscal 2017 salary increments.

MHBE canceled $5.6 million in total funds ($3 million in special funds and $2.6 million in federal funds). The most significant cancellations are:

- $1.4 million ($700,000 in special funds and federal funds) intended for connector entities;
- $900,000 in federal funds intended for indefinite delivery/indefinite quantity contracts;
- $750,000 ($400,000 in special funds and $350,000 in federal funds) intended for document and fulfillment services such as scanning, mailing, and notices;
- $510,000 in special funds that was intended for Small Business Health Options Program plans;
- $500,000 in special funds intended for a study on health care in rural communities that was spent in the Maryland Department of Health;
- $400,000 in federal funds due to vacancies and turnover;
- $250,000 in special funds intended for a study on racial disparities in health care;
- $200,000 in federal funds intended for software licenses;
- $150,000 in federal funds intended for marketing; and
- $50,000 in special funds due to decreases in rent.

Fiscal 2018

To date, MHBE's fiscal 2018 legislative appropriation has remained unchanged.

Appendix 2
Object/Fund Difference Report
Maryland Health Benefit Exchange

Object/Fund	FY 17 Actual	FY 18 Working Appropriation	FY 19 Allowance	FY 18 - FY 19 Amount Change	Percent Change
Positions					
01 Regular	67.00	67.00	67.00	0.00	0%
Total Positions	**67.00**	**67.00**	**67.00**	**0.00**	**0%**
Objects					
01 Salaries and Wages	$ 7,213,127	$ 7,710,709	$ 7,690,820	-$ 19,889	-0.3%
02 Technical and Spec. Fees	691	10,921	10,921	0	0%
03 Communication	105,170	76,884	77,715	831	1.1%
04 Travel	10,471	19,360	19,360	0	0%
08 Contractual Services	99,422,867	85,106,180	64,103,707	-21,002,473	-24.7%
09 Supplies and Materials	29,645	43,818	30,500	-13,318	-30.4%
10 Equipment – Replacement	10	0	0	0	0.0%
11 Equipment – Additional	79,411	0	337,500	337,500	N/A
12 Grants, Subsidies, and Contributions	8,971,141	10,000,000	10,000,000	0	0%
13 Fixed Charges	1,049,176	777,092	889,936	112,844	14.5%
Total Objects	**$ 116,881,709**	**$ 103,744,964**	**$ 83,160,459**	**-$ 20,584,505**	**-19.8%**
Funds					
03 Special Fund	$ 72,156,069	$ 56,284,035	$ 35,000,000	-$ 21,284,035	-37.8%
05 Federal Fund	44,725,640	47,460,929	48,160,459	699,530	1.5%
Total Funds	**$ 116,881,709**	**$ 103,744,964**	**$ 83,160,459**	**-$ 20,584,505**	**-19.8%**

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. The fiscal 2019 allowance does not include contingent reductions or cost-of-living adjustments.

Appendix 3
Fiscal Summary
Maryland Health Benefit Exchange

Program/Unit	FY 17 Actual	FY 18 Wrk Approp	FY 19 Allowance	Change	FY 18 - FY 19 % Change
01 Maryland Health Benefit Exchange	$ 48,450,928	$ 51,843,960	$ 52,055,575	$ 211,615	0.4%
02 Major Information Technology Development	28,889,225	30,601,004	31,104,884	503,880	1.6%
03 Maryland Health Insurance Program	39,541,556	21,300,000	0	-21,300,000	-100.0%
Total Expenditures	**$ 116,881,709**	**$ 103,744,964**	**$ 83,160,459**	**-$ 20,584,505**	**-19.8%**
Special Fund	$ 72,156,069	$ 56,284,035	$ 35,000,000	-$ 21,284,035	-37.8%
Federal Fund	44,725,640	47,460,929	48,160,459	699,530	1.5%
Total Appropriations	**$ 116,881,709**	**$ 103,744,964**	**$ 83,160,459**	**-$ 20,584,505**	**-19.8%**

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. The fiscal 2019 allowance does not include contingent reductions or cost-of-living adjustments.

Appendix 4
Uninsured Rate by Jurisdiction
Calendar 2016

	Total	Black/African American	White	Latino	Asian
Allegany	6%	8%	6%	10%	6%
Anne Arundel	3%	3%	2%	5%	3%
Baltimore County	4%	4%	3%	6%	4%
Baltimore City	8%	9%	6%	12%	8%
Calvert	3%	3%	2%	4%	3%
Caroline	5%	7%	5%	12%	6%
Carroll	2%	3%	2%	4%	3%
Cecil	4%	5%	4%	7%	5%
Charles	3%	3%	3%	4%	3%
Dorchester	7%	10%	6%	12%	9%
Frederick	3%	4%	2%	5%	3%
Garrett	6%	10%	6%	8%	8%
Harford	3%	4%	2%	5%	3%
Howard	2%	3%	2%	4%	2%
Kent	5%	6%	5%	9%	8%
Montgomery	3%	4%	2%	6%	3%
Prince George's	5%	5%	5%	10%	6%
Queen Anne's	3%	4%	3%	6%	4%
Somerset	7%	9%	6%	12%	10%
St. Mary's	3%	4%	3%	5%	4%
Talbot	4%	6%	4%	11%	6%
Washington	4%	7%	4%	7%	5%
Wicomico	6%	9%	5%	13%	6%
Worcester	5%	8%	5%	9%	6%

Source: Maryland Health Benefit Exchange