Department of Legislative Services

Maryland General Assembly
2013 Session

FISCAL AND POLICY NOTE

House Bill 228 (The Speaker, *et al.*) (By Request - Administration)
Health and Government Operations

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 and for-profit health maintenance organizations (HMOs), 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, 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. General fund expenditures increase by $24.2 million in FY 2015 to provide a dedicated funding source to MHBE. 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
FF Revenue	$398.2	$866.6	$894.2	$890.7	$902.0
GF Expenditure	($90.5)	($164.9)	($148.7)	($124.7)	($115.3)
FF Expenditure	$398.2	$866.6	$894.2	$890.7	$902.0
Net Effect	$90.5	$164.9	$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.

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 independent foster care adolescents up to age 26 (these individuals are already covered until age 20). 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.

Dedicated Funding Stream: In fiscal 2015, and each fiscal year thereafter, the Governor must provide an appropriation in the State budget to fully fund the operations of MHBE. The appropriation must be allocated from the premium tax paid by health insurers and for-profit HMOs. Funds allocated from the premium tax may only be used for funding MHBE. If, in any fiscal year, the allocation is insufficient, the Governor may provide a deficiency appropriation. Any unspent funds revert to the general fund at the end of each fiscal year.

Transition of MHIP Enrollees: Enrollment in MHIP 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, 2015, and no later than January 1, 2020.

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, 2015. 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 Maryland Health Benefit Exchange Fund, which currently is used to fund MHIP.

By October 1, 2013, and each year thereafter until MHIP no longer has 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 plan. The MHIP board may, beginning January 1, 2015, allow transfer of MHIP funds into the Maryland Health Benefit Exchange 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 require federal approval. Federal approval was originally required to use the assessment to fund MHIP.

Continuity-of-care Policies: On request, carriers and managed care organizations (MCOs) must honor prior authorizations from a relinquishing carrier or MCO 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. 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 or substance abuse disorders, bone fractures, joint replacements, recent heart attacks and cancer diagnoses, HIV/AIDS, and organ transplants. Except as otherwise provided under law, carriers/MCOs and nonparticipating providers must agree on the rate and method of compensation for services. The agreement must ensure that the copayments, deductibles, and any coinsurance required of an enrollee are the same as those that would be required if the enrollee were receiving services from a participating provider. If no agreement is reached, the nonparticipating provider is not required to continue to provide services and the carrier or MCO is not required to allow the services to be provided by the nonparticipating provider.

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 assess the implementation and efficacy of the continuity-of-care policies and develop a process to evaluate and monitor continuity of care and request the requisite data from carriers, MCOs, and health care providers. Uncodified language requires MHBE, DHMH, and the Maryland Insurance

Administration (MIA) to conduct a study on the implementation and efficacy of the continuity-of-care provisions and report by December 1, 2017, to the Governor and the General Assembly on the findings and recommendations.

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 Appeals Process: 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 meet standards for certification that are established in regulations and policies adopted by MHBE and not otherwise under the regulatory and enforcement authority of the Commissioner.

Certification requirements may 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. 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 $100 for each violation of or failure to comply with standards for certification. 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.

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 select a reference plan on which the contributions will be based and make a contribution that is either a fixed percentage of the premium of the reference plan or a dollar amount that ensures that all employees 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 qualified health plan (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.

MHBE Collection of Premium Payments: 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.

Miscellaneous Provisions: 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. Carriers must retain the responsibility for ensuring that the consumer protections required by the Insurance Article are afforded small employers and enrollees in a qualified plan, even if MHBE contracts to collect premiums, conduct billing, send required notices, provide required disclosures, or perform any other function normally performed by a carrier.

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 or a navigator of the Individual Exchange if the person has not received the appropriate license or certification.

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 its 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 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 $70.0 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 independent 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 independent 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).

General fund expenditures increase by an estimated $24.2 million beginning in fiscal 2015 due to the bill's mandated appropriation for MHBE. The bill requires that the Governor provide an appropriation in the State budget to fully fund the operations of MHBE. MHBE's operating budget is projected to be $70.1 million. As MHBE is required to be fully self-funded by January 1, 2015, it is assumed that federal funds will continue to be used for the first half of fiscal 2015. To fund the second half of fiscal 2015, $10.9 million in federal funds will be available for Medicaid administrative expenses. The remaining $24.2 million is expected to come from general funds. The bill requires that the appropriation be allocated from the premium tax paid by health insurers and for-profit HMOs. DLS assumes that these funds will come from general fund premium tax revenues. In fiscal 2012, premium tax revenues of $83.8 million were collected from health insurers, while premium tax revenues of $48.7 million were collected from for-profit HMOs (these revenues, along with the premium tax on MCOs, are distributed to the Rate Stabilization 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 $197.6 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 general fund expenditures under the bill to fund the exchange range from $24.2 million beginning in fiscal 2015 to $49.2 in fiscal 2018. The total net impact on the general fund, including dedicating general fund premium tax revenues to MHBE ranges from a savings of $90.5 million to $164.9 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.

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: SB 274 (The President, *et al.*) (By Request - Administration) - Finance and Budget and Taxation.

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

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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	20.0	40.0	40.0	40.0	40.0
(Previously Eligible for Medicaid)[2]					
Independent 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 New Expenditures					
General Funds	11.0	22.0	22.0	50.6	62.4
Federal Funds	398.2	866.6	894.2	890.7	902.0
Maryland Health Benefit Exchange					
Dedicated Funds from Premium Tax[5]	-	24.2	48.8	48.3	49.2
Net Impact on General Funds	**($90.5)**	**($164.9)**	**($148.7)**	**($124.7)**	**($115.3)**

Notes: Numbers may not sum due to rounding. The Governor's proposed fiscal 2014 budget for Medicaid reflects a reduction in $102.8 million in general funds and an increase in $348.6 million in federal funds. Expansion of Medicaid is anticipated to generate additional general funds 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% general 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.

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 Instiitute 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.