

D78Y01
Maryland Health Benefit Exchange

Operating Budget Data

(\$ in Thousands)

	<u>FY 11</u> <u>Actual</u>	<u>FY 12</u> <u>Working</u>	<u>FY 13</u> <u>Allowance</u>	<u>FY 12-13</u> <u>Change</u>
General Fund	\$0	\$0	\$1,890	\$1,890
Adjusted General Fund	\$0	\$0	\$1,890	\$1,890
Federal Fund	0	0	24,641	24,641
Adjusted Federal Fund	\$0	\$0	\$24,641	\$24,641
Adjusted Grand Total	\$0	\$0	\$26,530	\$26,530

- Deficiencies add 1 regular position and \$1,673,512 in general funds to the Maryland Health Benefit Exchange.
- The fiscal 2013 allowance for the exchange is just over \$26.5 million. Most of this funding, \$23.5 million, is for the development of the Exchange Eligibility System.

Personnel Data

	<u>FY 11</u> <u>Actual</u>	<u>FY 12</u> <u>Working</u>	<u>FY 13</u> <u>Allowance</u>	<u>FY 12-13</u> <u>Change</u>
Regular Positions	0.00	0.00	9.00	9.00
Contractual FTEs	<u>0.00</u>	<u>0.00</u>	<u>5.00</u>	<u>5.00</u>
Total Personnel	0.00	0.00	14.00	14.00

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	0.1	1.06%
Positions and Percentage Vacant as of 12/31/11	n/a	n/a

- The exchange will have a complement of 9 full-time equivalent (FTE) positions in fiscal 2013, including 6 FTEs transferred from the Department of Health and Mental Hygiene Administration budget.

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

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Analysis in Brief

Issues

Recommendations for a Successful Maryland Health Benefit Exchange: In December 2011, the exchange published a report outlining recommendations concerning the operation of the exchange. A number of the recommendations are reviewed.

Recommended Actions

1. Add language requesting a plan for sustainable long-term financing of the Maryland Health Benefit Exchange.

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Maryland Health Benefit Exchange

Operating Budget Analysis

Program Description

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

Performance Analysis: Managing for Results

The exchange has no formal Managing for Results goals at this point. Its immediate goal is to meet federal deadlines in order to operate the insurance marketplace envisaged under PPACA, a marketplace that must open for enrollment October 1, 2013, and be functional on January 1, 2014. After that time, the exchange should develop operational and other goals to properly measure its performance.

Fiscal 2012 Actions

There are two deficiency appropriations related to the Maryland Health Benefit Exchange:

- The addition of 1 new position, which when added to the 6 currently budgeted in the Department of Health and Mental Hygiene Administration (DHMH) budget for the exchange, brings the fiscal 2012 regular personnel complement to 7 full-time equivalent (FTE) positions.
- \$1,673,512 in general funds to provide the match to federal Medicaid funds which together support 42% of the exchange's budget for the Exchange Eligibility System based on the anticipated utilization of the system by Medicaid. This funding arrangement has been approved by the Centers for Medicare and Medicaid Services (CMS). Further discussion on the exchange's funding support for fiscal 2012 as well as that proposed for fiscal 2013 is provided immediately below.

Funding Supporting the Maryland Health Benefit Exchange: Fiscal 2011-2013

Federal Grant Funds

The fiscal 2013 allowance represents the first formal submission of a budget specifically for the Maryland Health Benefit Exchange. However, Maryland first received funding to support the development of a Maryland Health Benefit Exchange in early fiscal 2011 and in all has received three federal grants to date:

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- The Exchange Planning Grant, for almost \$1.0 million was designed to begin the planning process associated with an exchange. Maryland is 1 of 47 states together with the District of Columbia (DC) to receive such a grant (only three states, Arkansas, Florida, and Louisiana, chose not to apply for a grant).
- A \$6.2 million Early Innovator Grant. As initially announced, Maryland intended to use this grant to build off a prototype that was already developed – the Healthy Maryland initiative modeled on a system used in Howard County – as the point of access for the exchange, integration with Maryland legacy systems and the federal portal systems, and Maryland's consumption of planned federal web services (*e.g.*, verification and rules). However, that project did not materialize as was hoped, and the State is using a portion of the grant funding to support the proposed Maryland Health Benefit Exchange Eligibility System. Maryland is one of nine states that have accepted Innovator Grants.
- A \$27.2 million Exchange Establishment Grant. This grant, a so-called Level One Establishment Grant, is intended to provide up to one year of funding to states that have made some progress under their exchange planning grants. States may plan to reapply for a second year of funding under the level one establishment grants or apply for level two establishment grants if certain criteria have been established. Maryland is using the grant to conduct policy development and detailed planning to build on the work of Maryland's Exchange Planning and Innovator Grant; conduct intensive policy analysis that will shape the technical and operational infrastructure of the exchange; and implement the exchange Information Technology (IT) platform, including product licensing, system integration, and independent verification and validation. The State anticipates applying for a Level Two Establishment Grant before the end of the current fiscal year. Establishment Grants have been awarded to 29 states and DC.

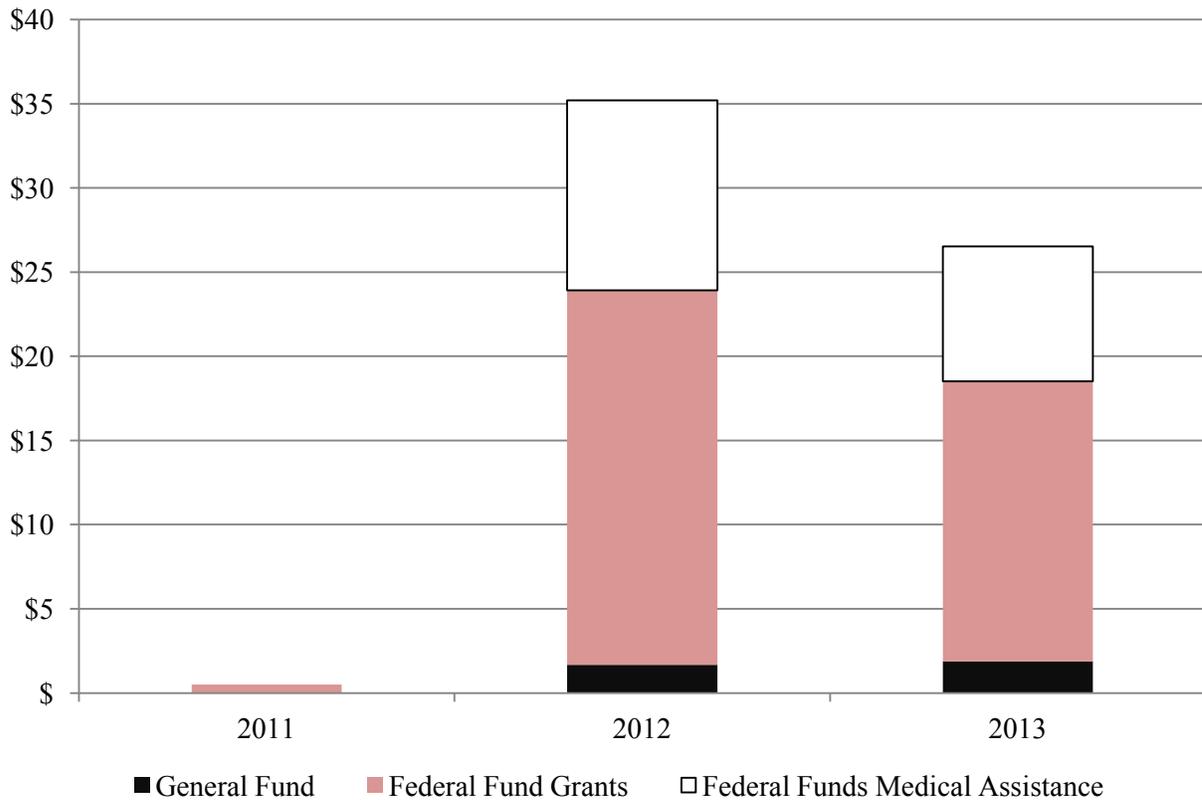
Medicaid and General Funds

Based on a funding allocation agreed to by the State and CMS, 42% of the expenditures related to the development of the exchange eligibility system are supported by Medicaid funds based on an estimate of the Medicaid program's ultimate utilization of that system. For the purposes of Exchange Eligibility System expenditures, the Medicaid federal matching percentage is 90%. Hence, the general fund support for the exchange is relatively small.

Fiscal 2011-2013 Expenditures

As shown in **Exhibit 1**, the initial appropriation for the work supporting the Maryland Health Benefit Exchange was made in the DHMH Administration budget and for fiscal 2011 totalled just

Exhibit 1
Maryland Health Benefit Exchange, Funding Levels and Fund Sources
Fiscal 2011-2013
(\$ in Millions)



Note: Funding levels include fiscal 2012 deficiencies and fiscal 2012 budget amendments that have not yet been processed.

Source: Department of Budget and Management; Department of Health and Mental Hygiene; Department of Legislative Services

over \$500,000, all federal grant funding. For fiscal 2012, the DHMH Office of the Secretary budget has just under \$1.5 million in federal grant funding for exchange operations. In addition, the Department of Legislative Services (DLS) is in receipt of two budget amendments, 061-12 and 079-12, the latter creating a formal fiscal 2012 appropriation for the exchange:

- Amendment 061-12 uses \$2,844,699 in Establishment Grant funding to support a variety of administrative costs including the salaries and fringe benefits for 6 exchange staff currently

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located in DHMH (\$742,950), miscellaneous office costs and rent (\$176,770), and contractual costs (\$1,924,979). The contractual costs are for a variety of studies being conducted by the exchange such as estimating the extent of take-up in the exchange, how to coordinate consumer assistance activities and determine the role for the exchange call center in facilitating enrollment, access and resolution of complaints, as well as responding to various legislative study requirements contained in Chapters 1 and 2 of 2011 (the legislation which formally established the exchange). Also included in this contract funding is \$349,979 to cover the costs of a memorandum of understanding (MOU) with the Office of the Attorney General related to the Health Education Advocacy Unit in the Consumer Protection Division.

- The Amendment 079-12 totals \$29,194,448, and is primarily for spending related to the Maryland Health Benefit Exchange Eligibility System.

The funding in the amendment is derived from three sources: \$14,136,944 from the Establishment Grant; \$3,766,472 from the Innovator Grant; and \$11,291,032 in federal Medicaid funds (of which \$8.1 million is transferred from the fiscal 2012 Medicaid budget that was designated for a non-specific health care reform information technology project). State matching funds associated with this project are included in the fiscal 2013 budget as a fiscal 2012 deficiency appropriation.

Specific uses for the funds include administrative expenses (\$75,644), computer hardware (\$951,582), and contractual services (\$28,167,222). Contractual service spending includes project management and consultant services, security services, software licenses, system integration services, as well as Independent Verification and Validation (IV&V).

Overall, fiscal 2012 expenditures are anticipated to total just over \$35.2 million. DLS would note that it is its understanding that the exchange requires a formal appropriation before it can award a contract for the Exchange Eligibility System because of the different procurement rules followed in making that award. Amendment 079-12 creates that appropriation. **DLS recommends approval of both amendments.**

As shown in Exhibit 1 and detailed in **Exhibit 2**, the fiscal 2013 allowance for the exchange is just over \$26.5 million.

Personnel

Personnel expenditures for the 9 FTE staff (6 FTE transferred from DHMH, 1 FTE created in a deficiency appropriation, and 2 new FTE positions) are anticipated at \$917,000. An organizational chart for the exchange is provided in **Exhibit 3**.

Exhibit 2
Proposed Budget
Maryland Health Benefit Exchange
(\$ in Thousands)

How Much It Grows:	General Fund	Federal Fund	Total
2012 Working Appropriation	\$0	\$0	\$0
2013 Allowance	<u>1,890</u>	<u>24,641</u>	<u>26,530</u>
Amount Change	\$1,890	\$24,641	\$26,530

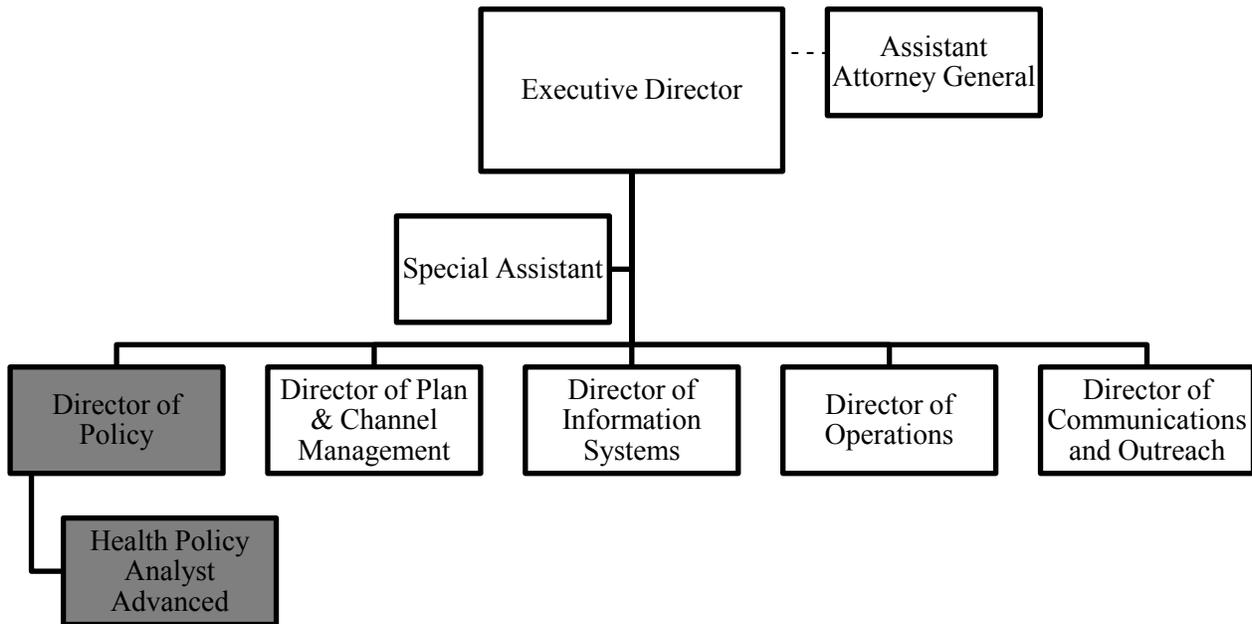
Where It Goes:

Personnel Expenses	\$916
Existing/transferred positions (7 FTEs)	\$693
New positions (2 FTEs)	223
Administrative Expenses Excluding Regular Personnel	\$2,040
Contracts for studies related to the implementation of the exchange.....	1,000
Contract with the Hilltop Institute for staff support.....	465
Contractual employment	303
Miscellaneous office expenses including rent.....	272
Information Technology	\$23,574
Health Benefit Exchange Eligibility System.....	23,521
Other IT related expenses.....	53
Total	\$26,530

FTE: full-time equivalent
IT: Information Technology

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

Exhibit 3
Maryland Health Benefit Exchange
Organizational Chart



Note: Shaded positions are new for fiscal 2013.

Source: Maryland Health Benefit Exchange

Administrative Expenses

Administrative expenditures outside of IT are anticipated at just over \$2.0 million. The largest item in this category of expenditures (\$1.0 million) is funding for outside consultants upon which the exchange continues to be reliant to conduct many of the studies required to assist it in gathering the information it needs. This actually represents a reduction over fiscal 2012 expenditures for similar studies which are expected to total \$1.5 million. The exchange also expects to continue to utilize the Hilltop Institute at the University of Maryland Baltimore County for staff support (\$465,000).

Information Technology

The largest expense anticipated in fiscal 2013 is for the development of the Exchange Eligibility System (just over \$23.5 million). This system, required under federal health care reform,

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is to provide, among other things, eligibility determination services to both Medicaid and non-Medicaid eligible Marylanders through the exchange. This eligibility system is a cornerstone of the exchange. The exchange must demonstrate to the federal government by January 1, 2013, that this system will be operational on January 1, 2014, and then be operational by that date. If not, the federal government will operate the Maryland Health Benefit Exchange.

Exhibit 4 provides details on the status of the Exchange Eligibility System. As noted, the project is broken down into multiple phases, and the funding noted in the exhibit is for Phase 1a only.

Identifiable risks associated with the project are significant, notably the extremely tight deadlines, the fact that some policy decisions about the operations of the exchange which could change requirements have yet to be made, the need for interoperability with multiple other federal and State systems (some of which have yet to be developed), and the need for strong project management oversight. Additionally, although ostensibly the federal government will be the fall-back provider of exchange services and Medicaid eligibility determination if Maryland's system is not functional, that raises more concern than it alleviates.

Exhibit 4
Maryland Health Benefit Exchange Eligibility System

Project Description:	Replace current eligibility systems for Medicaid and other social service programs with a single system that serves Medicaid, social service programs, as well as the needs of the Maryland Health Benefit Exchange.		
Project Business Goals:	<p>Provide seamless eligibility determination services to both Medicaid and non-Medicaid eligible Marylanders as part of the “Individuals” and “Small Business” exchanges under the Maryland Health Benefit Exchange. The federal government will make a determination as of January 1, 2013, of the likely readiness of the State to have an operational health benefit exchange ahead of coverage expansion that is scheduled for January 1, 2014. An operational eligibility system will be the cornerstone of the Maryland Health Benefit Exchange. If the system is not available, the Maryland exchange will be operated by the federal government.</p> <p>The system is envisaged to be implemented in multiple phases:</p> <p>Phase 1a: Core exchange functions and Modified Adjustable Gross Income (MAGI) Medicaid determinations including tools to compare qualified health plans, enroll in an insurance product, be evaluated for all applicable State health subsidy programs, and determine product costs. This also involves enrollment in Medicaid if applicable.</p> <p>Phase 1b: Maintenance, hosting, operations, and other selected services. The exchange is still making decisions on how it will implement all of the provisions of federal health care reform including the Small Business Health Options Program or SHOP exchange. These additional requirements may be met through separate task orders although the October request for proposals (RFP) requires a response from vendors on their ability to provide these services. An exception to this is for maintenance services where a detailed response is required.</p> <p>Phase 2: Incorporating non-MAGI eligibility determinations into the system, <i>e.g.</i>, seniors, people with disabilities, and individuals needing long-term care services.</p> <p>Phase 3: Integrating the capacity to conduct eligibility determinations for other social services programs such as Supplemental Nutrition Assistance Program (food stamps) and Temporary Assistance for Needy Families.</p>		
Estimated Total Project Cost:	\$70,376,550. This represents the costs for Phase 1a only	New/Ongoing Project:	New

Project Start Date:	December 2010	Projected Completion Data:	Phase 1a December 31, 2013
Schedule Status:	The RFP was issued October 21, 2011. An award is anticipated in February 2012. A more detailed project schedule will be available once the award is made.		
Cost Status:	A more detailed cost estimate for Phase 1a will be available once the award is made.		
Scope Status:	n/a		
Project Management Oversight Status:	<p>Because the exchange is exempt from the procurement process and project oversight, despite the fact that this project is critical to the operation of the largest program in State government, the eligibility system will not be subject to the oversight that DoIT applies to both Major Information Technology Development Projects or IT Procurements. Indeed, the time limitations on the project set against the time taken for normal DoIT review (and the compliance with that review required of the procuring agency) would have precluded anything other than the current arrangement of DoIT acting as an advisor rather than as the control agency as would be normal for a major information technology development project such as this.</p> <p>The exchange issued an RFP for a Program Management Office (PMO) on December 2, 2011, with responses due December 16, 2011. The PMO is responsible for delivering general project management and quality assurance support for the exchange IT system. The PMO contract (\$2.8 million over 18 months) was awarded in January.</p> <p>Using a DoIT IV&V contract as a model, DHMH will procure a third party contractor to perform an independent assessment of the eligibility project on a variety of objectives, including project governance, application of and adherence to sound project management controls, technical feasibility and financial control. Although the eligibility project is not subject to DoIT oversight, DoIT will review and comment on the third-party assessment.</p>		
Identifiable Risks:	<p>Major risks include the following: Tight Deadlines – the State needs to show the federal government that it is making substantial progress toward being operational on January 1, 2014 by January, 2013; Total Project Cost – Currently unknown, although Phase 1 funding is expected to be covered through Level 1 and 2 Establishment Grants and Medicaid (federal and State funding). While the federal government has committed to fund changes to eligibility systems at an enhanced matching rate (depending on the technical solution chosen), uncertainty at the federal level about out-year funding persists; State Funding – State funding is provided for most of Phase 1 needs in the fiscal 2013 budget. Beyond Phase 1, uncertainty as to State funding requirements remain; Policy Decisions Yet to be Made – some of the key policy decisions about the operation of the exchange and the specifics of the products to be offered through the exchange have yet to be made both at the federal and State level; Interoperability – the system will need to operate with MERP, interact with a variety of State and federal information systems, and may also need to interact with private systems; Project Oversight –</p>		

	specifically the need for strong project and contract management given the tight deadlines and the absence of the normal IT development oversight process.							
Additional Comments:	The State’s fall-back position if this system is not developed in a timely manner with regard to determining Medicaid eligibility is to rely on the federal government. Given that Medicaid eligibility changes in January 2014 come with very different federal matching rates, tracking the different populations is critical. It is unclear if changes would or could be made to CARES in a timely manner if the eligibility system is not ready ahead of Medicaid expansion. For those individuals looking to get insurance through the exchange, the lack of a State option would mean that the federal government would be required to operate the State exchange. Given that at least 3 states (Alaska, Florida, and Louisiana) have already indicated that they will not be developing exchanges, 20 more have not received Establishment grants, and even amongst those that have received grants not all will likely have an operational exchange by January 1, 2014; the federal government will have to develop a federal exchange to operate in those states. To date, the federal government has signed contracts worth over \$150 million with vendors to develop a federal data services hub, improve access to information on insurance products, and to build a federal exchange. However, there are many potential technical and political hurdles to overcome in order for the exchange to be operational on January 1, 2014.							
Fiscal Year Funding (000)	Prior Years	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	Balance to Complete	Total
Personnel Services	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Professional and Outside Services	500.6	30,868.0	23,574.0	7,717.0	7,717.0	0.0	0.0	70,376.6
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	\$500.6	\$30,868.0	\$23,574.0	\$7,717.0	\$7,717.0	\$0.0	\$0.0	\$70,376.6

CARES: Clients’ Automated Resource and Eligibility System
 DoIT: Department of Information Technology
 IT: Information Technology
 IV&V: Independent Verification and Validation
 MERP: Medicaid Enterprise Restructuring Project
 RFP: request for proposals

Source: Department of Health and Mental Hygiene; Department of Legislative Services; Department of Information Technology; Maryland Health Benefit Exchange

Issues

1. Recommendations for a Successful Maryland Health Benefit Exchange

During the 2011 interim, the Maryland Health Benefit Exchange and its various advisory committees undertook a prodigious amount of work as it strives to implement federal health care reform legislation and operate a State-run insurance exchange by January 1, 2014. Much of the work was summarized in the exchange's December 2011 report "*Recommendations for a Successful Maryland Health Benefit Exchange.*" The report's recommendations were grouped around a series of topics: operating model; market rules and risk mitigation; dental plans; the Small Business Health Options Program (SHOP); Navigator Program; advertising, marketing and public relations; financing; continuity of care; multi-State and regional contracting; and a plan for fraud, waste, and abuse.

Each of the recommendations has significant policy considerations in their own right. For the purpose of this analysis, the focus is on those recommendations that have more of a budget/operational impact: the use of the Maryland Health Insurance Plan (MHIP) assessment after January 1, 2014, the financing of the Exchange, and the development of a plan to combat fraud, waste and abuse. The issue will also look at a recommendation that has yet to be made, specifically whether to develop a basic health plan (BHP) option.

Use of the Maryland Health Insurance Plan Assessment

Perhaps the most significant recommendation around cost concerned the use of hospital assessments that currently support the MHIP, the State's high risk pool.

The expenses for the insurance products offered through MHIP are supported by premiums, a subsidy generated by a 1% assessment on hospitals, and a limited amount of federal grant funds. In the most recently completed fiscal year, the premiums supported approximately 44% of MHIP insurance expenditures, with the remaining subsidized through assessment revenue and federal grant funds. Effectively, that subsidy allows over 20,000 Marylanders to access health insurance.

MHIP is currently scheduled to end after December 2013. It is anticipated at that point that current MHIP members will have guaranteed access to insurance through the exchange. However, assuming that when the MHIP program ends MHIP individuals have access to coverage at standard rates and will enroll in the individual market, the impact of this on the individual market in the exchange is potentially problematic. As shown in **Exhibit 5**, a consultant's report that was commissioned by the exchange, estimated the potential impact on premiums if those markets are merged. Specifically, looking at claims collected versus claims paid, clearly looking at the two markets the merger would result in current premium levels being insufficient to cover claims. Assuming that carriers would be looking for a loss ratio of 80% (the current loss ratio for the individual market), in order to cover the level of claims and meet that ratio, premiums would have to increase by 29% if the current MHIP subsidy is excluded. Conversely, if the subsidy is retained, premium levels would only need to increase by 2%.

Exhibit 5
Impact of Rolling High-risk Pool Members into the Individual Market
(\$ in Millions)

	<u>Premium</u>	<u>Claims</u>	<u>Loss Ratio</u>
Current individual market	414.2	322.7	78%
Maryland Health Insurance Plan	50.5	158.1	313%
Combined market	464.7	480.9	103%
Premiums required to meet 80% loss ratio (29% increase)	601.1	480.9	80%
Assessment and other revenue	-127.3		
Premium required to meet 80% loss ratio if assessment and other revenue is used (2% increase)	473.8		

Note: A full explanation of the assumptions used in calculating the data used in Exhibit 5 is on pages 50-51 of the Mercer report.

Source: *Report of Market Rules and Risk Selection for the State of Maryland*, Mercer for the Maryland Health Benefit Exchange November 2011

Perhaps unsurprisingly, given the projected significant increase in premiums, the exchange recommends that the assessment revenues currently allocated for MHIP be allocated to the exchange for the purpose of reducing the impact of the cost of care for high-risk individuals. The consultant's report noted a number of issues with continuing the assessment for this purpose:

- The assessment is made against hospital net patient revenues, so in essence, people insured in markets other than the individual market would be subsidizing premiums in that market.
- Distributing funds to the carriers would not be a straightforward exercise.
- Carriers would need to have some knowledge of the payments in advance so they could build them into their premiums.

The consultant's report was clear that this was not intended to be an exhaustive list of issues. However, it should also be noted from a budget perspective that:

- Applying revenues from the MHIP assessment to offset anticipated expenditures that will result from the expansion of Medicaid and other aspects of federal health care reform was a key underpinning of the Governor's Health Care Reform Coordinating Council's estimate that federal health care reform would save the State almost \$900 million over 10 years. If the assessment revenues are instead allocated for premium subsidies in the exchange, those savings more than disappear.

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- At the federal level, significant attention has been paid to states' use of provider taxes or assessments such as the MHIP assessment levied on hospital revenues. That attention has come from both Democrats and Republicans. If not used to offset costs associated with federal health care reform, the ending of the MHIP program was also an opportunity to reduce the extent of hospital assessments, especially given Maryland's increased reliance on these assessments in the last two Medicaid budgets, and which continues to be a significant part of the Medicaid funding stream in fiscal 2013. While the State is currently under the federal provider tax ceiling from its hospital assessment, and certainly is able to re-allocate the MHIP assessment as proposed by the exchange, any significant downward revision of that tax could further strain the State's general fund.

Long-term Financing of the Exchange

The report was also silent on the ultimate financing solution for the exchange. By statute, the exchange must be self-sustaining with an adequate level of financing for ongoing operations by calendar 2015. Prior to that time, the expectation is that federal grant funds and Medicaid support will be available to support the exchange and the development of the Exchange Eligibility System. However, it should be noted that important functions, such as the Navigator Program to help people who get health insurance through their state exchange learn about their options and assist with enrollment, cannot be developed with federal grants funds.

By 2015, the exchange can be expected to be a fairly substantial operation. A consultant's report conducted for the exchange estimated that its operating costs could be between \$21 and \$30 million in calendar 2014 rising to \$36 to \$61 million in calendar 2016 depending on the level of enrollment and other considerations. Expenses are expected to include:

- typical administrative expenses (salaries and benefits, travel, office supplies and equipment, rent, and insurance);
- IT systems operation, maintenance and infrastructure expenses (these are expected to be significant and include the operation of the eligibility system, exchange website, customer service/call-center, and enrollment and premium billing, as well as normal hosting and security expenses);
- marketing and advertising;
- consulting services (for example, independent auditing);
- Navigator Grants (the principal outreach mechanism); and
- an appeals program to hear individual and employer appeals related to subsidy eligibility and the insurance mandate.

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While not making recommendations about specific funding proposals, the report did lay out certain principles it expected to use in developing a funding strategy:

- Funding should, at least to some extent, be broadly based. That is to say, because the exchange believes that it will be providing a broad public service, not just providing services to individuals and businesses actually buying and selling services through the exchange, the financing mechanism should tend to be similarly broadly based akin to other broad-based health care assessments that are already utilized to fund other regulatory commissions as well as Medicaid, MHIP, and other programs.
- The need for broad-based funding would be more important in the initial years of the exchange operations when both costs and utilization is likely to be uncertain. Once enrollment and costs stabilize, the use of narrower transaction fees could become more important.

The exchange originally indicated that it expected to make a decision on funding in early calendar 2013. To the extent that statutory recommendations may need to be made in the 2013 session on funding sources, it may be preferable for the exchange to outline its budgetary expectations and funding sources prior to the beginning of calendar 2013 so that there is consensus around a funding mechanism. The Administration has also recognized the need to make this decision earlier and has introduced legislation, Senate Bill 238, which includes the establishment of a joint legislative and administration group to make recommendations on financing by December 1, 2012. **As a backup, DLS recommends that language be adopted withholding funds pending the receipt of a report to that end.**

Fraud, Waste, and Abuse Prevention

There is also a recommendation for the development of a program to detect and prevent fraud, waste, and abuse within the exchange. The exchange is obviously subject to federal and state laws regarding fraud, waste, and abuse as well as subject to State and federal audits. Clearly, the credibility of the exchange to operate a well-run program is important, especially in the early years of its existence when it has no track record. The recommendations noted the need to define a framework for internal controls, control cycles, the performance of risk assessments, the development of documents processes, and the overall implementation of controls. The exchange intends to develop that framework before the end of calendar 2012. Senate Bill 238 also includes language on the development of a plan for a Fraud, Waste, and Abuse Prevention Program and a review and comment on that plan by the Senate Finance and House Health and Government Operations committees. The budget committees and the Joint Audit Committee may also want to review the plan.

Basic Health Plan

One of the options under PPACA is for states to develop a BHP option. This option is available to those meeting all of the following eligibility criteria:

- under the age of 65 years;
- adults with incomes between 138 and 200% of the federal poverty level (FPL) and certain legal immigrant populations who are not qualified for federal Medicaid funding;
- having no access to affordable, comprehensive employer subsidized insurance; and
- being ineligible for Medicaid.

Rather than getting subsidized coverage in the exchange, the State would contract with plans or providers for coverage arrangements known as BHPs. Under the program:

- All essential benefits must be covered (what constitutes essential benefits is another element of PPACA that has yet to be finalized).
- Premiums may not exceed levels that would be charged in the exchange.
- Actuarial values may not fall below specified levels.

Funding for the program would primarily be derived from the federal government. Specifically, 95% of what would have been spent for tax credits and other subsidies if BHP members had enrolled in the exchange would be placed in a State trust fund to be used only on BHP enrollees. Individual premiums may also be collected. States can add benefits to the BHP package. However, any costs over that provided by the federal government and premiums are fully charged to the State.

Exhibit 6 offers a brief overview of the advantages and disadvantages of the BHP option.

In January 2012, DHMH released a study conducted by the Medicaid program and the Hilltop Institute that re-iterated the advantages and disadvantages surrounding the BHP and also attempts to cost out the impact of the BHP on the State budget. The report's initial calculations conclude that federal support would be insufficient to cover the cost of the BHP program resulting in the need for additional State subsidies. However, as noted by the report and also by the federal Deputy Secretary for Health Care Financing in oral presentations as well as written correspondence during this session, there is too much uncertainty around the funding of start-up and administrative costs, the ultimate costs of exchange plans, the content of the essential health benefits package, the risk profile of beneficiaries, and other factors to make a definitive decision on whether to move forward with the BHP.

Exhibit 6
Basic Health Plan Considerations Around Implementation

Advantages of BHP

Coverage may be more affordable than that offered through the exchange

Plan, care, and network continuity up to 200% FPL (*i.e.*, reduces impact of churn)

Potentially limits increases in rates on the individual market (to the extent that the cohort below 200% FPL would drive up rates)

For the consumer it limits potential tax liability issues at year-end

Disadvantages of BHP

Impact on the exchange in reducing covered lives (scale, risk pool, and financing)

Potential costs to the State for administration and also costs above federally funded services

Availability of plans and providers willing to participate in the BHP depending on rate structure

Creates a second churn point at 200% FPL to the extent that the BHP is different from traditional Medicaid

BHP: Basic Health Plan
FPL: Federal Poverty Level

Source: Department of Health and Mental Hygiene; Urban Institute; Commonwealth Fund

Clearly, the BHP decision cannot be made absent of many other decisions that have to be made concerning the exchange as well as additional guidance from the federal government. **The exchange should provide the committees with additional detail on how that decision would be made, who would make it, and a timeline for making that decision.**

Recommended Actions

1. Add the following language to the federal fund appropriation:

provided that \$100,000 of this appropriation made for the operation of the Maryland Health Benefit Exchange may not be expended until the exchange submits a report to the budget committees detailing a sustainable long-term financing strategy for exchange operations. The report shall be submitted by December 1, 2012, and the committees shall have 45 days to review and comment. If the report is not submitted, the funds may not be expended or otherwise transferred by budget amendment but shall be cancelled.

Explanation: A recent report issued by the Maryland Health Benefit Exchange was silent on the ultimate financing solution for the exchange. By statute, the exchange must be self-sustaining with an adequate level of financing for ongoing operations by 2015. Cost estimates for the ultimate operation of the exchange range as high as \$61 million by calendar 2016. While the report indicated that the exchange would make a decision on financing by early calendar 2013, an earlier decision will provide additional time for discussion prior to the 2013 session.

Information Request	Author	Due Date
Long-term financing plan	Maryland Health Benefit Exchange	December 1, 2012

**Object/Fund Difference Report
Maryland Health Benefit Exchange**

<u>Object/Fund</u>	<u>FY 11 Actual</u>	<u>FY 12 Working Appropriation</u>	<u>FY 13 Allowance</u>	<u>FY 12 - FY 13 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	0.00	0.00	9.00	9.00	N/A
02 Contractual	0.00	0.00	5.00	5.00	N/A
Total Positions	0.00	0.00	14.00	14.00	N/A
Objects					
01 Salaries and Wages	\$ 0	\$ 0	\$ 916,857	\$ 916,857	N/A
02 Technical and Spec. Fees	0	0	302,744	302,744	N/A
03 Communication	0	0	36,120	36,120	N/A
04 Travel	0	0	32,800	32,800	N/A
08 Contractual Services	0	0	24,987,890	24,987,890	N/A
09 Supplies and Materials	0	0	19,000	19,000	N/A
11 Equipment – Additional	0	0	4,500	4,500	N/A
13 Fixed Charges	0	0	230,400	230,400	N/A
Total Objects	\$ 0	\$ 0	\$ 26,530,311	\$ 26,530,311	N/A
Funds					
01 General Fund	\$ 0	\$ 0	\$ 1,889,706	\$ 1,889,706	N/A
05 Federal Fund	0	0	24,640,605	24,640,605	N/A
Total Funds	\$ 0	\$ 0	\$ 26,530,311	\$ 26,530,311	N/A

Note: The fiscal 2012 appropriation does not include deficiencies.

**Fiscal Summary
Maryland Health Benefit Exchange**

<u>Program/Unit</u>	<u>FY 11 Actual</u>	<u>FY 12 Wrk Approp</u>	<u>FY 13 Allowance</u>	Change	<u>FY 12 - FY 13 % Change</u>
01 Maryland Health Benefit Exchange	\$ 0	\$ 0	\$ 2,956,335	\$ 2,956,335	0%
02 Major Information Technology Development Projects	0	0	23,573,976	23,573,976	0%
Total Expenditures	\$ 0	\$ 0	\$ 26,530,311	\$ 26,530,311	N/A
General Fund	\$ 0	\$ 0	\$ 1,889,706	\$ 1,889,706	N/A
Federal Fund	0	0	24,640,605	24,640,605	N/A
Total Appropriations	\$ 0	\$ 0	\$ 26,530,311	\$ 26,530,311	N/A

Note: The fiscal 2012 appropriation does not include deficiencies.