HB 1068

Department of Legislative Services
Maryland General Assembly
2007 Session

FISCAL AND POLICY NOTE

House Bill 1068 (Delegate Eckardt, *et al.*)
Health and Government Operations

Consumer Health Open Insurance Coverage Act of 2007

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, 2007. The provisions mandating enrollment in the exchange take effect July 1, 2008.

Fiscal Summary

State Effect: General fund revenues could decrease by at least $157.2 million in FY 2009 from the tax credit. MHCC special fund expenditures and revenues for the exchange could each increase by $150,000 in FY 2008 to hire an executive director for the exchange and $60.1 million in FY 2009 to administer the exchange. Maryland Health Insurance Plan (MHIP) special fund expenditures could decrease by at least $18.4 million in FY 2009 from the prohibition on new enrollees. State Employee and Retiree Health and Welfare Benefits Program expenditures may increase or decrease by a significant amount beginning in FY 2009. Future year estimates reflect inflation.

($ in millions)	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
GF Revenue	$0	($157.2)	($158.7)	($160.3)	($161.9)
SF Revenue	.1	60.1	60.8	61.4	62.0
SF Expenditure	.1	41.7	41.6	41.4	41.2
Net Effect	$0	($138.7)	($139.5)	($140.3)	($141.1)

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. Larger employers (51 plus employees) could participate in the exchange or continue to self-fund or purchase group coverage. In addition, a substantial portion of Medicaid enrollees would be covered under the exchange.

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.

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 exchange's accounts are special funds and 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 that will 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.

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

Medicaid: Non-disabled individuals under the age of 65 currently covered through Medicaid would be covered through the exchange, as permitted by federal law or waiver. The Department of Health and Mental Hygiene (DHMH), in consultation with MHCC, must develop a system to charge appropriate premiums for Medicaid recipients on a sliding scale based on income. On or after July 1, 2008, DHMH may not apply for a waiver for the program or expand Medicaid unless the waiver or expansion is provided through the exchange.

State Employee and Retiree Health and Welfare Benefits Program: The Department of Budget and Management 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: The 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, 2008. Participation in the pool is required for 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 and its funds 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 only in accordance with any right the individual may have to continue coverage under the federal Health Insurance Portability and Accountability Act.

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. Riders must be offered and priced separately. CSHBP includes guaranteed issuance and renewal, adjusted community rating with rate bands, and no 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 (nongroup) market.

Medicaid: An adult may qualify for Medicaid if the adult is: (1) aged, blind, or disabled; (2) in a family where one parent is absent, disabled, unemployed, or underemployed; or (3) a pregnant woman. Adults must also have very low incomes to qualify for Medicaid (about 46% federal poverty guidelines (FPG)). The Maryland Children's Health Program (MCHP) covers children with family incomes up to 300% of FPG and pregnant women with incomes up to 250% FPG.

Federal law limits Medicaid premiums to families with incomes above 150% FPG and excludes pregnant women, the institutionalized, hospice participants, women who qualify

for Medicaid due to breast or cervical cancer, children in foster care, and infants with family incomes to 185% FPG.

Maryland Health Insurance Plan: MHIP is an independent unit of the Maryland Insurance Administration. Created by Chapter 153 of 2002, this high-risk pool plan provides health insurance coverage to medically uninsurable individuals. MHIP is funded by enrollee premiums and an assessment on each hospital's base rate.

State Revenues: General fund revenues could decrease by at least $157.2 million in fiscal 2009 from the tax credit for individuals who have health insurance coverage. This estimate is based on the following facts and assumptions:

- at least 192,000 persons insured through the exchange (those previously insured through the individual market) are not part of a cafeteria plan health benefit plan;

- of these, 19,200 are individuals, eligible for the $500 credit and would claim an average credit of $445; and

- 172,800 are individuals plus at least one dependent, eligible for the $1,000 credit and would claim an average credit of $860.

To the extent that additional individuals, beyond those previously insured in the individual market, are insured through the exchange and are not part of a cafeteria health benefit plan, State general fund revenues would further decline. 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 2009, to cover the costs of administering the program. MHCC estimates about 1.2 million covered lives would enroll in the exchange. MHCC would impose a participation fee 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 certifying 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 special fund expenditures would increase by $149,928 in fiscal 2008 to hire a grade ES 8 executive director to implement and maintain the exchange.

Salary and Fringe Benefits	$142,953
Other Operating Expenses	6,975
Total	**$149,928**

MHCC special fund expenditures could increase by $60.1 million in fiscal 2009 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; (4) $15 million for claims processing; and (5) personnel expenses.

Legislative Services assumes about 1.2 million covered lives would enroll in the exchange, including: (1) approximately 380,000 nonelderly, nondisabled individuals from Medicaid; (2) 250,000 covered lives from the State plan; (3) 192,000 from the individual market; (4) 451,000 from the small group market; and (5) as many as 10,000 from MHIP. 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 2009. 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 Governor's proposed fiscal 2008 budget includes $674.8 million for the State plan. An additional $160.0 to $200.0 million will also be spent from a nonbudgeted fund. The plan provides health benefits coverage to approximately 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 in fiscal 2009 depending on the number of MHIP enrollees who disenroll from the program due to attrition and the number that move from MHIP to the exchange. Due to the bill's guaranteed renewal provision, a portion of MHIP enrollees will remain in MHIP. This number cannot be reliably estimated at this time; however, the anticipated attrition resulting from the prohibition on new enrollees is known. According to MHIP, approximately 180 individuals disenroll each month, or about 2,160 members annually. This represents an estimated 21.7% decrease in enrollment in fiscal 2008. A proportionate decrease of $18.4 million in MHIP's fiscal 2009 budget is projected. The Governor's proposed fiscal 2008 budget for MHIP is $84.9 million. Future year estimates reflect 4.1% inflation for the MHIP program.

Medicaid and Maryland Children's Health Program: Legislative Services assumes that the benefit package for Medicaid enrollees covered under the exchange would remain the same and therefore would not significantly alter State spending on medical care for this population. However, the bill's requirement to charge appropriate premiums for Medicaid recipients on a sliding scale based on income could result in cost savings to the Medicaid program.

For illustrative purposes only, about 62,000 Medicaid and MCHP enrollees are eligible for a premium and more than 12,000 already pay premiums. Enrollees eligible for the premium are primarily MCHP children although a premium may also be collected from some adults who qualify for Medicaid by spending down their income. Extending premiums to all premium eligible Medicaid/MCHP enrollees could reduce enrollment by at least 10,000 people. Savings would be realized from both the reduction in participation and from the shift of costs from the State to families paying the premium. Total savings could be $18.7 million, with more than 60% of savings attributable to a decrease in participation and reduced projected enrollment growth.

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 MCHP. To the extent these referrals are made and individuals enroll, Medicaid and MCHP expenditures could increase by a potentially significant amount, beginning in fiscal 2009.

Additional Information

Prior Introductions: Substantially similar bills were introduced in the 2006 session as SB 530 and HB 1416. The bills received unfavorable reports from the Senate Finance Committee and House Health and Government Operations Committee, respectively.

Cross File: SB 617 (Senator Pipkin, *et al.*) – Finance and Budget and Taxation.

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

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