D78Y01
Maryland Health Benefit Exchange

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$20,727	$0	$0	$0	
Deficiencies and Reductions	0	6,528	0	-6,528	
Adjusted General Fund	**$20,727**	**$6,528**	**$0**	**-$6,528**	**-100.0%**
Special Fund	45,935	36,657	75,090	38,433	104.8%
Deficiencies and Reductions	0	0	-13	-13	
Adjusted Special Fund	**$45,935**	**$36,657**	**$75,077**	**$38,420**	**104.8%**
Federal Fund	110,216	54,403	47,376	-7,027	-12.9%
Deficiencies and Reductions	0	6,391	-10	-6,401	
Adjusted Federal Fund	**$110,216**	**$60,794**	**$47,366**	**-$13,428**	**-22.1%**
Nonbudgeted Fund	23,682	0	0	0	
Adjusted Nonbudgeted Fund	**$23,682**	**$0**	**$0**	**$0**	
Adjusted Grand Total	**$200,561**	**$103,979**	**$122,443**	**$18,463**	**17.8%**

- There are two proposed general fund deficiencies and one federal fund deficiency for fiscal 2016 – funds to support increased call center expenditures ($5.7 million in general funds and $6.4 million in federal funds) and funds to retain outside legal counsel ($868,436 million in general funds).

- There is one general fund deficiency for fiscal 2015 to support increased call center expenditures and outside legal counsel ($1.6 million in general funds).

- The $38 million increase in special funds is due to the transfer of funds from the Maryland Health Insurance Plan to support reinsurance costs in the Maryland Health Benefit Exchange (MHBE).

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

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Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	76.00	74.00	69.00	-5.00
Contractual FTEs	0.00	1.00	0.00	-1.00
Total Personnel	**76.00**	**75.00**	**69.00**	**-6.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions		2.96	4.00%
Positions and Percentage Vacant as of 12/31/15		6.00	8.69%

- The fiscal 2017 allowance includes 5 fewer regular full-time equivalents (FTE) and 1 fewer contractual FTE than in the fiscal 2016 working appropriation. The 5 FTEs were a result of the wind-down of the Maryland Health Insurance Program, part of which has been consolidated into MHBE, while the contractual FTE came from MHBE directly.

- The agency's vacancy rate has decreased significantly from last year's rate at (26.09%) but remains higher at 8.7% than budgeted turnover (4.0%).

Analysis in Brief

Major Trends

Measuring Success: MHBE has submitted formal Managing for Results performance measures for the second time. However, data to assess the success of health care reform in the State (with consideration of metrics such as accessibility, comprehensiveness of coverage, and changes in health care safety net utilization) is still limited.

The Uninsured Rate Continues to Decrease: The proportion of individuals under 65 with health insurance has increased in both calendar 2013 and 2014. The proportion of low-income adults under 65 without health insurance has decreased from calendar 2012 yet still remains high at 27.5%.

Premiums Are Increasingly Less Affordable: The average total single person premium for Qualified Health Plans (QHP) and all small group plans as a percentage of the Maryland average wage continues to increase. The silver metal level QHP maintains the largest proportion of enrollments, increasing in calendar 2015.

Issues

Health Care Affordability and Network Adequacy: During the third open enrollment, one carrier (BlueCross) continued to capture more than half of the market despite having increased rates two years in a row. Consumers may choose BlueCross for a variety of reasons, one of which may be the inadequacy of networks among other carriers. A workgroup was formed to address the adequacy of networks. In addition, 20% of the plans chosen through the exchange are high-deductible plans. The popularity of such plans may contribute to health care being unaffordable for many consumers.

Federal Audit Findings: In March 2015, the U.S. Department of Health and Human Services Office of the Inspector General (OIG) issued a report that concluded that MHBE did not allocate costs to its establishment grants and Medicaid in accordance with federal requirements and its cost allocation plan. OIG concluded that MHBE misallocated these costs because it did not have adequate internal controls to ensure the proper allocation of costs and, as a result, OIG recommended that MHBE refund $28.4 million to the Centers for Medicare and Medicaid Services that was misallocated.

Settlement with IT Contractor: MHBE reached a $45 million settlement with Noridian Healthcare Solutions, LLC over the technology used during the initial launch of the health care exchange. The State has received a portion of funds from the settlement and is considering legal action against other vendors involved with the development of the original IT platform.

Recommended Actions

		Funds	Positions
1.	Reduce 3 vacant positions.	$ 205,889	3.0
	Total Reductions	**$ 205,889**	**3.0**

Updates

Progress Report on MHBE: The second open enrollment after the switch to a new information technology (IT) platform was generally successful. The third open enrollment included additional enhancements and saw an increase in the number enrolled in QHPs from the second enrollment.

Report on Connector Entities: Due to concerns over lower than expected enrollment, the 2015 *Joint Chairmen's Report* (JCR) requested an update on the role of, and expectations for, connector entities in shaping enrollment, including how the role of connector entities is expected to evolve. The report was submitted by MHBE in December 2015.

Report on System Integration: The new eligibility determination IT system of MHBE does not currently offer the single point-of-entry for benefits determinations that had been the long-term goal of the original MHBE system. MHBE submitted a report as requested by the 2015 JCR providing plans to move toward a single point-of-entry.

D78Y01
Maryland Health Benefit Exchange

Operating Budget Analysis

Program Description

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

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

Performance Analysis: Managing for Results

1. Measuring Success

MHBE has submitted formal Managing for Results performance measures for the second time. However, data to assess the success of health care reform in the State (with consideration of metrics such as accessibility, comprehensiveness of coverage, and changes in health care safety net utilization) is still limited. In calendar 2016, MHBE will develop metrics that will allow for the measurement of carrier partner performance with respect to enrollment, network adequacy, quality information, and complaints and grievances.

To date, MHBE has reported actual data related to:

- the average total single person premium for all QHPs as a percentage of the Maryland average wage, estimated at 8.3%, up from 6.8% in calendar 2014;

- the average total single person premium for all small group plans divided by the Maryland average wage, 10.8% in 2014 up from 10.4% in calendar 2013;

- the proportion of individuals under age 65 with health insurance, 93.5% in 2014 up from 88.3% in calendar 2013;

- the proportion of individuals under 100% of the federal poverty level (FPL), age 19 to 64, without health insurance, 27.4% in 2014 down from 40.0% in calendar 2012;

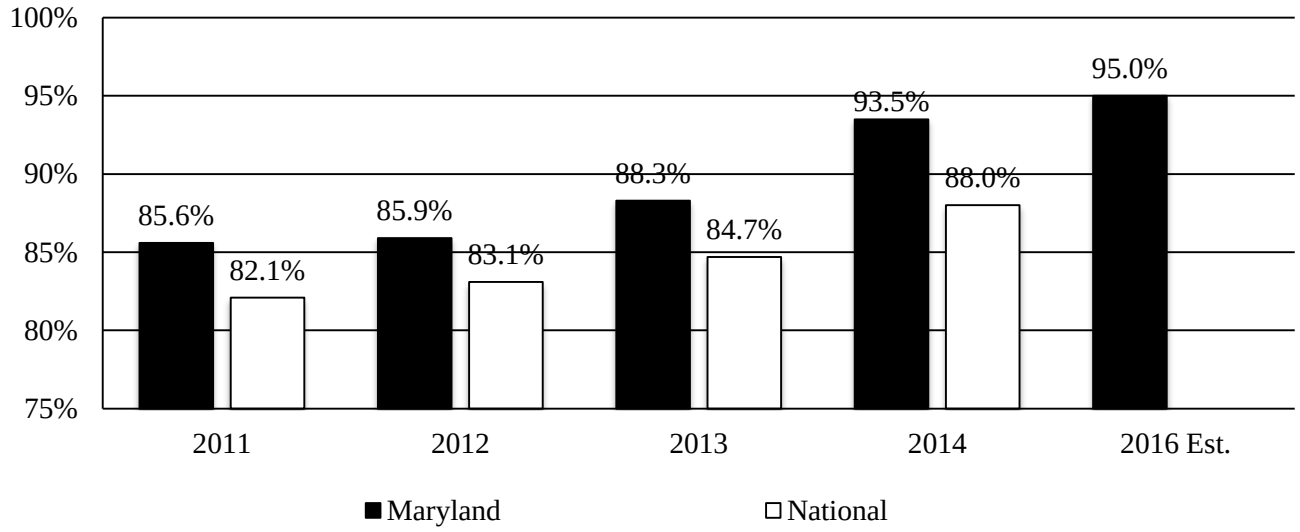
- the enrollee satisfaction with eligibility and services as measured in an annual survey, 67.0% and satisfaction with QHP plan, 95%; and

- the number of Marylanders enrolled in QHPs through MHC (an estimated 140,731 for calendar 2015) and number of Marylanders enrolled in Medicaid through MHC (an estimated 864,489 for calendar 2015).

2. The Uninsured Rate Continues to Decrease

The proportion of individuals under the age of 65 with health insurance continues to increase. **Exhibit 1** shows the proportion of individuals under the age of 65 with health insurance increasing from 85.6% in calendar 2011 to 93.5% in calendar 2014. Maryland's insured rate is greater than the national rate of 88.0% for this same population in calendar 2014. The Maryland Health Care Commission (MHCC) estimates a 95.0% insured rate for this population in calendar 2016 and 2017.

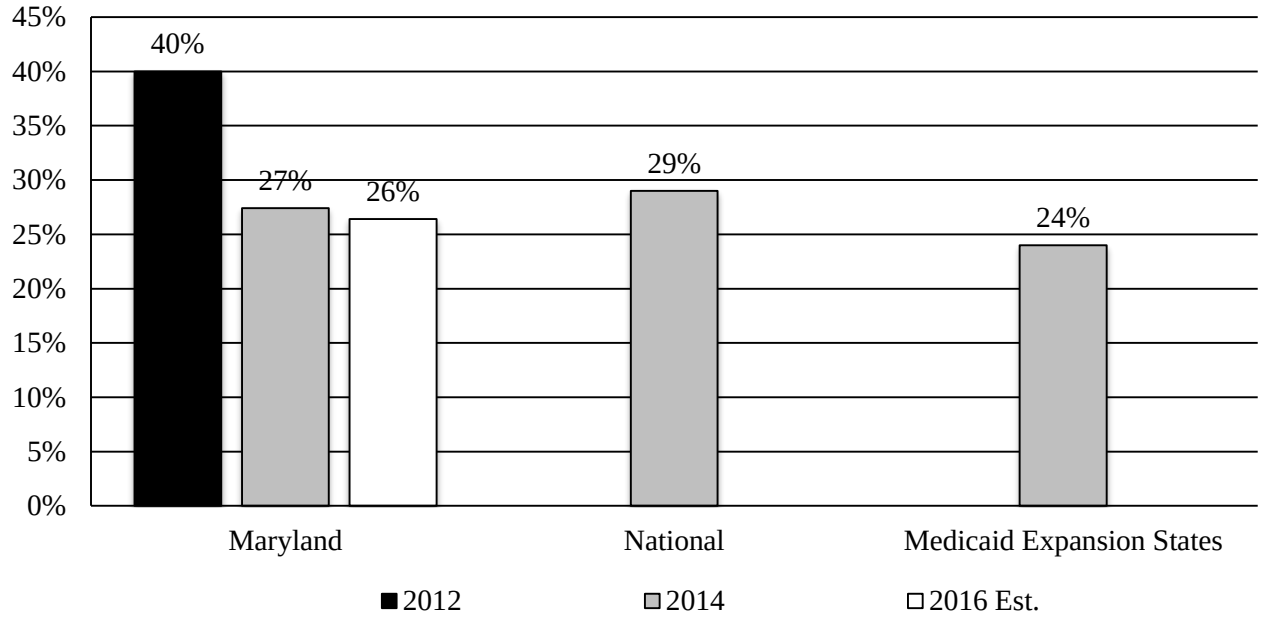
Exhibit 1
Proportion of Individuals under Age 65 with Health Insurance
Calendar 2011-2016 Est.



Source: Maryland Health Care Commission; Census Bureau

The proportion of individuals under 100.0% of the FPL, age 19 to 64, without health insurance has decreased. **Exhibit 2** shows a decline from 40.0% in calendar 2012 to 26.0% in calendar 2016. This decline reflects the expansion of Medicaid in Maryland allowed under the ACA. The calendar 2014 proportion in Maryland (27.4%) is lower than the national proportion (29.0%); however, it is higher than the average for states that expanded Medicaid (24.0%).

Exhibit 2
Proportion of Individuals under 100% of FPL without Health Insurance
Calendar 2012, 2014, and 2016 Est.



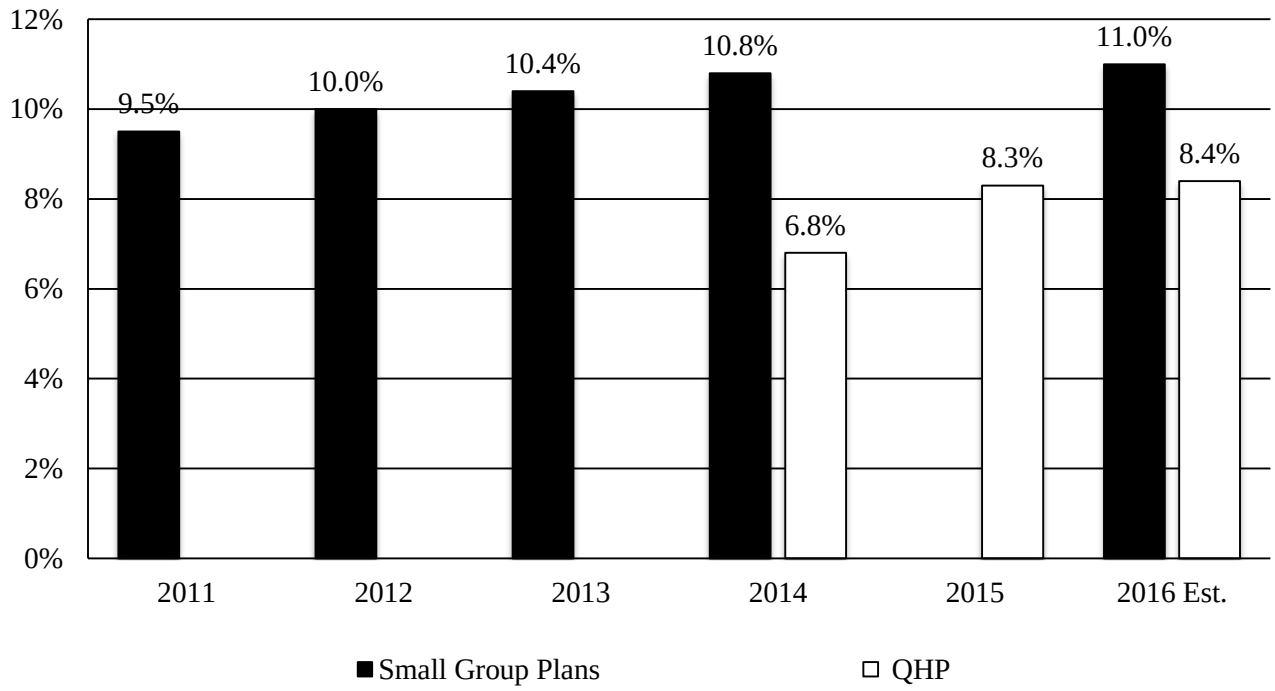
FPL: federal poverty level

Source: Maryland Health Care Commission; Census Bureau

3. Premiums Are Increasingly Less Affordable

Exhibit 3 shows the average total single-person premium for all QHPs as a percentage of the Maryland average wage from calendar 2011 to 2015. The first year this was measured was 2014 at 6.8% and is expected to increase 22.0% to 8.3% in calendar 2015. This average total single-person premium for all small group plans as a percentage of the Maryland average wage increased from 9.5% in calendar 2011 to 10.8% in calendar 2014 and is expected to increase to 11.0% in calendar 2016.

Exhibit 3
Average Total Single-person Premium for QHPs and Small Group Plans as a Percentage of the Maryland Average Wage
Calendar 2011-2016 Est.

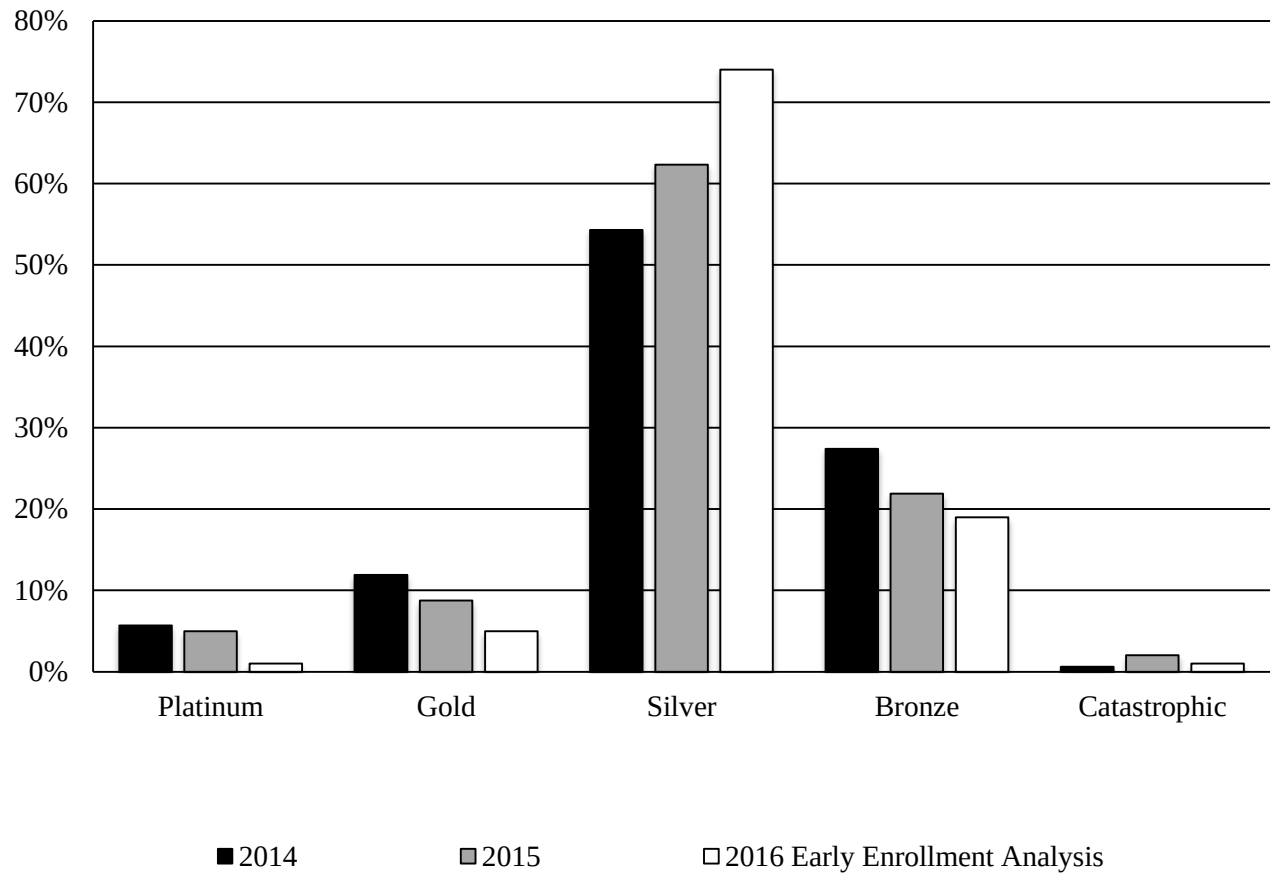


QHP: Qualified Health Plan

Source: Maryland Health Benefit Exchange

In terms of QHP plan selection, in 2015, the silver metal level was the most selected level by consumers for the second year with an average monthly premium cost of $322.81 before the Advanced Premium Tax Credit (APTC). **Exhibit 4** shows the percentage of QHP consumers choosing this plan in calendar 2015, 62%, increasing from 53% in calendar 2014. Plans with a higher metal level typically have higher premiums and lower out-of-pocket costs. Plan levels include bronze, silver, gold, and platinum. For example, in a silver metal plan, on average, the issuer pays 70% of health care costs while the insured pays 30% out-of-pocket. Consumers chose fewer bronze and gold plans, while platinum stayed consistent at around 5%. In calendar 2015, 22% of QHP consumers chose a bronze plan with an average premium cost of $251. Silver plans are the only plans where an individual under 250% of the FPL can qualify for cost-sharing reductions. People under the age of 30 and some people with limited incomes may buy an alternative kind of coverage called a "catastrophic" health plan. A more detailed discussion on the implications of plan choice is found in Issue 1.

Exhibit 4
Quality Health Plan Enrollment by Metal Level
Calendar 2014-2016



Source: Maryland Health Benefit Exchange

Fiscal 2016 Actions

Proposed Deficiency

As a result of the significant changes to planned spending in fiscal 2016, there are two proposed general fund deficiencies and one proposed federal fund deficiency:

- funds to support increased call center expenditures ($12.1 million – $5.7 million in general funds and $6.4 million in federal funds);

- general funds for the retention of outside legal counsel ($868,436), as MHBE pursues potential claims related to the prior exchange eligibility system (HIX) failure; and

- general funds to cover fiscal 2015 expenses for the consolidated service center and legal services ($1.6 million).

It should be noted that of the $12.1 million in call center expenditures, $11.2 million of this amount was to assist with issues surrounding Medicaid redeterminations. During calendar 2015, the State began conducting redetermination using the health benefit exchange eligibility system (HBX) in lieu of the HIX and the Client Automated Resource and Eligibility System (CARES) eligibility system. Of the additional funding for 2016, only $0.8 million carries forward into fiscal 2017. It is assumed that with auto enrollment, there will be less demand on the call center since consumers are in the new system. Fiscal 2017 also has no funding budgeted for legal fees. Legal costs are still not known at this time, so there is the possibility of an additional deficiency for legal fees in fiscal 2016 and 2017.

Proposed Budget

The fiscal 2017 allowance for MHBE increases by $18.5 million (17.8%) from the fiscal 2016 working appropriation adjusted for deficiencies and cost containment. As shown in **Exhibit 5** the increase is driven by growth in special funds in fiscal 2017, largely due to the transfer of the Maryland Health Insurance Plan (MHIP) fund balance for reinsurance costs in MHBE.

Exhibit 5
Proposed Budget
Maryland Health Benefit Exchange
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Nonbud. Fund	Total
Fiscal 2015 Actual	$20,727	$45,935	$110,216	$23,682	$200,561
Fiscal 2016 Working Appropriation	6,528	36,657	60,794	0	103,979
Fiscal 2017 Allowance	0	75,077	47,366	0	122,443
Fiscal 2016-2017 Amount Change	-$6,528	$38,420	-$13,428	$0	$18,463
Fiscal 2016-2017 Percent Change	-100.0%	104.8%	-22.1%		17.8%

Where It Goes:	
Personnel Expenses	
Retirement	$173
Employee and retiree health insurance	134
Miscellaneous adjustments	101
Turnover adjustments	29
Other fringe benefit adjustments	-19
Regular earnings and accrued leave payments	-47
Abolished positions (5 full-time equivalents)	-780
Maryland Health Insurance Plan (MHIP) Expenses and Reinsurance	
MHIP Reinsurance Fund	40,090
Reduction in operating expenses for MHIP	-1,047
Other Operational Expenses	
Telecommunications	-78
Advertising	-200
Reduced training, procurement, and current services costs overhead	-452
Maximus fulfillment support	-500
Unprovided for fiscal 2015 legal services paid in fiscal 2016	-716
Removal of fiscal 2016 deficiency for legal services	-868
Reduction in information technology enhancements	-1,420
Reduction in call center funding	-1,820
Reduced grant to connector entities	-2,000
Removal of fiscal 2016 deficiency for call center	-12,100
Other	-18
Total	**$18,463**

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

Across-the-board Reductions

The fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. This agency's share of these reductions is $13,086 in special funds and $9,984 in federal funds. There is an additional across-the-board reduction to abolish vacant positions statewide, but the amounts have not been allocated by agency.

Personnel Expenses

Personnel expenses decrease the MHBE budget by $408,124. The largest reduction of $780,346 is due to the abolition of 5 positions from the Maryland Health Insurance Program as the program ended and is consolidated into MHBE.

These decreases were offset by increases in health insurance of $134,404 and retirement contributions of $173,074. The budget increases by an additional $29,123 to reflect turnover adjustments as the agency continues to fill vacant positions. The allowance also provides a $101,479 increase to allow positions to be hired above the base salary level.

MHIP Reinsurance Fund and MHIP-related Expenses

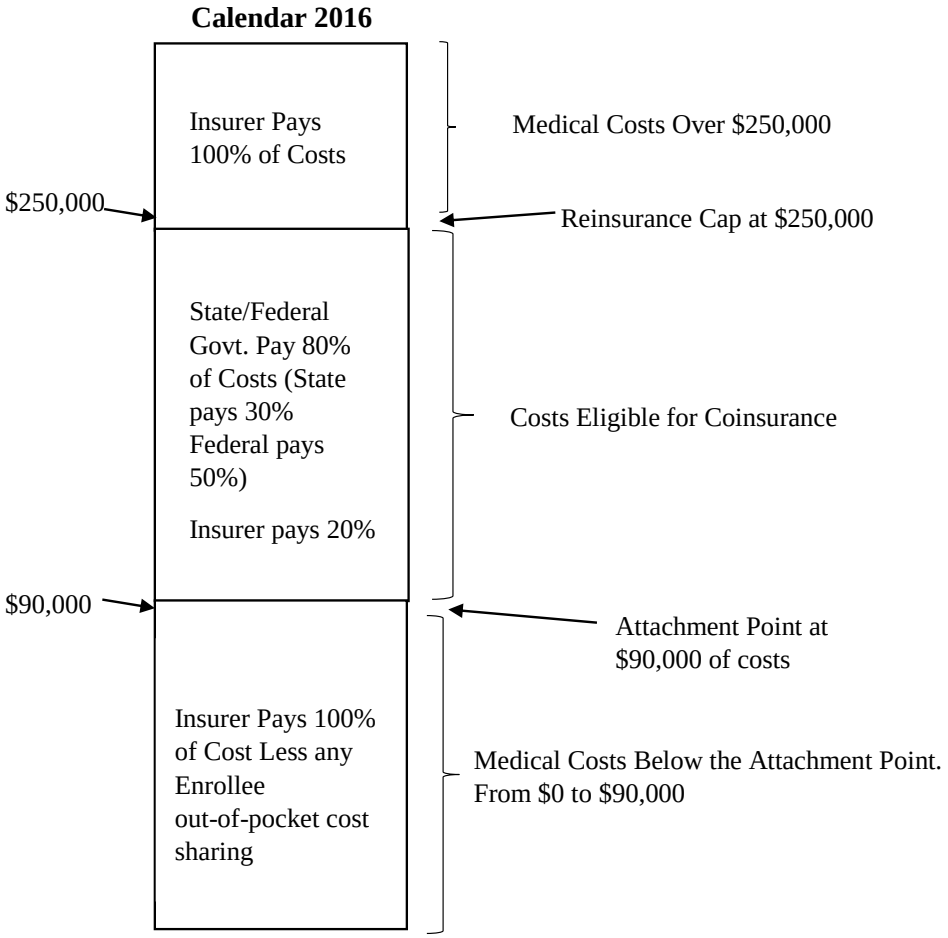
The MHIP Reinsurance Fund increased the agency's budget by $40.0 million. This $40.0 million is to pay for calendar 2015 claims. Calendar 2016 claims will be paid out of the fiscal 2018 budget. The fiscal 2017 allowance includes a reduction for the operating costs associated with MHIP including $0.9 million for administrative hearings and fee-for-service, $85,000 for a management study and consultation, and $43,000 for other operating costs.

Use of the Maryland Health Insurance Plan Fund Balance for Reinsurance in MHBE

One of the changes made by Chapter 159 of 2013, the Maryland Health Progress Act, was to establish a State Reinsurance Program with funding for the program to be derived from the MHIP fund balance. Under the ACA, each state must have a reinsurance program in place for fiscal 2014 through 2016, either created by the state or administered on behalf of the state by the U.S. Department of Health and Human Services (HHS). The goal of the reinsurance program is to reduce the need for insurers to charge higher premiums due to the uncertainty of the health status of the new enrollees in the market. Under the program, insurance carriers make reinsurance contributions to HHS and the Department of the Treasury. These funds are then distributed to health insurance carriers for high-cost enrollees whose insurance claims exceed a certain threshold.

HHS administered the program on behalf of Maryland. HHS allows states to supplement their reinsurance program by three general methods: (1) decreasing the national attachment point; (2) increasing the national reinsurance cap; and/or (3) increasing the national coinsurance rate. Maryland did not supplement the federal reinsurance program in calendar 2014. In calendar 2015, Maryland supplemented the federal reinsurance program by increasing the coinsurance rate from 50% to 80%, using funds made available from MHIP. The coinsurance rate refers to the percentage of health care costs for an individual, between the attachment point and the reinsurance cap, at which HHS will provide reinsurance payment to the carrier. The attachment point refers to the health care payment threshold for an individual, at which HHS will begin providing reinsurance payments to carriers ($90,000 in 2016), and the reinsurance cap refers to the health care payment threshold for an individual, at which HHS will stop providing reinsurance payments to carriers ($250,000 in 2016). The reinsurance funding parameters are illustrated in **Exhibit 6**.

Exhibit 6
Reinsurance Payment Parameters
Calendar 2016



Source: Maryland Health Benefit Exchange

For calendar 2016, Maryland will continue to supplement the coinsurance rate, increasing it to 80%. The calendar 2016 costs will be funded from the remaining MHIP fund balance in the fiscal 2018 budget. Any continuation of a transitional reinsurance program beyond calendar 2016 will likely require dedicated funding as the MHIP fund balance will be exhausted. Legislation introduced in the 2016 session will repeal the current MHIP fund revenue source (a 0.3% hospital assessment). **Given the discontinuation of this dedicated funding stream, the agency should comment on efforts to ensure affordable premiums after funding for the reinsurance program ends.**

Nonpersonnel Operations

After significant efforts to ensure the success of the second and third open enrollment, nonpersonnel operational costs in fiscal 2017 are more reflective of the cost to maintain general operations, with fewer funds needed for technical enhancements. In fiscal 2017, the MHBE budget decreases by $7.0 million due to decreased operational costs, including:

- a reduction in the MHBE main operating program of $2.76 million including fulfillment support from Maximus of $500,000 due to sending more notifications through emails (consumers can now opt out of mail), $144,000 for call center overhead, $140,000 for a procurement consultant, and $167,877 for consumer and customer service staff training;

- a reduction of $1.8 million for the call center with total costs of $24.1 million;

- lower levels of grants to connector entities ($2.0 million);

- lower expenditures of $1.42 million for information technology (IT) operations including $200,000 for reductions in the Small Business Health Options Program (SHOP), $300,000 for reductions in the maintenance and operations contract (Deloitte Consulting in fiscal 2016), and $800,000 for a reduction due to fewer overall enhancements including dental and auto renewals;

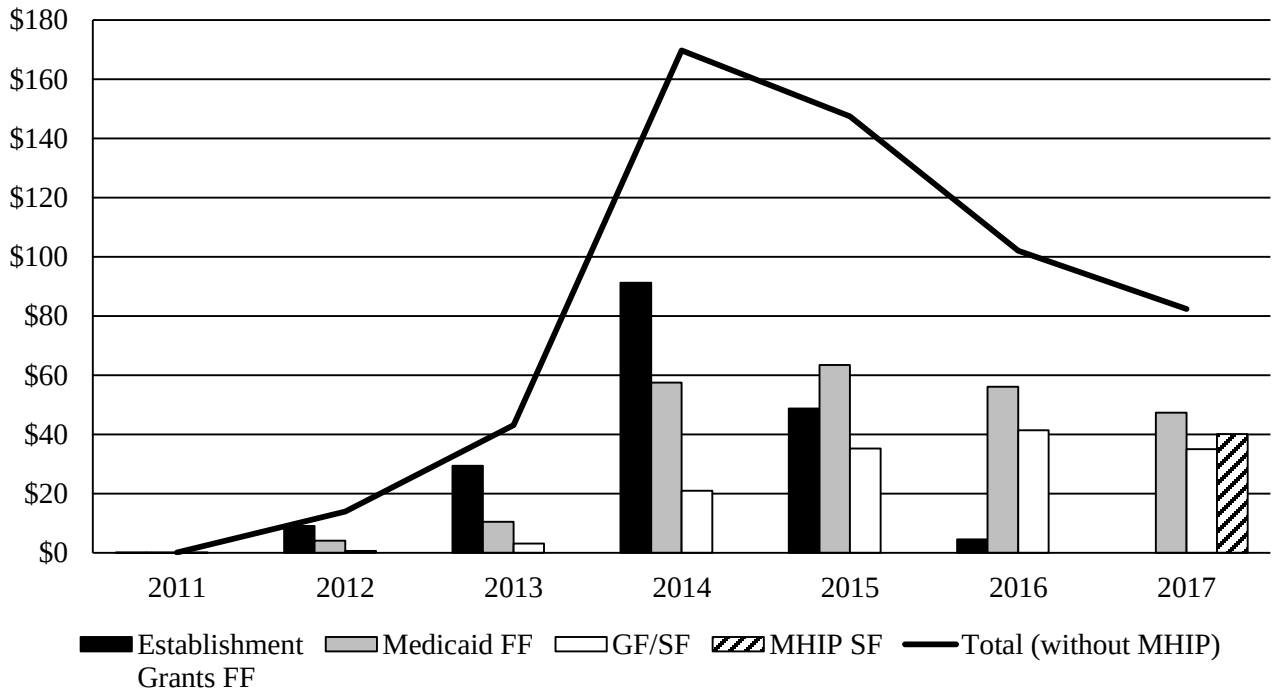
- a technical adjustment reflecting unprovided for fiscal 2015 legal services that were paid out of the fiscal 2016 budget ($0.7 million); and

- lower marketing costs from GMMB ($200,000) for printing.

Sources of Funding

Sources of funding for MHBE are shown in **Exhibit 7**. As shown in the exhibit, fiscal 2017 completes the transitions away from federal establishment grant funding, with State funding now more prominent.

Exhibit 7
Budget by Fund Source
Fiscal 2011-2017
($ in Millions)



FF: federal fund
GF: general fund
MHIP: Maryland Health Insurance Plan
SF: special fund

Source: Maryland Health Benefit Exchange; Department of Legislative Services

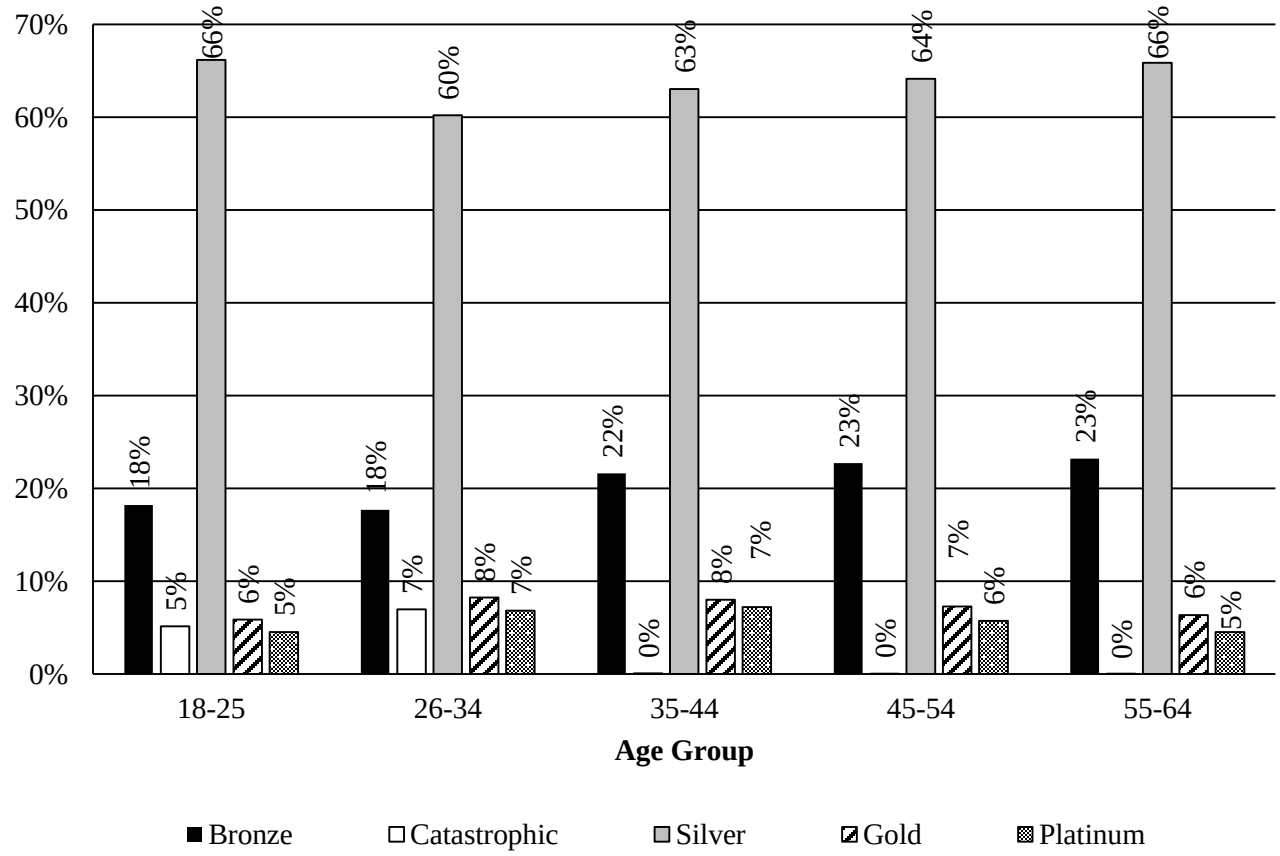
Current law mandates an annual appropriation of at least $35 million to the MHBE fund to support MHBE beginning in fiscal 2016. It should be noted that a requirement of state-run exchanges by the ACA was to be self-sufficient (have a dedicated funding stream) by 2015. The special funds devoted to MHBE are a diversion of revenues derived from a tax on all insurance premiums. The fiscal 2017 allowance includes that $35 million.

Issues

1. Health Care Affordability and Network Adequacy

In calendar 2015, 24% of the plans chosen through the exchange were high-deductible plans (catastrophic or Bronze). For consumers who do not think that they will widely utilize the plan, such as healthier, younger individuals, this may be an affordable option. However, older individuals are more likely to choose a bronze plan through the exchange than younger individuals as shown in **Exhibit 8.** This could be a result of younger consumers having relatively lower incomes, thereby qualifying them for cost-sharing reductions only available under silver plans (less than 250% of the FPL).

Exhibit 8
Enrollment by Metal Level
Calendar 2015



Source: Maryland Health Benefit Exchange; Department of Legislative Services

Metal Level Premiums and Affordability

The average monthly premium (before APTC) decreased for all metal levels in calendar 2015 from 2014, except catastrophic. The APTC is a federal subsidy available to individuals and families who earn less than 400% of the FPL to offset the cost of premiums. Although the average monthly metal level premium decreased, consumers are on average paying more because one carrier (BlueCross) captures a majority of the market (65%), despite having increased rates two years in a row (16% and 26%). Consumers may be choosing BlueCross because of the inability to find a provider from other carriers in their geographic region. One way insurers can reduce costs is by picking and choosing which providers to include in their networks. Carriers with narrow networks may pass these cost savings off to the consumer in the form of reduced premiums or provide increased benefits. However, consumers may not be aware that choosing a lower premium may reduce their ability to find a provider in their network. Additionally narrow-network providers may not be an option for consumers in all areas, leaving consumers with a reduced choice among plans. The issue of network adequacy can be of particular concern in areas with shortages of providers, such as rural areas. For calendar 2016, 17% of plans offered are narrow-network health maintenance organization (HMO) plans, up from 10% in calendar 2015. Currently, Evergreen and UnitedHealthcare offer narrow-network HMO plans.

Network Adequacy and Affordability

During the 2015 interim, the MHBE Standing Advisory Committee established a Network Adequacy and Essential Community Providers (ECP) Workgroup to develop policy options for provider network standards for QHPs. The workgroup reached consensus on seven policy options including that MHBE should work with stakeholders to analyze network adequacy using claims and encounter data; assess the number, capacity, and types of active providers; and educate consumers on how to find a provider and obtain relief when they cannot find a provider.

The ability to find a provider can directly affect the affordability of health care for a consumer. If there are not enough providers in network within their geographic region, a consumer may be forced to go out-of-network, incurring higher costs. A carrier may provide relief when a consumer cannot find a provider; however, consumers may not be aware that this relief is possible.

Improving the Accuracy of Provider Directories

An additional policy option was to improve the accuracy of provider directories including whether or not the provider is accepting new patients. For consumers trying to find a provider, inaccurate provider directories can be misleading. Consumers may choose a plan assuming that the providers on the carrier list are still in practice, accepting the carrier's insurance, and accepting new patients. If the list is inaccurate, they may be unable to access a nearby provider, or any provider at all with the carrier they chose.

Another issue discussed during the workgroup was whether or not the specialty of the provider should be listed. Regarding behavioral or mental health, providers often specialize in a particular area.

If this information is not listed, a consumer will have to contact multiple providers asking for their specialties before they can decide which insurance carrier to choose.

The workgroup was unable to reach consensus on policy options including broadening the definition of ECPs to include local health departments (LHD), certain behavioral health providers, and school-based health centers; and expanding the types of providers included in provider directories.

QHP Certification Standards for Fiscal 2017

The MHBE board considered these recommendations as it developed QHP certification standards for fiscal 2017. Every year carriers get the application timeline, procedures, and any new standards they should follow. The carrier has to submit an application, and each plan has to meet requirements if they want to be offered on the exchange. In December 2015, MHBE published its letter to issuers setting forth the proposal for the 2017 Carrier and Plan Certification Standards.

New for fiscal 2017 to assist consumers in assessing the issuer provider networks, issuers must report certain quantitative provider network metrics. These metrics will include the average wait time for primary care providers (PCP) and mental health (MH) providers, average drive distance to PCP and MH providers, percent of PCP and MH providers in network accepting new patients, consumer assessment of health care providers and systems scores, and additional metrics for any other specialist categories of the issuer's choosing optional.

To address provider directory accuracy, MHBE will use a multistep multi-year process starting in calendar 2016 as part of the 2017 plan year certification requirements. As part of its 2017 plan certification applications, the issuer will provide information to MHBE about the accuracy of the provider directory, including the carrier-selected method of assessment, the issuer's accuracy assessment and steps by the issuer taken to improve accuracy. During calendar 2016, MHBE will propose a standard assessment methodology, baseline target, and requirements for accuracy improvements to the MHBE board for adoption. In preparation for its 2018 plan certification applications, issuers will use the board-adopted standard assessment methodology in order to assess the accuracy of its provider directories. The issuer will include the assessment outputs in their 2018 application.

Beginning in calendar 2017, MHBE will include in the definition of an ECP, an LHD, an outpatient mental health center or substance use disorder treatment provider that is licensed or approved by the Department of Health and Mental Hygiene (DHMH) as program or facilities, or a school-based health center. All providers that fall in these categories must be able to meet the issuer's credentialing certification standards in order to be considered an ECP for that issuer.

Additionally, beginning in calendar 2017, the issuer must contract with at least 30% of available ECPs in each plan's service area as part of each plan's provider network. Issuers must offer contracts in good faith to any willing LHD in the plan's service area.

MHBE received comments and presented the final standards to the board on January 25, 2016, after which the board adopted final plan certification standards. MHBE will release a final 2017 Letter

to Exchange Issuers in early March 2016. **The agency should comment on whether or not they have set a specific deadline for the development of quantitative standards and what that deadline may be.**

2. Federal Audit Findings

In March 2015, the HHS Office of the Inspector General (OIG) issued a report that concluded that DHMH (which processes grant allocation and reimbursements on behalf of MHBE) did not allocate $28.4 million in costs to its establishment grants and Medicaid funds in accordance with federal requirements and its cost allocation plan. The audit recommended that MHBE refund the funds to the Centers for Medicare and Medicaid Services (CMS) and seek CMS approval to claim a portion of the funds through Medicaid, as well as immediately revise its cost allocation methodology and establish adequate controls to ensure proper allocation of costs. If CMS requires these funds to be returned or allows the claims to be resubmitted through Medicaid at a lesser reimbursement rate, additional State funds will be needed to cover these past costs. MHBE is in conversations with CMS. **The agency should comment on the potential payout of claims if CMS requires these funds to be returned.**

3. Settlement with IT Contractor

Following significant IT problems during the initial MHC rollout in October 2013, MHBE retrofitted the Connecticut exchange IT platform as a replacement system for the MHC second open enrollment period in 2014 at an MHBE-estimated cost of approximately $45 million. Fallout from the IT problems continued through 2015, including an investigation by HHS OIG, a financial settlement with the primary contractor on the initial IT system, and an audit report issued by the Office of Legislative Audits.

In July 2015, Noridian Healthcare Solutions, LLC agreed to pay the State $20.0 million upfront and an additional $25.0 million in annual installments of $5.0 million over five years to avoid legal action over its performance. The payments represent a recovery of 61% of the total amount paid to the company for the failed website development and launch in calendar 2013. The settlement is subject to federal approval. In December 2015, the contractor paid out $20.0 million. Of this amount, $14.4 million went to the federal government and the State General Fund received $5.6 million. The State will receive the same percentage (28% or $1.4 million) in each of the five years that the additional sum is paid. In total, the State should receive $12.6 million to the General Fund. The State is considering legal action against other vendors based on the failure of the original IT platform.

Recommended Actions

		Amount Reduction		Position Reduction
1.	Reduce 3 vacant positions. Two of these positions have never been filled. One has been vacant for longer than four months.	$ 205,889	SF	3.0
	Total Special Fund Reductions	**$ 205,889**		**3.0**

Updates

1. Progress Report on MHBE

The switch to a new IT platform (based on Connecticut's existing platform) has been generally successful. In addition, MHBE has made progress with regard to enrollment and carrier participation.

Initial Open Enrollment Period Marred by IT Problems

MHC went live on October 1, 2013, for individuals seeking coverage through the individual exchange. Problems almost immediately arose that prevented consumers from creating accounts and enrolling in coverage. While some consumers were ultimately successful in enrolling through the website or were assisted through the call center or consumer assisters, the IT system never worked as anticipated. The executive director of MHBE resigned, ties with the original IT contractor were severed, new consultants were hired, and the Secretary of Information Technology was put in charge of getting the IT system on track. Despite IT problems, MHBE enrolled 66,203 individuals into commercial plans during the initial open enrollment period.

Second Open Enrollment Period Generally Successful

Following the problems of the initial open enrollment period, MHBE weighed several options for the IT system. In April 2014, MHBE decided to upgrade to the Connecticut IT platform. This option allowed for rapid implementation of a proven IT solution, was feasible given the timeline for the upcoming 2014 open enrollment period, and maximized use of existing software licenses and hardware components. Development costs of $40 million to $50 million (from a combination of reallocated grant funds, Medicaid funds, and other State funds) were in line with the costs of the alternative of migrating to the federally facilitated marketplace and less than the cost of fixing the existing system.

All major milestones for the development of the new MHBE IT platform were completed on time, and the new platform went live with no issues at the start of the second open enrollment period on November 15, 2014. In fact, no major system issues were observed until the final week of open enrollment, when some users had difficulty accessing the system. These issues were relatively minor (particularly compared with the significant issues with the system in the last open enrollment period), but open enrollment was consequently extended from February 20 to February 28, 2015. The MHC website has since been reported to be functioning well.

Going forward, IT management responsibilities that had previously been handled by the Secretary of Information Technology will be handed off to the MHBE Project Management Office (PMO) as MHBE transitions from an implementation phase to an ongoing operations phase.

Third Open Enrollment Period

After a generally successful second open enrollment, the call center experienced high call volumes as Medicaid consumers who were initially provided enrollment through the State's CARES and HIX were directed to enroll through the new exchange eligibility system for continuation of coverage. This added pressure on the call center and resulted in longer wait times and higher abandonment rates for calls. In calendar 2017, call volume may be reduced if auto renewals increase as more consumers are in the new system and if broker support is leveraged.

Broker Assistance Transfer Program

To reduce pressure on the call center in the future, MHBE piloted the Broker Assistance Transfer (BAT) program to have licensed insurance brokers embedded in the call center prior to the start of open enrollment. This process works through phone software installed on a broker's computer. Brokers would log into the software, and the call center would set up a special queue in the software where brokers are waiting to assist consumers in selecting a QHP. After a customer service representative (CSR) determines a consumer's eligibility and offers the consumer help from a broker, the CSR dials the broker queue and begins a three-way call with the consumer, the CSR, and the broker. The CSR then hangs up, and the broker is still on the line with the consumer and helps the consumer with plan enrollment.

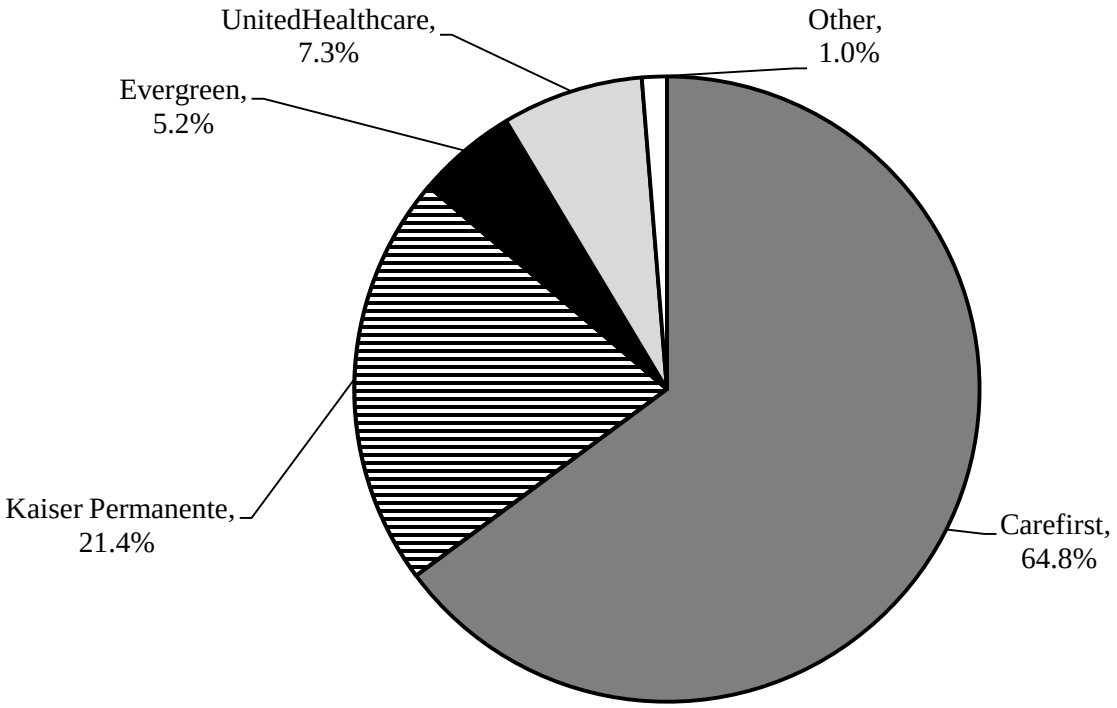
In selecting the brokers to participate in the pilot program, MHBE requires that the broker be located in Maryland, has experience with QHP enrollment, and is supportive of the program's goals. MHBE will also consider the broker's history of commitment to MHBE and the ACA and the amount of time the broker can commit to the program. The pilot project started out on a small scale, 25 brokers, and MHBE will compare statistics for enrollments with and without brokers to assess the program's effectiveness. If the BAT program is successful, it can be expanded to include other experts on the phone such as navigators, caseworkers, and SHOP administrators.

Progress in Enrollment and Carrier Participation

As of January 14, 2016, 364,711 individuals had enrolled during the current enrollment period, with 81,592 individuals enrolled in commercial plans, and 289,119 individuals enrolled in Medicaid. (This includes Medicaid redeterminations, which are made on a rolling basis throughout the year.) This brings total enrollment to 962,887, 800,192 of which are Medicaid.

In fiscal 2016, Marylanders enrolling in commercial plans were able to select from 53 unique health plans offered by five partner carriers. Enrollment by carrier is shown in **Exhibit 9**. As of January 14, 2016, a significant majority of enrollees, 65%, are enrolled in CareFirst. However, this represents a more diverse market than the prior years, 79% of enrollees were enrolled in CareFirst in 2015 and 90% in 2014. MHBE attributes this change to the changes made by carriers to the different plans they offer. MHBE also rolled out "anonymous browsing," allowing consumers to shop plans prior to creating an account.

Exhibit 9
Enrollment by Carrier
January 14, 2016



Source: Maryland Health Benefit Exchange; Department of Legislative Services

MHBE, in conjunction with MHCC, produced a rating system in the MHC *Quality Report* 2015, which summarized quality and performance information on the QHPs offered. Each carrier's star-rating score (out of five stars) is displayed to consumers during plan shopping. All carriers participating in the marketplace, except for All-Savers Insurance Company and Evergreen Health Cooperative, received a star-rating score.

In fiscal 2016, MHBE added Stand-Alone Dental Plans (SADP). Consumers may enroll in health and dental coverage at the same time. MHBE offers family and child-only dental plans – 18 plans in all from six participating dental insurers. As of January 14, 2016, 4,122 individuals were enrolled in a SADP while others enrolled in dental coverage in conjunction with a private health plan. Almost half of consumers (44%) enrolled in a SADP from carrier Dominion Dental, and 21% enrolled in CareFirst.

Average premium rate changes from calendar 2015 to 2016 range from a decline of 14% for Kaiser Permanente to an increase of 26% for CareFirst and Group Hospitalization and Medical Services, Inc. Premium rates vary according to age, geographic region, and the metal level of the health plan (the percentage of medical costs paid by the health plan, compared with the percentage paid by the consumer). Plan levels offered range from catastrophic to bronze, silver, gold, and platinum.

Status of the Small Business Health Options Program Exchange

Due to IT problems in the initial enrollment period, the SHOP Exchange for small businesses was delayed, though small businesses have gained access to a federal tax credit through authorized SHOP Exchange brokers. The Hilltop Institute at the University of Maryland Baltimore County had projected that more than 8,000 employees of small businesses would enroll in the first year; however, in calendar 2014, only 42 small employers with about 250 employees were enrolled in the SHOP Exchange, through a paper-based process. Enrollment in other states has also been reported to be low.

However, MHBE approved a three-phase plan to implement a more robust SHOP Exchange, which will function in partnership with selected third-party administrators. In August 2014, the MHBE board selected Kelly Services, Group Benefit Services, and Benefit Mall to implement the SHOP Exchange over the next two years. These third-party administrators launched phase two of the three-phase implementation in January 2015. This phase involved extending existing platforms to allow employers and employees to access their enrollment application, census, and account information through a website.

Six carriers offer plans through the MHC small business exchange. In August 2015, the employee choice option became available where employers can select from two "choice" options. In the employer choice option, the employer picks one insurance company on the SHOP, and employees can choose any plan offered by that insurer. In the employee choice option, the employer picks the metal level that will be open to employees. Employees can then choose a plan at that metal level from any insurer on the exchange. As of January 14, 2016, 122 groups had enrolled, covering 785 employees. SHOP enrollment may see less growth in calendar 2016 than anticipated due to the change in definition of small employer in October 2015 to not more than 50 employees. Beginning on or after January 1, 2016, small employers will be those that during the previous calendar year employed an average of not more than 50 employees.

2. Report on Connector Entities

Due to concerns over lower than expected enrollment, the 2015 *Joint Chairmen's Report* (JCR) requested an update on the role of, and expectations for, connector entities in shaping enrollment, including how the role of connector entities is expected to evolve. The ACA requires exchanges to develop navigator programs and fund them through grants and offers a broad outline of the funding requirements, eligibility criteria, duties and standards, while still leaving states significant flexibility in designing their own programs.

MHBE developed the Maryland Connector Program, which is organized geographically to provide outreach and enrollment services by region employing both certified navigators and noncertified staff. The goal of the Connector Program was to provide effective, local outreach and enrollment services to individuals who did not have insurance and who would be more inclined to receive information and seek assistance within their own community. The Connector Program targets vulnerable and hard to reach populations including consumers with limited English proficiency, those with limited education, individuals who live in especially remote or rural areas, and older (non-Medicare adults), as these groups are less likely to apply online without assistance.

The connector entity is responsible for organizing all partners and services across the region and provides a single point of responsibility for engagement with MHBE and the Maryland Insurance Administration. The Connector Program includes navigators, application counselor sponsoring entities (ACSE), authorized producers, and agency partner caseworkers. Navigators are tasked with conducting public education, distributing fair, accurate, and impartial information about enrollment into health plans and the availability of tax credits, facilitating enrollment in health plans, providing referrals to applicable agencies for enrollees with grievances, complaints, or questions, providing information in a culturally linguistically appropriate manner and maintaining expertise in eligibility, enrollment, and specifications for insurance and affordability programs including financial assistance for QHPs and Medicaid Programs.

In addition to navigators, the ACSE program assists consumers with trained counselors who are certified by MHBE and sponsored by community-based organization, health care providers, units of State or local government, and other entities authorize by MHBE. The number of ACSEs increased from 29 to 53 in the last year, and the number of certified application counselors (CAC) increased from 140 to 253. MHBE provides training for CACs but does not provide any other financial support to the ACSEs or CACs. CACs only have access to the consumer facing portal, not the "worker" portal, so they may not be able to handle more complex issues.

Authorized producers, or insurance brokers, enroll individuals in QHPs and are the acknowledged experts in the private carrier market. MHBE has been increasing engagement with brokers and instituted a pilot project with the call center that allows real-time phone transfer of QHP-eligible consumers to producers for plan shopping and selection. MHBE had 1,123 authorized producers as of September 30, 2015, and 27,555 people were enrolled in QHPs by producers from January 1 to September 30, 2015. Authorized producers, however, are not always well trained on Medicaid issues, and there is no compensation arrangement for Medicaid enrollments.

Caseworkers in LHDs and local departments of social services (LDSS) have participated in MHC training and have participated in the process of transferring cases from the legacy CARES system to MHC. Caseworkers cannot assist consumers with QHP enrollment, but they are State experts in Medicaid eligibility and enrollment and also perform behind-the-scene tasks such as verifying documents and solving inter-system glitches between MHC and the Medicaid Management Information System (MMIS).

During the first year of enrollment, before the ASCE program was implemented and with less emphasis on producers, the Connector Program staff were the primary in-person resource for consumers along with local agencies. Due to technical challenges, the Connector Program staff had to

shift focus from outreach activities to becoming technical experts to help consumers navigate the challenging system. When open enrollment ended, the staff learned a new system for the second open enrollment period, and many received more extensive training on eligibility rules, cultural competence, and strategies for teaching health literacy. During the second year of open enrollment, navigators were able to use the worker portals instead of only consumer portals as in the first open enrollment. Navigators also helped local agencies move Medicaid enrollees at redetermination from two systems, CARES and the HIX, to another (HBX).

According to the report, residents need continuing in-person assistance with maintaining and renewing coverage, post-enrollment issues, reporting changes, enrolling outside of open enrollment during special enrollment periods, and churning between insurance affordability programs. Although brokers can assist QHPs and LHDs with Medicaid enrollment, navigators can provide education and enrollment assistance across all insurance affordability programs offered through the exchange and can help consumers with post-enrollment billing questions and issues. As more of the uninsured enroll, the hardest to reach populations will be left and will be more difficult to find, educate, and enroll. These challenges are especially significant in rural areas – where low population density, lack of public transportation, and a smaller number of health care providers contribute to decreasing consumer motivation to seek coverage.

The Connector Program can act as regional hubs to MHBE: expanding the number of ACSEs and CACs; integrating producers into QHP enrollment opportunities; providing technical assistance with complex cases to the producers and CACs in their region through a dedicated hotline; handling additional application processing responsibilities through expanded user roles in the system; acting as a coordinator for communication between consumer-facing staff and MHBE policy and operations staff contributing to marketing and communication ideas with local knowledge to expand community awareness; identifying and implementing training needs; and improving health literacy. The ACSEs and CACs will become an increasingly important part of the consumer assistance program, and the report notes that it will be important to have a strong Memorandum of Understanding in place that defines the interaction between their respective staff and LHD and LDSS caseworkers and the roles and responsibilities of each State agency – the Department of Human Resources (DHR), DHMH, and MHBE – especially in the administration of Medicaid programs.

3. Report on System Integration

Due to concerns about the lack of the single point-of-entry for benefits determinations that had been the long-term goal promised of the exchange, the budget committees included narrative in the 2015 JCR requesting a report detailing plans to move toward this system. A report was submitted by MHBE on December 3, 2015.

In the report, MHBE provides a summary of the savings and benefits to Marylanders of integrating the State's eligibility and enrollment systems and processes into a single point-of-entry and an approach, which could be employed if the decision were to be made to move forward with integration. The report identifies redundancies in operating three separate IT systems through DHR,

DHMH and MHBE which all have separate hosting, maintenance and operations, and development contracts.

The new MHBE IT system, mirroring the Connecticut model, does not offer the level of functionality – particularly with regard to Medicaid enrollment – that had been promised of the original MHBE system. There is still no ability to convert income and other data from CARES to the new MHBE platform, so modified adjusted gross income (MAGI)-eligible enrollees who initially enrolled through CARES are still applying through the new MHBE platform. Furthermore, because the new MHBE IT platform was not designed to handle non-MAGI-based determinations, eligibility for non-MAGI-eligible groups will continue to be determined through CARES. Thus, the system remains fractured. While MHBE is able to determine eligibility for Medicaid based on MAGI levels, DHMH and DHR continue to administer the other health and social services programs provided by the State which include non-MAGI Medicaid, the Food Supplement Program (FSP), Temporary Cash Assistance (TCA), and the Maryland Energy Assistance Program (MEAP). Currently, a worker needs to submit applications in different systems based on the benefit that the citizen is looking for and needs to verify the same document twice if the citizen is applying for multiple programs across the system. There are separate call centers and business operations based on the agency. Additionally, enrolling into Medicaid is a multi-step process, and it takes approximately five to seven weeks to complete the enrollment.

The report cites opportunity for administrative simplification through streamlining call centers, creating an online environment with a narrower network of in-person support, and supporting on-the-ground private-sector resources rather than sustaining State personnel offices. This would create a shared infrastructure that would integrate eligibility and enrollment, case management, client information systems, and provider/plan management. This simplification could include a single streamlined application for intake of all health and human services programs, a single streamlined application for document verifications and an opportunity to use the HBX consumer portal to enroll in non-MAGI Medicaid or other social services programs. The report notes that moving to an integrated platform must also be accompanied by a corresponding effort to streamline, coordinate, and align agencies' operations in order to increase efficiencies and decrease costs.

The report then lays out the phases in which the system integration could be accomplished. Phase I would include enhancements to the current system such as retroactive Medicaid, managed care organization online plan selection, Medicaid age out and postpartum, client information system interface and eligibility status check with MMIS, establishing direct interface of Medicaid transactions with MMIS, and the Enterprise Content Management System integration. These activities are estimated to take approximately 10 to 12 months to complete. The report suggests a planning session with DHR and DHMH to devise a strategy as well as discussions with relevant stakeholders before moving forward with subsequent phases.

Following this planning session, the report cites Phase II with the goal of streamlining and consolidating data collection and determining eligibility and enrollment for all health insurance applicants under MAGI or non-MAGI guidelines (in addition to targeting the conversion of existing eligibility and enrollment information of the non-MAGI population to HBX). The estimated duration of Phase II is approximately 18 to 20 months.

Phase III would integrate data collection and real time eligibility determination for FSP cash (TCA) and MEAP applications with an estimated duration of 12 to 14 months. Phase IV would integrate data collection and real time eligibility determination for the remaining social service applications Children's Electronic Social Services Information Exchange System and Child Support Enforcement System with an estimated duration time of 12 to 16 months.

The report concludes that the four agencies involved must first undertake a collaborative, comprehensive planning process that must address all components of a successful integration effort, including project governance, IT development, business processing, and funding.

The federal government has extended enhanced funding (90% Federal Medicaid Assistance Percentage) for system integration for an additional two years.

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 2015					
Legislative Appropriation	$15,514	$90,938	$43,584	$0	$150,037
Deficiency Appropriation	5,524	0	0	0	5,524
Cost Containment	-310	0	0	0	-310
Budget Amendments	0	33	85,259	0	85,292
Reversions and Cancellations	0	-45,036	-18,628	0	-63,664
Actual Expenditures	**$20,727**	**$45,935**	**$110,216**	**$0**	**$176,879**
Fiscal 2016					
Legislative Appropriation	$0	$36,592	$42,838	$0	$79,430
Budget Amendments	0	65	11,565	0	11,630
Working Appropriation	**$0**	**$36,657**	**$54,403**	**$0**	**$91,060**

Note: The fiscal 2015 appropriation excludes nonbudgeted funds. The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

The fiscal 2015 budget for MHBE closed $26.8 million above the legislative appropriation. A deficiency appropriation increased general funds by $5,523,727 to supplement existing funding for the call center ($2.0 million), retain outside legal counsel ($1.2 million), and funds the contract with Deloitte Consulting to build the new IT system ($2.3 million).

Cost containment reduced the legislative appropriation for MHBE by $310,277 in general funds to realign the 2 % cost containment between agencies. Funding for website and IT enhancements were reduced by this amount.

Budget amendments increased the fiscal 2015 legislative appropriation for MHBE by $85.3 million including $85.26 million in federal funds and $26,000 in special funds. Of this amount, $59,761 ($33,161 in special funds and $26,585 in federal funds) reflects the fiscal 2015 cost-of-living adjustment approved during the 2014 session but not included in the fiscal 2015 allowance. One budget amendment increases the federal fund appropriation for MHBE by $85.2 million to supplement funding for IT contractual services and various operating costs.

IT contractual services ($52.1 million) make up the bulk of new spending and represent costs associated with:

- the design, development, and implementation (by Deloitte Consulting) of the new MHBE IT system, which will replace the faulty, original MHBE system;

- oversight through a PMO contract, which continues to be necessary due to the transition between systems: and

- operating costs ($33.1 million) make up the remainder of new spending and include:

    - call center contractual services ($20.9 million), which includes additional staff and costs associated with moving the call center to a new location;

    - connector entities ($4.2 million), which includes additional staff;

    - IT contractor operational support ($3.3 million), which includes costs related to the transition between systems (including workarounds);

    - advertising ($1.3 million); and

    - other operational support ($3.4 million).

Cancellations totaled $18.6 million in federal funds and $45.0 million in special funds. Of this amount, $16.5 million in federal funds represents federal funds that could not be encumbered due to

the unavailability of State matching funds for MHBE and $47.0 million ($45.0 million in special funds and $2.0 million in federal funds) were cancelled due to overestimates of program spending for MHIP.

Fiscal 2016

To date, the fiscal 2016 legislative appropriation for MHBE has been increased by $11.6 million. Of this amount, $65,000 in special funds reflects the restoration of the 2% pay reduction. Another budget amendment increased federal funds by $11.6 million to cover the cost of call center activities ($8.1 million), Medicaid related activities ($3.2 million), a procurement consultant ($130,000), and an assessment study ($190,000).

Appendix 2

Audit Findings

Audit Period for Last Audit:	June 1, 2011 – July 23, 2014
Issue Date:	October 2015
Number of Findings:	10
Number of Repeat Findings:	0
% of Repeat Findings:	%
Rating: (if applicable)	n/a

Finding 1: MHBE procurement policy was not followed for certain contracts and MHBE did not always retain relevant procurement documentation.

Finding 2: Certain payments for contractual services were made without sufficient support or documented review.

Finding 3: Grant expenditures for the Connector Program were not verified for propriety.

Finding 4: Federal fund reimbursement requests were not made in a timely manner.

Finding 5: MHBE did not accurately maintain control and detail records or properly account for all of its equipment.

Finding 6: The Board of Trustees of the exchange violated the Open Meetings Act.

Finding 7: Personally identifiable information was not appropriately safeguarded.

Finding 8: Administrative access to the MHBE network was excessive and not properly restricted.

Finding 9: MHBE lacked assurance that critical data on contractor servers were properly secured.

Finding 10: MHBE network was not properly secured.

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

Object/Fund Difference Report
Maryland Health Benefit Exchange

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	76.00	74.00	69.00	-5.00	-6.8%
02 Contractual	0.00	1.00	0.00	-1.00	-100.0%
Total Positions	**76.00**	**75.00**	**69.00**	**-6.00**	**-8.0%**
Objects					
01 Salaries and Wages	$ 6,360,374	$ 8,089,077	$ 7,704,023	-$ 385,054	-4.8%
02 Technical and Spec. Fees	631	0	59,172	59,172	N/A
03 Communication	288,374	194,973	75,988	-118,985	-61.0%
04 Travel	33,336	32,598	23,897	-8,701	-26.7%
07 Motor Vehicles	3,896	4,016	0	-4,016	-100.0%
08 Contractual Services	174,825,462	69,880,689	103,801,804	33,921,115	48.5%
09 Supplies and Materials	81,234	77,284	44,346	-32,938	-42.6%
11 Equipment – Additional	130,470	2,008	6,900	4,892	243.6%
12 Grants, Subsidies, and Contributions	18,042,859	12,000,000	10,000,000	-2,000,000	-16.7%
13 Fixed Charges	794,660	779,566	749,594	-29,972	-3.8%
Total Objects	**$ 200,561,296**	**$ 91,060,211**	**$ 122,465,724**	**$ 31,405,513**	**34.5%**
Funds					
01 General Fund	$ 20,727,332	$ 0	$ 0	$ 0	0.0%
03 Special Fund	45,935,397	36,657,070	75,090,000	38,432,930	104.8%
05 Federal Fund	110,216,140	54,403,141	47,375,724	-7,027,417	-12.9%
07 Nonbudgeted Fund	23,682,427	0	0	0	0.0%
Total Funds	**$ 200,561,296**	**$ 91,060,211**	**$ 122,465,724**	**$ 31,405,513**	**34.5%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
Maryland Health Benefit Exchange

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Maryland Health Benefit Exchange	$ 62,844,755	$ 56,208,073	$ 50,837,730	-$ 5,370,343	-9.6%
02 Major Information Technology Development Projects	83,032,778	32,962,449	31,537,994	-1,424,455	-4.3%
03 Maryland Health Insurance Program	0	0	40,090,000	40,090,000	0%
01 Maryland Health Insurance Program	54,683,763	1,889,689	0	-1,889,689	-100.0%
Total Expenditures	**$ 200,561,296**	**$ 91,060,211**	**$ 122,465,724**	**$ 31,405,513**	**34.5%**
General Fund	$ 20,727,332	$ 0	$ 0	$ 0	0.0%
Special Fund	45,935,397	36,657,070	75,090,000	38,432,930	104.8%
Federal Fund	110,216,140	54,403,141	47,375,724	-7,027,417	-12.9%
Nonbudgeted Fund	23,682,427	0	0	0	0.0%
Total Appropriations	**$ 200,561,296**	**$ 91,060,211**	**$ 122,465,724**	**$ 31,405,513**	**34.5%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.