D78Y01
Maryland Health Benefit Exchange

Executive Summary

The Maryland Health Benefit Exchange (MHBE) provides a marketplace for individuals and small businesses to access affordable or no-cost health coverage.

Operating Budget Data

($ in Thousands)

	FY 18 Actual	FY 19 Working	FY 20 Allowance	FY 19-20 Change	% Change Prior Year
Special Fund	$49,154	$35,005	$35,000	-$5	
Adjustments	0	26	134	108	
Adjusted Special Fund	**$49,154**	**$35,031**	**$35,134**	**$103**	**0.3%**
Federal Fund	42,975	48,164	48,332	168	0.3%
Adjustments	0	18	93	75	
Adjusted Federal Fund	**$42,975**	**$48,182**	**$48,425**	**$243**	**0.5%**
Adjusted Grand Total	**$92,129**	**$83,213**	**$83,559**	**$346**	**0.4%**

Note: The fiscal 2019 appropriation includes deficiencies, a one-time $500 bonus, and general salary increases. The fiscal 2020 allowance includes general salary increases.

- Overall, the fiscal 2020 budget for MHBE changes little from the fiscal 2019 working appropriation. However, relative spending between different functional aspects of the exchange's work changes to more closely reflect how MHBE is actually spending its budget in fiscal 2019. Specifically, there is additional spending on various information technology-related contracts.

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

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Personnel Data

	FY 18 Actual	FY 19 Working	FY 20 Allowance	FY 19-20 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	2.69	4.02%
Positions and Percentage Vacant as of 12/31/18	4.00	5.97%

Key Observations

- Legislative action taken in the 2018 session to create a State Reinsurance Program proved successful in stabilizing premiums in the individual market, although premium costs remain high for those that do not receive Advanced Premium Tax Credit subsidies. However, funding for that program was derived from a one-time premium tax. An ongoing funding source is necessary if the program is to continue at current levels beyond calendar 2020. Other efforts aimed at making products in the individual market more attractive, such as an individual mandate, are also likely to be considered in the 2019 session.

- All of this activity to stabilize the individual market is taking place against the backdrop of continued litigation surrounding the Affordable Care Act, almost nine years after its enactment in March 2010.

Operating Budget Recommended Actions

		Funds
1.	Reduce funding for the service center based on actual spending levels.	$ 2,400,000
2.	Adopt narrative requesting the Maryland Health Benefit Exchange to document the resolution of a potential federal liability identified in the Fiscal 2018 State Closeout audit report.	
	Total Reductions	**$ 2,400,000**

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 access affordable or no-cost 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 health 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.

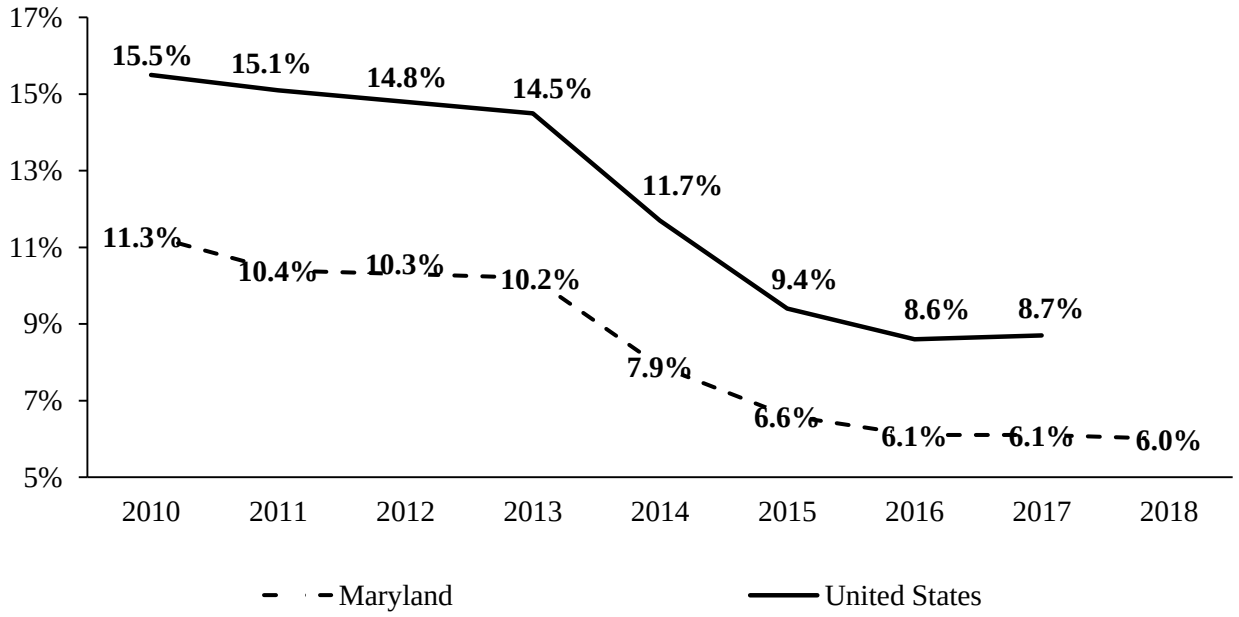
Performance Analysis: Managing for Results

1. Percentage of Marylanders Who Are Uninsured Continues to Decline

As shown in **Exhibit 1**, the percentage of Marylanders without health insurance is reported by MHBE to have dropped to 6% in 2018, mirroring the overall drop in the uninsured nationally. In calendar 2017, it was estimated that just over 28 million people in the United States remained without health care coverage, 366,000 in Maryland. The three drivers in this decline are:

- Maryland's decision to expand Medicaid under the ACA provides coverage to just under 310,000 individuals as of December 2018. This expansion is by far the largest factor in the drop in the State's uninsured rate. Similarly, at the national level, the decline in the uninsured rate is much more significant in states that have expanded Medicaid compared to those that have not. In 2017, in the 31 states and the District of Columbia where Medicaid has been expanded, the uninsured rate was 6.5% compared to 12.2% in the nonexpansion states.

Exhibit 1
U.S. and Maryland Uninsured Rate
Calendar 2010-2018



Source: Maryland Health Benefit Exchange; U.S. Census Bureau

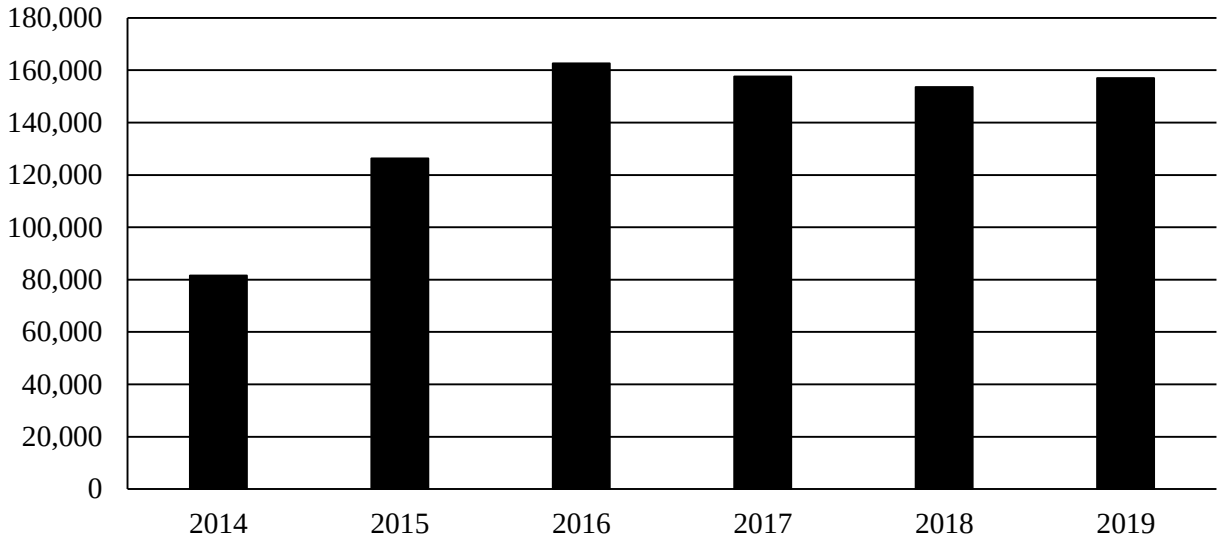
- General economic improvement since the great recession, with unemployment falling to 4.2% in 2018 (through November).

- The availability of health insurance through MHBE.

2. Coverage in QHPs through the Individual Market

MHBE regularly reports data on the number of individuals enrolled in QHPs through the individual market. For calendar 2019, MHBE reported that 156,963 individuals enrolled through MHC, with off-exchange enrollment increasing that number to 212,149. As shown in **Exhibit 2**, this represents a slight increase over enrollment from calendar 2017, although still below the 2016 level.

Exhibit 2
Enrollment in Open Enrollment in a Qualified Health Plan through the Maryland Health Connection
Calendar 2014-2019



Source: Maryland Health Benefit Exchange

It should be noted that there tends to be a decline in enrollment over the course of the calendar year, in the order of 10%.

3. Measures of the Relative Affordability of Individual QHPs

MHBE reports on several measures that indicate the relative affordability of products offered through the exchange (see **Exhibit 3**). The exhibit illustrates the upward pressure on premiums experienced in recent years, reflecting such influences as initial low premium pricing strategies, participant acuity, the ending of the temporary reinsurance program authorized under the ACA, and the current federal administration's decision to end cost-sharing subsidies. It was this pressure that prompted the State action to develop its own reinsurance program (discussed more fully in Issue 1).

Specifically:

- The first two lines in the exhibit distinguish between those individual who do qualify for Advanced Premium Tax Credits (APTC), individuals within incomes up to 400% of the federal poverty level, prior to the application of the APTC and those who do not and what their premium

experience has been. Both groups see an increase in premiums as a percentage of the average wage through 2018. Interestingly, the average premiums as a percentage of the average wage for those individual who do qualify for an APTC but prior to the application of the APTC are actually higher than those who do not qualify for an APTC *i.e.*, they are able to choose more expensive plans because of the subsidy they will ultimately receive that will lower premiums. In calendar 2018, insurers disproportionately increased the price of silver plans, so-called silver loading, so that individuals with APTCs saw little or no premium increases for silver plans after subsidies. This further drove up the overall cost of premiums for individuals without an APTC.

- The last two lines show individual premium prices for the second lowest cost silver plan as a percentage of the average wage with and without an APTC. This measure is chosen because APTCs are based on the second lowest cost silver plan. In this data, growth in the premium price without an APTC is dramatically higher than for those with APTCs. While the data underscores the value of APTCs in making plans affordable, it is important to remember that those who do not qualify for APTCs have to bear the full cost of that premium increase.

Exhibit 3
Various Measures of Qualified Health Plan Affordability
Calendar 2014-2018
(Premium Cost as a % of Average Wage)

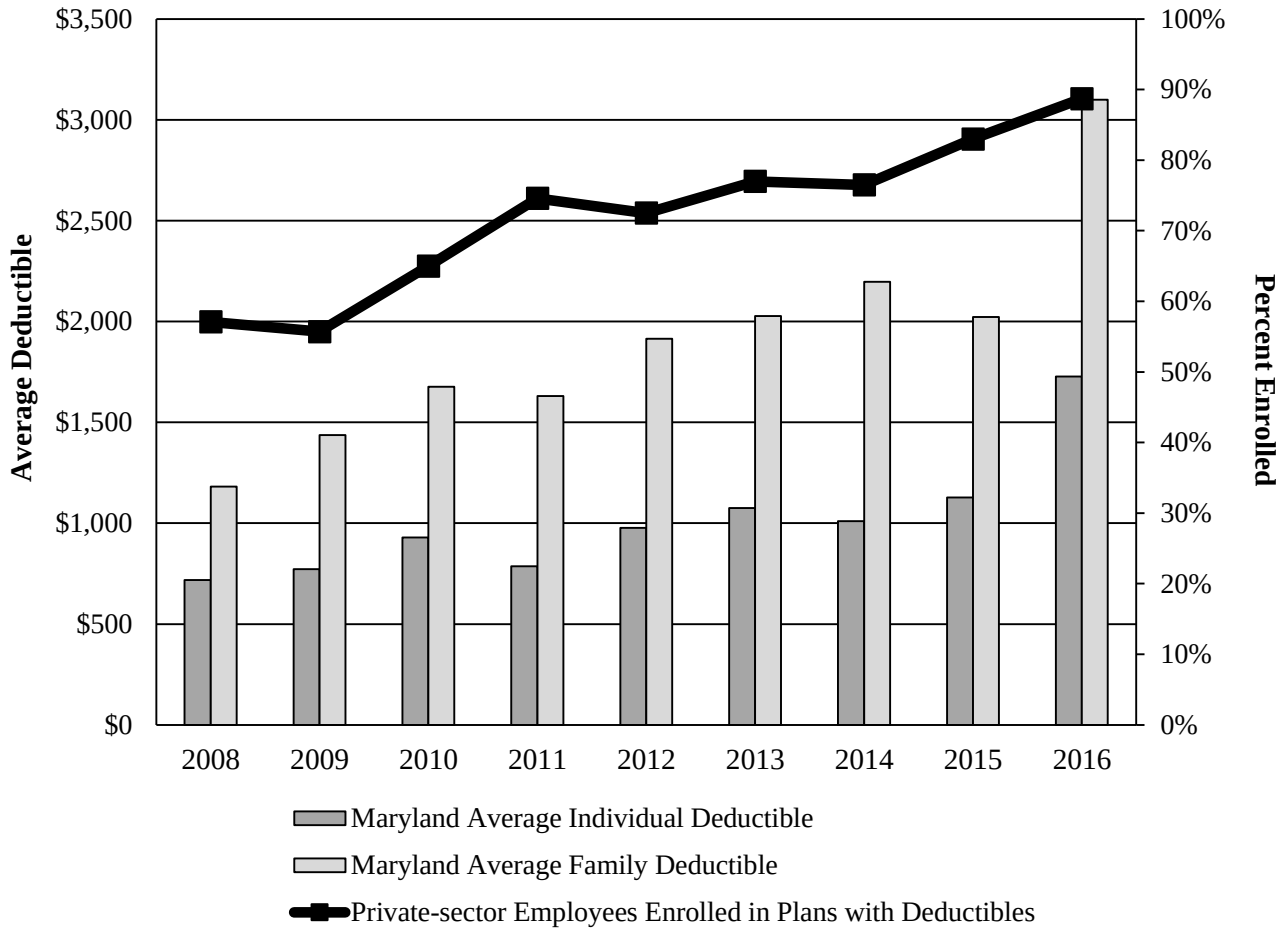
	2014	2015	2016	2017	2018
Average total single person premium for all QHPs as a percent of average wage for individuals that do not qualify for an APTC	6.5%	5.5%	6.1%	7.7%	11.0%
Average total single person premium for all QHPs as a percent of average wage for individuals that do qualify for an APTC prior to the application of the APTC	6.8%	8.1%	7.4%	8.5%	13.0%
Average single person premium for individual in second lowest cost silver plan as a percent of average wage without APTC	8.6%	6.5%	6.8%	8.2%	12.6%
Average single person premium for individual in second lowest cost silver plan as a percent of average wage with APTC	2.3%	1.9%	1.8%	1.8%	1.6%

APTC: Advanced Premium Tax Credits
QHP: Qualified Health Plan

Source: Maryland Health Benefit Exchange

However, it should be noted that these measures do not capture the full cost of health insurance, for example, spending on deductibles and copayments. Increasingly more commercial health insurance products have deductibles, and those deductibles have been increasing. As shown in **Exhibit 4**, for example, the percentage of private-sector employees enrolled in plans with deductibles increased from just over half in calendar 2008 to almost 90% in calendar 2016, and the level of average deductibles rose in the same time period.

Exhibit 4
Private-sector Employees in Health Plans with a Deductible and Average Deductibles
Calendar 2008-2016



Source: Health Services Cost Review Commission

Interestingly, in data developed by the Maryland Insurance Administration (MIA) for fiscal 2019 with the reinsurance program developed under the Section 1332 waiver, for unsubsidized coverage, this potential level of health spending is starkly illustrated. For example:

- for an individual age 40 in a silver plan in Metro Baltimore with the State average income of $63,127, premium costs range from 9% to 16% of after tax income depending on the plan, but if the maximum out-of-pocket expense is reached, that increases to 26% to 33%; and

- for a family of four with the State average household income of $103,622, in a similar silver plan also in Metro Baltimore, premium costs range from 18% to 33% of after tax income depending on the plan, but if the maximum out-of-pocket expense is reached, that increases to 39% to 50%.

Fiscal 2019 Actions

Proposed Deficiency

MHBE will receive $44,544 ($26,483 in special funds and $18,061 in federal funds) in centrally budgeted funding for costs associated with the April 1, 2019 one-time $500 bonus and 0.5% general salary increase.

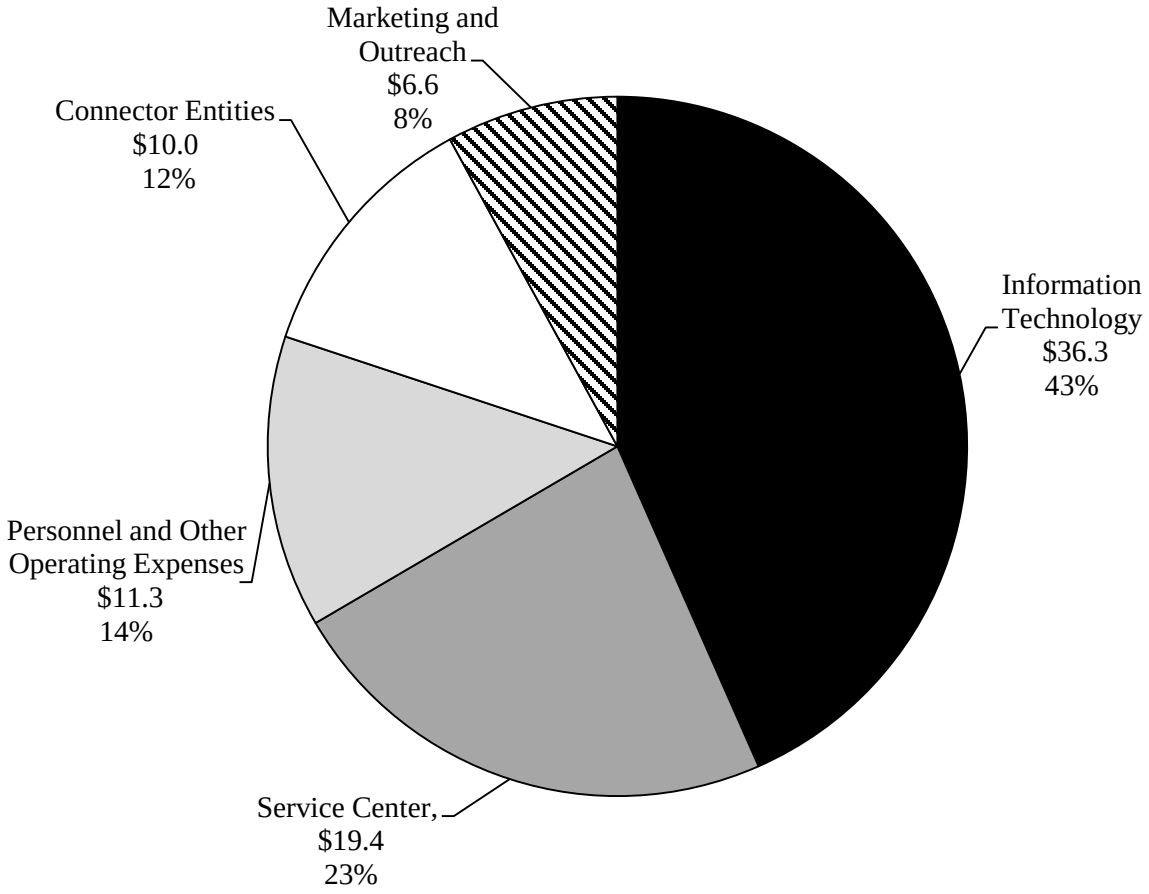
Fiscal 2020 Allowance

Overview of Agency Spending

As MHBE has matured as an organization, the relative share of spending on its core activities (outside of reinsurance payments, of which there are none in fiscal 2020), has become more predictable. As shown in **Exhibit 5**, just under half of the proposed budget will be dedicated to information technology (IT) related activity. The MHBE IT system is the key enrollment portal not only for QHPs but also Medicaid income-based enrollment. Supporting Medicaid enrollment enables MHBE to claim federal Medicaid matching funds on eligible expenses. Having ongoing federal Medicaid financial support was a strategic decision in how Maryland initially decided to organize MHBE, and in fiscal 2020, 58% of MHBE's budget is supported by federal Medicaid funds. The remaining 42% is through special funds derived from a mandated $35 million diversion of premium tax revenues that would otherwise go to the General Fund. However, any of these special funds that remain unspent at fiscal year closeout, revert to the General Fund.

Almost one-quarter of the MHBE budget is directed to its service center, a call and enrollee support center currently operated by Maximus. MHBE also provides $10 million in grants to connector entities, consumer assistance organizations that span the State in eight regions and are staffed by trained navigators who provide free, in-person assistance to help consumers learn about, apply for, and enroll in health coverage.

Exhibit 5
Most of MHBE's Budget Is Spent on Contracts and Grants for Enrollee Support And Its IT Platform
Fiscal 2020
($ in Millions)



MHBE: Maryland Health Benefit Exchange
IT: information technology

Source: Department of Budget and Management; Department of Legislative Services

Proposed Budget Change

As shown in **Exhibit 6**, although MHBE's adjusted fiscal 2020 budget grows by only $346,000, 0.4%, over the adjusted fiscal 2019 working appropriation, there is some shifting of resources between spending on IT contracts and other contract activities. However, it should be noted that this shift more accurately reflects on how MHBE intends to spend its fiscal 2019 appropriation. MHBE has proposed a budget amendment that has not yet been processed, and is thus not reflected in

the fiscal 2019 working appropriation, to effect this shift in focus. MHBE's ability to do this is principally because the fiscal 2019 funding originally earmarked for the service center contract, $26 million, is significantly higher than will be required based on favorable contract terms negotiated with Maximus. The proposed budget amendment reallocates almost $4.4 million into various IT-related activities, similar in scale and nature to the relative spending shown in fiscal 2020. Similarly, additional funding in marketing is already happening in fiscal 2019 and is proposed to continue at that higher level in fiscal 2020.

Exhibit 6
Proposed Budget
Maryland Health Benefit Exchange
($ in Thousands)

How Much It Grows:	**Special Fund**	**Federal Fund**	**Total**
Fiscal 2018 Actual	$49,154	$42,975	$92,129
Fiscal 2019 Working Appropriation	35,031	48,182	83,213
Fiscal 2020 Allowance	35,134	48,425	83,559
Fiscal 2019-2020 Amount Change	$103	$243	$346
Fiscal 2019-2020 Percent Change	0.3%	0.5%	0.4%

Where it Goes:

Personnel Expenses	**$101**
Fiscal 2020 cost of the 3% general salary increase and annualization of fiscal 2019 general salary increases offset by fiscal 2019 cost of 0.5% general salary increase and $500 one-time bonus	$170
Retirement contributions	49
Employee and retiree health insurance	-118
Other fringe benefit adjustments	-1
Information Technology Contracts	**$4,572**
Website enhancements	2,688
Increase in maintenance and operations costs due to the replacement of the current hosting vendor with migration to MD THINK platform, which will mean additional responsibilities for the current vendor for work not supported under the MD THINK platform utilization and professional services, such as incident/change management and help desk support	1,216
Various systems support contracts	768
Contract to facilitate the migration of the Maryland Health Benefit Exchange to the MD THINK shared Amazon web services platform	700
Security assessment	350
Project management office	183

Where it Goes:	
Migration from current hosting vendor (Conduent) to MD THINK shared platform	-503
Software licenses	-828
Outreach, Enrollee Services, and Other Administrative Expenditures	**-$4,314**
Marketing (aligning to actual fiscal 2019 levels approved by MHBE board but not yet reflected in working appropriation) to overcome any confusion surrounding the impact of the reinsurance program, policy changes at the federal level, and the limitations of the previous marketing budget in a high cost market	1,205
SHOP administrative fee	600
Printing expenses	500
Statewide allocated costs	108
Miscellaneous administrative contracts	-102
Service center contract based on favorable renegotiated rate that is still $2.8 million above the most recent actual to reflect uncertainty in QHP policy landscape, uncertainty about current contract renewal, and variability in federal participation rate	-6,624
Other	-13
Total	**$346**

MD THINK: Maryland Total Human-services Information NetworK
MHBE: Maryland Health Benefit Exchange
QHP: qualified health plan
SHOP: Small Business Health Options Program

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

Website Enhancements

In addition to various activities associated with the migration of MHBE IT system upcoming migration to the Maryland Total Human-services Information NetworK platform, the largest spending initiative relates to a variety of website enhancements. According to MHBE, these enhancements are designed to:

- **Improve the user experience** and in doing so, reduce the need for call center and other support, with particular emphasis on improving the mobile device experience as over 50% of the customer traffic is coming on mobile devices via the exchange's mobile app and mobile browsers.

- **Enhance security** such as multifactor authentication while simplifying the user experience through fingerprint/face identification.

- **Improve operational efficiency** by using the latest technology for customer support and key operational processes, such as document verification and notice generation and improving reporting metrics.

- **Facilitate mobile auto form fill** with demographic and address information and allowing for the scanning of customer identification documents.

- **Enhance data analytics** to include capturing real-time data.

- **Update the notices platform** so that it is more user friendly and allows consumer notices to be more quickly updated and be performed without extensive technical support.

Issues

1. Anticipation of State Reinsurance Program Reduces Individual Market Premium Rates, but Ongoing Funding Is Required

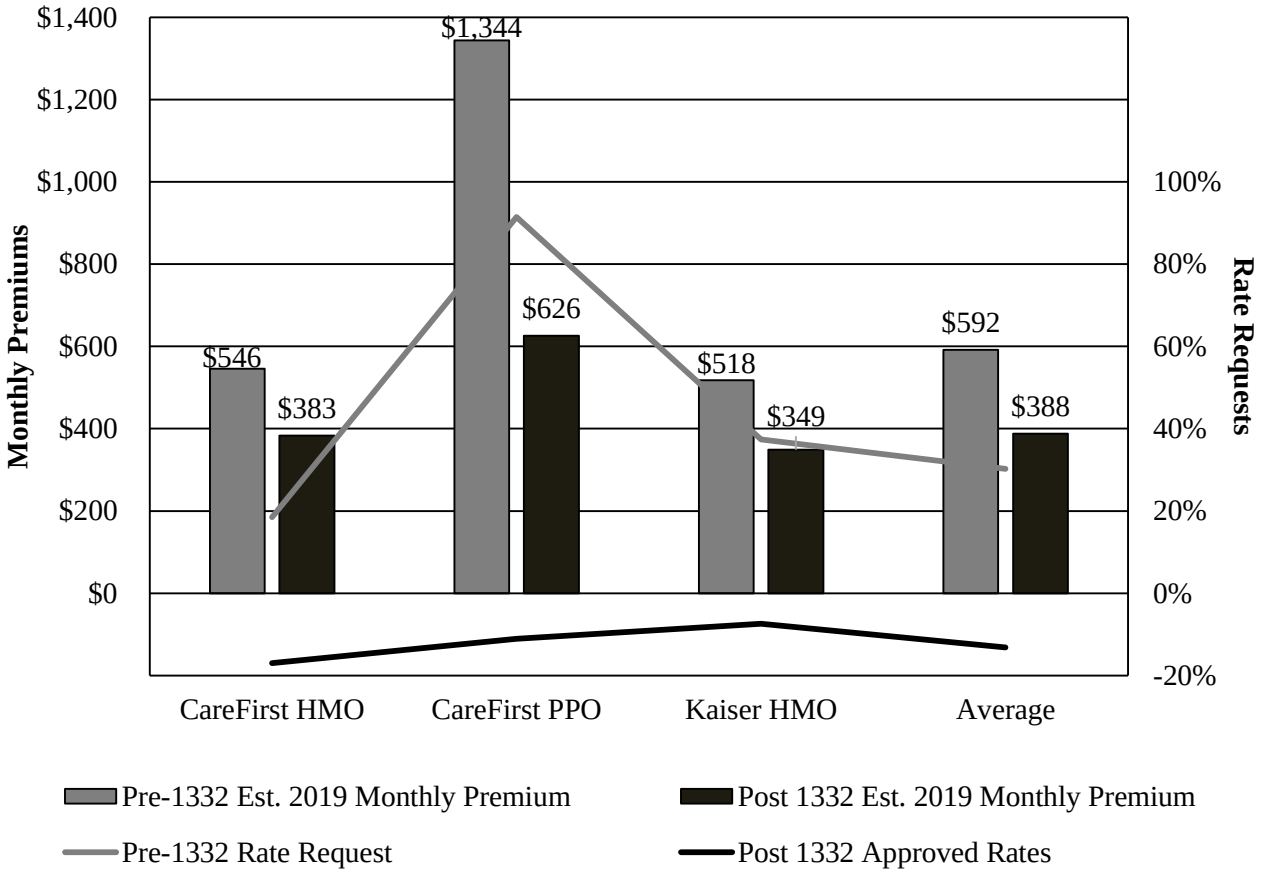
Reinsurance is insurance for carriers that protects against significant losses. Chapters 6 and 7 of 2018 required MHBE to submit an application for a State Innovation Waiver under Section 1332 of the ACA to establish a State Reinsurance Program and seek federal pass-through funding. The federal government approved the waiver in August 2018. The waiver is approved through 2023.

For calendar 2019, the State Reinsurance Program will provide reinsurance to carriers that offer individual health benefit plans in the State. Carriers that incur total annual claims costs on a per individual basis between a $20,000 attachment point (the dollar amount of insurer costs above which an insurer is eligible for reinsurance) and a cap of $250,000 will be reimbursed for 80% of those claims costs. Payments to insurance carriers will be made after the plan-year ends and all costs have been recorded and reconciled.

Impact on 2019 Premium Rates in the Individual Market

Approval of the Section 1332 waiver and the availability of federal pass-through funds for the State Reinsurance Program had a dramatic impact on the final 2019 individual market premium rates approved by MIA. This impact is shown in **Exhibit 7**, which displays carrier rate requests and the associated estimated 2019 monthly premiums pre-1332 (before the waiver was approved) compared with rates approved by MIA and the associated estimated monthly premiums post-1332 (after the waiver was approved).

Exhibit 7
Impact of the State Reinsurance Program on Rates in the Individual Market



HMO: health maintenance organization
PPO: preferred provider organization
Pre-1332: prior to approval of the Section 1332 waiver
Post-1332: following approval of the Section 1332 waiver

Note: Estimated monthly premiums reflect rates for the lowest cost silver plan for a 40-year-old, male, nonsmoker in the Baltimore Metro area.

Source: Maryland Insurance Administration, Department of Legislative Services

Prior to approval of the Section 1332 waiver, Maryland carriers requested calendar 2019 rate increases averaging 30.2% (ranging from 18.5% for the CareFirst health maintenance organization product to 91.4% for CareFirst preferred provider organization products). Based on these rate submissions, MIA anticipated granting rate increases averaging 23.0%. However, following waiver

approval, carriers revised their rate requests, and the average requested rate increase fell to 23.4%. Ultimately, the rates approved by MIA declined by an average of 13.2%. Per MIA, this represents the first decrease in individual market premium rates in decades.

Compared with initial average rate requests of 30.2%, the final approved rates reflect an overall reduction of 43.3%. MIA advises that, in dollar terms, this reduction equates to consumers in the individual market paying $481 million less in calendar 2019 premiums than they would have based on pre-1332 rate requests. Furthermore, as a result of the State Reinsurance Program and the associated reduction in premiums, MHBE projects a 5.8% increase in individual exchange enrollment for calendar 2019.

Reinsurance Program Requires Ongoing Funding Source

Funding for the State Reinsurance Program includes State special funds and federal pass-through funding. Chapters 37 and 38 of 2018 established, for calendar 2019 only, a 2.75% assessment on specified health insurance carriers to recoup the aggregate amount of the health insurance provider fee that would have been assessed under the ACA for calendar 2019 but was temporarily suspended for that year by action at the federal level. The assessment must be used for the State Reinsurance Program. Under the Section 1332 waiver, Maryland is able to use federal pass-through funds (federal funding that would have been provided to Maryland residents in the form of advanced premium tax credits in the absence of the reinsurance program) to provide additional funding for the program.

Total funding for the State Reinsurance Program is estimated at $1.1 billion between calendar 2019 and 2021, including $365 million in State funds from the one-time assessment on health insurance carriers and an estimated $730 million in federal pass-through funds. Although the Section 1332 waiver is approved through 2023, by calendar 2021, additional funding will be required to continue the program and maintain the significant rate reductions realized in calendar 2019.

2. Legislation to Impose State-based Individual Mandates Will Be Considered in the Absence of Federal Penalty in 2019

Individual mandates require individuals to purchase health insurance coverage or pay a penalty. Individual mandates are intended to guard against adverse selection, reduce free riders, and recognize the cost of the uninsured and uncompensated care.

A principal feature of the ACA, the federal individual mandate requires individuals to have minimum essential coverage, qualify for an exemption, or make a shared responsibility payment with their federal income tax. Payment for tax year 2018 is the greater of $695 per adult/$347.50 per child (up to a maximum of $2,085 per family), or 2.5% of household income.

The Tax Cuts and Jobs Act of 2017 zeroed out the penalty on individuals for not having minimum essential coverage under the ACA. Thus, the federal individual mandate will no longer be

enforced, effective calendar 2019. The Congressional Budget Office projected that, nationally, elimination of the mandate penalty will decrease health insurance enrollment by three million to six million individuals between 2019 and 2021 and increase individual market premiums by 10%, while reducing federal spending by $318 billion over 10 years due to fewer premium tax subsidies being paid.

In response, in 2018, nine states (including Maryland) and the District of Columbia considered implementing state-based individual mandates to encourage younger, healthier consumers to maintain coverage and preserve a broader risk pool. Penalty revenues could be used for market stabilization or other efforts. To date, only New Jersey, Vermont, and the District of Columbia have enacted individual mandates. New Jersey's mandate, which took effect January 1, 2019, largely mirrors the federal mandate, with penalties being used for the state's reinsurance program. Vermont's mandate will not take effect until 2020, and a separate working group was established to develop recommendations on what the specific penalties and enforcement mechanisms will be. The District of Columbia adopted an individual mandate similar to the federal mandate but with significant additional exemptions based on income. The penalty will be developed annually by the DC Health Benefit Exchange Authority. Several other states considered, but did not pass, individual mandates, including Connecticut, Hawaii, and Maryland. In the 2018 session, the legislature considered SB 1011 and HB 1167, which mirrored the federal mandate regarding penalties and exemptions but allowed penalty payments to be used as a down payment for coverage. Neither bill was enacted. Similar legislation will be introduced during the 2019 session.

The Urban Institute estimates that a Maryland individual mandate could decrease the number of uninsured individuals by 15.8% and reduce the average individual market premium by as much as 13.5%. In calendar 2016, the most recent year for which data is available, 68,150 Maryland returns paid the penalty, for a total of $51.0 million in penalties. Of the returns subject to penalty, 96% had an adjusted gross income (AGI) less than $100,000, 76% had an AGI less than $50,000, and 34% had an AGI less than $25,000.

3. Potential Impact of Pending Litigation

The federal ACA includes, among other features, an individual mandate requirement, an allowance for states to expand Medicaid eligibility up to 138% of federal poverty guidelines (FPG), APTCs for qualified individuals who purchase a health benefit plan through an exchange, and significant changes to private insurance including guaranteed issuance and renewal regardless of preexisting conditions.

In February 2018, 20 states filed suit in *Texas v. United States* that the ACA (as amended by the federal Tax Cut and Jobs Act of 2017, which eliminated the tax penalty of the individual mandate) is unconstitutional as it is not supported by a tax penalty. The lawsuit asserts that the entire ACA is unlawful. Seventeen state Attorneys General are defending the ACA and assert that the mandate remains constitutional and that, even without the individual mandate, the remainder of the ACA would stand. On December 14, 2018**,** Judge Reed Charles O'Connor issued a grant of summary judgment that the entire ACA is invalid. On December 30, 2018**,** Judge O'Connor issued a stay and partial final

judgment on the claim that the ACA's individual mandate is unconstitutional, which permitted immediate appeal and allows the ACA to remain in full effect pending appeals.

In response to *Texas v. United States*, on September 13, 2018, Maryland Attorney General Brian E. Frosh filed a lawsuit in the U.S. District Court for the District of Maryland seeking a declaratory judgment that the ACA is constitutional and that Congress' decision to eliminate the individual mandate penalty does not invalidate any of the ACA's remaining provisions. The suit asserts that eliminating the ACA would cause immediate and long-term harm to Maryland, citing that Maryland received $2.77 billion in federal funds in fiscal 2017 under the ACA, as well as $65 million in public health funding between fiscal 2012 and 2016.

Potential Fiscal Impact on Maryland of *Texas v. United States*

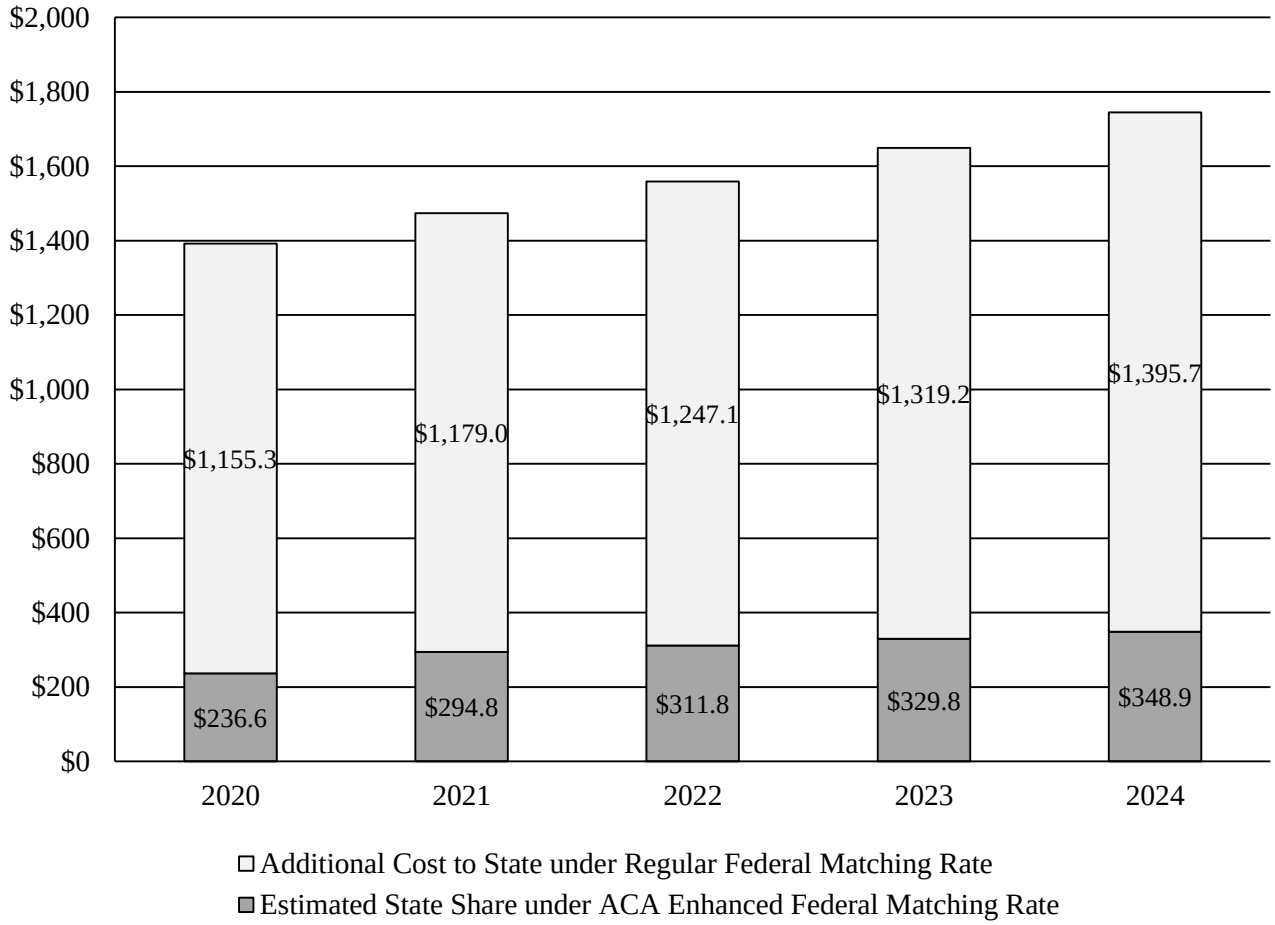
A final decision under *Texas vs. United States* ruling the ACA invalid would have a significant financial impact on Maryland, specifically the Medicaid expansion, consumer financial assistance under APTCs and the future of MHBE, and Maryland's Section 1332 waiver.

Medicaid Expansion

Chapter 159 of 2013 expanded Medicaid coverage to Marylanders with incomes up to 138% of FPG. The expansion was 100% federally funded in calendar 2014 through 2016. Enhanced federal funding is 93% in calendar 2019 and will decrease to 90% in calendar 2020 and subsequent years. If the ACA is ruled invalid, Maryland (along with 31 other states) must decide whether to maintain the expansion. Discontinuation could eliminate health coverage for as many as 310,000 enrollees. If the State preserves coverage, expenditures increase substantially due to loss of enhanced federal funding. In fiscal 2019, the cost to serve the Medicaid expansion population is estimated to be $2.7 billion, 93.5% of which is federally funded.

As shown in **Exhibit 8**, in the absence of an enhanced federal matching rate, the net cost to Maryland (based on Maryland's traditional 50.0% matching rate minus the State liabilities currently assumed under the ACA assuming that the State could claim that matching rate) would be $1.2 billion in fiscal 2019 and 2020, rising to $1.4 billion by fiscal 2024.

Exhibit 8
Additional Cost to Maryland to Cover the Medicaid Expansion Population At the Regular Federal Matching Rate
Fiscal 2020-2024
($ in Millions)



ACA: Affordable Care Act

Note: Fiscal 2020 costs based on the Department of Legislative Services' fiscal 2020 baseline estimate.

Source: Department of Legislative Services

Advanced Premium Tax Credits

In calendar 2018, more than 128,200 individuals were enrolled in the individual exchange. A majority of enrollees (86.2%) received a federal APTC to help pay their monthly premiums. For

calendar 2018, the estimated value of APTCs for Maryland consumers statewide was $727.5 million. If the ACA is ruled invalid, consumers will lose federal APTC assistance. Further, the State will have to decide whether to discontinue MHBE or continue it with State funding.

Section 1332 Waiver

Should the ACA be ruled invalid, Maryland's waiver would be invalidated and the State Reinsurance Program discontinued. In the absence of the program, premium rates in the individual market would rise substantially. As discussed earlier in this analysis, prior to approval of the Section 1332 waiver, MIA anticipated granting rate increases in the individual market averaging 23%. This reflects a significant increase over the average 13.2% reduction in rates approved by MIA following approval of the Section 1332 waiver.

Additional Implications for Maryland Consumers

The ACA includes numerous consumer-related insurance reforms, most notably protections for preexisting conditions. Most of Maryland's insurance law, which mirrors these requirements, is based on cross-references to the ACA. Should the ACA be ruled invalid, these provisions would also become invalid. This includes requirements for guaranteed issue and renewal, prohibitions against preexisting condition exclusions, and community rating standards (carriers cannot charge higher premiums based on health status). Legislation is anticipated during the 2019 session to codify preexisting condition protections in Maryland law.

4. Fiscal 2018 Closeout Audit Highlights Potential Liability

The fiscal 2018 statewide closeout audit identifies a potential liability of $28.4 million pertaining to certain misallocated expenditures under federal establishment grants, the original grants authorized by the federal government to establish state marketplaces such as MHBE. This potential liability dates back to a federal audit from 2015, an audit to which MHBE and Maryland Department of Health (MDH) responded that they did not concur with the findings and recommendations. However, the federal Department of Health and Human Services Office of Inspector General (HHS-OIG) disagreed with MHBE and MDH and still has the recommendation to recover the $28.4 million in a report from July 2018 on its website.

MHBE notes that the audit finding concerned cost allocations (*i.e.*, how much should be charged to federal funds and how much to State funds) and the accuracy of the cost allocation methodology used by MHBE. Further, MHBE notes that the Centers of Medicare and Medicaid Services (CMS) disagreed with HHS-OIG, specifically because an office within CMS approved the cost allocation methodology. A letter from the acting administrator for CMS to HHS-OIG in March 2015 advised that CMS had worked with states on the appropriate cost allocation methodology and the enrollment data to be used in developing that cost allocation and that it was aware that MHBE had adjusted its cost allocation methodology for the last round of establishment grant funding based on revised enrollment data. However, no additional correspondence has been received from CMS on the audit finding since that time.

MHBE indicates that it has reached out to CMS to determine the status of the finding and, at the time of writing, had not heard from CMS. MHBE is thus standing behind the 2015 CMS position and disagrees with the closeout finding.

The Department of Legislative Services recommends the adoption of narrative requesting MHBE to seek formal resolution of this audit finding in writing from CMS.

Operating Budget Recommended Actions

		Amount Reduction	
1.	Reduce funding for the service center based on actual spending levels. The Maryland Health Benefit Exchange negotiated a favorable rate for the operation of its service center. Spending on the contract in fiscal 2018 was $6.7 million lower than budgeted, and the fiscal 2020 budget recognizes some savings from the contract but still allows for spending growth. The reduction aligns contract spending closer to the fiscal 2018 actual.	$ 1,000,000 $ 1,400,000	SF FF

2. Adopt the following narrative:

Potential Federal Liability: The Fiscal 2018 State Closeout audit report identified a potential liability of $28.4 million pertaining to certain misallocated expenditures under federal establishment grants expended by the Maryland Health Benefit Exchange (MHBE). The finding was made by the U.S. Department of Health and Human Service Office of the Inspector General (HHS-OIG). While the Maryland Department of Health and MHBE dispute the finding and the Centers for Medicare and Medicaid Services (CMS) has written to the HHS-OIG confirming the cost allocation methodology used by MHBE, the finding remains on the HHS-OIG website in a report as recent as July 2018. The committees request MHBE to obtain written confirmation from CMS that this finding has been resolved and submit that documentation to the committees. In any event, MHBE should send an update to the committees by September 1, 2019.

Information Request	Author	Due Date
Potential federal liability	MHBE	On receipt of written confirmation of resolution of the issue from CMS or September 1, 2018

Total Reductions	**$ 2,400,000**
Total Special Fund Reductions	**$ 1,000,000**
Total Federal Fund Reductions	**$ 1,400,000**

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2018					
Legislative Appropriation	$0	$56,284	$47,461	$0	$103,745
Deficiency/Withdrawn Appropriation	0	-60	-46	0	-106
Cost Containment	0	0	0	0	0
Budget Amendments	0	0	0	0	0
Reversions and Cancellations	0	-7,070	-4,440	0	-11,510
Actual Expenditures	**$0**	**$49,154**	**$42,975**	**$0**	**$92,129**
Fiscal 2019					
Legislative Appropriation	$0	$34,967	$48,137	$0	$83,104
Budget Amendments	0	38	26	0	65
Working Appropriation	**$0**	**$35,005**	**$48,164**	**$0**	**$83,169**

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. Numbers may not sum to total due to rounding.

Fiscal 2018

The fiscal 2018 legislative appropriation for the Maryland Health Benefit Exchange (MHBE) was reduced by $11.6 million. The MHBE budget was reduced by $106,323 ($60,410 in special funds and $45,913 in federal funds) by Section 19 of the fiscal 2019 Budget Bill due to a surplus in the health insurance account.

MHBE canceled $11.5 million in total funds ($7.1 million in special funds and $4.4 million in federal funds). The most significant cancellations are:

- $6.7 million ($3.9 million in special funds and $2.8 million in federal funds) due to savings from a new call center contract;
- $1.7 million ($920,000 in special funds and $802,000 in federal funds) intended for indefinite delivery/indefinite quantity contracts;
- $1.0 million ($409,000 in special funds and $558,000 in federal funds) due to vacancies and turnover;
- $483,000 in special funds due to rent savings by charging federal funds; and
- $419,000 in special funds for reinsurance based on refunds from CareFirst claims and pharmacy rebates.

Fiscal 2019

To date, MHBE's fiscal 2019 legislative appropriation increased by $64,536 ($38,130 in special funds and $26,406 in federal funds) for a general salary increase effective January 1, 2019, that was centrally budgeted.

Appendix 2
Audit Findings

Audit Period for Last Audit:	July 2014 – June 2017
Issue Date:	October 2018
Number of Findings:	8
Number of Repeat Findings:	3
% of Repeat Findings:	38%
Rating: (if applicable)	n/a

Finding 1: Maryland Health Benefit Exchange (MHBE) relied solely on the Maryland Automated Benefits System (MABS), without using federal tax information (FTI), to verify the income of certain applicants even though MABS excluded many types of applicant income. If an applicant's attested income matched MABS data within certain tolerance levels, no additional verification was done. If the income variation was beyond the tolerance level, manual verification occurred but again not using FTI. FTI was only used if no MABS data was available. MABS data does not include all income (*e.g.*, interest, dividend, alimony, and rental income), does not include income not reported to MABS, and does not identify net earnings from self-employment. Additionally, MHBE excluded unemployment compensation data. MHBE concurred with the finding and audit recommendation to verify all applicant income information using both MABS and FTI and, in conjunction with Medicaid, amend its agreement with the Centers of Medicare and Medicaid Services to require such a verification.

Finding 2: MHBE did not properly restrict or document its review of user access to the Maryland Health Connection and did not use available reports to monitor critical changes to applicant eligibility information. MHBE partially concurred with the finding but agreed to the recommendations to limit access to the SuperUser role, ensure that all user capabilities are subject to an annual review, and use available system reports to identify and review changes to the initial manual verification eligibility status.

Finding 3: MHBE did not obtain MHBE Board approval for its Information Systems Master Contract and did not adequately document its evaluation of vendor task order proposals nor ensure that all vendors approved under the individual task orders were properly qualified. MHBE concurred with the finding and recommendations to obtain board approval for the information systems master contract and task orders over $200,000, document all technical evaluations and rankings, ensure that vendors selected for tasks have been approved to provide work in that information technology functional area, verify technical qualifications of all proposed and substitute employees, and review the qualifications of unqualified vendors and vendor employees and take appropriate corrective action.

Finding 4: MHBE's procurement policies and procedures did not establish a minimum period for submission of solicitations or adequate control over the bid submission and bid opening

processes. As a result, different solicitation periods were allowed for procurements that were functionally similar and potentially impacted responses. MHBE concurred with the finding and recommendations to establish a minimum solicitation period, restrict access to bid documents, and maintain documentation of bid openings.

Finding 5: **MHBE did not sufficiently verify the propriety of billings from its customer support vendor, which totaled $25.6 million during fiscal 2017, and ensure that the vendor met certain contract performance measures. MHBE partially concurred with the finding noting the contract oversight and monitoring that it does perform but concurred with the recommendation to review sufficient documentation to verify expenditures.**

Finding 6: MHBE did not verify the propriety of payroll expenditures reported by one of the seven Connector Program grantees. MHBE concurred with the finding and the recommendation to review sufficient documentation to verify expenditures charged to Connector Program grants.

Finding 7: **MHBE did no establish adequate application maintenance controls for documenting, approving, and moving program changes into production and lacked intrusion detection prevention system coverage for encrypted traffic entering the hosted Exchange System network. MHBE concurred with the finding and recommendations to generate appropriate reports of changes to production program source code, document that changes have been reviewed, and to document and review network security risks on the hosted Exchange System data center.**

Finding 8: **MHBE lacked security assurances over critical data on servers hosted by contractors. MHBE concurred with the finding and recommendations to obtain appropriate Systems and Organization Controls reports. This finding applied to both the original Exchange System as well as the replacement Exchange System.**

*Bold denotes item repeated in full or part from preceding audit report.

Appendix 3
Object/Fund Difference Report
Maryland Health Benefit Exchange

Object/Fund	FY 18 Actual	FY 19 Working Appropriation	FY 20 Allowance	FY 19 - FY 20 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	$ 6,744,303	$ 7,702,107	$ 7,620,899	-$ 81,208	-1.1%
02 Technical and Spec. Fees	10,922	10,921	11,786	865	7.9%
03 Communication	100,673	77,715	101,318	23,603	30.4%
04 Travel	20,675	19,360	22,360	3,000	15.5%
08 Contractual Services	74,360,579	64,100,842	64,276,800	175,958	0.3%
09 Supplies and Materials	30,435	30,500	58,616	28,116	92.2%
11 Equipment – Additional	243,392	337,500	350,000	12,500	3.7%
12 Grants, Subsidies, and Contributions	9,700,891	10,000,000	10,000,000	0	0%
13 Fixed Charges	917,101	889,936	890,181	245	0%
Total Objects	**$ 92,128,971**	**$ 83,168,881**	**$ 83,331,960**	**$ 163,079**	**0.2%**
Funds					
03 Special Fund	$ 49,153,697	$ 35,005,010	$ 35,000,000	-$ 5,010	0%
05 Federal Fund	42,975,274	48,163,871	48,331,960	168,089	0.3%
Total Funds	**$ 92,128,971**	**$ 83,168,881**	**$ 83,331,960**	**$ 163,079**	**0.2%**

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. The fiscal 2020 allowance does not include general salary increases.

Appendix 4
Fiscal Summary
Maryland Health Benefit Exchange

Program/Unit	FY 18 Actual	FY 19 Wrk Approp	FY 20 Allowance	Change	FY 19 - FY 20 % Change
01 Maryland Health Benefit Exchange	$ 40,755,739	$ 52,063,997	$ 47,080,941	-$ 4,983,056	-9.6%
02 Major Information Technology Development	30,491,832	31,104,884	36,251,019	5,146,135	16.5%
03 Maryland Health Insurance Program	20,881,400	0	0	0	0%
Total Expenditures	**$ 92,128,971**	**$ 83,168,881**	**$ 83,331,960**	**$ 163,079**	**0.2%**
Special Fund	$ 49,153,697	$ 35,005,010	$ 35,000,000	-$ 5,010	0%
Federal Fund	42,975,274	48,163,871	48,331,960	168,089	0.3%
Total Appropriations	**$ 92,128,971**	**$ 83,168,881**	**$ 83,331,960**	**$ 163,079**	**0.2%**

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. The fiscal 2020 allowance does not include general salary increases.