D78Y01
Maryland Health Benefit Exchange

Operating Budget Data

($ in Thousands)

	FY 12 Actual	FY 13 Working	FY 14 Allowance	FY 13-14 Change	% Change Prior Year
General Fund	$1,674	$1,890	$14,141	$12,251	648.3%
Adjusted General Fund	**$1,674**	**$1,890**	**$14,141**	**$12,251**	**648.3%**
Special Fund	0	15	0	-15	-100.0%
Adjusted Special Fund	**$0**	**$15**	**$0**	**-$15**	**-100.0%**
Federal Fund	29,194	51,629	70,782	19,153	37.1%
Contingent & Back of Bill Reductions	0	0	-7	-7	
Adjusted Federal Fund	**$29,194**	**$51,629**	**$70,774**	**$19,146**	**37.1%**
Adjusted Grand Total	**$30,868**	**$53,533**	**$84,915**	**$31,382**	**58.6%**

- Deficiency appropriations for the Maryland Health Benefit Exchange (MHBE) total $27.5 million ($6.1 million in general funds). The funding covers a wide variety of operating and information technology-related activities and reflects the growing intensity of activity ahead of the upcoming enrollment and operational deadlines.

- The increase in the fiscal 2014 budget over the 2013 working appropriation ($31.4 million, 58.6%) is overstated if the 2013 deficiency appropriations are considered. With those deficiencies, growth is a more modest $3.9 million, 4.8%.

- The deficiency appropriations and fiscal 2014 budget both see an increasing general fund commitment for MHBE.

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

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Personnel Data

	FY 12 Actual	FY 13 Working	FY 14 Allowance	FY 13-14 Change
Regular Positions	0.00	42.00	70.00	28.00
Contractual FTEs	0.00	5.00	0.00	-5.00
Total Personnel	**0.00**	**47.00**	**70.00**	**23.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	1.22	2.91%
Positions and Percentage Vacant as of 12/31/12	33.00	78.57%

- The fiscal 2014 budget adds an additional 28 regular positions to MHBE, for a total personnel complement of 70 full-time equivalents.

- While the Board of Public Works authorized 33 new regular positions for MHBE in September 2012, those positions had not been filled by the end of calendar 2012. Hiring generally has been slow. That will need to change quickly.

Analysis in Brief

Major Trends

Enrollment Projections: The latest enrollment projections indicate slightly lower demand for exchange insurance products.

Issues

Long-term Financing of the Maryland Health Benefit Exchange: A report on long-term financing options for MHBE was released in December 2012. In proposed 2013 session legislation, the Governor opted to take a slightly different approach.

Recommended Actions

1. Concur with Governor's allowance.

Updates

Basic Health Plan: Too many unknowns combined with new projected enrollment data means no proper analysis of the impact of the basic health plan option can be done at this time.

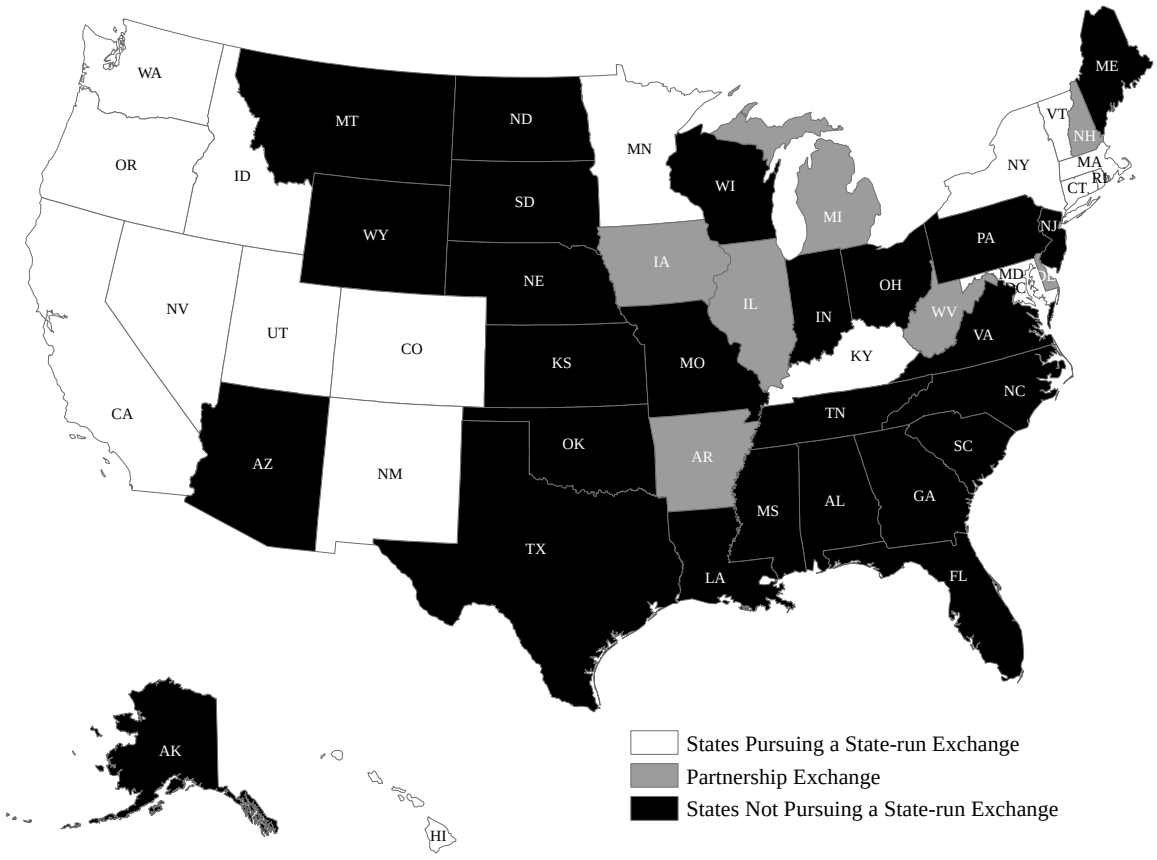
D78Y01
Maryland Health Benefit Exchange

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 of 2010 (ACA). The exchange is intended to provide a marketplace for individuals and small businesses to purchase affordable health coverage. As shown in **Exhibit 1**, as of February 13, 2013, Maryland is one of a minority of states (17) that is currently pursuing a State-run exchange. The majority of states are either partnering with the federal government (7) or relying on the federal government to operate exchanges in their states (26).

Exhibit 1
Announced State Intentions of Establishing a Health Benefit Exchange
February 2013



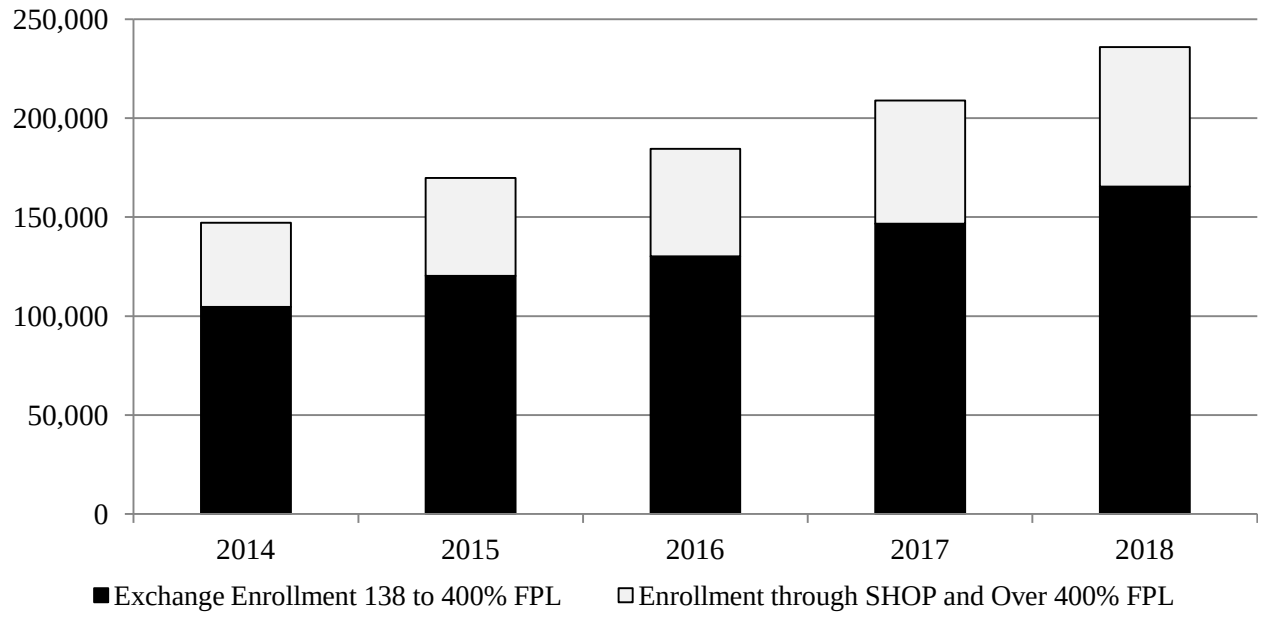
Source: National Association of State Health Policy; Department of Legislative Services

Performance Analysis: Managing for Results

1. Enrollment Projections

The latest enrollment projections from the Hilltop Institute indicate slightly lower demand for exchange insurance products. As shown in **Exhibit 2,** it is estimated that initial fiscal 2014 enrollment for the 138 to 400% federal poverty level (FPL) population eligible for some amount of federal subsidy support will be 105,000, with an additional 42,500 enrolling through the Small Business Health Options Program (SHOP) exchange and individual exchange over 400% FPL (*i.e.*, without a federal subsidy). It is anticipated that these numbers will grow to 165,000 and 71,000, respectively, by fiscal 2018. In addition, Modified Adjustable Gross Income (MAGI) determined Medicaid enrollment will be done through the Health Exchange Eligibility System (HIX). Hilltop anticipates that 104,000 new Medicaid enrollees will enter the program in fiscal 2014 (80% of them from the existing the Primary Adult Care (PAC) program).

Exhibit 2
Enrollment Estimates
Fiscal 2014-2018



FPL: federal poverty level
SHOP: Small Business Health Options Program

Source: Hilltop Institute; Department of Legislative Services

The exchange has no formal Managing for Results (MFR) goals at this point. Its immediate goal is to meet federal deadlines in order to operate the insurance marketplace envisaged under the ACA, a marketplace that must open for enrollment October 1, 2013, and be functional on January 1, 2014. However, MHBE has developed performance measures that it is hoping to finalize in March around access, affordability, consumer satisfaction, stability, and health equity. All of these measures lend themselves to tracking both through the StateStat and MFR processes. Appropriate measures should be included in the fiscal 2015 budget submission.

Fiscal 2013 Actions

Proposed Deficiency

There are two fiscal 2013 deficiency appropriations for MHBE:

- $3.9 million ($2.2 million in general funds and $1.7 million in federal funds) to fund:
  - additional salary requirements for 33 new regular full-time equivalents (FTE) created by the Board of Public Works (BPW) in September 2012 ($601,000 in federal grant funds);
  - a wide variety of advertising and outreach activities ($766,000 from Medicaid – $383,000 of each general and federal funds);
  - various studies, including billing collection, continuity of care, and cost allocation ($366,000 from Medicaid – $183,000 of each general and federal funds); and
  - navigators ($1.0 million from Medicaid – $500,000 of each general and federal funds, and an additional $1.16 million in general funds).
- $23.6 million in Medicaid funds ($3.9 million in general funds and $19.7 million in federal funds) for what are broadly considered information technology-related activities, specifically:
  - $9.1 million ($0.9 million in general funds and $8.2 million in federal funds) for ongoing development of HIX;
  - $6.9 million ($0.7 million in general funds and $6.2 million in federal funds) for legacy and other State system interoperability with HIX;
  - $2.8 million ($0.3 million in general funds and $2.5 million in federal funds) for HIX independent verification and validation;
  - $1.3 million ($0.65 million of each general and federal funds) for the Consolidated Service Center; and

- $3.5 million ($1.4 million in general funds and 2.1 million in federal funds) to support a variety of other activities including testing related to the Client Automated Resource and Eligibility System (CARES), navigator credentialing, HIX consumer support, and kiosk installation.

When the proposed deficiency is added to the budget amendments that have already been approved for MHBE since the fiscal 2013 budget was originally passed (see **Appendix 1** for additional detail), the MHBE fiscal 2013 appropriation totals $81.0 million compared to the original $26.5 million legislative appropriation. Some of the funding included in the deficiency appropriation represents matching funds for federal funds included in the budget amendments already approved in fiscal 2013. This increase reflects the increasing pace of activity surrounding MHBE as it approaches the upcoming federal enrollment and operational deadlines.

Proposed Budget Growth Is Overstated Due to Fiscal 2013 Deficiency Appropriations

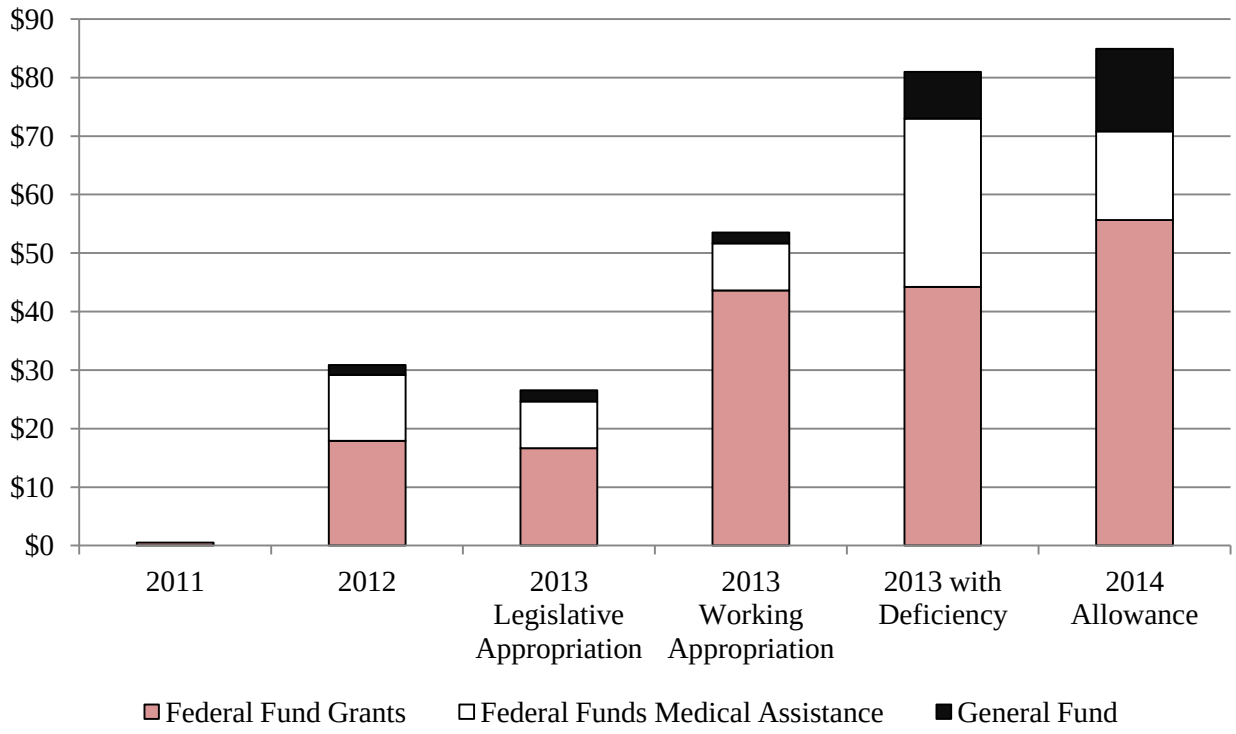
The Governor's fiscal 2014 budget is $31.4 million (58.6%) above the fiscal 2013 working appropriation. However, as shown in **Exhibit 3**, if the 2013 deficiency appropriations are added to the 2013 working appropriation, the growth is only $3.9 million, or 4.8%. Similarly, if the deficiency appropriation is considered, the significant growth in general funds noted in Exhibit 3 ($12.3 million, 648.3%) is tempered to $6.1 million, 76.5%.

MHBE's Changing Fund Mix

As also shown in Exhibit 3, in both the deficiency spending as well as in the fiscal 2014, the general fund growth reflects additional activities that are being supported with Medicaid funds thereby requiring a general fund contribution, as well as activities like the navigators that under the ACA are required to be funded with state funds.

The growth in Medicaid-supported activities that were added through budget amendment to the fiscal 2013 legislative appropriation, with the fiscal 2013 deficiency, and in the fiscal 2014 budget mark the expanded use of Medicaid funds beyond HIX. HIX is split-funded between Medicaid and the various MHBE-related federal grants based on anticipated utilization of the system (Medicaid paying 42% of the costs, an arrangement agreed to by the federal government). Of the HIX-related costs, the Federal Medical Assistance Percentage (FMAP) was 90%, with the general fund only required for 10%.

Exhibit 3
Ramping Up Spending Ahead of January 1, 2014
Fiscal 2011-2014



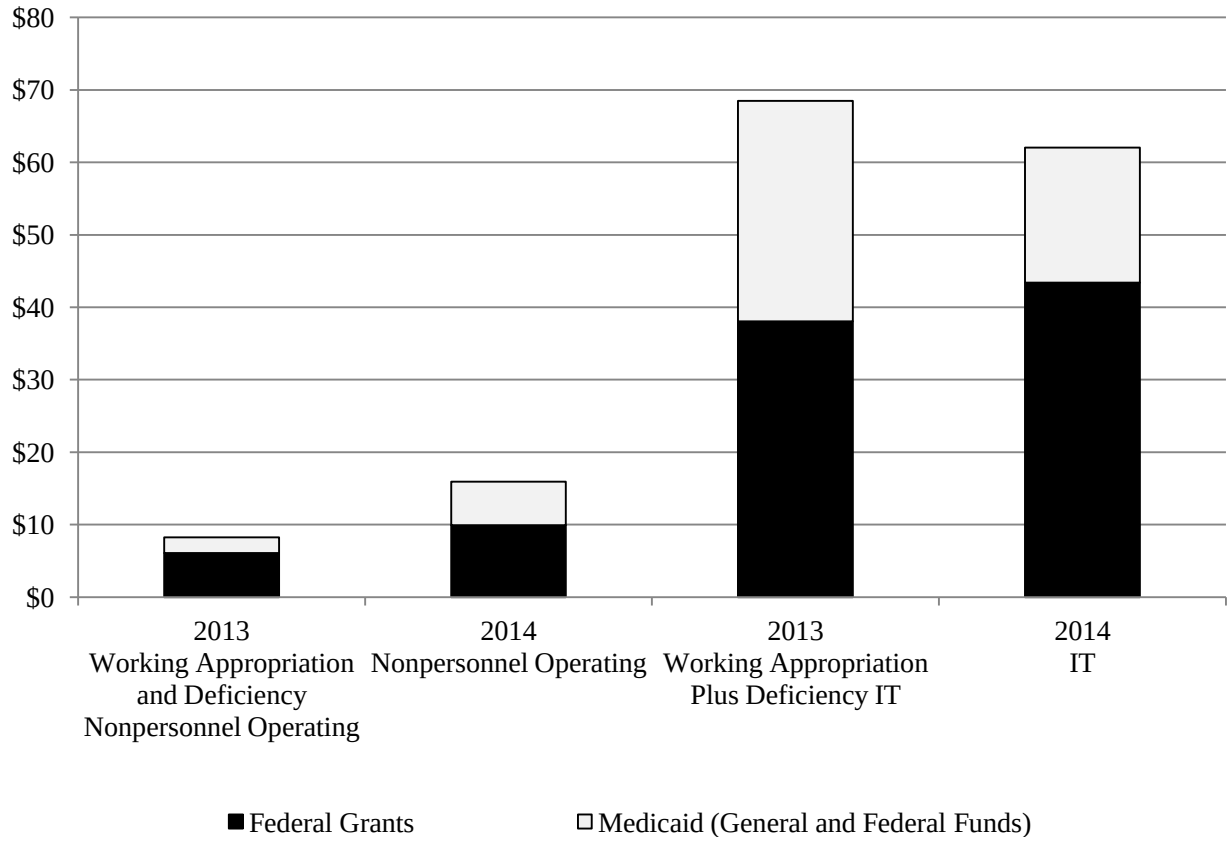
MHBE: Maryland Health Benefit Exchange

Note: Fiscal 2013 working appropriation and working appropriation with deficiency data excludes a $15,000 special fund grant from the Annie E. Casey Foundation.

Source: Maryland Health Benefit Exchange; Department of Legislative Services

While Medicaid funding continues to support HIX development, it is now also being used for operational expenses and other more broad information technology-related projects and contracts. Furthermore, for many of these non-HIX expenditures, the more traditional 50% FMAP applies. As illustrated in **Exhibit 4**, when considering the proposed fiscal 2013 deficiency appropriation with the fiscal 2014 budget, Medicaid will support 26% of MHBE's core nonpersonnel operating functions in fiscal 2013 rising to 38% in fiscal 2014. For information technology (IT), Medicaid provides 44% of the support for fiscal 2013, although this falls to 30% in fiscal 2014 primarily because of expenditures on activities that Medicaid will not participate in (for example, the development of the SHOP exchange system).

Exhibit 4
Medicaid Support for Core Nonpersonnel Operating and Information Technology Expenses
Fiscal 2013 and 2014
($ in Millions)



IT: information technology

Note: Fiscal 2013 information is the working appropriation with deficiency data but excludes a $15,000 special fund grant from the Annie E. Casey Foundation.

Source: Maryland Health Benefit Exchange; Department of Legislative Services

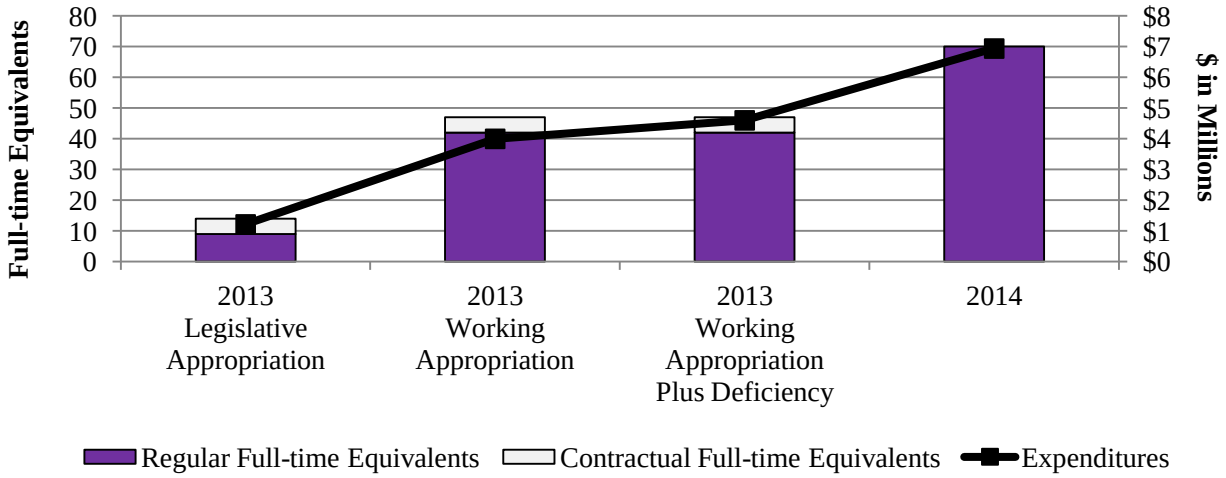
According to MHBE, the intent is that eligible expenses covered by the federal Level 2 Establishment Grant Medicaid will again provide 42% of the costs reflecting the expectations of new Medicaid enrollment in fiscal 2014. Moving forward, as discussed in Issue 1, it is anticipated that by fiscal 2016 Medicaid could support 45% of the MHBE budget.

The decision to use Medicaid funds (which include a general fund component) as part of the MHBE financing appears to be different from that in other states where exchanges are being established completely through available federal grants. According to MHBE, although this decision has a more immediate impact on the State budget in terms of demand for general funds, in the long term, it is beneficial. When MHBE has to be self-financing, the availability of federal funds through the Medicaid match to support ongoing operations will lower overall need for an alternative funding source. Obviously it is easier to make the argument that Medicaid funds should be used for MHBE ongoing support if that has been the financing strategy from the beginning rather than using federal grant funds only and then asking the federal government to continue to partially support the agency.

Personnel Expenses

Exhibit 5 illustrates that the growth in the MHBE budget as it prepares to implement the ACA has been mirrored by a recent spurt in authorized positions: from 9 regular and 5 contractual FTEs in the legislative appropriation to a proposed 70 regular positions in fiscal 2014. This increase reflects the addition of positions at BPW (33 FTEs) and another 28 FTEs in the fiscal 2014 budget. Hiring has been proceeding much slower than the positions have been authorized. The 33 FTEs created by BPW in September 2012 remained unfilled at the end of calendar 2012. MHBE has begun to fill those positions in the past few weeks and will obviously need to pick up the hiring pace in the coming months. The deficiency appropriation also provides additional salary funding for those 33 FTEs.

Exhibit 5
Positions and Expenditures
Fiscal 2013-2014



Note: For the purpose of this chart, personnel expenditures include Regular and Contractual Employment. Prior to fiscal 2012, Maryland Health Benefit Exchange-related positions were funded in the Department of Health and Mental Hygiene.

Source: Maryland Health Benefit Exchange; Department of Legislative Services

The 28 new FTEs in the fiscal 2014 budget are not budgeted with the typical 25% turnover adjustment because of the need to hire quickly. Likewise, budgeted turnover is also very low (with $448,000 in turnover relief provided in fiscal 2014 compared to the working appropriation) because of the need to fill all positions.

Aside from funding for new positions, as shown in **Exhibit 6**, the most noticeable personnel increase is $811,000, which is identified as miscellaneous adjustments. This funding reflects the fact that new hires in fiscal 2013 and 2014 will be above the base salary levels that are included in the budget for regular salaries.

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

How Much It Grows:	General Fund	Special Fund	Federal Fund	Total
2013 Working Appropriation	$1,890	$15	$51,629	$53,533
2014 Allowance	14,141	0	70,782	84,922
Amount Change	$12,251	-$15	$19,153	$31,389
Percent Change	648.3%	-100.0%	37.1%	58.6%
Contingent Reductions	$0	$0	-$7	-$7
Adjusted Change	$12,251	-$15	$19,146	$31,382
Adjusted Percent Change	648.3%	-100.0%	37.1%	58.6%

Where It Goes:		
Personnel Expenses	**$3,233**	
New positions (28 full-time-equivalents)		$1,763
Miscellaneous adjustments		811
Turnover adjustments		448
Social Security contributions		97
Retirement contributions		77
Annualization of fiscal 2013 2% cost-of-living adjustment		32
Other fringe benefit adjustments		5
Administrative costs	**$11,009**	
Navigator grants		8,640
Advertising and other outreach activities		3,661

Where It Goes:

In-state services (including DHMH indirect cost recovery)		281
Rent		171
In-state travel		48
Contractual personnel		-303
Outside consultant studies		-454
Office equipment		-469
Contract expenses		-566
Information Technology	**$17,158**	
Production hosting		12,176
Consolidated service center		10,260
Project management office		1,760
Post-production enhancements to HIX		1,575
Call center licenses and network connectivity		1,000
SHOP exchange		649
Kiosk maintenance		400
Other information technology contract changes		143
Navigator credentialing functionality		-574
HIX consumer support functions		-574
Independent Validation and Verification		-585
HIX operations and maintenance		-1,046
HIX core development		-3,603
Legacy and other system interoperability with HIX		-4,422
Other		-18
Total		**$31,382**

DHMH: Department of Health and Mental Hygiene
HIX: Health Exchange Eligibility System
SHOP: Small Business Health Options Program

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

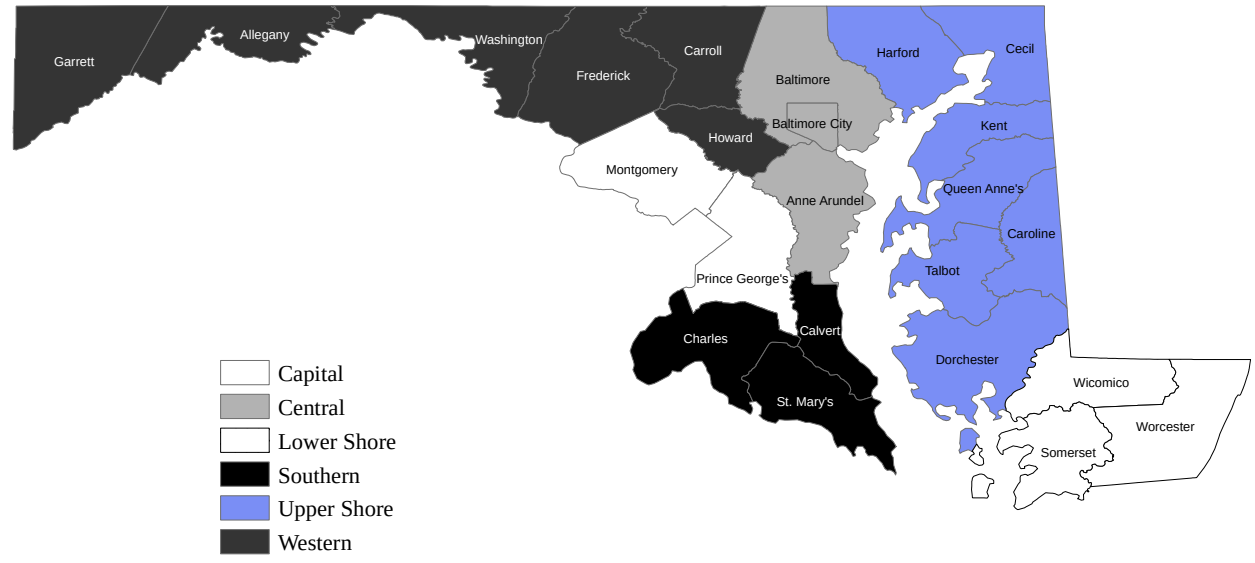
Administrative Expenses

As also noted in Exhibit 6, there is $11.0 million growth in nonpersonnel administrative expenses for core MHBE operations in fiscal 2014 over 2013. This growth is modified to $7.7 million if 2013 deficiency appropriations are considered. The most significant areas of growth are:

- $8.6 million for navigators (or $6.4 million above the fiscal 2013 amount provided in the deficiency appropriation). Of this $8.6 million, $4.0 million is funded from Medicaid ($2.0 million in each of general and federal funds) and $4.6 million is in general funds. Navigators will be employed/contracted by regional connector agencies to conduct outreach and education; distribute information and facilitate selection, enrollment, renewal and disenrollment in qualified plans; facilitate eligibility determination for Medicaid, the Maryland Children's Health Program, and premium subsidies; and provide ongoing support for these functions (see **Exhibit 7**). Navigators will be certified by the MHBE to operate in the Individual Exchange or the SHOP exchange.

  The ACA was always clear that navigator functions could not be supported by federal grant funding provided to exchanges and states through the ACA. The U.S. Department of Health and Human Services (DHHS) has recently announced an effort to work around this federal limitation by offering grant funding for another category of persons/organizations to assist individuals accessing insurance through the exchanges, so-called "in-person assisters" who will fill a similar if not identical role to navigators. Maryland has already indicated that it will be seeking funding for such assisters in addition to the State funding already provided for navigators.

Exhibit 7
Proposed Regional Connector Entities



Source: Maryland Health Benefit Exchange

Exhibit 8 details the level of funding MHBE anticipates awarding in regional connector grants in fiscal 2014. The funding level reflects both the funding at the State level for navigators plus an anticipated $16 million in new as yet unawarded federal grants for assisters. Set performance bonuses will also be available if connector entities enroll above a certain baseline figure (bonuses available for enrollment 10, 20 and 30% above the baseline figure).

It should be noted that a recent study drawn from the experience of consumers in Massachusetts underscores the need for, and importance of, the connector program in helping individuals make choices in the exchange.

Exhibit 8
Proposed Funding of Connector Entities

Funding Source	Western	Central	Capital	Southern	Upper Shore	Lower Shore
New federal grant	$2,124,460	$4,943,610	$4,870,910	$872,401	$1,324,758	$727,001
Navigator (State)	1,188,000	2,992,000	2,948,000	528,000	704,000	440,000
Total	**$3,312,460**	**$7,935,610**	**$7,818,910**	**$1,400,401**	**$2,028,758**	**$1,167,001**

Note: Total funding shown of $23.7 million does not include potential incentives which could total up to $1.3 million. State grants equal $8.8 million, above the level in the fiscal 2014 budget although the Maryland Health Benefit Exchange also has fiscal 2013 deficiency appropriations.

Source: Maryland Health Benefit Exchange

- $3.7 million for advertising and other outreach activities (or $2.9 million above the proposed fiscal 2013 amount as provided in the deficiency appropriation). Of this increase, $2.0 million is supported by Medicaid ($1.0 million each from general and federal funds) with the remainder by federal grants. Major activities include $725,000 for a launch event (GO LIVE 2013) and $1.9 million for media activities. The overall strategy can be summarized as education of existing media about MHBE, outreach to corporate, community and faith-based organizations, followed by a mass media campaign. There is also ongoing support for an external public relations team and the development of education and outreach materials.

Other changes include an increase in funding for in-state services (primarily services provided by the Office of the Attorney General and the Department of Health and Mental Hygiene (DHMH) on behalf of MHBE). Specifically, there is an increase in funding to DHMH to reflect support services offered by the department to MHBE. Rent expenses also increase by $171,000, reflecting MHBE's move from Patterson Avenue to downtown Baltimore. Offsetting these and other increases in operational expenses are decreases in contractual employment, one-time expenses, and initial start-up expenses. It should be noted that the overall decrease in contract spending masks a significant change

in focus for MHBE spending. For example, spending on contracts for studies declines but is replaced by increases in proposed spending for administrative hearings. Again, these changes reflect the changing focus of MHBE as it approaches operational status.

Information Technology

As noted in Exhibit 6, there is a $17.2 million growth in IT expenses in fiscal 2014 over 2013. However, this growth becomes a $6.4 million decrease if the 2013 deficiency appropriations are considered.

Between the fiscal 2013 working and the fiscal 2014 budget, major increases include:

- $12.2 million for production hosting, that is, the hosting of all of MHBE's servers as well as ongoing IT maintenance and support;

- $10.3 million for a consolidated service center (a $9.0 million increase over the fiscal 2013 working appropriation as adjusted for deficiencies). The consolidated service center will support consumer inquiries for exchange services across all MHBE service offerings. Inquiries can be done by phone, email, fax, or other means and the center must have culturally and linguistically appropriate communication channels. MHBE is currently seeking bids for an initial five-year contract term;

- $1.8 million for ongoing project management support;

- $1.6 million for any required post-production enhancements to HIX; and

- $1.0 million for call center software licenses and network connectivity.

Significant budget declines in the IT area include:

- $1.0 million in systems maintenance;

- $3.6 million in HIX development expenses (reflecting the development timeline which ends in the first half of fiscal 2014); and

- $4.4 million in costs associated with ensuring interoperability between HIX and other State systems, including major legacy systems of CARES and the Medicaid Management Information System.

HIX

Although expenditures on HIX falls in fiscal 2014 compared to fiscal 2013, the success of this system is the key to the functionality of MHBE and also the expansion of Medicaid. **Exhibit 9** provides an overview of the status of the project. As noted, the project is broken down into multiple phases, and the funding noted in the exhibit is for Phase 1 only.

Identifiable risks associated with the project are significant, notably extremely tight deadlines, limited State resources, program management, and the need for interoperability with multiple other federal and State systems.

The issue of interoperability was one raised by the Department of Legislative Services (DLS) in the 2012 interim. HIX needs to interact with a variety of existing State IT systems. The most important systems with which HIX must be interoperable are Medicaid Enterprise Restructuring Project, the backbone billing system in Medicaid which itself is in the process of being replaced, and CARES. However, there are many other State IT systems that have been identified with which HIX may need to interface. For some systems, an interface may be relatively straightforward; for others, especially legacy systems such as CARES, implementing an interface may be more involved. Further, because the State systems support critical non-MHBE activities, managing the interface development so as not to negatively impact the ability of other agencies to undertake those other activities is an important consideration.

DLS' specific concern about interoperability with existing State systems was prompted by the lack of routine project development documents (including funding requirements) for the various interoperability projects at a time when the HIX project development schedule available to DLS indicated that these projects should be well underway. Certainly, conversations with the Department of Information Technology indicated a potentially troubling communications issue.

Ultimately, it was determined that all of the interoperability work will be funded and procured through MHBE, thus making redundant the need for regular project development documentation and normal procurement. State funding support is still required in the form of the Medicaid match with Medicaid supporting 42% of total costs.

Exhibit 9
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 and social service programs, as well as the needs of the Maryland Health Benefit Exchange (MHBE).		
Project Business Goals:	Provide seamless eligibility determination services to both Medicaid and non-Medicaid eligible Marylanders as part of the "Individuals" and "Small Business" exchanges under MHBE. The Federal government has conditionally approved MHBE ahead of coverage expansion that is scheduled for January 1, 2014. An operational eligibility system will be the cornerstone of MHBE. If the system is not available, the Maryland exchange will be operated by the federal government. The system is envisaged to be implemented in multiple phases: • ***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; • ***Phase 1b:*** Maintenance, hosting, operations, and other selected services; • ***Phase 2:*** Incorporating non-MAGI eligibility determinations into the system, *e.g.*, seniors, people with disabilities, and individuals needing long-term care services; and • ***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.		
Estimated Total Project Cost:	$51.4 million. This represents the development costs for Phase 1 only. Operations and maintenance costs are in addition to this amount.	**New/Ongoing Project:**	Ongoing.
Project Start Date:	December 2010.	**Projected Completion Data:**	Phase 1 – December 31, 2013.
Schedule Status:	The RFP was issued on October 21, 2011. An award was made in February 2012. The project appears to be on schedule.		
Cost Status:	Cost data is lower than shown in fiscal 2013 as data is based on actual contract information.		
Scope Status:	n/a.		

Project Management Oversight Status:	Because the exchange is exempt from the procurement process and project oversight, the eligibility system will not be subject to the oversight that the DoIT applies to both Major Information Technology Development Projects and IT Procurements. The exchange awarded a Program Management Office (PMO) contract ($2.8 million over 18 months) in January 2012, and that contract is extended in the 2014 budget. The PMO is responsible for delivering general project management and quality assurance support for the exchange IT system. Using a DoIT IV&V contract as a model, MHBE has procured 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. The initial IV&V assessments have identified a variety of risks and risk mitigation strategies. Identified risks are closed/remain open/new as appropriate.
Identifiable Risks:	Major risks include the following: • **Tight Deadlines:** MHBE begins accepting enrollees on October 1, 2013; • **Total Project Cost:** Currently unknown, beyond Phases 1a and 1b which are covered by Level 1 and 2 Establishment Grants and Medicaid (federal and State funding); • **State Funding:** Beyond Phase 1, uncertainty as to State funding requirements remain; • **Interoperability:** The system will need to operate with the MERP, a variety of State and federal information systems, and may also need to interact with private systems. At this point, the major concern is the lack of information about progress with the federal data hub, the main source of federal data for enrollment purposes; • **State Resources:** The demands being placed on other State resources (IT and program staff) are considerable and have potential consequences for both HIX and other activities those resources have responsibility for; • **Project Management:** Lack of a single overall program manager; and • **Integration with Other MHBE Functions:** Integration of other MHBE functionality currently being contracted into HIX.

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 the demands on the federal government to establish exchanges, this is a tenuous option. Based on an identified need to ensure a single overall direction for HIX in the months before it goes live, MHBE's executive director recently announced the development of a revised governance structure and a sharpened focus on deliverables ahead of October 1, 2013.

Fiscal Year Funding (000)	**Prior Years**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**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	9,854.3	19,849.7	21,693.2	0.0	0.0	0.0	0.0	51,397.2
Other Expenditures	0.0	0.0		0.0	0.0	0.0	0.0	0.0
Total Funding	**$9,854.3**	**$19,849.7**	**$21,693.2**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$51,397.2**

CARES: Client 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

Notes: Fiscal data reflects estimated payment schedule not when funds were appropriated. Actual payments in fiscal 2013 and 2014 may change based on deliverables.

Source: Department of Legislative Services; Maryland Health Benefit Exchange

Fourteen State IT systems were identified as potentially being required to interface with HIX (**Exhibit 10**). However, 8 systems were ultimately identified as being a high priority and for which interfaces were required. The other 6 systems are a lower priority and do not require interfaces at this time either because the data contained in those other systems was available elsewhere or because the interface was not immediately necessary.

Of greater concern is that much of the data required by HIX to make eligibility determination decisions will be accessed from a federal data hub that is currently under development. In the 2012 interim, the federal government has provided some information on the range of data that is going to be made available through the federal data hub including Social Security number verification; citizenship verification; incarceration verification; certain benefit information; Modified Adjusted Gross Income (MAGI) information from the Internal Revenue Service (IRS); and immigration status.

However, it should be noted that states are still waiting to know exactly what data will be made available and whether additional state sources will be required. For example, concerns have been raised about the specific income data that will be available from the IRS. Indeed, there is a considerable degree of skepticism among many observers about whether the federal data hub itself will be operable (this is separate from privacy, contracting, and other concerns that have been raised about the data hub). As recently as May 2012, DHHS admitted that it did not have agreements with some of the federal agencies on whose data they are relying on being available through the data hub. While initial testing of the interface between HIX and the federal data hub has been successful, this testing has not included real data and may not until the system goes live. Other than general assurances, there is little public detail on the status of the development of the federal data hub.

Interestingly, DHHS has already backed down on one requirement of exchange eligibility systems, namely that the eligibility processes for the exchange and Medicaid be a single seamless process. That requirement has been pushed back until January 2015. For Maryland, this decision changes nothing in that HIX will be the system that conducts MAGI determinations (the bulk of Medicaid enrollment).

Spending Down Federal Grant Funds

As noted in Exhibit 3, MHBE has been able to take advantage of a series of federal grants as the primary funding support through fiscal 2004. Those grants included:

- an Exchange Planning Grant, for almost $1.0 million;
- a $6.2 million Early Innovator Grant;
- a $27.2 million Level One Exchange Establishment Grant; and
- a $123.0 million Level Two Establishment Grant.

Exhibit 10
Interoperability of HIX with Existing State IT Systems

Existing State System – Priority Interoperability	Estimated Interoperability Cost ($)	Existing State Systems Not Being Made Interoperable at This Time
MMIS: Verification of current Medicaid eligibility and the transfer of new applications from HIX to process claims.	$15,500,000	Lottery (querying dataset for lottery winnings).
CARES: Data transfer of newly eligible from HIX to CARES and MMIS.	Cost included in MMIS amount	MVA (querying for residency not required because of federal data hub).
CIS: Transfer of all MAGI determinations from HIX to CIS.	Cost included in MMIS amount	Jail Match (querying for incarceration records not required because of federal data hub).
CSES: Verification of income and other services between HIX and CSES.	600,000	DC Online (querying for residency not required because of the availability of other data sources).
CHESSIE: Sharing Medicaid eligibility between HIX and CHESSIE.	600,000	Kidney Disease Program (non-MAGI program so not part of current phase).
SAIL: SAIL portal and administration functionality will be incorporated into HIX and non-MAGI and social services data sent to CARES.	600,000	Vital Records (querying for mortality not required because of federal data hub).
PAC: Incorporate PAC dataset into HIX as PAC will end January 1, 2014.	200,000	
MABS: Verification of current monthly income between MABS and HIX	600,000	

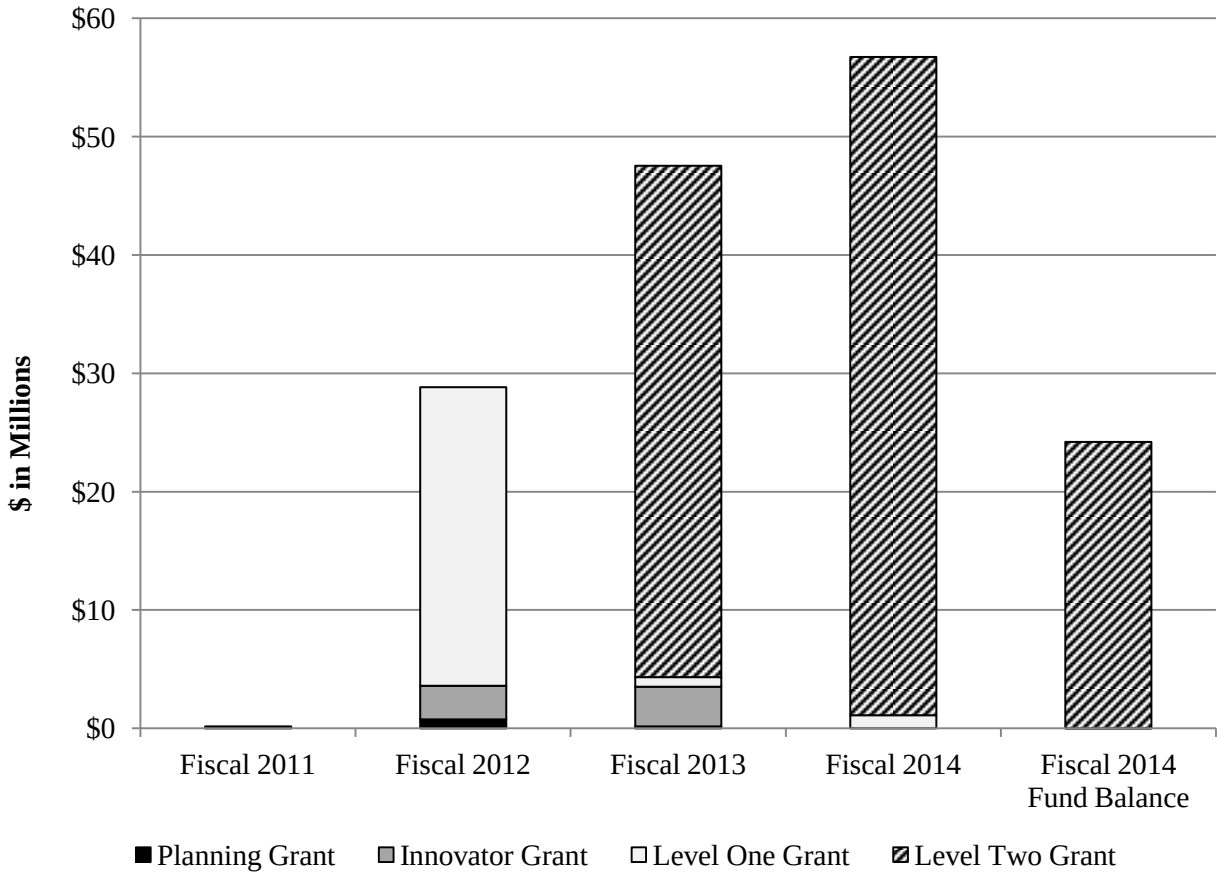
Note: Costs, except for CARES/ MMIS, are placeholders. Except for MABS, agencies have not identified costs. Estimated interoperability costs for systems that are considered low priority are estimated at $200,000 to $400,000 per system but will vary considerably.

CARES: Client Automated Resource and Eligibility System
CHESSIE: Children's Electronic Social Services Information Exchange
CIS: Client Information System
CSES: Child Support Enforcement System
HIX: Health Exchange Eligibility System
IT: information technology
MABS: Maryland Automated Benefits System
MAGI: Modified Adjusted Gross Income
MMIS: Medicaid Management Information System
MVA: Motor Vehicle Administration
PAC: Primary Adult Care
SAIL: Service Access and Information Link

Source: Maryland Health Benefit Exchange; Department of Legislative Services

By the close of fiscal 2014, the State anticipates having $24.2 million in federal grants available to support operation in the first half of fiscal 2015, after which MHBE is required to be self-financing (**Exhibit 11**). However, it should be noted that in the past, MHBE has indicated that it may be able to access additional federal grant funds to fund activities prior to calendar 2015.

Exhibit 11
Use of Federal Grants
Fiscal 2011-2014



Note: Fiscal 2011 and some fiscal 2012 expenditures were actually budgeted in the Department of Health and Mental Hygiene prior to the exchange having its own appropriation.

Source: Maryland Health Benefit Exchange; Department of Legislative Services

Issues

1. Long-term Financing of the Maryland Health Benefit Exchange

Chapter 148 of 2012 (the fiscal 2013 budget bill) included language withholding funds pending the receipt of a report detailing how MHBE will become financially self-sustaining. Beginning in calendar 2015, as required under federal health care reform legislation, health insurance exchanges are required to be self-sustaining. In December 2012, the exchange submitted a report to the legislature that included considerations for financing options. However, the Governor chose a different approach in HB 228/SB 274 of 2013.

Developing a Budget Estimate

As shown in **Exhibit 12**, the MHBE out-year budget projection has an estimated budget gap for operations of approximately $34 million to $35 million on an ongoing fiscal year basis beginning in fiscal 2016.

Exhibit 12
Budget Estimates
Fiscal 2014-2018

	2014 Allowance	2015 Est.	2016 Est.	2017 Est.	2018 Est.
General Funds (GF)	$4,460,000	$2,320,000			
Medicaid Funds (GF/FF)	24,837,735	21,710,000	$28,700,000	$28,706,000	$28,706,000
FF	55,624,533	24,200,000			
Gap		21,825,000	34,430,000	33,907,000	34,808,522
Total	**$84,922,268**	**$70,055,000**	**$63,130,000**	**$62,613,000**	**$63,514,522**
Medicaid %	29%	31%	45%	46%	45%

FF: federal funds

Source: Maryland Health Benefit Exchange

This estimate is based on a number of assumptions of which the most intriguing is the proportion of costs attributed to Medicaid funding; specifically that Medicaid funding will total 45% of MHBE's overall budget. That percentage is derived from an assumption that certain shared

services will be funded 75% Medicaid/25% MHBE, while other costs will be exclusively the responsibility of MHBE.

As noted above, the Administration has made Medicaid funding an integral part of the overall MHBE financing strategy. This is reasonable given that Medicaid eligibility determinations, initially for MAGI enrollment, and at some later point potentially for all Medicaid enrollment, will be done through HIX.

According to MHBE, the federal government has agreed to this financing strategy. However, the ultimate methodology chosen to determine the share of costs to be borne by Medicaid may be subject to further discussion.

Certainly there are many ways that Medicaid's future share of MHBE's costs could be determined. **Exhibit 13**, for example, shows three different scenarios:

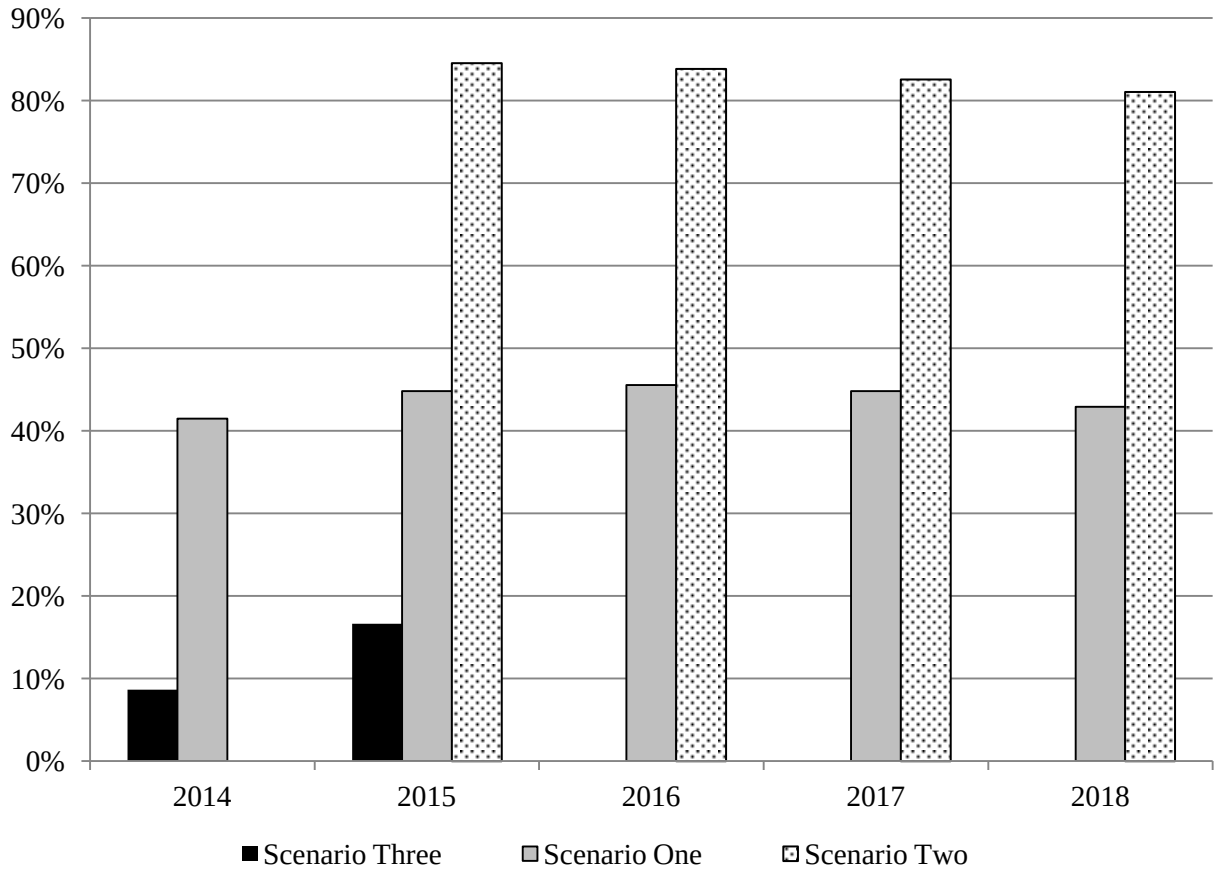
- The first scenario looks at total new projected Medicaid population as of January 1, 2014, as a proportion of that enrollment plus those projected to buy insurance through MHBE. Under this scenario, then Medicaid enrollment will eventually stabilize at around 45%.

- In the second scenario, which reflects redeterminations for Medicaid, just based on Medicaid MAGI determinations, enrollment through HIX will be dominated by Medicaid, at or above 80% of total enrollment. This figure appears to be the one underpinning the 75/25% split for certain eligible services that drives the thinking noted in Exhibit 12.

- In the third scenario, which looks only at the near term, at least some 80% of new Medicaid enrollees are already enrolled in the Primary Adult Care program. If that population were excluded from the calculation in the first scenario, the Medicaid participation rate would be somewhat lower, less than 10% in fiscal 2014, 17% in fiscal 2015, certainly lower than that being used for budgeting purposes.

There are clearly many other potential scenarios. Not surprisingly, the fiscal 2014 budget includes funding for a cost allocation study to provide additional guidance on what the appropriate funding split between Medicaid and non-Medicaid funds should be.

Exhibit 13
Using Medicaid Enrollment to Determine Future Estimates of the Medicaid Share of MHBE Funding
Fiscal 2014-2018



MHBE: Maryland Health Benefit Exchange
PAC: Primary Adult Care

Note: See text for additional details.

Source: Hilltop Institute; Department of Legislative Services

A Financing Strategy: December 2012 Report

The December 2012 report opted for a financing strategy that reflects the premise that the exchange has an impact at different levels – on the carriers who will participate in issuing policies through the exchange; on the health care system as a whole (not least through the addition of federal funding via tax credits that should decrease uncompensated care and bad debt and increase premium and provider revenue); and a broader impact on the State as a whole through such things as increased economic activity and improved access to healthcare.

Accepting that premise, the report discusses a variety of financing strategies drawn from these broadly impacted groups:

- An assessment on issuers of non-group and small group plans with a preference for a broader-based assessment on all enrollees in the non-group and small group markets versus limiting this assessment to policies issued to members in the exchange.

- An assessment on the broader health care market. The report notes that a variety of broad-based assessments are possible; imposing an assessment on hospital revenues (similar to assessments currently in place to fund such things as Medicaid and the Maryland Health Insurance Plan), imposing an assessment on licensed providers (similar to the assessment currently used to finance the Maryland Health Care Commission), and an assessment on the commercially insured large group health insurance market.

  However, the report recommended against the use of a hospital-based assessment given a variety of concerns about the use of this kind of assessment, seeming to prefer the use of an assessment on issuers of commercial large group health insurance.

- Broad-based public financing. The report's focus was on an increase in the tax on cigarettes. Although only 15% of adult Marylanders smoke, the report argues that smokers are more likely to be uninsured and more likely to need health care services than the general population. Utilization of a broader-based tax or funding support over more targeted assessments has the benefit that the cost would not be passed on to consumers through higher premiums, although of course the costs would be borne in the case of the cigarette tax by smokers.

Ultimately, the report recommends spreading the funding of the exchange across various revenue streams. Arguments in favor of this approach include limiting the impact on any one market sector, providing for a more stable revenue stream than one simply tied to exchange enrollment while at the same time maintaining some link to enrollment, and reflecting the wide and varied impact and value of the exchange.

Recommendation of the Governor

House Bill 228/Senate Bill 274 of 2013 proposes that beginning in fiscal 2015, and each fiscal year thereafter, the Governor provide an appropriation in the State budget to fully fund the operations of MHBE. The appropriation must be allocated from the premium tax paid by health insurers and for-profit health maintenance organizations (HMO). Currently, the premium tax revenues collected from for-profit HMOs, $48.7 million in fiscal 2012, together with the premium tax on MCOs, are distributed to the Rate Stabilization Fund which funds the Medicaid program. Premium tax revenues collected from health insurers, $83.8 million in fiscal 2012, currently go to the general fund. DLS assumes that MHBE will receive its appropriation from general fund premium tax revenues, as no change is made to the distribution of the revenues from the Rate Stabilization Fund. In any event, it should be noted that expectation are that premium tax revenues will increase as more insurance policies are written with the opening of MHBE.

Approaches of Other States

At this point, there are a variety of funding approaches being adopted for exchanges in other states. Many states (for example, California, Connecticut, Nevada, and Oregon) that have announced their intention to operate their own exchanges have also announced their intention to fund them through an assessment on premiums sold through the exchange. In California, for example, the anticipated assessment level is initially 3.0%, falling to 2.0% by 2017. States that have decided not to build their own exchanges and have one run by the federal government will also be financing through a surcharge on premiums capped at 3.5%.

However, other states are thinking more broadly beyond the exchange market, and Massachusetts, which developed its exchange, the Health Connector, prior to the ACA relies much more heavily on general fund revenues (approximately 70% of its 2012 budget) and much less on a surcharge on policies sold through the connector (just under 20% of the total budget, with the remainder from other sources).

Conclusion

It should be noted that there is also the option under current law that MHBE may convert to a nonprofit entity. However, at this point, the financing mechanism outlined in HB 228/ SB 274 is intended to satisfy the State and federal requirement for self-financing by calendar 2015. While premium tax collections are projected to increase as a result of health insurance expansion in calendar 2014, it remains unclear if this increase will be sufficient to offset all of the general funds needed to fund MHBE (including the Medicaid matching requirement).

Finally, absent any discussion to the contrary at the budget hearings, DLS will be recommending the release of the withheld funding associated with the MHBE financing report.

Recommended Actions

1. Concur with Governor's allowance.

Updates

1. Basic Health Plan

Chapter 148 of 2012 (the fiscal 2013 budget bill) included language withholding funds pending the receipt of a report about the viability of developing a basic health plan (BHP) option.

Under the ACA, states can develop a BHP for individuals meeting all of the following eligibility criteria: under the age of 65 years; adults with incomes between 138 and 200% of the FPL and certain legal immigrant populations who are not qualified for federal Medicaid funding; no access to affordable, comprehensive employer subsidized insurance; and 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; premiums may not exceed levels that would be charged in the exchange; and actuarial values may not fall below specified levels.

Funding for the program would primarily be derived from the federal government. Specifically, a percentage 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.

In January 2012, DHMH had released a study that concluded that based on initial calculations, 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, there was 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.

The report required by Chapter 148 was intended to update the original January 2012 report based on information that had been previously unavailable. The report was submitted but noted that there were still areas that require additional federal guidance including:

- How the federal payment will be determined. Specifically, the ACA requires the federal government to use a variety of data points including age, geography and health status in making the payment determination on a per enrollee basis. These specifics remain unknown. Similarly, it is unclear whether states get 95 or 100% of cost sharing subsidies as the federal payment. Additionally, these payments are not considered mandatory spending and thus could be subject to sequestration which remains unresolved at the time of writing.

- Whether states have to provide a three-month coverage grace period for enrollees who do not pay their premiums. This grace period applies to Qualified Health Plans but not specifically for BHPs. Clarification is necessary because it would have an impact on cost.

- How the reconciliation of overpayments and underpayments would work. Funding for the BHP would be prospective so payment reconciliation becomes an issue, especially if a state reinvests what it believes are savings into other health improvement efforts only to subsequently discover that it has been overpaid. Overpayment to a state in one year would likely be offset in the following year's payment thus exposing a state to potential cost. As seen in Maryland's averted uncompensated care assessment reconciliation process, this is never an easy process.

- If funding for administrative functions is included in the federal payment. The ACA is unclear if states can use a portion of the federal payment for administrative expenses. If not, these costs could be significant.

- What role the federal government will take in overseeing BHPs. This federal function would not impact cost per se, but would be something that the state would need to know prior to establishing a BHP option.

Finally, projected enrollment in the BHP has fallen from the original estimate made in January 2012 (to 45,000 individuals in fiscal 2016 from the original 82,000) with overall exchange enrollment falling from 270,000 (including the SHOP exchange) to 184,000. This has implications in terms of the potential impact if a BHP is established thereby reducing the number of covered lives in the risk pool and thus likely increasing the cost of insurance in the exchange.

In summary, absent the appropriate federal guidance, an updated cost estimate is not available at this time. Nonetheless, given the legislative interest in the BHP, the department agreed to update its estimates within 90 days of appropriate federal guidance being released. Since a BHP can be established at any time, this "wait-and-see" approach seems sensible given the absence of federal guidance and general uncertainty about exchange enrollment and pricing.

Finally, absent any discussion to the contrary at the budget hearings, DLS will be recommending the release of the withheld funding associated with the BHP option.

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2012					
Legislative Appropriation	$0	$0	$0	$0	$0
Deficiency Appropriation	1,674	0	0	0	1,674
Budget Amendments	0	0	29,194	0	29,194
Reversions and Cancellations	0	0	0	0	0
Actual Expenditures	**$1,674**	**$0**	**$29,194**	**$0**	**$30,868**
Fiscal 2013					
Legislative Appropriation	$1,890	$0	$24,638	$0	$26,528
Budget Amendments	0	15	26,990	0	27,005
Working Appropriation	**$1,890**	**$15**	**$51,629**	**$0**	**$53,533**

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

Fiscal 2012

MHBE began fiscal 2012 without a distinct legislative appropriation. Funding for operations was part of DHMH. However, during fiscal 2012, a separate appropriation was created for the exchange in order that it could procure HIX under the procurement rules and regulations governing the exchange which are different from those governing DHMH. As a result, the exchange ended the fiscal year with an expenditure level of just under $30.9 million. That expenditure level was derived as follows:

- $1.7 million in general funds provided through a deficiency appropriation to serve as the match to federal Medicaid funds which together support 42% of the exchange's budget for HIX based on the anticipated utilization of the system by Medicaid. This funding arrangement has been approved by the Centers for Medicare and Medicaid Services.

- $29.2 million in federal funds, again primarily for spending related to the HIX procurement. This funding was derived from three federal sources: (1) $14.1 million from the Establishment Grant; (2) $3.8 million from the Innovator Grant; and (3) $11.3 million in federal Medicaid funds (of which $8.1 million was transferred from the fiscal 2012 Medicaid budget that was designated for a non-specific health care reform IT project).

  Specific uses for the funds include administrative expenses ($76,000), computer hardware ($952,000), and contractual services ($28.2 million). Contractual service spending includes project management and consultant services, security services, software licenses, and system integration services, as well as Independent Verification and Validation.

Fiscal 2013

To date, the fiscal 2013 legislative appropriation for MHBE has been increased by $27.0 million. All but $23,000 are federal funds available from a federal Level 2 Health Exchange Establishment grant. That grant was awarded in August 2012. The total amount of the grant is $123.0 million. This funding is broken into two distinct parts:

- $5.6 million in increased operating expenditures. Just under $3.3 million in operating expenditures is directly related to cover salaries and associated expenses for 33 newly created FTEs approved by BPW in September 2012. These positions supplement the 9 employees currently at the exchange and reflect the need to staff-up ahead of the official opening of the exchange for enrollment on October 1, 2013.

  Other major increases in operating expenditures include $1.1 million in contract funding for outreach and marketing activities, $500,000 in consulting fees, and $260,000 for legal support through the Office of the Attorney General.

- $21.3 million for various IT related activities. This increase when combined with $14.2 million in fiscal 2013 appropriations that would otherwise have supported the ongoing development of HIX but are no longer required for that purpose because of the availability of fiscal 2012 encumbrances, results in a net increase in spending of $35.5 million for a variety of activities.

  The new spending being supported through the amendment and the existing fiscal 2013 appropriation includes $13.0 million for the design and maintenance of the SHOP, $9.6 million for interoperability activities between HIX and other State IT systems, $3.9 million for HIX independent verification and validation, $2.4 million for connection data management and support systems, $1.74 million for a consolidated service center, and $1.2 million for customer kiosk installation and set-up.

The other $23,000 is a $15,000 grant from the Casey Foundation for a grant writer for the Level 2 Establishment grant, and $8,000 in federal funds added to the fiscal 2013 legislative appropriation is to support the fiscal 2013 cost-of-living adjustment.

Object/Fund Difference Report
Maryland Health Benefit Exchange

Object/Fund	FY 12 Actual	FY 13 Working Appropriation	FY 14 Allowance	FY 13 - FY 14 Amount Change	Percent Change
Positions					
01 Regular	0.00	42.00	70.00	28.00	66.7%
02 Contractual	0.00	5.00	0.00	-5.00	-100.0%
Total Positions	**0.00**	**47.00**	**70.00**	**23.00**	**48.9%**
Objects					
01 Salaries and Wages	$ 0	$ 3,698,226	$ 6,938,789	$ 3,240,563	87.6%
02 Technical and Spec. Fees	0	302,745	0	-302,745	-100.0%
03 Communication	0	154,967	146,570	-8,397	-5.4%
04 Travel	5,678	146,020	194,040	48,020	32.9%
08 Contractual Services	30,862,282	48,362,044	68,438,674	20,076,630	41.5%
09 Supplies and Materials	0	23,107	15,235	-7,872	-34.1%
11 Equipment – Additional	0	486,549	18,000	-468,549	-96.3%
12 Grants, Subsidies, and Contributions	0	0	8,640,000	8,640,000	N/A
13 Fixed Charges	0	359,613	530,960	171,347	47.6%
Total Objects	**$ 30,867,960**	**$ 53,533,271**	**$ 84,922,268**	**$ 31,388,997**	**58.6%**
Funds					
01 General Fund	$ 1,673,512	$ 1,889,706	$ 14,140,600	$ 12,250,894	648.3%
03 Special Fund	0	15,000	0	-15,000	-100.0%
05 Federal Fund	29,194,448	51,628,565	70,781,668	19,153,103	37.1%
Total Funds	**$ 30,867,960**	**$ 53,533,271**	**$ 84,922,268**	**$ 31,388,997**	**58.6%**

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.

Fiscal Summary
Maryland Health Benefit Exchange

Program/Unit	FY 12 Actual	FY 13 Wrk Approp	FY 14 Allowance	Change	FY 13 - FY 14 % Change
01 Maryland Health Benefit Exchange	$ 0	$ 8,636,081	$ 22,867,271	$ 14,231,190	164.8%
02 Major Information Technology Development Projects	30,867,960	44,897,190	62,054,997	17,157,807	38.2%
Total Expenditures	**$ 30,867,960**	**$ 53,533,271**	**$ 84,922,268**	**$ 31,388,997**	**58.6%**
General Fund	$ 1,673,512	$ 1,889,706	$ 14,140,600	$ 12,250,894	648.3%
Special Fund	0	15,000	0	-15,000	-100.0%
Federal Fund	29,194,448	51,628,565	70,781,668	19,153,103	37.1%
Total Appropriations	**$ 30,867,960**	**$ 53,533,271**	**$ 84,922,268**	**$ 31,388,997**	**58.6%**

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.