Department of Legislative Services

Maryland General Assembly
2013 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 274 (The President, *et al.*) (By Request - Administration)
Finance and Budget and Taxation Rules and Executive Nominations

Maryland Health Progress Act of 2013

This Administration bill modifies State law to further implement federal health care reform under the federal Patient Protection and Affordable Care Act (ACA). The bill expands Medicaid eligibility, establishes a dedicated funding stream for the Maryland Health Benefit Exchange (MHBE) from the insurance premium tax on health insurers, provides for the transition of Maryland Health Insurance Plan (MHIP) enrollees into MHBE, establishes a State Reinsurance Program, establishes continuity-of-care requirements, and makes clarifying and administrative changes.

The bill takes effect June 1, 2013, with the exception of the Medicaid provisions and the exemption for carriers that only offer student health plans from the requirement to offer health benefit plans in the exchange, which take effect January 1, 2014, and the continuity-of-care requirements, which take effect January 1, 2015.

Fiscal Summary

State Effect: Medicaid general fund expenditures decline by $90.5 million in FY 2014 and $189.1 million in FY 2015 to implement the *expansion* of Medicaid on January 1, 2014. Due to a 100% Federal Medical Assistance Percentage (FMAP, or matching rate) for newly covered populations and the shifting of current populations covered at 50% FMAP to a 100% FMAP, Medicaid federal fund expenditures increase by $398.2 million and $866.6 million in FY 2014 and 2015, respectively, for the *expansion*. However, Medicaid general and federal fund expenditures also increase by $14.1 million and $10.9 million each in FY 2014 and 2015 for Medicaid's share of MHBE expenses in those years. General fund revenues decline by $24.2 million in FY 2015 to provide a dedicated funding source to MHBE, while special fund revenues and expenditures increase by a corresponding amount. Thus, the net beneficial impact on the general fund is $76.3 million in FY 2014 and $154.0 million in FY 2015. Future years reflect

enrollment growth and inflation and a decline in FMAP in FY 2017 and 2018. **This bill establishes a mandated appropriation beginning in FY 2015.**

($ in millions)	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
GF Revenue	$0	($24.2)	($34.4)	($33.9)	($34.8)
SF Revenue	$0	$24.2	$34.4	$33.9	$34.8
FF Revenue	$398.2	$866.6	$894.2	$890.7	$902.0
GF Expenditure	($76.3)	($178.2)	($183.2)	($158.6)	($150.1)
SF Expenditure	$0	$24.2	$34.4	$33.9	$34.8
FF Expenditure	$398.2	$866.6	$894.2	$890.7	$902.0
Net Effect	$76.3	$154.0	$148.7	$124.7	$115.3

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

Local Effect: None.

Small Business Effect: The Administration has determined that this bill has a meaningful impact on small business (attached). The Department of Legislative Services (DLS) concurs with this assessment. (The attached assessment does not reflect amendments to the bill.)

Analysis

Bill Summary:

Medicaid Expansion: Effective January 1, 2014, Medicaid eligibility is expanded to children ages 6 through 18 and adults younger than age 65 with family or household incomes up to 133% of federal poverty guidelines (FPG) and former foster care adolescents up to age 26 (these individuals are already covered until age 20). DHMH is *authorized* to provide coverage to former foster care adolescents who, on their eighteenth birthday, were in foster care in another state or the District of Columbia. Subject to the limitations of the State budget, the Department of Health and Mental Hygiene (DHMH) must implement the Medicaid expansion authorized under ACA, including coverage of parents and caretaker relatives who have a dependent child living in the home and adults who do not meet certain requirements for a federal Medicaid eligibility category and who are not enrolled in Medicare.

MHBE Financing: Beginning January 1, 2015, a portion of the insurance premium tax must be distributed annually to the MHBE Fund to fund the operation and administration of MHBE. The funds must be allocated from the premium tax paid by health insurers, excluding managed care organizations (MCOs) and for-profit health maintenance organizations (HMOs). Beginning in fiscal 2015, the amount distributed to the fund must be sufficient to fully fund the operation and administration of MHBE. Premium tax revenues received by the MHBE Fund may only be used for funding the operation and administration of MHBE. Expenditures from the fund may be made only with an

appropriation approved by the General Assembly in the State budget or by budget amendment. MHBE operating expenses must be charged to non-State funds before State funds where possible.

In fiscal 2015, the Governor must provide an annual appropriation in the State budget for MHBE of no less than $10.0 million. Annually thereafter, the appropriation must be no less than $35.0 million. Any unspent funds revert to the general fund at the end of each fiscal year.

The bill exempts qualified nonprofit health insurance issuers established under ACA from the premium tax. These entities are part of the Consumer Operated and Oriented Plan (CO-OP) program under ACA. This exemption terminates June 30, 2018.

Transition of MHIP Enrollees: Enrollment in MHIP, including reenrollment of former enrollees, must be closed as of December 31, 2013. The MHIP board, in consultation with MHBE, must determine the appropriate date on which the plan must decline to reenroll existing plan members. The date on which coverage will no longer be provided must be no earlier than January 1, 2014, and no later than January 1, 2020. Beginning October 1, 2013, and annually thereafter until coverage is no longer provided, the MHIP board must provide specified notice to members of the new insurance options available to them as of January 1, 2014.

State Reinsurance Program: MHBE, in consultation with the Maryland Health Care Commission (MHCC), and with the approval of the Insurance Commissioner, is authorized to establish a State Reinsurance Program on or after January 1, 2014. The purpose of the program is to mitigate the impact of high-risk individuals on rates in the individual insurance market inside and outside the exchange. Funding for the program is authorized from the portion of the hospital assessment transferred to the MHBE Fund, which currently is used to fund MHIP.

By October 1, 2013, and by October 1 of each year thereafter until MHIP no longer has liability for claims submitted by enrollees, the MHIP and MHBE boards must determine (1) the amount of money that will be needed to pay MHIP claims and support MHIP operations for the following calendar year and (2) the amount of money that will be needed to fund the State Reinsurance Program. The MHIP board may, beginning January 1, 2014, allow transfer of MHIP funds into the MHBE Fund for the purpose of funding the State Reinsurance Program. DLS notes that federal approval to use the hospital assessment currently used to fund MHIP for this new purpose may be required. Federal approval was originally required to use the assessment to fund MHIP.

By December 31, 2013, and by December 31 of each year thereafter until MHIP no longer has liability for claims submitted by enrollees and the State Reinsurance Program is terminated, the MHIP and MHBE boards must report to the Governor and the General

Assembly on the transition of plan enrollees out of MHIP and the use of the MHBE Fund for the State Reinsurance Program.

Continuity-of-care Policies: On request, a receiving carrier or MCO must accept a preauthorization from a relinquishing carrier, MCO, or third-party administrator (TPA) for treatment for covered services for the lesser of the course of treatment or 90 days and for the duration of the three trimesters of a pregnancy and the initial postpartum visit. At the request and with the consent of an enrollee, a carrier, MCO, or TPA must provide a copy of a preauthorization to the receiving carrier or MCO within 10 days of receipt of the request. Carriers and MCOs may perform their own utilization review at the end of this period.

Also on request, carriers and MCOs must, for certain specified conditions, allow nonparticipating providers to continue health care services for the lesser of the course of treatment or 90 days and for the duration of the three trimesters of a pregnancy and the initial postpartum visit. Eligible conditions include acute or serious chronic conditions, pregnancy, mental health conditions, substance use disorders, and any other agreed-upon condition. The receiving carrier or MCO must pay the nonparticipating provider the rate and use the method of payment the carrier or MCO would normally pay and use for similar participating providers. The nonparticipating provider may decline the rate or method by giving 10 days' prior notice to the enrollee and the receiving carrier. Separate provisions specify continuity-of-care requirements for treatment in progress for dental services. For both health care and dental services, an enrollee is not subject to balance billing, and cost sharing for an enrollee may not exceed the cost sharing that would apply if the enrollee were receiving the services from a participating provider.

With respect to benefits covered under Medicaid fee-for-service (FFS), the continuity-of-care requirements *do not* apply to an enrollee transitioning from a carrier to Medicaid but do apply when an enrollee is transitioning from Medicaid to a carrier, but only for behavioral health and dental benefits authorized by a TPA. Continuity-of-care requirements apply to contracts issued or renewed on or after January 1, 2015.

The Commissioner and the Secretary of Health and Mental Hygiene are each authorized to adopt regulations to enforce continuity-of-care requirements. The Commissioner, the Secretary, and MHBE must collaborate to determine the data necessary to assess the implementation and efficacy of the continuity-of-care policies and develop a process to evaluate and monitor continuity of care. On request of the Commissioner, the Secretary, or MHBE, carriers, MCOs, and health care providers must provide the requisite data.

Consolidated Services Center and Exchange Enrollment Permits: MHBE is authorized to establish a consolidated services center (CSC) or call center, which may employ individuals to assist the Small Business Health Options Program (SHOP) Exchange or the Individual Exchange. CSC employees are required to hold a SHOP Exchange enrollment permit or an Individual Exchange enrollment permit.

To qualify for an enrollment permit, an applicant must be age 18 or older, trustworthy, and of good moral character. Applicants must also be engaged by, and receive compensation only through, the CSC and complete and comply with any ongoing training program requirements. Applicants for a SHOP Exchange enrollment permit must also pass the written examination for a SHOP navigator license.

Plan Certification and Appeals Process: To be certified as a qualified health plan (QHP), a health benefit plan must be offered by a carrier that offers in each exchange at least one QHP at each of the bronze, silver, and gold levels of coverage.

Certification requirements must include providing data and meeting standards related to enrollment; essential community providers; complaints and grievances; network adequacy; quality; transparency; race, ethnicity, language, interpreter, need, and cultural competency (known as RELICC); plan service area; accreditation; and compliance with fair marketing standards.

MHBE may, subject to contested case hearing provisions, deny certification to a health benefit plan, a dental plan, or a vision plan, or suspend or revoke the certification of a qualified plan, based on a finding that the plan does not satisfy the requirements or has otherwise violated standards for certification that are established in regulations and interim policies adopted by MHBE and not otherwise under the regulatory and enforcement authority of the Commissioner.

Instead of or in addition to denying, suspending, or revoking certification, MHBE may require that corrective action be taken and impose a penalty of up to $5,000 for each violation of or failure to comply with standards for certification. MHBE must consider specified factors in determining the amount of a penalty. The penalties must be in addition to any criminal or civil penalties imposed for fraud or other violations under any other State or federal law.

A carrier or plan may (1) appeal an order or decision issued by MHBE and (2) request a hearing. A demand for a hearing stays a decision or order of MHBE pending the hearing and a final order of MHBE resulting from it under specified circumstances.

SHOP Exchange Rules for Premium Contribution: The bill specifies that no employer is required to make any premium contributions on behalf of employees. If an employer chooses to contribute, the employer must (1) select a reference plan on which the contributions will be based and (2) make a contribution that is either a fixed percentage of the premium of the reference plan, based on the coverage level selected by the member and the member's job classification, or a dollar amount that ensures that all employees with the same coverage level and job classification would pay the same amount if they purchased the reference plan.

Carriers that Participate in the Exchange and the Individual or Small Group Market: If a carrier participates in the Individual Exchange and in the individual market, the carrier must offer at least one QHP at the silver level and one at the gold level in the individual market. If a carrier participates in the SHOP Exchange and the small group market, the carrier must offer at least one QHP at the silver level and one at the gold level in the small group market.

Carrier Delegation to MHBE: The MHBE board must establish a trust account to hold premium payments accepted from qualified plan enrollees and small employers by MHBE on behalf of a carrier. MHBE must maintain separate records of account for each carrier on whose behalf it accepts premium payments. The payment of a premium by an enrollee or a small employer to MHBE is deemed to be a payment to the carrier on whose behalf MHBE accepted the payment.

The bill specifies that, when MHBE has assumed certain functions on behalf of a carrier, the carrier is not liable or subject to regulatory sanction by the Insurance Commissioner for the failure of MHBE to take certain actions. MHBE and the carrier must hold a consumer harmless from any adverse consequences related to the purchase of coverage under a qualified plan and caused by the failure of MHBE to comply with the law or contract in taking delegated actions. The bill establishes the regulatory role of the Commissioner over MHBE when MHBE assumes delegated functions for a carrier. The Commissioner is prohibited, in his or her role as a member of the MHBE board, from participating in any matter that would create a conflict of interest with his or her role as a regulator of MHBE.

Qualified Vision and Dental Plans: MHBE may determine whether a carrier may elect to offer coverage for nonessential vision benefits in either the SHOP or Individual exchanges. MHBE may require children enrolling in a QHP to have the essential pediatric dental benefits required under ACA whether offered in the QHP, in conjunction with or as an endorsement to the QHP, or as a stand-alone dental plan.

Captive Producers: A "captive producer" is an insurance producer licensed by the State who (1) receives an authorization from MHBE; (2) has a current and exclusive appointment with a single carrier; and (3) receives compensation as a captive producer only from that carrier. A captive producer may transition a carrier's existing enrollees into a qualified plan in the exchange and provide enrollment assistance for individuals who contact the carrier. Until January 1, 2017, a captive producer may enroll specified individuals in a qualified plan offered in the Individual Exchange by the carrier from which the captive producer has an exclusive appointment without being certified as an Individual Exchange navigator.

A captive producer must refer consumers back to any insurance producer of record, make specified disclosures to consumers, and document that such disclosures were provided. A carrier and its captive producers must comply with fair marketing standards and act in the

best interest of the consumer. If a carrier or captive producer fails to comply with specified requirements, MHBE may suspend, revoke, or refuse to renew the captive producer's authorization and impose sanctions against the carrier.

Application Counselors: An "application counselor" means an individual who holds an Individual Exchange application counselor certification from MHBE. MHBE may designate a community-based organization, health care provider, unit of State or local government, or other entity as an application counselor sponsoring entity and certify any agent, employee, or volunteer of that entity as an application counselor if the individual meets the requirements for Individual Exchange navigator certification. Application counselors may not be compensated by MHBE, a carrier, an insurance producer, or a TPA for their enrollment services nor may they impose a fee for services. Application counselors must disclose to MHBE and to individuals to whom they provide services any relationships they have with specified health insurance entities and must act in the best interest of the individuals for whom they are authorized to provide services.

Miscellaneous Provisions: The MHBE board is authorized to adopt interim policies, if necessary, pending adoption of regulations, to ensure MHBE is prepared to begin successful operation by October 1, 2013. The Insurance Commissioner may adopt regulations establishing the minimum length of time for which, and the manner in which, MHBE is required to maintain records of insurance transactions. The bill exempts an employee of MHBE, including CSC employees, from the definition of "administrator" for purposes of bond requirements and other provisions not applicable to public entities. In addition to establishing *ad hoc* advisory committees, the MHBE board must establish a standing advisory committee by March 15, 2014 (rather than at least two standing advisory committees as required under current law). Carriers that offer only student health plans are exempt from the requirement to offer a health plan in the exchange. Consistent with the new federal framework, the bill substitutes "connector" for "navigator" entities where appropriate. The bill also authorizes the Secretary of Health and Mental Hygiene to provide grants to the State's designated health information exchange (HIE) for the development and effective operation of the State's HIE.

Fraudulent Insurance Acts: It is a fraudulent insurance act for a person to represent to the public that the person is a navigator of the SHOP Exchange, a navigator of the Individual Exchange, or an application counselor certified by the Individual Exchange if the person has not received the appropriate license or certification.

Uncodified Reporting Requirements: MHBE and MIA must conduct four studies and report their findings and recommendations to the Governor and the General Assembly on (1) the impact of ACA's allowance of a tobacco use rating of 1.5 to 1 and the options that may be available to the State to address any adverse consequences, due September 1, 2014; (2) the impact of federal regulations governing the manner in which pediatric dental benefits must be offered and the options that may be available to the State to address any adverse consequences, due December 1, 2014; (3) the captive

producer program, due December 1, 2015; and (4) the implementation and efficacy of the bill's continuity-of-care provisions, which must be conducted with DHMH and MHCC, and is due December 1, 2017.

Current Law/Background:

Medicaid: Medicaid is a joint federal and state program that provides assistance to indigent and medically indigent individuals. Medicaid eligibility is limited to children, pregnant women, elderly or disabled individuals, and low-income parents. To qualify for benefits, applicants must pass certain income and asset tests.

Medicaid eligibility varies by population or service covered, including children younger than age 1 (family income up to 185% FPG), children ages 1 through 5 (family income up to 133% FPG), children ages 6 through 18 (family income up to 100% FPG), independent foster care adolescents younger than age 21 (household income up to 300% FPG), family planning services (family income up to 200% FPG), and pregnant women (family income up to 250% FPG). Children not eligible for Medicaid are covered under the Maryland Children's Health Program for family incomes up to 300% FPG.

Chapter 7 of the 2007 special session (SB 6) expanded Medicaid eligibility for parents and relative caretakers with a dependent child living in the home with household incomes up to 116% FPG. Chapter 7 also expanded coverage for adults with household incomes up to 116% FPG who do not meet specific categorical requirements for Medicaid eligibility and who are not enrolled in Medicare. These individuals receive limited benefits under the Primary Adult Care (PAC) program.

Under ACA, beginning January 1, 2014, Medicaid eligibility will be expanded to nearly all individuals younger than age 65 with incomes up to 133% FPG. ACA language specifies that childless adults are Medicaid-eligible with modified adjusted gross income at or below 133% FPG. That definition of adjusted gross income is based on the Internal Revenue Code but is subsequently modified by ACA to add an additional 5% income disregard, effectively changing the threshold to 138% FPG. The Medicaid expansion is 100% federally funded for the first three years (calendar 2014 through 2016) and at least 90% federally funded thereafter.

On June 28, 2012, in *National Federation of Independent Business v. Sebelius,* the U.S. Supreme Court ruled that the expansion of Medicaid under ACA exceeded Congress's authority under the Spending Clause of the U.S. Constitution. The court determined that the appropriate remedy was to prohibit the Secretary of Health and Human Services from withholding all Medicaid funding if a state does not participate in the expansion. The Secretary may, however, withdraw funds provided under ACA if a state chooses to participate in the Medicaid expansion but fails to comply with its requirements. Therefore, Maryland may choose whether or not to participate in the Medicaid expansion. If it chooses not to participate, it would still receive federal funding

for its current program as long as it complies with nonexpansion Medicaid provisions. It should be noted that there is no legal requirement that Maryland enact legislation to participate in the Medicaid expansion, which could be accomplished through a State Plan Amendment; however, all previous expansions of the Maryland Medicaid program have been done through legislation.

To date, 24 states (including Maryland and Delaware) and the District of Columbia will participate in the Medicaid expansion. Sixteen states (including Pennsylvania and Virginia) do not plan to participate, while an additional 10 states (including West Virginia) have not yet made a formal decision.

DLS notes that, although the bill repeals language added by Chapter 7 of the 2007 special session that expanded Medicaid coverage to parents and relative caretakers with household incomes up to 116% FPG, the assessment on averted uncompensated care savings under § 19-214(d)(2)(ii) of the Health-General Article used to fund the expansion will continue as the State has an obligation to fund this population at 50% general funds/50% federal funds.

Maryland Health Benefit Exchange: ACA requires states that elect to operate a health benefit exchange to implement the exchange by January 1, 2014. The exchanges are intended to provide a marketplace for individuals and small businesses to purchase affordable health coverage. Chapters 1 and 2 of 2011 (SB 182/HB 166) established the governance, structure, and funding of MHBE, the primary function of which is to certify and make available QHPs and qualified dental plans to individuals and businesses and to serve as a gateway to an expanded Medicaid program under ACA. MHBE is a public corporation and independent unit of State government with a nine-member Board of Trustees.

Chapter 152 of 2012 (HB 443) expanded the operating structure of MHBE by, among other things, authorizing the exchange to contract with health insurance carriers, establishing the framework for the SHOP Exchange, and establishing navigator programs for the SHOP and Individual exchanges and a process for selecting the benchmark plan that will serve as the standard for the essential health benefits for health benefit plans offered in the small group and individual markets, both inside and outside the exchange.

Market Participation Rules: Subject to certain exceptions, carriers may not offer health benefit plans in the small group market unless they also offer QHPs in the SHOP Exchange. Similarly, carriers may not offer health benefit plans in the individual market unless they offer QHPs in the Individual Exchange. Beginning January 1, 2014, the exchange must allow any qualified plans that meet minimum standards to be offered in the exchange.

SHOP Exchange: The SHOP Exchange must allow qualified employers to (1) designate a coverage level within which their employees may choose any QHP or (2) designate a

carrier or insurance holding company system and a menu of QHPs offered by the carrier or insurance holding company system from which their employees may choose. The SHOP Exchange may allow qualified employers to designate qualified dental plans and qualified vision plans as options for their employees.

Transitional Reinsurance and Risk Adjustment: MHBE, with the approval of the Insurance Commissioner, must implement or oversee the implementation of ACA requirements relating to transitional reinsurance and risk adjustment. In consultation with MHCC and with the approval of the Commissioner, MHBE must operate or oversee a transitional reinsurance program for coverage years 2014 through 2016.

Insurance Premium Tax: Title 6 of the Insurance Article imposes a 2% premium tax on each authorized insurance company, surplus lines broker, or unauthorized insurance company that sells, or an individual who independently procures, *any type* of insurance coverage upon a risk that is located in the State. Revenues accrue to the general fund. For-profit HMOs and Medicaid MCOs are also subject to the tax. Since fiscal 2007, revenues from the tax imposed on for-profit HMOs and MCOs are distributed to the Maryland Health Care Provider Rate Stabilization Fund. Historically, money in the fund was used to pay authorized medical professional liability insurance premium subsidies and to fund Medicaid. In recent years, revenues have been used solely to support Medicaid operations.

In fiscal 2012, general fund revenues from the premium tax on insurers were $300.1 million. They are projected to be $310.5 million in fiscal 2013 and $315.2 million in fiscal 2014. Special fund revenues from the premium tax on for-profit HMOs and MCOs to the Maryland Health Care Provider Rate Stabilization Fund were $99.6 million in fiscal 2012 and $105.9 million in fiscal 2013. The Governor's proposed fiscal 2014 budget includes $104.6 million in special fund revenues to the fund.

CareFirst Premium Tax Exemption: As a nonprofit health service plan, CareFirst is exempt from the premium tax. CareFirst must file an annual report with MIA that demonstrates that it has used funds equal to the value of its premium tax exemption in a manner that serves the public interest. Statute further requires that CareFirst, as a condition of its exemption, subsidize the Senior Prescription Drug Assistance Program (SPDAP), the Kidney Disease Program (KDP), the Community Health Resources Commission (CHRC), and the provision of mental health services to the uninsured. In fiscal 2014, the CareFirst premium tax exemption subsidy is providing a total of $38.3 million to support SPDAP ($18.2 million), KDP ($5.7 million), CHRC ($8.0 million), and mental health services ($6.5 million). CareFirst provides a second subsidy of up to $4.0 million annually in years when it generates a surplus over a certain amount. The second subsidy supports SPDAP and mental health services for the uninsured.

Maryland Health Insurance Plan: MHIP provides health care coverage for individuals who have certain qualifying conditions or do not have access to health insurance. Members are required to pay a premium based on age, subscriber type, and type of benefit plan. Individuals with incomes below 300% FPG may receive discounted premiums through MHIP+. DHMH's Prevention and Health Promotion Administration (PHPA) funds premiums, deductibles, and copayments for a portion of MHIP enrollees.

The expenses for the insurance products offered through MHIP are supported by premiums, a subsidy generated by a 1% assessment on hospitals, and a limited amount of federal grant funds. In fiscal 2012, premium revenues of $102.0 million supported approximately 44% of MHIP insurance expenditures, with the remaining expenditures subsidized through assessment revenue ($115.5 million) and federal funds ($15.0 million). The Governor's proposed fiscal 2014 budget includes $271.9 million for MHIP, including $157.2 million in special funds from the MHIP assessment, $87.6 million in nonbudgeted income from premium collections, and $27.1 million in federal funds. MHIP's fund balance at the end of fiscal 2012 was $148.9 million.

MHIP is currently scheduled to end after December 2013. It is anticipated at that point that current MHIP members will have guaranteed access to insurance through the individual market or the exchange. As discussed in the November 2011 Mercer report commissioned by MHBE, the transition of MHIP enrollees into the individual market or exchange is potentially problematic as it would significantly increase medical loss ratios for carriers and likely result in an increase in premiums of 29%. If the MHIP assessment and other revenues were continued, premiums would only need to increase by 2%. Thus, the report recommended that the State may want to consider continuing the current MHIP assessment in order to mitigate the rate increase that would otherwise result from folding MHIP members into the individual market in 2014.

Financing the Maryland Health Benefit Exchange: The federal government is responsible for funding expenses for state exchanges through 2014. Beginning January 1, 2015, state exchanges must be self-funded. Chapter 152 of 2012 established the Joint Committee on Health Benefit Exchange Financing to examine and make recommendations on how MHBE should be funded. In December 2012, the joint committee issued a report which concluded that a financing mechanism that would support MHBE's short- and long-term sustainability should include at least two revenue streams to support both transactional and fixed operating costs. The report recommended that, in selecting the optimal mix of funding sources, the Governor and the General Assembly should not consider an increase in the hospital assessment and should consider only a modest increase, if any, in the assessment on other providers. The preferable options for consideration are some combination of transaction-based carrier assessments on the nongroup and small group markets, broad-based assessments on the large group insurance market, and/or an increase in the tobacco tax.

The Governor's proposed fiscal 2014 budget includes $84.9 million in funding for MHBE, including $70.8 million in federal funds and $14.1 million in general funds.

Overall expenditures are projected to decline to $70.1 million in fiscal 2015, as a result of a reduction in contractual costs related to completion of start-up costs for information technology systems, and stabilize at approximately $63.0 million thereafter.

Health Insurance Exchange Activities in Other States: To date, 18 states have declared their intent to operate a state-based exchange, 7 are planning for a state-federal partnership exchange, and 25 states and the District of Columbia have defaulted to a federally facilitated exchange. Only a few states have indicated how their exchanges will be funded in 2015 and beyond. At least four states (California, Connecticut, Nevada, and Oregon) plan to finance their exchanges with a surcharge on premiums on policies sold in the exchanges. West Virginia and Washington are considering a surcharge on individual and small group premiums sold both inside and outside the markets. Massachusetts, whose Health Connector program was a model for federal reforms, funds its program through a combination of state funds ($25 million in 2013) and a 2.5% to 3.5% surcharge on policies sold through the exchange ($6.9 million in 2013).

Continuity-of-care Advisory Committee: Chapter 152 of 2012 also directed MHBE to study and make recommendations on requirements for continuity of care in Maryland's health insurance markets. MHBE established a continuity-of-care advisory committee and submitted a report in January 2013. The report notes that, once Maryland Health Connection is operational and Medicaid eligibility is expanded in 2014, individuals will transition between commercial plans, plans offered through Maryland Health Connection, and Medicaid. These transitions can cause disruptions in coverage, affect access to care, add to administrative costs, and pose problems for continuity of care, particularly for individuals with chronic conditions. The report recommended, among other things, that individual and small group health plans should (1) accept prior-authorization determinations and (2) allow new enrollees within specified courses of treatment to receive care from out-of-network providers who were rendering specified treatments at the time of the enrollees' transition to a new plan. In each scenario, plans should allow such activities for 90 days or through delivery and the postpartum visit for pregnant women. The report also recommended that treating providers should be reimbursed at the rate established under existing law for an out-of-network provider and that MHBE should begin collecting data and develop a process to evaluate and monitor continuity of care on an ongoing basis. These recommendations are reflected in the bill's continuity-of-care provisions.

Hilltop Institute Maryland Health Care Reform Simulation Model: In July 2012, the Hilltop Institute developed a Health Care Reform Simulation Model to project enrollment in the various health care programs mandated by ACA, anticipated increases in health care expenditures, and the economic impact on implementing ACA on the State. **Exhibit 1** displays key projections from this model about anticipated increases in Medicaid enrollment, total enrollment in the exchange, the overall reduction in hospital uncompensated care from all aspects of federal health care reform, and anticipated increases in premium tax revenues under health care reform.

Exhibit 1
Key Projections from The Hilltop Institute's Health Care Reform Simulation Model
($ in Millions)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Additional Medicaid Enrollees	101,685	135,402	151,935	167,146	174,994
Total Enrollment in the Exchange	147,233	169,836	184,323	208,145	234,721
Total Reduction in Hospital Uncompensated Care	$118	$306	$404	$452	$519
Additional Premium Tax Revenues	$8	$43	$45	$51	$59

Source: The Hilltop Institute, Maryland Health Care Reform Simulation Model, July 2012

State Fiscal Effect: Medicaid general fund expenditures decline by $90.5 million, while Medicaid federal fund revenues and expenditures increase by $398.2 million in fiscal 2014, from implementation of the Medicaid expansion to 133% FPG effective January 1, 2014, which reflects the January 1, 2014 effective date of the bill's Medicaid provisions. This estimate is based on the following information and assumptions:

- it will cost an estimated $44.7 million in fiscal 2014 to cover approximately 10,900 newly eligible parents and childless adults at an annualized cost of about $6,300 per parent and $9,000 per childless adult;
- it will cost an estimated $360.0 million in fiscal 2014 to cover 80,000 individuals formerly enrolled in PAC with full Medicaid benefits at an annualized cost of about $9,000 per person;
- it will cost an estimated $20.0 million in fiscal 2014 to cover approximately 8,000 parents and children currently eligible but not enrolled in the Medicaid program (also known as the "woodwork effect") at an annualized cost of about $6,300 per parent and $2,300 per child;
- it will cost an estimated $2.0 million in fiscal 2014 to expand coverage of former foster care adolescents beyond age 19 to those younger than age 26;
- individuals currently covered by Medicaid under the Medically Needy category will become eligible for 100% FMAP (rather than the current 50%), resulting in general fund savings of $42.0 million in fiscal 2014, which will result in a corresponding increase in federal funds;
- transfer of individuals currently served by PAC to Medicaid will result in general fund savings of $59.5 million in fiscal 2014 (with corresponding federal fund savings), reflecting what costs would otherwise have been to cover this population in fiscal 2014;
- expenditures associated with newly eligible parents and childless adults and individuals previously covered under PAC will qualify for 100% FMAP through the second half of fiscal 2017; and

- expenditures associated with parents and children currently eligible for Medicaid will remain eligible for 50% FMAP.

The Governor's proposed fiscal 2014 budget includes $348.6 million in additional federal funds for the Medicaid expansion and reflects general fund Medicaid savings of $102.8 million. Based on DLS estimates of costs, these amounts may overestimate potential savings and underestimate potential federal funds available; the true cost of implementing the expansion will be determined by actual enrollment patterns and final federal regulations.

In fiscal 2015, the first full fiscal year of the *expansion*, Medicaid general fund expenditures decline by $189.1 million, while Medicaid federal fund expenditures increase by $866.6 million from implementation of the Medicaid expansion. This estimate is based on the following information and assumptions:

- it will cost an estimated $138.4 million in fiscal 2015 to cover approximately 16,400 newly eligible parents and childless adults at a cost of about $6,500 annually per parent and $9,250 per childless adult;
- it will cost an estimated $742.5 million in fiscal 2015 to cover 80,000 former PAC enrollees with full Medicaid benefits at an annual cost of about $9,300 per person;
- it will cost an estimated $40.0 million in fiscal 2015 to cover approximately 16,000 parents and children currently eligible but not enrolled in the Medicaid program (also known as the "woodwork effect") at an annual cost of about $6,500 per parent and $2,300 per child;
- it will cost an estimated $4.0 million in fiscal 2015 to expand coverage of former foster care adolescents beyond age 19 to those younger than age 26;
- Medicaid general fund expenditures for Medically Needy individuals will decline by $87.4 million in fiscal 2015, with a corresponding increase in federal funds; and
- transfer of individuals currently served by PAC will result in general fund savings of $123.7 million in fiscal 2015 (with corresponding federal fund savings).

Total funding for MHBE in fiscal 2015 is projected to be $70.1 million. Funding will come from a combination of federal grant funds (available through December 31, 2014), general and federal Medicaid funds largely for the Health Exchange Eligibility System (HIX) that will be budgeted under MHBE, and special funds dedicated from the premium tax on health insurers, as required by the bill. An estimated $24.2 million in federal grant funds and $21.7 million in Medicaid funds (50% general funds, 50% federal funds) is anticipated. The remaining $24.2 million is expected to come from special funds allocated to the MHBE Fund from the premium tax paid by health insurers, excluding MCOs and for-profit HMOs. In fiscal 2012, premium tax revenues of $83.8 million were collected from health insurers. The bill requires that, in fiscal 2015, the mandated appropriation for MHBE be *no less than* $10.0 million. However, DLS estimates that

$24.2 million will be required to fully fund MHBE in that year. Thus, general fund revenues decline, while special funds revenues and expenditures increase, by an estimated $24.2 million in fiscal 2015.

In subsequent years, the bill specifies that the mandated appropriation must be *no less than* $35.0 million; this estimate assumes that $35.0 million is appropriated as required in fiscal 2016 through 2018. However, because slightly less than $35.0 million is projected to be needed in those years, the analysis also assumes that the portion of special funds from the premium tax that is not expended reverts to the general fund.

A summary of the fiscal impact of the bill is shown in **Appendix 1**. Though total expenditures of $426.7 million to $1.0 billion are anticipated as a result of the Medicaid expansion, due to 100% FMAP through the second half of fiscal 2017 and significant savings from shifting Medically Needy and PAC enrollees under the expansion, general fund expenditures for Medicaid are reduced by $90.5 million to $197.5 million annually. In calendar 2017, the FMAP for expansion populations will decline to 95% and the State will assume 5% of the costs associated with the expansion population. In calendar 2018, the FMAP will decline to 94% and the State will assume 6% of the costs associated with the expansion population. New special fund expenditures under the bill to fund the exchange range from $24.2 million beginning in fiscal 2015 to $34.8 in fiscal 2018. As these special funds comprise premium tax revenues that would otherwise accrue to the general fund, their use for this purpose results in a decrease in general fund revenues and a corresponding increase in special fund revenues and expenditures. The total net impact on the general fund, including dedicating premium tax revenues to MHBE and Medicaid's share of MHBE expenses ranges from a savings of $76.3 million to $154.0 million annually.

As larger numbers of individuals enroll in Medicaid under the expansion, additional general fund savings may be generated from a reduction in public health and safety net services currently provided by PHPA; however, the amount of such savings cannot be reliably estimated at this time and, therefore, is not reflected in this analysis. Additional general fund savings will also occur from a reduction in premiums, deductibles, and copayments currently funded by PHPA for certain MHIP enrollees as individuals transition from MHIP to the exchange. These savings also cannot be reliably estimated at this time and are not reflected in this analysis.

The impact on the Department of Human Resources (DHR) to determine eligibility for the Medicaid expansion under this bill through local departments of social services cannot be reliably estimated at this time and has not been factored into this estimate. Even so, the Governor's proposed fiscal 2014 budget includes a turnover adjustment to yield approximately $2.6 million which may be used to fill vacant positions for this purpose. Moreover, the exchange's role in Medicaid eligibility determination vis-à-vis DHR's role is unclear.

This analysis does not account for any additional expenditures for grants from DHMH to the State HIE, as authorized under the bill. The Administration indicates that as much as $700,000 in general funds may be provided over a period of two to three years in order to draw down approximately $6.1 million in federal matching funds. Furthermore, MHBE expenditures may increase in fiscal 2015 by as much as $400,000 to complete the required studies on tobacco use rating (due September 1, 2014) and pediatric dental benefits (due December 1, 2014). As MHBE will remain federally funded through December 31, 2014, federal funds are assumed for these studies. MHBE special fund expenditures may increase by as much as $150,000 in fiscal 2016 to complete a study of the captive producer program (due December 1, 2015). General fund expenditures for DHMH will increase by an unknown amount in fiscal 2018 to complete a study of the bill's continuity-of-care provisions (due December 1, 2017).

Additional Comments: The Hilltop Institute's model projects significant reductions in hospital uncompensated care under federal health care reform activities beginning in fiscal 2014. As these activities are not all attributable to this bill, they are not part of the estimate. To the extent that such a reduction is achieved, hospital rates may be lowered and additional savings will accrue to the Medicaid program, as well as commercial payors.

Additional Information

Prior Introductions: None.

Cross File: HB 228 (The Speaker, *et al.*) (By Request - Administration) - Health and Government Operations.

Information Source(s): *Report of Market Rules and Risk Selection for the State of Maryland*, Mercer Government Human Services Consulting, November 8, 2011; "Insurance Surcharges Will Fund Most Online Exchanges Created Under Health Law," Kaiser Health News, December 1, 2012; *Maryland Health Care Reform Simulation Model: Detailed Analysis and Methodology*, The Hilltop Institute, July 2012; Kaiser Family Foundation; Department of Budget and Management; Maryland Health Insurance Plan; Department of Health and Mental Hygiene; Maryland Insurance Administration; Judiciary (Administrative Office of the Courts); Office of Administrative Hearings; Department of Legislative Services

Fiscal Note History: First Reader - February 12, 2013
ncs/ljm Revised - Senate Third Reader - April 2, 2013

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Appendix 1 – Summary of the Fiscal Impact of SB 274/HB 228
Fiscal 2014-2018
($ in Millions)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Medicaid Expansion					
Parents and Childless Adults[1]	$44.7	$138.4	$142.9	$147.9	$152.7
PAC Enrollees to Medicaid[1]	360.0	742.5	767.0	793.4	819.2
Parents and Children (Previously Eligible for Medicaid)[2]	20.0	40.0	40.0	40.0	40.0
Former Foster Care Adolescents[2]	2.0	4.0	4.0	4.0	4.0
Total Expenditures (GF/FF)	**$426.7**	**$924.9**	**$953.9**	**$985.3**	**$1,015.8**
Savings Over Current Spending					
Medically Needy Population[3]					
General Funds	(42.0)	(87.4)	(90.9)	(89.8)	(87.8)
Federal Funds	42.0	87.4	90.9	89.8	87.8
PAC Enrollees to Medicaid[4]					
General Funds	(59.5)	(123.7)	(128.7)	(133.8)	(139.2)
Federal Funds	(59.5)	(123.7)	(128.7)	(133.8)	(139.2)
Total Net Expenditures					
General Funds	(90.5)	(189.1)	(197.5)	(173.0)	(164.5)
Federal Funds	398.2	866.6	894.2	890.7	902.0
Maryland Health Benefit Exchange[5]					
Federal Funds (Grants)	56.7	24.2	-	-	-
Special Funds (Premium Tax)[6]	-	24.2	34.4	33.9	34.8
General Funds (Medicaid)	14.1	10.9	14.4	14.4	14.4
Federal Funds (Medicaid)	14.1	10.9	14.4	14.4	14.4
Total Expenditures (GF/FF/SF)	**$84.9**	**$70.1**	**$63.1**	**$62.6**	**$63.5**
Net Impact on General Funds	**($76.3)**	**($154.0)**	**($148.7)**	**($124.7)**	**($115.3)**

Notes: Numbers may not sum to total due to rounding. The Governor's proposed fiscal 2014 budget for Medicaid reflects a reduction of $102.8 million in general funds and an increase of $348.6 million in federal funds. Expansion of Medicaid is anticipated to generate additional general fund savings from a reduction in spending on public health and safety net programs; however, those savings are not reflected in this analysis. This estimate does not reflect any cost to the Department of Human Resources for eligibility workers in the local departments of social services; however, the Governor's proposed fiscal 2014 budget includes a turnover adjustment of $2.6 million that will allow the department to fill existing vacant positions to be used for this purpose.

[1]Reflects a Federal Medical Assistance Percentage (FMAP) of 100% through the first half of fiscal 2017. For the second half of fiscal 2017 and first half of fiscal 2018, the FMAP declines to 95%. In the second half of fiscal 2018, the FMAP declines to 94%.

[2]Reflects an FMAP of 50% in all fiscal years.

[3]Moving individuals currently covered under the Medically Needy category at 50% FMAP to the expansion at a 100% FMAP results in a fund swap of federal funds for general funds in each fiscal year, but overall costs are not increased for this population. The ability to transfer Medically Needy individuals to the expansion is based on the Department of Health and Mental Hygiene's interpretation of federal regulations. To the extent these regulations change, savings could be significantly reduced.

[4]Savings reflect the amount that would have been spent on the current Primary Adult Care (PAC) program in the absence of the expansion. PAC is funded with 50% general funds and 50% federal funds.

[5]Federal law requires the Maryland Health Benefit Exchange to be financially self-sufficient by January 1, 2015; thus, this estimate assumes that federal funding will continue to be used through the first half of fiscal 2015. After that time, a combination of general, federal, and special funds will be used. Medicaid general and federal funds will be used largely for the Health Exchange Eligibility System (HIX). Special funds from the premium tax will be used for administration and operations.

[6]Use of special funds from the premium tax results in a general fund revenue loss (that, although not shown, is reflected in the net impact on the general fund) and a corresponding special fund revenue and expenditure increase.

Source: Department of Legislative Services

ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: Maryland Health Progress Act of 2013

BILL NUMBER: Senate Bill 274/House Bill 228

PREPARED BY: Maryland Health Benefit Exchange staff: Frank Kolb

PART A. ECONOMIC IMPACT RATING

This agency estimates that the proposed bill:

__ WILL HAVE MINIMAL OR NO ECONOMIC IMPACT ON MARYLAND SMALL BUSINESS

OR

_X_ WILL HAVE MEANINGFUL ECONOMIC IMPACT ON MARYLAND SMALL BUSINESSES

PART B. ECONOMIC IMPACT ANALYSIS

Senate Bill 274 and House Bill 228 put in place the remaining policies necessary for the Maryland Health Benefit Exchange, created by legislation in the 2011 legislative session, to begin open enrollment by October 1, 2013. Health insurance offered to individuals and small businesses through the Exchange will be effective January 1, 2014. The bills expand Medicaid coverage, enable the Exchange to become financially self-sufficient by 2015, establish a state reinsurance program, transition enrollees from MHIP, adopt Board recommendations regarding continuity of care and the Small Business Health Options Program (SHOP), and provide additional clarifications. With specific reference to small employers, the bills set forth the permissible forms of employer contributions in the SHOP, while at the same time reaffirming that an employer is not required to make any premium contribution.

The exact impact of the bills on small businesses is difficult to quantify at this time. Beginning in 2014, however, the Exchange will be the only place small businesses will be able to receive tax credits for offering coverage, providing incentives for small businesses who do not offer coverage today.

Additionally, the bills will have a positive impact on small businesses by allowing another venue for small businesses to access affordable insurance coverage. First, employers will now be able to offer employees a choice of carriers in the market (employee choice) as opposed to being required to offer only one carrier (employer choice). Second, by setting a framework for permissible form of employer

contributions, providers will be given explicit guidance as to which forms of employer contribution are acceptable under the law.

Finally, it is important to note that the health care market will be infused with approximately $500 million in the first year due to subsidies from the federal government for individuals in the Exchange, and millions more federal dollars from the federally-financed expansion of Medicaid. The federal subsidies will be in the form of payments for premiums for those in the individual market under 400% of the poverty level (approximately $44,000 for an individual). The Medicaid expansion will provide coverage for adults up to 133% of FPL. These individuals who receive new coverage through the Exchange and Medicaid will be utilizing services differently than they have in the past; traditionally, uninsured individuals have used the hospital system as their main point of coverage. With new coverage, these individuals will receive preventive care, have access to specialists outside the hospital system, will have comprehensive drug coverage, and other access to other covered services. As a result, small businesses in the healthcare industry will be impacted by more individuals using services provided by small provider practices and other small employers, rather than relying almost exclusively on hospital services.

While not segregating the impact on small business from that on all health sector and related industry, an independent analysis by Hilltop Institute of University of Maryland Baltimore County determined the projected impact of the Medicaid expansion and the Exchange on all providers, health care expenditures, and jobs. The projected increase in funds to providers is $682 million, overall health care expenditures in 2014 is $1.06 billion, and the number of new jobs is 9,000.