SB 530

Department of Legislative Services

Maryland General Assembly
2006 Session

FISCAL AND POLICY NOTE

Senate Bill 530 (Senator Pipkin)
Finance

Consumer Health Open Insurance Coverage Act of 2006

This bill creates the Maryland Health Insurance Exchange within the Maryland Health Care Commission (MHCC). The purpose of the exchange is to provide a choice of health insurance plans to participating individuals and employer groups.

The bill takes effect July 1, 2006. The provisions mandating enrollment in the exchange take effect July 1, 2007.

Fiscal Summary

State Effect: General fund revenues could decrease by $171 million in FY 2008 from the tax credit. MHCC special fund expenditures and revenues for the exchange could each increase by $60 million in FY 2008. Maryland Health Insurance Plan (MHIP) special fund expenditures could decrease by $43.3 million in FY 2008 from the abolition of the high-risk pool. State Employee and Retiree Health and Welfare Benefits Program expenditures may increase or decrease by a significant amount, beginning in FY 2008. Future year estimates reflect inflation.

($ in millions)	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
GF Revenue	$0	($171.0)	($172.7)	($174.4)	($176.2)
SF Revenue	0	60.0	60.6	61.2	61.8
SF Expenditure	0	16.7	12.5	7.9	2.6
GF/SF/FF Exp.	0	-	-	-	-
Net Effect	$0	($127.7)	($124.7)	($121.1)	($117.0)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: Meaningful. Rates for small business employees could either increase or decrease based on the differences between current community rates for small groups and the new community rates under the exchange.

Analysis

Bill Summary: The exchange replaces health insurance coverage currently offered in the small group and individual markets. In addition, larger employers (51 plus employees) could participate in the exchange or continue to self-fund or purchase group coverage.

The Exchange: The exchange director must develop and administer a program that will offer all eligible individuals the opportunity to purchase a health benefit plan through the exchange. The exchange is responsible for providing descriptions of the coverage, benefits, limitations, copayments, and premiums for all participating plans. It must collect and transmit to the participating plans all premium payments or contributions made by participating individuals or employers. The exchange director must publicize the existence of the exchange and disseminate information on eligibility requirements and enrollment procedures.

An individual is eligible to receive health benefits through the exchange if the person is: (1) a State resident; (2) employed at least 20 hours a week in the State and the individual's employer does not offer group health insurance; (3) enrolled in or eligible to enroll in a participating employer-subsidized plan; (4) self-employed and the principal place of business is in the State; (5) a full-time student attending an institution in the State; or (6) a qualified dependent of an individual who is eligible to participate in the exchange.

Any individual may apply directly to the exchange to enroll as a participating individual. If an employer participates in the exchange, an individual enrolled in the participating employer-subsidized plan is automatically enrolled in the exchange. A qualified dependent of a participating individual is also a participating individual. A membership organization, including a labor union, a professional organization, a trade association, or a civic association may apply to the exchange on behalf of its members seeking enrollment in the exchange.

The exchange must establish and collect fees from participating individuals, participating plans, and participating employer-subsidized plans sufficient to fund the costs of administering the exchange. The accounts of the exchange are special fund accounts and the money in the accounts are not part of the general fund of the State. The State may not provide general fund appropriations to the exchange. The exchange must pay certain

commission fees to insurance brokers who refer individuals for participation in the exchange.

The bill provides requirements and limitations on health benefit plans offered through the exchange regarding rate setting, continuation coverage, creditable coverage, waiting periods, and coverage exclusions.

The exchange must offer to participating individuals only health benefits plans that have been certified by the Insurance Commissioner as eligible to be offered through the exchange. For each plan year, the exchange must offer plans that: (1) agree to abide by the rules governing plan participation; and (2) have been certified by the Insurance Commissioner as eligible.

Every employer in the State must file annually with MHCC a form for each employee indicating (1) the health insurance coverage status of the employee and the employee's dependents; (2) if the employee or a dependent is not covered by a health insurance plan, whether the employee has elected to become a participating individual in the exchange; and (3) whether the employee has elected to be considered for eligibility under any publicly-financed health insurance program or premium subsidy program administered by the State. MHCC must transmit copies of all forms to the appropriate department or agency to facilitate eligibility determination and enrollment.

The exchange must establish and administer at least one service center, which must provide information on the exchange and health benefit plans offered through the exchange to applicants.

Small Group Health Insurance Market: This bill repeals the current regulatory scheme of the small group health insurance market by the Maryland Insurance Administration (MIA). A health insurer, nonprofit health service plan, or HMO (carrier) may not issue or renew a group health benefit plan to a small employer, other than through the exchange, after the first day of the plan year following the first regular open season conducted by the exchange. A carrier may offer a health benefit plan through the exchange if: (1) the plan includes specified benefits including hospital, surgical, in-hospital medical, ambulatory, prescription drug, and mental health and substance abuse treatment benefits; and (2) the plan provides a detailed description to potential enrollees of the specified benefits offered, including any maximums, exclusions, copayment requirements, or other benefit limitations. A carrier may not offer a health benefit plan through the exchange unless the Insurance Commissioner has first certified to the exchange that: (1) the carrier is licensed to issue health insurance in Maryland and is in good standing with MIA; (2) the plan meets the rate setting and benefits requirements; and (3) the plan and the carrier are in compliance with all other applicable insurance laws. The Insurance Commissioner may not certify any plan that excludes individuals

from coverage who are otherwise determined by the exchange to meet eligibility requirements. Certification is valid for at least one year, but may be made automatically renewable. The Insurance Commissioner may elect not to renew the certification.

Non-group Market: A carrier may not issue or renew an individual health benefit plan other than through the exchange.

State Employee and Retiree Health and Welfare Benefits Program: The Department of Budget and Management (DBM) must contract with the exchange for the exchange to provide health insurance benefits to all individuals eligible for the State Employee and Retiree Health and Welfare Benefits Program (State plan). State plan enrollees who are Medicare-eligible are not required to enroll and receive benefits in the exchange.

Tax Credit: An individual may claim a credit against the State income tax in an amount equal to 100% of the eligible health insurance premiums paid by the individual, if the individual (and spouse and dependent children if applicable) is covered by health insurance purchased through the exchange for at least six months of the taxable year and on December 31 of the taxable year. The tax credit may not exceed $500 for one insured individual or $1,000 for two or more individuals.

Maryland Health Insurance Risk Transfer Pool: Insurance Commissioner must establish the Maryland Health Insurance Risk Transfer Pool. The pool must be operational and may reinsure claims on or after July 1, 2007. The Commissioner must require participation in the pool by all carriers issuing health benefit plans in the State. With approval of the Commissioner, the pool may enter into an agreement with a self-funded health benefit plan to permit the plan to be a reinsuring carrier for all primary insureds covered by the plan who are State residents or employed in the State, and their covered dependents.

The reinsuring carriers must elect a board of directors, and the board must appoint an executive director. The board must establish a methodology to determine premium rates to be charged by the pool to reinsure individuals and employer groups. The pool must manage and invest all monies collected by or on behalf of the pool through premium charges, assessments, earnings from investments, or otherwise, through a financial management committee. All pool operating expenses must be paid from funds collected by or on behalf of the pool. The pool account is a special fund account and the monies in the account are not part of the general fund of the State.

Maryland Health Insurance Plan: MHIP may not accept any new enrollees on or after the first day of the plan year following the first open season conducted by the exchange. Individuals who remain enrolled in MHIP may continue coverage until the first day of the plan year following the third regular open season conducted by the exchange.

Current Law:

Small Group Market: The Comprehensive Standard Health Benefit Plan (CSHBP) is a standard health benefit package (standard plan) that carriers must sell to small businesses (2-50 employees). Carriers must offer the standard plan to all small businesses, but may sell additional benefits or enhancements through riders. Any riders must be offered and priced separately. CSHBP includes guaranteed issuance and renewal, adjusted community rating with rate bands, and the elimination of preexisting condition limitations. In order to maintain affordability, the average CSHBP premium rate per employee must remain below 10% of Maryland's average annual wage. MIA and MHCC jointly regulate the small group market.

Individual Market: A carrier may sell a health benefit plan to an individual, subject to certain restrictions such as creditable coverage, preexisting conditions, and continuation coverage. A carrier may use medical underwriting in the individual market, which means some people may be medically ineligible to purchase health insurance in the individual market. MIA regulates the individual (non-group) market.

Maryland Health Insurance Plan: MHIP is an independent unit of MIA. Created in 2002 (Chapter 153 of 2002), this high-risk pool plan provides health insurance coverage to medically uninsurable individuals. MHIP is funded primarily by enrollee premiums and an assessment on each hospital's base rate. MHIP's fiscal 2007 budget allowance is $53 million, of which $14 million is earmarked for its Senior Prescription Drug Assistance Program.

State Revenues: General fund revenues could decrease by as much as $171 million in fiscal 2008 from the tax credit for individuals who have health insurance coverage. This estimate is based on the following facts and assumptions:

- 180,000 persons insured through the exchange are not part of a cafeteria plan health benefit plan;

- of these, 18,000 are individuals, eligible for the $500 credit; and

- 162,000 are individuals plus at least one dependent, eligible for the $1,000 credit.

Future year estimates reflect 1% increase in the number of individuals claiming the credit.

Exchange special fund revenues increase by $60 million, beginning in fiscal 2008, to cover the costs of administering the program. MHCC estimates about 900,000 covered lives would be enrolled in the exchange and would impose a participation fee of $66.70 per enrollee to exactly offset the estimated costs of the program. Future year estimates reflect 1% inflation.

State Expenditures:

Maryland Insurance Administration: Under the bill, MIA would no longer need to review small group or individual health benefit plans. Instead, it would be responsible for establishing a risk transfer pool and to certify health benefit plans that may participate in the exchange. These changes in duties could be handled with existing MIA budgeted resources.

Maryland Health Care Commission: MHCC states special fund expenditures and could increase by $60 million in fiscal 2008 to administer the exchange. This cost includes: (1) $24 million for a third party administrator to manage the exchange; (2) $14 million for systems support/administration; (3) $7 million for administering the reinsurance pool actuarial and support systems; and (4) $15 million for claims processing.

MHCC is assuming about 900,000 covered lives would enroll in the exchange, including (1) 250,000 covered lives from the State plan; (2) 192,000 from the individual market; (3) 451,000 from the small group market; and (4) 7,000 from MHIP. Based on this expected population size, expenditures would be $66.70 per enrollee. Future year estimates reflect 1% inflation in enrollment and operating costs.

State Plan: To the extent State plan enrollees are transferred to the exchange, State plan expenditures could increase or decrease, beginning in fiscal 2008. While the State plan would no longer administer specified benefits for enrollees that are transferred to the exchange, it is assumed that the State would continue to pay its subsidy, which is about 80% of total premiums. It is unknown whether premiums under the exchange would be more or less expensive than what the State pays now.

The State plan fiscal 2007 budget allowance is $893.1 million to provide health insurance and other health benefits coverage to 250,000 covered lives, and the employee benefits division has 41 full-time equivalent positions to administer the plan. Since Medicare-eligibles are not required to enroll in the exchange and the State plan offers other benefits such as flexible spending accounts and term life insurance, the employee benefits division would have to continue some operations for remaining enrollees.

State plan expenditures assume a fund mix of 60% general funds, 20% federal funds, and 20% special funds; with 20% of expenditures reimbursable through employee contributions.

Maryland Health Insurance Plan: MHIP special fund expenditures would decrease by about $43 million in fiscal 2008. MHIP's budget allowance for the high risk pool is about $39 million in fiscal 2007. Future year estimates reflect 11% health insurance inflation. It is assumed MHIP would continue to run the Senior Prescription Drug Assistance Program.

Medicaid and Maryland Children's Health Program: The exchange is responsible for making preliminary eligibility determinations on enrollees and other individuals it receives data on from employers to determine whether individuals are eligible for enrollment in other State health programs such as Medicaid or the Maryland Children's Health Program (MCHP). To the extent these referrals are made and individuals do enroll, Medicaid and MCHP expenditures could increase by a potentially significant amount, beginning in fiscal 2008.

Additional Information

Prior Introductions: None.

Cross File: HB 1416 (Delegate Smigiel) – Health and Government Operations.

Information Source(s): Department of Health and Mental Hygiene (Maryland Health Care Commission), Maryland Insurance Administration, Department of Budget and Management, Department of Legislative Services

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