Department of Legislative Services

Maryland General Assembly
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FISCAL AND POLICY NOTE

Senate Bill 107 (Senator Astle)
Finance

Health Benefit Exchanges - Establishment and Operation

This bill imposes requirements for the establishment and operation of any health insurance exchange in the State. The bill requires an exchange to be a nonprofit entity and prohibits it from being established as a governmental agency. The primary purpose of an exchange must be securing health care coverage for uninsured individuals. The cost of establishing and operating an exchange must be borne without any public funding, except specified grants, and without an assessment or user fee on persons that do not use the exchange.

The bill takes effect July 1, 2011.

Fiscal Summary

State Effect: The bill's reporting requirement can be handled within existing budgeted resources.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: An exchange must focus its efforts on carrying out the exchange functions established under federal health care reform law including facilitating the purchase and sale of qualified health benefit plans (QHPs) in the individual market and assisting qualified small employers in facilitating the enrollment of their employees in QHPs offered in the small group market. The bill prohibits an exchange from taking on

functions or providing products or services that are not related to carrying out essential exchange functions or soliciting business from individuals and small employers that already participate in the individual or small group market outside of the exchange.

The Maryland Insurance Commissioner must examine the duties of persons employed by, under contract with, or otherwise acting on behalf of an exchange that relate to the sale, solicitation, or negotiation of health insurance and ensure appropriate regulation of such persons, including requiring a person to be licensed as an insurance producer, if appropriate.

Uncodified language requires the Insurance Commissioner and the Secretary of Health and Mental Hygiene to conduct a study to (1) determine how the State may best utilize private-sector resources, including third-party administrators and similar entities, to establish an efficient and effective exchange that meets the requirements of federal health care reform law; and (2) examine the potential effects that an exchange may have on the employment of insurance producers. The study's findings and recommendations must be submitted to the Governor and the General Assembly by January 1, 2013.

Current Law: None.

Background:

Federal Health Care Reform – the Affordable Care Act: In March 2010, major federal health care reform legislation, the Patient Protection and Affordable Care Act (ACA), was enacted to expand health care coverage, control health care costs, and improve the health care delivery system. Under ACA, each state must establish a health benefit exchange that facilitates the individual purchase of QHPs. Initial structure and governance must be established by March 23, 2012. If a state fails to act, the federal government will step in to establish an exchange by January 1, 2013. By January 1, 2014, exchanges must become operational and offer consumers a choice of plans, establish common rules regarding the offering and pricing of plans, and provide information to help consumers better understand the coverage options available to them. By January 1, 2015, exchanges must be financially self-sustaining. ACA requires that an exchange perform the following core functions:

- certification, recertification, and decertification of plans;
- operation of a toll-free hotline;
- maintenance of a website for providing information on plans to current and prospective enrollees;
- assignment of a price and quality rating to plans;
- presentation of plan benefit options in a standardized format;

- provision of information on Medicaid and Children's Health Insurance Program eligibility and determination of eligibility for individuals in these programs;
- provision of an electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions;
- certification of individuals exempt from the individual responsibility requirement;
- provision of information on certain individuals and to employers; and
- establishment of a Navigator program that provides grants to entities assisting consumers.

Additional functions required of the exchange include presentation of enrollee satisfaction survey results, provision of open enrollment periods, consultation with stakeholders, and publication of data on the administrative costs of the exchange.

While federal law and regulations define many elements, each state may design significant aspects of the operation and financing of its exchange. States must determine:

- governance and operation of the exchange (must be run by a government agency or a nonprofit entity);
- how many exchanges to establish (*i.e.*, combine individuals and small businesses, consider regional and multistate exchanges);
- functions of the exchange (*i.e.*, ensure that the state exchange meets federal requirements such as certifying qualified plans);
- market considerations (*i.e.*, should the state require carriers to participate, regulate plans inside and outside the exchange differently, collect premiums from small businesses, and direct the contributions to the insurance plans chosen by employers?);
- participation by small businesses (whether to allow employers with up to 50 or up to 100 employees to participate); and
- required benefits (whether or not to mandate benefits beyond the federally defined essential health benefits for insurance plans sold through the exchange and how to defray the extra cost of those benefits).

Implementation of Health Care Reform in Maryland: The Health Care Reform Coordinating Council (HCRCC) was established by executive order in 2010 to facilitate implementation of ACA in Maryland. The council issued its final report and recommendations in January 2011. The first recommendation was to establish the basic structure and governance of Maryland's Health Benefit Exchange, a "required building block of reform." HCRCC recommended that the enabling statute create an independent public entity, establish a board and governing principles for transparency and accountability, ensure sufficient flexibility with respect to procurement and personnel

practices, and confer authority to begin some federally mandated implementation activities immediately while developing recommendations for the Governor and the General Assembly on others. HCRCC noted that, while an initial public entity is ideal, the exchange may evolve into a nonprofit later on. Therefore, HCRCC recommended that the exchange study and report to the Governor and the General Assembly by 2015 its findings and recommendations on whether it should be transformed into a nonprofit or remain a public entity.

In September 2010, DHMH received a $997,227 planning and implementation grant from the U.S. Department of Health and Human Services to:

- create an information infrastructure plan;
- develop an outreach and communications strategy;
- fund Maryland-specific studies of insurance coverage and health care expenditures to determine whether to merge the individual and small group markets and whether to provide additional protection against adverse selection;
- assess current public-sector technological capabilities;
- determine whether the existing public or private-sector capacity could be adapted for online public access; and
- develop a request for proposal for eligibility system expansion or acquisition.

A portion of these funds will be expended in fiscal 2011, with the remainder in fiscal 2012. If progress is made under the exchange planning grant, Maryland will qualify for a level one establishment grant to fund the exchange in federal fiscal 2012.

Exchange Activity in Other States: In 2006, Massachusetts enacted landmark health reform legislation, which created the first health insurance exchange. The Massachusetts Connector sets standards for the health insurance that Massachusetts residents must have, provides waivers of the individual mandate for those who cannot afford coverage, helps individuals and employers access coverage, provides subsidized or no-cost health insurance through the Commonwealth Care program, and provides the Commonwealth Choice program. Commonwealth Choice is an unsubsidized offering of six private health plans, selected by competitive bidding, and available through the Connector to individuals, families, and small employers (2 to 50 employees). The private plans have received the Connector's "Seal of Approval" to offer a range of benefits options, grouped by level of benefits and cost-sharing at the Bronze, Silver, and Gold levels. There is also a special, lower-priced Young Adults Plan offering from the same six carriers, exclusively for individuals between the ages of 18 and 26. The Connector is funded through retention of 3.75% of Commonwealth Care premiums and 4.5% of Commonwealth Choice premiums. In fiscal 2010, revenues were $30.7 million

($26.9 million for the 165,000 Commonwealth Care enrollees and $3.8 million for the 24,500 Commonwealth Choice enrollees).

Utah established the Utah Health Exchange in 2009. The exchange is an Internet-based information portal that connects consumers to information about available health plans and facilitates the electronic purchase of and enrollment in such plans. The exchange was set up as a public agency in the Utah Office of Consumer Health Services with an initial appropriation of $600,000; ongoing funding is provided through budget appropriations and technology fees.

At least 21 states, including Maryland, have pending legislation to establish a health insurance exchange. In 2010, California became the first state to enact legislation to establish a health benefit exchange in response to ACA. The California Health Benefit Exchange will be run by an independent state agency governed by a five-member board appointed by the Governor and Legislature. The exchange will include a website that provides standardized comparison information on QHPs, a calculator for applicants to compare costs across plan options, a web-based eligibility portal to help link individuals to health coverage options available to them, and a toll-free consumer hotline. Participating carriers must offer at least one product within each of the five levels of coverage inside and outside of the exchange. Carriers not participating in the exchange are prohibited from selling the catastrophic plan. The California Health Facilities Financing Authority is authorized to loan up to $5 million for initial exchange operations, and the exchange is authorized to impose an assessment limited to one year's approved operating budget.

Additional Information

Prior Introductions: None.

Cross File: Although designated as a cross file, HB 516 (Delegates Bromwell and Kipke) – Health and Government Operations, is not identical.

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

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