December 17, 2012

The Honorable Edward J. Kasemeyer
Chair
Senate Budget & Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

The Honorable Thomas M. Middleton
Chair
Senate Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chair
House Health and Government
Operations Committee
241 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2012 Joint Chairmen's Report (p. 21) – Report on Long-Term Financing Strategy for Exchange Operations

Dear Chairmen Kasemeyer, Conway, Middleton and Hammen:

Page 21 of the Joint Chairmen's Report of 2012 requests that the Maryland Health Benefit Exchange (MHBE) submit a report detailing the strategy for long-term financing of MHBE Operations. The language requesting the report withholds a $100,000 appropriation made for the operation of the MHBE pending submission of this report. During the 2012 interim, a Joint Committee on Health Benefit Exchange Financing met and authored a report providing options for long-term financing for the MHBE. The report lays out options for the legislature to consider when financing the MHBE and recommends a broad-based approach coupled with a transaction fee to cover the $35M operating budget. The report of this Joint Committee is attached.

I hope that you find this information useful. I respectfully request that the restricted funding be released. If you have any questions or need more information on this subject, please do not hesitate to contact me at 410-764-5986.

Sincerely,

Rebecca E. Pearce
Executive Director
Maryland Health Benefit Exchange

Enclosure

cc: Sarah Albert
Simon Powell
Carolyn Quattrocki

Options for Financing the Maryland Health Benefit Exchange

Report and Recommendations to the Governor and General Assembly

Joint Committee on Maryland Health Benefit Exchange Financing

12/1/2012

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EXECUTIVE SUMMARY

The Maryland Health Benefit Exchange Act of 2012 established the Joint Committee on Health Benefit Exchange Financing (Joint Committee) to examine and make recommendations on how the Maryland Health Benefit Exchange (MHBE or Exchange) should be funded after 2014. The Joint Committee worked over a six-month period with an expert consultant, the MHBE's Financing and Sustainability Advisory Committee, and the public through oral and written comment to develop and analyze a variety of potential financing mechanisms, based on a potential budget for 2015-2017.

The Joint Committee offers the following recommendations and guidance to the Governor and General Assembly for their consideration.

MHBE Projected Budget

The expert consultant concluded that the MHBE's operations can be projected to cost $35 million in 2015 and will fall to $33 million by 2017. These estimates do not include the costs allocated to Medicaid. These totals will likely need some adjustment based on actual enrollment as operations move forward.

Principles

The following general principles should guide design of MHBE funding mechanisms:

1. The MHBE has both business and public value, benefiting consumers, carriers, brokers, the health care sector, the State and the general public.
2. The allocation of fixed, variable, and Medicaid-related costs should inform determination of the appropriate revenue streams.
3. A hybrid approach, which combines two or more revenue streams, reflects MHBE's business and public value and is most likely to ensure its sustainability.
4. MHBE revenue streams should be designed to support its short and long-term financial sustainability.
5. Where possible, assessments should be characterized by simplicity and ease with respect to compliance and administration.

Guidance and Recommendations

In addition to these guiding principles, the Joint Committee submits for consideration the following recommendations and input.

Multiple Revenue Sources

While the recommended hybrid approach to financing the Exchange assumes at least two revenue streams to support both variable and fixed costs, the possibility of more than two funding sources

should also be considered. Promoting equity, ensuring stability and other goals may militate in favor of multiple funding sources.

Transactional/Variable Cost Models

Two options under this model should be considered, *i.e*. an assessment on carriers' enrollment in the Exchange only, and an assessment on non-group and small group enrollment both inside and outside the Exchange.

Type of assessment: With respect to selecting the structure of the assessment, the Committee offers the following considerations.

a. *Percentage-based fee*: If the assessment is based on a percentage of premium, a cap should be considered to place an outside limit on its penalizing impact on higher-cost policies; and
b. *Flat fee*: If the assessment is a flat, per member fee, different fees should attach to each insurance line, *i.e*. medical, dental and vision.

Assessment on Exchange-only QHPs or all non-group and small group plans sold inside and outside Exchange: With respect to evaluating the relative advantages and disadvantages of an assessment on MHBE membership only versus enrollment both inside and outside the Exchange, the following key factors should be given serious consideration.

a. *Business risk*: Assessing Exchange enrollment only creates a business risk because it would provide carriers a lower yield on policies sold in the Exchange, and it would make calculating an adequate assessment rate more difficult in the early years because enrollment will be uncertain. Thus, an assessment both inside and outside the Exchange may be more fiscally prudent, establishing greater predictability and stability in the early years. Moving to an Exchange only assessment could be revisited later once enrollment stabilizes.
b. *Administrative simplicity*: An assessment both inside and outside the Exchange would be less administratively complex and burdensome because the Maryland Insurance Administration already has in place a collection mechanism for its existing premium assessment.
c. *Carrier flexibility*: Both options provide flexibility to carriers as to how to pass through and spread the costs of the assessment. Because the premium rates of the identical plan design sold inside and outside the Exchange must be the same, consumers will not be affected differentially under either option.

Broad-Based/Fixed Cost, Health Care Market-Based Model

The three options presented under this model are an assessment on the commercial, large group insurance market, on hospital patient revenue, and on other licensed health care professionals.

Hospital Assessment: An increase in the current assessment on hospital revenues should not be considered as a viable funding mechanism. Because Maryland is near the federal limit in using a hospital-based assessment, and because that limit may be lowered by Congress, this option is not a reliable and sustainable funding source.

Assessment on other licensed providers: If an increase in the current Maryland Health Care Commission assessment is considered, it should be limited to a modest increase over existing levels. One complexity is that determining the correct individual rates of assessment for different kinds of providers not similarly situated in their ability to recoup the costs will be difficult.

Assessment on large group commercial insurance market: This option should be considered to support the MHBE's fixed costs. Together with the transactional assessment, it would provide the benefit of reaching indirectly most components of the health care system, thereby capturing the MHBE's value to the broader health care market. It also allows for a relatively low rate of assessment by virtue of a sizable revenue base.

Broad-Based/Fixed Cost Public Funding Models

An increase in the tobacco tax should also be considered to support the Exchange's fixed costs. With tobacco users more likely to be uninsured and to require health care services, this option is closely tied to the public value of the Exchange. About 15% of adult Marylanders smoke; should this number decline as a result of a modest tax increase, the resulting cost savings and greater productivity would benefit the entire State. If this funding mechanism is considered, there should be a plan to maintain revenue in the event that smoking rates decline.

Effect of Financing Options on Health Insurance Premiums

Because carriers generally pass assessments through to consumers in premiums, the expectation is that all other factors being equal, a carrier assessment used to fund the Exchange will be reflected fully in premiums. This assumption, however, does not account for new competitive market factors brought about by the Exchange. Carriers' incentives to price strategically in order to compete for enrollees, who will be particularly sensitive to premium rates, may induce them not to include the entire amount of an assessment into premiums. Because they will nonetheless pass at least some portion of any direct or indirect assessment through to consumers, however, the only financing option unlikely to have any upward, direct effect on health insurance premiums is an increase in the cigarette tax. This expectation also militates in favor of selecting broader-based assessments.

OPTIONS FOR FINANCING THE MARYLAND HEALTH BENEFIT EXCHANGE

BACKGROUND

Joint Committee: Establishment and Charge

The Maryland Health Benefit Exchange Act of 2012 (MHBE Act of 2012) put in place many of the policy decisions necessary to govern operations of the Maryland Health Benefit Exchange (MHBE or Exchange). With respect to how the MHBE should be financed to ensure its sustainability after 2014, however, the O'Malley-Brown Administration and General Assembly made the judgment that more analysis of the issues involved would be beneficial. As such, the MHBE Act of 2012 established a joint executive and legislative committee (Joint Committee) to conduct further study of the MHBE financing options and to submit a report and recommendations to the Governor and General Assembly by December 1, 2012.

The law directed that the Joint Committee, building on the 2011 recommendations of the MHBE's Board and its Finance and Sustainability Advisory Committee (Advisory Committee), should examine a combination of broad-based and transactional funding mechanisms with the goal of ensuring a stable and flexible revenue stream. It should consider existing assessment mechanisms, the impact of any new assessments, and how best to align the revenues and expenditures of the MHBE.[1]

[11] Specifically, the MHBE Act of 2012 provides that the Joint Committee shall:

(1) (i) build on the recommendations of the 2011 Report and Recommendations of Maryland Health Benefit Exchange and the 2011 report of the Finance and Sustainability Advisory Committee of the Exchange; and
(ii) in assessing total funds needed to sustain the Exchange and to minimize duplication of functions and costs, consider the expertise of and functions already performed by the Department of Health and Mental Hygiene, the Maryland Health Care Commission, the Maryland Insurance Administration, and the Health Services Cost Review Commission;
(2) examine a combination of funding mechanisms for the Exchange with the goal of developing an approach that will:
(i) ensure a stable revenue stream;
(ii) allow the Exchange to adjust revenue levels to accommodate fluctuations in enrollment and other factors affecting its fixed and variable costs; and
(iii) rely on:
1. a consistent, broad–based assessment that can be adjusted to scale in order to reduce the Exchange's vulnerability to enrollment fluctuations; and
2. additional funding from transaction fees;
(3) consider existing broad–based financing of health programs such as the Maryland Health Care Commission's assessments on health care industry sectors;

Joint Committee Process

Committee Membership

The Joint Committee is made up of the following members: Joshua M. Sharfstein, Secretary, Department of Health & Mental Hygiene; T. Eloise Foster, Secretary, Department of Budget and Management; Therese M. Goldsmith, Commissioner, Maryland Insurance Administration; John M. Colmers, Chair, Health Services Cost Review Commission; Craig P. Tanio, M.D., Chair, Maryland Health Care Commission; Meredith L. Borden, Assistant Attorney General and designee of Douglas F. Gansler, Attorney General; Senator Robert J. Garagiola; Senator James N. Robey; Delegate Robert A. Costa; Delegate James W. Hubbard; Darryl J. Gaskin, Ph.D, MHBE Board; and Thomas S. Saquella, M.A., MHBE Board.

Work with Consultant and MHBE Financing and Sustainability Advisory Committee

In May, 2012, with funds from its federal Establishment I grant, the MHBE contracted with Wakely Consulting Group, Inc. (Wakely) to assist the Joint Committee in its analysis of financing options. The MHBE's Financing Advisory Committee was then re-convened to assist Wakely in formulating the menu of financing options to be considered. Wakely presented the options to the Joint Committee in July, and then conducted its analysis and finished its report in September. It also worked with MHBE staff to conduct a separate analysis of MHBE's projected budget for 2015-17 to help inform financing.

Advisory Committee Feedback and Public Comment

Wakely's report was released for a 30-day period of written public comment on September 22, 2012, and was then presented at public meetings of the Advisory Committee and the Joint Committee in late September and early October. At the November 2nd Joint Committee meeting, Wakely also presented its analysis of the MHBE's projected budget, and stakeholders were invited to give oral comments.

Joint Committee's Formulation of Report and Recommendations

At its November 2 meeting, the Joint Committee articulated its goal of providing meaningful guidance to the Governor and General Assembly that would help inform their decision-making, but would also respect the broader fiscal and policy context in which the decisions would unfold, and the budget and legislative processes necessary to put them in place. It then set forth general principles to guide design of the revenue streams and its views on the pros and cons of each potential option. The Governor's Office of Health Reform prepared and circulated a draft report which the Joint Committee approved at its final meeting on November 14, 2012.

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(4) taking into account all of the ramifications of and funding available under the Affordable Care Act and changes in the State's health care delivery system, consider the impact of any funding mechanism on health insurance premiums and the State's Medicare waiver;

(5) consider whether an assessment or transaction fee cap, formula, or other mechanism should be used to align the revenues and expenditures of the Exchange; and

(6) develop recommendations on the specific mechanisms that should be used to finance the Exchange for consideration by the General Assembly during the 2013 session. 2012 Laws of Maryland Chapter 152

RESOURCES OF JOINT COMMITTEE

Maryland Health Benefit Exchange Board's Recommendation

In its 2011 report, "Recommendations for a Successful Maryland Health Benefit Exchange", the Board based its financing recommendation on three key considerations: 1) in addition to providing value to those involved directly in its insurance marketplace, the MHBE will provide benefit to all Marylanders; 2) MHBE enrollment will be uncertain in the initial years; and 3) the MHBE's funding must be consistent and reliable. It concluded that "because of the significant benefits the Exchange offers to Marylanders, the foundation for the Exchange's funding should be a broad-based assessment with additional funding coming from transaction fees tied to enrollment within the Exchange."

Wakely's Analysis

Wakely's "Detailed Analysis for Financing the Maryland Health Benefit Exchange," builds on the Exchange Board's recommendation and the work of the Advisory Committee. (Report attached as Appendix A).

Value of the MHBE

First, the report sets forth a qualitative analysis of the MHBE's benefit to different market segments, the State, and the public, concluding that it has both a business and public value. It provides benefit to carriers by increasing their membership opportunities, aggregating premiums for small businesses, and providing marketing, eligibility determinations, enrollment, and other services. It benefits the health care market by infusing $600 million in new federal dollars into the system, reducing uncompensated care and bad debt, increasing premium and provider revenue, and supporting payment and benefit design innovation. The MHBE offers value to the State by lowering the rate of uninsured, creating jobs, increasing tax revenues, and enhancing economic activity generally. Finally, the public benefits through expanded access to affordable health care, lower insurance premiums, "uninsurance insurance," a trustworthy source of information, and a streamlined, no-wrong-door eligibility and enrollment process.

Three Revenue Models

The report then examines and applies a set of evaluative criteria to three potential revenue models focused on: 1) issuers of non-group and small group plans; 2) carriers and providers in the broader health care market; and 3) broad-based public funding sources like a tobacco or other "sin" tax. For each model, it assesses the Exchange's value and impact on the assessed market; any differential impact on MHBE consumers; the relative stability of the revenue yield, the method of collection and cash flow; administrative ease; and lead time necessary to adjust the assessment.

QHP Issuer Model

The report examines two options within the non-group and small group issuer model, *i.e.*, assessment on MHBE membership only, and assessment on issuers' total non-group and small group membership. It finds, on the positive side, that the QHP Exchange membership option: 1) is most closely related to MHBE business operations; 2) would not affect MHBE consumers differentially because the assessment would be spread across an issuer's entire membership; and 3) could be adjusted fairly easily as long as changes aligned with issuers' pricing cycles. On the downside: 1) the revenue stream would be highly sensitive to MHBE enrollment; 2) the assessment could create a disincentive for carriers to sell inside the MHBE because of the difference in yield for QHPs sold outside the Exchange; 3) collections would be

tied to timing of MHBE enrollment; and 4) cash flow and administrative ease would depend on whether MHBE functions will ultimately include billing.

With respect to assessing an issuer's total membership, this option retains a close link to MHBE business relationships, including incorporation of the MHBE's spill-over benefits on issuer membership outside the Exchange. It also eliminates the disincentive for carriers to sell inside the Exchange, allows for a lower and more stable assessment because of its broader base, and could be administered easily by utilizing current Maryland Insurance Administration (MIA) collection processes. Finally, it would not affect MHBE consumers differentially and could be adjusted in concert with issuers' pricing cycles.

Health Care Market-Based Revenue Models

The report considers two potential options within the health care market: 1) assessment on the commercially-insured large group market; and 2) assessment on providers, such as a hospital net patient revenue assessment or an increase in the fees on providers that fund the Maryland Health Care Commission.

With respect to the evaluative criteria, these options reflect the MHBE's value to the health care market, would eliminate carriers' disincentive to sell in the Exchange, and would be spread across an expanded base, thereby allowing for a lower assessment and more stable revenue stream. The ability to leverage existing premium and provider assessments would create administrative ease, but lead time to adjust the assessment would likely be tied to current annual assessment processes.

Broad-Based, Public Funding Sources

Finally, the report considers broad-based public funding streams not linked to health industry revenue sources. It focuses on a tobacco tax as a potentially good option, given the link between tobacco use reduction and public health. Cigarette tax increases have led to declines in smoking rates, which in turn prevent disease, reduce mortality, and decrease health care costs. Smokers are also more likely to be uninsured and to require more extensive health care services. A cigarette tax recognizes the MHBE's value to the public and does not affect the insurance market or MHBE consumers. Collection would be annual, with relative administrative ease but more lead time necessary for any adjustments.

MHBE Budget

The report also includes a Budget Supplement which projects the MHBE's expenditures and revenue needs from 2015-17. (Attached as Appendix B).

MHBE Scale and Cost of Operations: MHBE's projected enrollment, a significant driver of overall operating expenses, is an average of 198,000 lives over the three-year period. [2] The projected operating budget, in round numbers, is $35 million for CY'15, $34 million for CY'16, and $33 million for CY'17. On a per member, per month (PMPM) basis, expenses for CY '15 – '17 will be $16.75, $14.66, and $12.64 respectively. The projected expenses also reflect allocating back to Medicaid its share of the cost of shared functions, like eligibility determinations.

[2] Estimated year-end total non-group and small group enrollment is 177,080 for CY'15, 196,234 for CY'16, and 221,433 for CY'17. Non-group enrollment will be greater than small group, and these projections assume the State will not establish a Basic Health Program for individuals below 200% of FPL.

Breakdown of Operating Expenses: The Budget Supplement breaks out operating expenses into fixed and variable costs, and those with components of each. Fixed costs will remain relatively constant regardless of MHBE scale, whereas variable costs will be highly sensitive to changes in enrollment. This breakdown is important in managing and projecting MHBE operating budgets going forward.

The major categories of expenses are IT systems and operations (call center, eligibility and enrollment, staff salary and benefits, and navigators). Lesser expense categories are consulting (actuarial, IT, and reinsurance-related), facilities and equipment, appeals, marketing and advertising, and administrative. Approximately 61% of estimated costs are fixed and 39% are variable. The budget does not include broker commissions, since they will be paid directly by carriers, as they are today.

Specific Financing Options for Consideration

Recommended Hybrid Approach: Acknowledging that a single assessment on one market would be theoretically possible, the report advises against this approach in favor of a hybrid model combining variable, transaction-based and fixed, broad-based revenue streams. This approach would: 1) decrease the rate of assessment on any single market sector; 2) ensure a more stable revenue stream not tied exclusively to MHBE enrollment uncertainty and variability; 3) link part of the funding to enrollment, making it scalable to financing needs that change based on enrollment; and 4) most accurately reflect the multi-faceted business and pubic value of the Exchange.

Specific Options: The report then sets forth specific options that would provide the requisite $35 million revenue stream. The options under the non-group and small group issuer model are variable/transaction-based, while the options under the health care market and public funding models are fixed/broad-based. The following chart sets forth the rate of assessment required under examples of each model when adjusted for the actual budget projections and revised estimates of cigarette tax revenue from the Department of Budget and Management.[3]

Market Denominator	Revenue Base	$13.7 Million Variable Costs	$21.3 Million Fixed Costs
NG/SG Combined	$2,936,173,431	0.46%	--
Large Group	$3,545,634,074	--	0.60%
Provider (Hospital)	$15,091,683,229	--	0.14%
Cigarette Packs Sold	199,500,000	--	$0.18

Public Comment on Proposed MHBE Financing Mechanisms

Stakeholders and members of the public were invited to provide written comment on the MHBE financing options during a 30-day comment period following release of the Wakely report. Eleven stakeholder organizations submitted comments; six were health insurance carriers, dental carriers, and

[3] The report uses a placeholder of $42 million for the MHBE budget, pending the preparation of actual budget projections as set forth in the Budget Supplement. The Department of Budget and Management projects slightly different revenue yields on the cigarette tax increase because it assumes elasticity of demand, *i.e*. smoking rates will decline as tax rates increase.

an insurance industry association; three were hospital providers and a hospital association; and two were consumer advocacy organizations. The Joint Committee also invited oral stakeholder presentations at its November 2, 2012 meeting. Three organizations that submitted written comments (two hospital providers and a consumer advocacy organization) made presentations. The following summarizes the key issues raised and addressed in the stakeholder input. (Attached as Appendix C is a chart setting forth public comment in greater detail and by organization).

Several organizations provided comments in support of general approaches or principles for financing MHBE operations. Six recommended the hybrid approach that would incorporate more than one revenue source; two groups commented on the importance of transparency in the funding plan; and two groups stated that assessments for the purpose of funding MHBE operations should be limited to the minimum amount necessary to cover costs. No other organizations submitted statements in opposition to these comments. Additionally, these positions are consistent with the feedback received from the MHBE's Financing and Sustainability Advisory Committee.

With respect to specific financing mechanisms, one consumer advocacy group supported use of a tobacco excise tax increase because of its additional public health benefit of reducing teen smoking. Similarly, four other stakeholders supported use of a broad-based "sin" tax, citing a tobacco excise tax as an example. No organizations opposed this mechanism.

Additionally, the three hospital provider organizations submitted comments opposing the use of a hospital assessment to fund the MHBE, expressing concerns that it could have a negative impact on Maryland's "all-payer" system and the Medicare waiver. By contrast, three other groups representing carriers and consumer advocates recommended using some type of provider assessment as part of a broad-based hybrid approach to financing.

While no organizations opposed use of a carrier assessment, several raised issues regarding how such an assessment could be structured. First, two carriers and one consumer organization supported an assessment that would be applied to plans sold inside and outside the Exchange to ensure that no plans are placed at a competitive disadvantage and to spread the cost across a larger enrollment base. Taking the opposite view, three carriers supported an assessment only on plans sold inside the Exchange on the grounds that only those plans should pay for its operations. Second, the two dental carriers recommended that assessments on plans be made in proportion to the percentage of premium collected, stating that a flat transaction fee would disproportionately affect consumers purchasing plans, such as dental plans, with lower premiums. Conversely, two health insurance carriers supported a flat transaction fee, stating that a percentage-based assessment would place a greater burden on carriers selling higher priced plans. Finally, two insurance carriers recommended that any carrier assessment be structured so as to exclude it from medical loss ratio calculations. No comments were offered in opposition to this view.

Joint Committee Recommendations to Governor and General Assembly

The Joint Committee's guidance to the Governor and General Assembly first sets forth five principles which should inform design of the MHBE's financing mechanisms. It then provides input on the proposed financing models, indicating which options the Joint Committee feels should not be considered at all by policymakers, and the pros and cons of those models it feels do merit consideration.

Principles to Guide Design of MHBE's Financing Mechanisms

Based on all of the reports and public comment, the Joint Committee believes the following principles should guide design of the Exchange's revenue streams.

1. The MHBE has both business and public value, benefiting consumers, carriers, brokers, the health care sector, the State and the general public.

- *Business value*: The MHBE benefits those involved directly in the offer and purchase of insurance in the Exchange.
- *Value to health care sector*: The MHBE infuses $600 million in subsidies; increases premium and provider revenue; reduces uncompensated care and bad debt; and supports payment and benefit design innovations.
- *Value to public*: The MHBE reduces the rate of uninsured; reduces the hidden tax currently embedded in premiums by reducing uncompensated care; provides "uninsurance insurance" and a trustworthy source of information; and establishes a no-wrong-door eligibility and enrollment system.
- *Value to State:* The MHBE lowers the rate of uninsured; lowers unemployment; increases state and local tax revenues; and generates enhanced economic activity.

2. The allocation of fixed, variable, and Medicaid-related costs should inform determination of the appropriate revenue streams to ensure MHBE sustainability.

An estimated 61% of MHBE-specific spending is fixed (salary/benefits; equipment/communications; facilities), and 39% is variable (navigators; administrative). This percentage breakdown reflects the fact that some functions have both a fixed and variable component (marketing/advertising; consulting; IT systems/operations; appeals). The MHBE's budget is based on an understanding that a substantial fraction of costs for eligibility infrastructure (as much as 75%) will be covered separately through the Medicaid program.

3. A hybrid approach, which combines two or more revenue streams, reflects MHBE's business and public value and is most likely to ensure its sustainability.

The MHBE Board, the MHBE Act of 2012, and the 2012 Wakely report encourage a combination of transactional (variable) and broad-based (fixed) revenue models because this approach reflects the business and public value of the MHBE. It is also most likely to meet the different revenue needs of

fixed costs (stable and predictable regardless of enrollment), and variable costs (dependent upon and scalable to enrollment).

4. MHBE revenue streams should be designed to support its short and long-term financial sustainability.

5. Where possible, assessments should be characterized by simplicity and ease with respect to compliance and administration.[4]

MHBE Financing Options Considered by the Joint Committee

In addition to these guiding principles, the Joint Committee offers the following recommendations and input on the issues raised by the financing options and their relative advantages and disadvantages.

Multiple revenue sources

First, options for the MHBE's financing mechanisms should not necessarily be limited to a combination of two funding sources only. While the recommended hybrid approach suggests at least one transaction-based and one broad-based revenue source, consideration should also be given to combinations of more than two revenue streams. Objectives regarding equity, stability, flexibility and other factors may well militate in favor of multiple funding sources.

Transactional/Variable Cost Models

Percentage of premium assessment versus flat, per member fee: The factors favoring a percentage-based assessment are that: 1) the MIA's current premium assessment is percentage based, and thus using the same methodology would be simpler administratively; and 2) it would not penalize dental and vision carriers whose premiums are much lower per member. The advantage of a flat, per member fee is that it would not penalize higher cost policies. The Committee recommends that if a flat fee were utilized, the burden on dental and vision carriers should be addressed by imposing different fees on each insurance line. With respect to a percentage assessment, the Committee recommends considering a cap so as to limit its penalizing impact on high cost policies.

Assessment on MHBE membership only or non-group and small group enrollment both inside and outside Exchange: Without making a hard and fast recommendation, the Committee offers several observations and then key factors which should be given serious consideration in deciding between the two options.[5] First, the Committee observes that:

[4] One Joint Committee member suggested a sixth principle which would direct consideration of any secondary impacts or unintended consequences of potential financing options. Because these principles are not intended to serve as an actual roadmap but rather as a broad framework to guide policy-makers, the Joint Committee opted to address the potential for secondary impact in its evaluation of each individual financing option.

[5] The Committee notes in this context that in 2016, the definition of a small employer eligible to participate in the Exchange will change from ≤ 50 to ≤ 100 employees, which could alter the considerations around this assessment on ~~QHP~~ plan enrollment.

1. The Affordable Care Act requires the premium rates of the same plan sold inside and outside the Exchange to be the same, and an issuer's risk pool inside and outside the Exchange must be aggregated. Thus, regardless of which options chosen, consumers would not be affected differentially;

2. Assessing only QHP Exchange enrollment creates a business risk for the MHBE, both because carriers will receive less yield on QHPs sold in the Exchange, and because the MHBE will have difficulty projecting enrollment in the initial years precisely enough to calibrate the amount of the revenue stream needed if relying only on Exchange QHPs. Thus, assessing all non-group and small group plans in both markets is more fiscally prudent, and policymakers can revisit later whether an Exchange-only assessment might be preferable once enrollment is stable;

3. The MHBE Act of 2012 provides that at least initially, all issuers which meet the minimum premium threshold will be required to sell in the Exchange, which means functionally that all carriers in Maryland will participate in the Exchange;[6]

4. Assessing issuers' enrollment in both markets would be less administratively burdensome since the MIA already collects an assessment on issuers' entire membership; and

5. In establishing any carrier assessment, attention should be given to its potential effect on the possibility that reciprocal assessments could be imposed on Maryland-domiciled insurers by other states.

In view of these observations, the Committee recommends that the following factors be weighed in making this selection:

1. The MIA's existing premium assessment renders an assessment both inside and outside the Exchange the simpler path for the Exchange, avoiding a reinvention of the wheel;

2. An assessment both inside and outside the Exchange will establish greater predictability and stability in the early years and could be revisited once enrollment stabilizes; and

3. Both options give issuers flexibility as to how to spread costs of the assessment.

Broad-Based/Fixed Cost Health Care Market Models

With respect to options for assessments on the broader health care market, the Committee makes the following recommendations:

Hospital assessment: An increase in the current assessment on hospital revenues should not be

[6] The law sets forth a minimum annual premium threshold above which a carrier must participate in the Exchange ($10 million in the non-group market and $20 million in the small group market), but the only carrier with a footprint in Maryland small enough to fall below the threshold has already indicated its intent to sell in the Exchange. This requirement does not apply, however, to managed care organizations.

considered as a viable funding mechanism. Because Maryland is near the federal limit in using a hospital-based assessment, and because that limit may be lowered by Congress, this option is not a reliable and sustainable funding source.

Assessment on other licensed providers: If an increase in the current Maryland Health Care Commission assessment is considered, it should be limited to a modest increase over existing levels. One complexity is that determining the correct individual rates of assessment for different kinds of providers not similarly situated in their ability to recoup the costs will be difficult.

Assessment on large group commercial health insurance market: An assessment on the commercially insured large group market should be considered as a viable option for MHBE's broad-based, fixed cost funding mechanism. Working in concert with the transactional-based fee on the non-group and small group market, it carries the benefit of reaching indirectly most components of the health care system, thereby recognizing and capturing the value of the MHBE to the broader health care market. It also allows for a lower rate of assessment because of a relatively expansive base, and it can leverage the existing mechanism for MIA collection of premium taxes. As with respect to the transaction-based assessment on the non-group and small group markets, however, attention should be given to potential reciprocal assessments which could be levied on Maryland insurers by other states.

Broad-based/Fixed Cost Public Funding Models

A broad-based public funding mechanism should be considered as a component of the MHBE's revenue stream, and an increase in the tax on cigarettes constitutes the option most closely tied to the public value of the Exchange. Studies show that tobacco users are more likely to be uninsured and more likely to need health care services than the general population. About 15% of adult Marylanders smoke; should this number decline as a result of a modest tax increase, the resulting cost savings and greater productivity would benefit the entire state. If this funding mechanism is considered, there should be a plan to maintain revenue in the event that smoking rates decline.

Effect of Financing Options on Health Insurance Premiums

Generally, carriers will pass through the cost of any assessment on to consumers through premium adjustments. In the same vein, an assessment on providers, which would in turn increase carriers' costs, would similarly be passed on to consumers. Thus, all other factors being equal, the percentage assessment imposed to finance the Exchange could be expected to cause the same percentage increase in premiums. The biggest determinant regarding the increase to premiums is the size of the market segment being assessed. For example, the percentage impact on premiums to raise $35 million to offset the Exchange's operating costs will be greater if applied to just the non-group market, than if applied to the sum of the non-group, small group and large group market segments.

The assumption that carriers will load the entire assessment into premiums, however, does not take into account changes in market factors brought about by the Exchange. Because all carriers will be required to participate in the Exchange, (subject to certain premium thresholds and not including managed care organizations), it may create competitive pressure to price qualified health plans strategically. A robust

Exchange infrastructure and enrollment, with enrollees who are particularly sensitive to price, could induce carriers not to pass the entirety of any assessment through to consumers in order to maximize their competitive advantage. Massachusetts' experience in this regard is instructive; it was able to keep premium trend for its subsidized program to under 5% premium growth, well below the then prevailing market trend of 8%.

The likelihood that most, if not all, of any assessment will be reflected in premiums, however, counsels in favor of using the broadest base possible in order to keep the rate of assessment as low as possible. The only option unlikely to have any direct effect on premiums would be the cigarette tax increase. Even with a cigarette tax increase, however, the cost will be borne by consumers purchasing cigarettes and tobacco products.

CONCLUSION

In sum, a financing mechanism which would support the MHBE's short and long-term sustainability should include at least two revenue streams to support both its transactional and fixed operating costs. In selecting the optimal mix of funding sources, the Governor and General Assembly should not include for consideration 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 non-group and small group markets, broad-based assessments on the large group insurance market, and/or an increase in the tobacco tax.

Wakely
Consulting Group

Detailed Analysis for Financing the Maryland Health Benefit Exchange

Wakely Consulting Group

September 19, 2012

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CONTENTS

Executive Summary

This report has been prepared as a result of a Request for Proposals dated May 23, 2012 issued by the Maryland Health Benefit Exchange for Detailed Analysis for Financing the Maryland Health Benefit Exchange (MHBE), and subsequent proposal and award of work to Wakely Consulting Group (Wakely). The preparation of this report is intended to inform the joint legislative-executive committee (Joint Committee), which, per the Maryland Health Benefit Exchange Act of 2012, is required to make recommendations regarding Exchange financing and self-sustainability to the Governor and General Assembly by December 1, 2012.

Wakely developed this report to provide technical analysis to the Joint Committee regarding revenue model options for the MHBE. Wakely's role in this project was to identify, evaluate and assess different financing options against a set of evaluative criteria identified based upon feedback from the Joint Committee and the Financing & Sustainability Advisory Committee (Advisory Committee). In addition, Wakely is assisting in the development of an operating budget. As outlined in the design of this process, Wakely does not opine as to a preferred financing mechanism. Specific work performed by Wakely during this process included the following:

1. A qualitative analysis and discussion of the value of the Exchange to different market segments;
2. A detailed assessment of exchange financing models relative to evaluative criteria prepared by Wakely and processed with the Financing and Sustainability Advisory Committee, and Joint Committee;
3. Proposed Financing Model Options for consideration; and
4. An expected implementation timeline

For the section in which proposed financing model options are discussed and the impact to the market quantified, we have used $42 million as a placeholder for the total operating expense of the MHBE. This estimate is not Maryland-specific, but represents the upper end of a range of cost that would be expected to be incurred by an efficiently operated exchange under the ACA, including Navigator funding, and allows for the full development of financing model options for consideration. A Maryland specific budget will be prepared and presented to the Joint Committee in October 2012.

The MHBE will serve a broad range of markets and populations, and has both a business value and a public value. One aspect of the Exchange's operations includes narrowly focused operational and administrative activities. Another aspect involves elements that benefit the entire health care marketplace, such as the development of a web portal that simplifies the comparison of carriers and plan designs, along with the provision of subsidizes to make insurance more affordable. Yet a third aspect of the MHBE more broadly benefits the general

population of Maryland by expanding access to affordable health care, streamlining the shopping and enrollment process, and providing certain regulatory functions. All of these values provided by the Exchange should be considered in the context of selecting a financing model for the MHBE.

In determining the best financing model for the MHBE, two specific models we recommend that the Joint Committee ***not consider*** as the sole financing stream for the Exchange include a transaction fee that only applies to Exchange enrollment and a financing model that only consists of a broad-based public fee. A model that only contemplates an assessment on premiums for Exchange enrollment will create too great of a business risk for the MHBE due to the uncertainty and potential fluctuation in enrollment, while a public-only fee will require a substantial lead-time for implementation and will be inflexible, especially during the start-up years of the Exchange.

We recommend that the Joint Committee consider a model that incorporates a blended methodology, or Hybrid Approach, to manage against risks associated with any one particular model and in recognition of the Exchange's multi-faceted value proposition. Although there are a number of permutations that could be developed, for illustrative purposes, we have identified three variations of a Hybrid Approach. Our approach introduces the concept of offsetting scalable, transaction-based variable cost with a relevant revenue base, and fixed cost, that does not fluctuate with enrollment scale, with a broad-based revenue stream. The specific models are:

1. Variable cost offset by combined Non-group and Small Group premium revenue, and fixed cost offset by Large Group premium revenue;
2. Variable cost offset by combined Non-group and Small Group premium revenue, and fixed cost offset by Provider revenue;
3. Variable cost offset by combined Non-group and Small Group premium revenue, and fixed cost offset by a Cigarette Sales Tax.

A financing mechanism that incorporates more than one underlying revenue base will mitigate the financial risk associated with any one model, and provide the MHBE with maximum financial flexibility as it evolves from a start-up entity to a more mature and stable organization financially and organizationally.

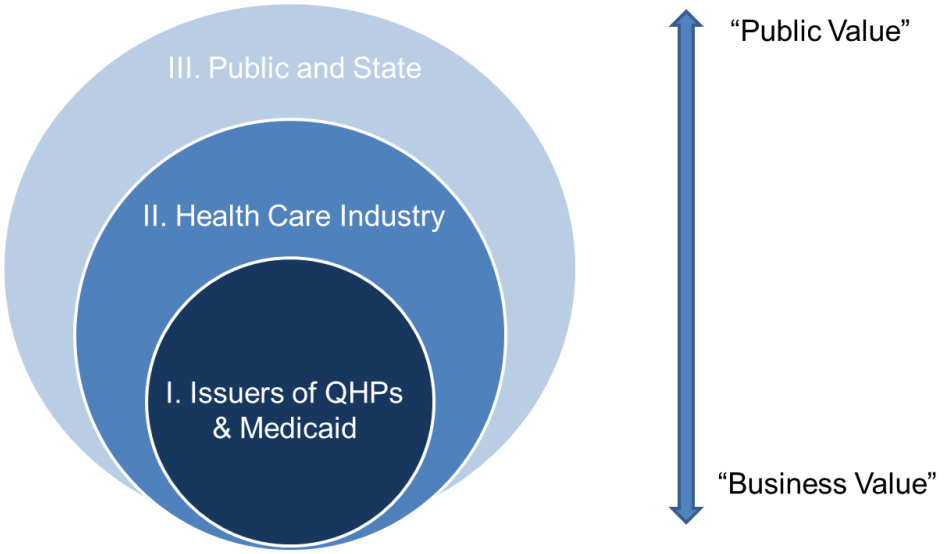
Value of the Exchange

The MHBE is an intricate public/private initiative that provides a number of different functions and services that benefit a wide range of constituents. Among its required functions, the MHBE must perform the following:

- Review and certify issuers and health benefit plans as Qualified Health Plans (QHPs)
- Develop and host a web portal to support individual and employer comparison of health plans and purchase of insurance
- Determine individual eligibility for and administer the distribution of federal tax credits and subsidies
- Enroll individuals and small businesses in health insurance coverage
- Provide customer service support and consumer assistance
- Oversee and finance a Navigator program
- Engage in targeted and broad-based marketing to encourage enrollment
- Provide for the acceptance and adjudication of individual and employer appeals
- Provide a host of public reporting on health plan quality and Exchange operations

The MHBE will serve a broad range of markets and populations, and has both a business value and a public value. One aspect of the Exchange's operations includes narrowly focused activities that directly benefit its issuer partners, such as the marketing of health plans, the determination of individual eligibility for federal tax credits and cost sharing subsidies, and the required monthly reconciliation and reporting of federal tax credits. Another aspect involves elements that more broadly benefit the entire health care marketplace, such as the development of a web portal that simplifies the comparison of carriers and plan designs, along with the provision of subsidizes to make insurance more affordable. By making insurance more accessible, especially for the previously under-insured or uninsured, the Exchange is expected to increase coverage, benefiting the entire health care market (i.e., carriers and providers). Yet a third aspect of the MHBE is to provide services that benefit the general population of Maryland. These include discrete functions such as its role in granting certificates of exemption under the individual responsibility requirement, as well as its much more broadly defined value related to its role in improved ability of Maryland residents and small businesses to easily and efficiently access affordable health care coverage.

Figure 1. Three Levels of Exchange Value



In all of its activities, the MHBE must balance its business-like aspects with those of its public mission and value proposition. Because it must be fully self-sustaining by January 2015 and will be operating in a functioning market to attract and enroll individuals and small employers, it must operate in many respects like a private-market entity. At its core, and consistent with the vision of the MHBE Act of 2011, the MHBE is a facilitator for the purchase of privately-offered health insurance products, and must perform this function efficiently and cost-effectively so that consumers and health insurance carriers will look to the MHBE as a viable destination and business partner. In addition to this business-like focus on efficiency and market-appeal, the Exchange must also retain focus on its public mandate to foster efficiency and quality in the health insurance market and expand access to coverage for all Marylanders.

In evaluating potential revenue models to support the organization's ongoing operations, we need to first identify the markets, populations, and entities that derive value from the Exchange, and determine the specific ways in which these groups will benefit from the activities of the MHBE. To help structure this assessment, we have divided the constituencies benefitting from the MHBE into three categories or levels, ranging from the most focused and narrowly defined benefit to the broadest and most widely-shared type of benefit. The three categories or levels are: Issuers of QHPs and Medicaid, the Health Care Market, and the Public and the State.

Value to Issuers of QHPs & Medicaid

The first type of value being provided by the Exchange will accrue to the organization's business partners: issuers of QHPs and the state's Medicaid office. As a direct service provider to these groups, the Exchange will perform a number of critical functions on behalf of these entities, including eligibility determination and enrollment; account installation and management; broad-based and targeted marketing; front-end communications, including collateral material production and web-portal hosting; customer service and consumer assistance; and ensuring accurate data transmittal for tax credit purposes.

The value of the Exchange performing these functions is particularly relevant in the small and non-group insurance markets, where administration as a share of total premium cost is highest, due to the high number of transactions for low enrollment yields. Whereas an issuer that closes a single sale in the large group market may yield thousands of new members, it may take that same issuer hundreds of individual sales in the small and non-group market – with all of their associated marketing, account set up, and customer service costs – to yield the same level of membership. The Exchange's role in organizing the market, providing a single web portal, and leveraging its scale efficiencies to perform many of these administrative functions is therefore of particular value to issuers selling small and non-group insurance.

Beyond the technical and administrative functions provided by the Exchange, the greatest value provided by the Exchange may be the membership opportunity it presents: as the only entity empowered to provide federal premium tax and cost-sharing subsidies and the gateway for determining eligibility for Medicaid, the MHBE will be the channel through which approximately 305,238 Maryland residents in 2015 will gain access to coverage[1].

As both a source of membership and a provider of marketing, sales, and account installation services, the Exchange will function in a manner analogous to carriers' sales, marketing, and enrollment departments. Because of the scale of enrollment anticipated to move through the Exchange and the type of systems being developed, the MHBE should be able to provide efficiencies for issuers of QHPs in the marketing and installation process.

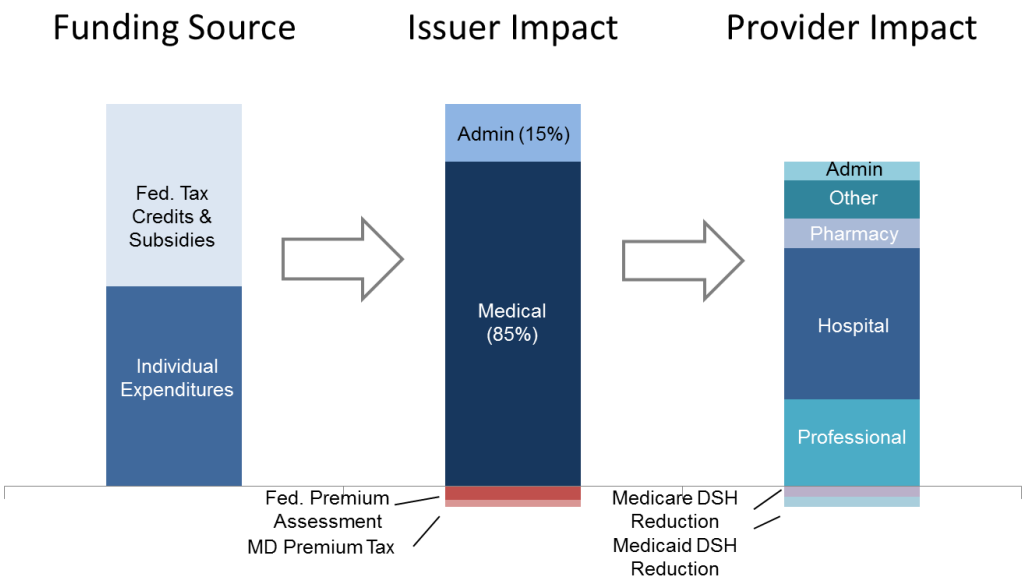
Value to the Health Care Market

The Exchange also provides specific and tangible value to the health care industry as a whole, including both health insurers and health care providers. First and foremost, the Exchange will

[1] Fakhraei, S. H. (2012). *Maryland health care reform simulation model: Detailed analysis and methodology.* Baltimore, MD: The Hilltop Institute, UMBC.

provide a path for enrollment in 2015 to approximately 305,238 individuals in Maryland, as mentioned previously. Additionally, as illustrated in the diagram below, the Exchange will capture federal subsidy dollars as well as individual and employer contributions, and distribute these funding streams throughout the health care market. They will first be paid to insurers in the form of premium revenue, and next to the provider community as the majority of insurance premium revenue is distributed to pay for medical services. The total expected federal subsidy dollars for premium tax credits and cost sharing subsidies is expected to be $607 million in 2015, and growing to over $1.3 billion by 2020. Correspondingly, as a direct result of activity generated from implementing the ACA, the expected increase in total health care expenditures is estimated to be over $2 billion in 2015 and just under $4 billion in 2020.[2]

Figure 2. Exchange Coverage Funds Flow Diagram



As indicated in Figure 2, the ACA has been structured to require that insurers and hospitals make a financial contribution toward the effort in recognition of the fact that they are anticipated to realize revenue gains as a result of expanded coverage. These contributions will come in the form of a federal premium assessment and reductions in Medicare Disproportionate Share Hospital (DSH) payments for Medicare and Medicaid. There are differing opinions as to the net impact on these industries from the implementation of the ACA, but the general consensus is that the increase in coverage and reduction in uncompensated care will be a net positive. For example, additional Federal health expenditures in Maryland for hospital services are expected to be approximately $305 million in 2015 and $639 million in

[2] Fakhraei, S. H. (2012). *Maryland health care reform simulation model: Detailed analysis and methodology.* Baltimore, MD: The Hilltop Institute, UMBC.

2020. Additional payments for all health services including hospital, professional, pharmacy and other is expected to be $1.16 billion in 2015 and $2.21 billion in 2020.[3]

In addition to the direct impact of the Exchange on issuer and provider revenue through its enrolled membership, the Exchange will perform a number of other functions that benefit this sector. By providing broad-based communication and outreach underscoring the need for health insurance and the availability of tax credits and subsidies, the Exchange will have an impact on expanding coverage beyond the population that enrolls directly through the MHBE.

The Exchange will also provide a simple-to-use web portal and web-based decision support tools, such as provider search functions and a health care cost calculator. These functions will encourage more educated health care consumers and, in theory, save time and money by reducing provider bad debt and other inefficiencies. The MHBE can be a catalyst for change within the broader health care market by providing health insurance carriers and providers a platform with which to test or "incubate" innovative benefit designs, product features, or reimbursement methodologies, and if successful, influencing the market outside the exchange as well.

Finally, the Exchange will also provide information and metrics on cost and quality. Making this information publicly available will serve as a source of information and knowledge to consumers; by providing a source of comparative information, it may also encourage carriers and providers to improve their quality and efficiency both in absolute terms as well as relative to one another through competition for exchange enrollment and the adoption of best practices.

Value to the Public and the State

Beyond its direct business relationships and the health care market, the Exchange also provides significant and quantifiable value to the public and the state in the form of expanded coverage, greater security in the ability to access affordable coverage when necessary, positive economic impact, and greater access to health care information.

First and foremost, the Exchange will provide a convenient destination to purchase affordable coverage, and allow Maryland residents to obtain Federal tax credits and cost sharing subsidies for those who qualify. This will provide the state with a form of "uninsurance insurance." In other words, the existence of the MHBE will provide a significantly greater degree of security or "peace of mind" to Maryland residents who lose or are without health insurance coverage by providing a mechanism that will allow them to obtain coverage from carriers that have a trusted seal of approval through the MHBE QHP certification process. As part of the QHP certification process, the MHBE will be ensuring the offering of plan designs that meet

[3] Fakhraei, S. H. (2012). *Maryland health care reform simulation model: Detailed analysis and methodology.* Baltimore, MD: The Hilltop Institute, UMBC.

minimum coverage standards relative to benefits and cost sharing levels. This will provide additional protection for the residents of Maryland that the insurance products sold by the Exchange meets federal standards, and will provide comprehensive health benefit coverage should the need arise.

Second, the ripple effects generated by the expansion of health insurance coverage will have a positive effect on the fiscal and physical health of the state. While the increased insurer and provider revenue is anticipated to aid the state's broader economy, the increased access to health care is expected to have a positive impact on the overall health outcomes of the population. For example, if the ACA is not implemented, 12.3% of Maryland's total population is expected to remain uninsured in 2015. On the other hand, with the implementation of the ACA, the uninsurance rate in 2015 is expected to decline to 8.6% of the total population. The uninsurance rate will further decline to 6.3% by 2020. The macro-economic effects from the ACA are expected to be significant as well. The rate of unemployment in 2015 will be 0.3 percentage points less as a result of the implementation of the ACA, going from 5.8% without the ACA to 5.5% under the ACA. By 2020, the unemployment rate as a result of the ACA implementation is expected to be 3.7% compared to 4.3% if the ACA was not implemented.[4] It is also expected that the ACA will cause about $2 billion in 2015 of additional economic output in Maryland, growing to $3.3 billion in 2020. This additional economic output will generate $98 million and $163 million of state and local tax revenue, not including premium taxes, in 2015 and 2020 respectively[5]. The Exchange will serve a critical role in the implementation of the ACA, which as evidenced above, will contribute significantly to the economic growth of Maryland.

Third, the Exchange will provide a valuable service as a trusted, objective source of information about health care generally, and about health insurance carriers specifically. Understanding and interpreting health care terms such as coinsurance, copay and deductibles, as well as differences between plan designs and carriers is extremely difficult for the typical individual or small business looking to purchase health insurance. By bringing best-in-class information technology and a deep understanding of the health insurance market, the MHBE will bring order to the current disorder of purchasing health insurance. Due to the significant amount of broad-based marketing and advertising that is expected, the MHBE will likely become a destination site for the general public for seeking information about health care reform. For example, in Massachusetts, the Health Connector was compelled to hire approximately three to four staff to solely triage calls and handle the number of public inquiries that were only remotely associated with programs administered by the exchange.

Finally, the Exchange will be responsible for administering the ACA-required process for eligibility appeals and is also responsible for granting certificates of exemption to the individual responsibility requirement (individual mandate). The MHBE will also be a valuable state-based

[4] Fakhraei, S. H. (2012). *Maryland health care reform simulation model: Detailed analysis and methodology.* Baltimore, MD: The Hilltop Institute, UMBC.
[5] Fakhraei, S. H. (2012). *Maryland health care reform simulation model: Detailed analysis and methodology.* Baltimore, MD: The Hilltop Institute, UMBC.

asset to assist individuals seeking cost-effective health care options as a result of employment transitions or stitching together part-time employment in which health care is not offered or available.

Table 1. Summary of Exchange Value by Constituency Group

Constituency	Source of Value
I. Issuers of QHPs	• Marketing, Enrollment, Account Installation, and Administrative Services • Membership Opportunity • Premium Aggregation for Small Business
II. Health Care Market	• Increased premium and provider revenue • Reduction in hospital charity care • More widely available consumer information • Supporting use of innovative product designs and provider payment methodologies • Reduced provider bad debt
III. Public and State	• "Uninsurance insurance" • Reduction in the number of uninsured Maryland residents • Enhanced coverage in minimum health insurance benefits • Trusted source of health care information • Comparison of health insurance carriers and benefits • Eligibility and mandate appeals administration

Exchange Financing Models

Although there are a wide variety of potential financing models that could support Exchange operations, for ease of discussion they can be grouped into the three broad categories discussed previously relating to the Exchange value proposition and the related market

stakeholders: (1) revenue models focused on issuers of QHPs; (2) revenue models focused on the broader health care market (e.g., insurers and/or provider revenue (hospitals and physicians)); and (3) broader public funding sources. Examples of these revenue models are highlighted in the table below.

In this section, we will consider each of these broad categories of models, highlight their unique characteristics, and outline the important considerations of each model. While there are important differences worth considering between different revenue options within each broad category, for the most part, these differences are relatively minor and/or nuanced relative to differences between the larger groups. We will discuss some of these within-group differences when discussing each type of revenue option in the section below.

In addition to the separate models itemized below, the Exchange may also employ a hybrid model or combination of different revenue models to finance its ongoing operations.

Revenue Type	Examples of Specific Revenue Bases
1. QHP Issuers	QHP Issuer Surcharge – Exchange Enrollment
	QHP Issuer Surcharge – All Issuer Enrollment (inside and outside Exchange)
2. Health Care Market	Insurance Premium Revenue Assessment
	Hospital Revenue Assessment
	Other Provider Revenue Assessment
3. Public Funding Source	Ex. Tobacco
	Other Broad-based Revenue Source

Evaluation Criteria

To help structure our discussion of these different models, we will discuss each revenue model in relation to the set of evaluative criteria that have been developed, and previously shared with the Advisory Group and Joint Committee, to provide a balanced view of each option, as well as to highlight the relative strengths, potential risks, and considered trade-offs associated with different aspects of each model. As outlined in the table below, the considerations that inform an appropriate revenue stream are multi-faceted. In addition to factors such as whether the method can generate sufficient funding, be reasonably predictable, not discourage participation in the Exchange, and align with the Exchange value proposition, there are important considerations related to the timing of cash flows and the ability of the Exchange (or State on behalf of the Exchange) to administer the revenue mechanism.

With respect to cash flow and timing, which are two criteria often overlooked when considering Exchange revenue options, the Exchange must consider whether incoming cash flow from revenue sources can meet the timing requirements of outgoing cash flow from expenses. In particular, managing the transition from 2014, when the Exchange can rely upon federal funding, to 2015, when it must be fully self-sustaining, will necessitate careful timeline planning. Providing funds to support the Navigator program in late 2013, before the effective date of health insurance coverage sold by the Exchange, is another important consideration.

In addition, the type of revenue stream selected will affect the Exchange's ability to predict and rely upon the availability of adequate revenue. For example, a broad-based assessment targeted to yield a given amount of funding will provide a greater degree of certainty in the total revenue position than a transaction-based, membership model that introduces a greater level of uncertainty, especially during the first few years of operations.

Evaluative Criteria	Questions for Consideration
1. Exchange Value Relationship	How closely tied is the Exchange to the assessment? How valuable (on a relative scale) is the Exchange to the market being assessed? Does the Exchange perform a specific function(s) on behalf of the market? Are there efficiencies to be gained through the Exchange?
2. Market Impact	Does the assessment distort the market? Does the assessment create an economic disadvantage to the Exchange? Is carrier competition enhanced or impaired?
3. Impact to Exchange Enrollees	Does the fee or assessment disproportionately affect Exchange enrollees? Will the assessment decrease enrollee take-up?

4. Variability of Revenue Yield	How stable is the expected revenue stream to the Exchange? Does the predictability change over time?
5. Collection Timing and Cash Flow	What is the method of collection and frequency of available cash to the Exchange? What is the reliability of expected collections?
6. Administrative Ease	How difficult or administratively costly is the revenue model to the Exchange? Can current State/Exchange processes be leveraged to implement the fee?
7. Lead Time to Alter	If necessary to alter or change the fee, what is the process and lead time necessary to change?

QHP Issuer-based Revenue Models

A QHP issuer-based assessment would involve charging a fee to issuers of QHPs, most likely based upon a percent of premium or a flat per-member per-month (PMPM) amount. This model is narrowly focused on the carriers that most directly benefit from Exchange enrollment. This type of funding mechanism can be viewed as a fee for services provided to issuers to offset the value of services provided to them by the Exchange. Specifically, this value includes the marketing, administrative, and account installation functions performed by the Exchange, as well as access to additional subsidy-eligible enrollment that is provided exclusively through the Exchange.

There are two types of assessment that can be charged to issuers of QHPs: one that only applies to Exchange membership and one that applies to the issuer's entire enrollment base. The first model assumes that the Exchange will assess a percentage or fixed fee on QHPs for the revenue and/or membership they earn on their Exchange business. Under ACA rating rules, premiums for the same product must be the same inside and outside the Exchange. Therefore, this fee will not make premiums higher inside the Exchange than they would be outside; rather, carriers will spread this fee cost across their entire small or non-group book of business. While premium prices will remain the same inside and outside the Exchange, carrier yields for the same product will be somewhat lower for business sold through the Exchange due to the assessment on Exchange business.

The second approach, a fee on total issuer membership or revenue, would more explicitly spread the cost of the Exchange across the issuers' total small and non-group book of business, or, alternatively, across their entire insured book. In this model, the premium yield to issuers would be the same for business sold inside and outside the Exchange, meaning there would be no economic dis-incentive for issuers to write business outside the Exchange. The rationale for expanding the assessment to an issuer's total non and small group or total insured book of business would be that (a) the availability of the Exchange as a shopping and comparison tool would benefit carriers' non-Exchange enrollment, as it is likely that some individuals comparing products on the Exchange will make purchases outside of the Exchange; and (b) by providing an increase in overall enrollment and greater organization to the market, the Exchange provides a benefit to an issuer's total business that should be recognized in a way that does not disadvantage the Exchange as an enrollment channel.

From an administrative stand-point, the collection process for an assessment on Exchange-only enrollment is fairly straightforward if the Exchange administers premium billing services. To collect a transactional fee the Exchange can simply withhold a portion of the monthly premium that is owed to the Issuers as a transaction fee. The Exchange will have great administrative ease and control over the collection process and in addition, payment will be received immediately after the enrollee's monthly premium is processed. Currently, the MHBE plans to perform premium billing services for its SHOP exchange and is considering allowing carriers to perform premium billing for the Non-group Exchange. This approach will reduce the administrative efficiency, should the Exchange adopt a transaction or QHP membership-based revenue model, as the Exchange will need to develop a process to invoice carriers and collect revenue separate from the carrier's enrollee billing and collections system.

An assessment on QHP issuers' total insured membership would need to be implemented in a similar manner to a broad based insurance premium assessment similar to those currently administered by the Maryland Insurance Administration (MIA). Given that Maryland's Exchange statute requires issuers participating in the small and non-group market to participate in the Exchange (based on certain overall enrollment levels and the MHBE is not an active purchaser), it is likely that most or all current market participants will participate. As a result, the Exchange may be able to utilize existing State infrastructure to collect payments. In this scenario, cash would likely be collected less frequently than under an Exchange only model (i.e., quarterly instead of monthly).

QHP ASSESSMENT – EXCHANGE MEMBERSHIP ONLY

Exchange Value Relationship	This funding mechanism is most closely related to Exchange business operations and market relationships, and is narrowly focused on carriers that benefit from Exchange enrollment.
Market Impact	The larger the differential between Exchange business and non-Exchange business from a carrier yield perspective (for example, if enrollment is low and the fee high), the more incentive carriers will have to sell outside the Exchange (even in this case, however, the fee differential will not affect member premiums for the same product inside vs. outside the Exchange). At low levels of Exchange enrollment, the fee as a percent of premium may be high and create market distortion.
Impact to Exchange Enrollees	This funding mechanism is invisible to enrollees, in that it is spread across the market inside and outside the Exchange.
Variability of Revenue Yield	This method is highly sensitive to Exchange enrollment, and can be unpredictable and/or variable during the start-up period and/or in the case of low enrollment. However, as enrollment grows, this method can become more predictable, and allows the Exchange to lower the assessment rate over time.
Collection Timing and Cash Flow	Timing of collections would be tied to Exchange membership enrollments, meaning funds would not be available until 2014 and total collections would increase and decrease parallel with Exchange membership. On an ongoing basis, cash flow would depend on the Exchange approach to premium billing: if the Exchange performs premium billing, cash flow would be realized in real time; if carriers perform this function, the Exchange would need to invoice carriers and collect funds with a slight lag, relative to the Exchange performing billing and collections, in receiving earned revenues.

Administrative Ease	Administrative ease would also depend somewhat on the Exchange approach to billing: if the Exchange performs billing, it will have the ability to withhold a portion of member premiums prior to remitting the balance to issuers. If issuers perform this function, the Exchange will need to develop a reconciliation, reporting, invoicing, and collection process to bill issuers.
Lead Time to Alter	The Exchange will have the ability to quickly change the fee if necessary. Practically speaking, it should strive to minimize the changes applied to this fee and will also need to align any fee changes to the issuer pricing cycle so that issuers have the ability to incorporate fees into their product pricing.

QHP ASSESSMENT – ISSUERS' TOTAL MEMBERSHIP

Exchange Value Relationship	This method retains a close link to Exchange business relationships by focusing the assessment only on carriers that participate in the Exchange. This model captures the aspect of Exchange value that allows individuals to "shop" using the Exchange and then purchase coverage in the outside market, and therefore recognizes the spill-over benefits the Exchange is likely to have on issuer business outside of the Exchange.
Market Impact	This method reduces the incentive for carriers to sell outside the Exchange by eliminating the difference in yield for business sold inside and outside the Exchange. However, the distinction it creates between participating carriers (which are charged a fee on a substantial portion of their book of business) and non-participating (which are not) may incent non-participation. This method also allows for the possibility that the relative market share for some issuers will be lower within the Exchange than outside, meaning the relative financial contribution of large off-Exchange issuers may not comport with their relative share of Exchange enrollment.
Impact to Exchange Enrollees	This funding mechanism is invisible to enrollees, in that it is spread across the market inside and outside the Exchange.

Variability of Revenue Yield	The larger base for assessment relative to an Exchange business-only user fee allows for a lower fee level, as well as greater stability and predictability in the revenue source. However, relative to a more broad-based assessment across the entire health care market, the revenue base remains relatively narrow, and this method does allow for some risk that if carriers with large market share drop out or decline to participate, the revenue model becomes unsustainable.
Collection Timing and Cash Flow	Unlike a transaction fee levied on Exchange enrollment only, this model would require the Exchange to invoice issuers and collect payment outside of the billing & collections process. However, the Exchange should be able to control the frequency of collections (e.g., monthly, quarterly, or annually), meaning that cash flow can be realized on a regular basis throughout the year.
Administrative Ease	If the Exchange elects to collect money directly from Issuers, it will need to develop a reconciliation, reporting, invoicing, and collection process to bill issuers. Because this method would draw upon issuers total market share, and because all issuers participating in the small and non-group market are required to participate in the Exchange under Maryland law (as long as the Exchange is not an active purchaser), this method would operate much like current broad-based insurance assessments operated by the MIA. The Exchange could therefore likely leverage current reporting, invoicing, and collection processes to raise funds.
Lead Time to Alter	As with an assessment on Exchange enrollment only, the Exchange could alter the fee with little lead time, but would likely be constrained by the need to align with issuer pricing.

Health Care Market-based Revenue Models

The second broad type of revenue model would place an assessment onto the health care market. Examples of potential models in this category include an assessment on total health insurance revenue (similar to Maryland's current insurance premium tax) or an assessment on hospital net patient revenue (similar to the funding mechanism that finances a portion of the Maryland Health Insurance Plan). Expanding the base of assessment relative to QHP-focused

mechanisms will allow for a lower assessment percentage across a broader revenue base. Broadening the base in this way will also reduce the amount of variability and uncertainty in the underlying exchange revenue estimate. While there are different specific revenue streams that could form the basis for an assessment, the nature of the health care market – especially in Maryland's case, where hospital payments are highly regulated – means that these different options mostly reflect different methods of sourcing the same general revenue stream.

To understand this dynamic, it is worth considering the funding stream represented by the Exchange and how it works its way through the health care market. The Exchange channels money from federal tax credits and subsidies, in combination with individual and employer contributions, into premium revenue. Based on ACA required medical loss ratio (MLR) requirements, at least 85 percent of this revenue (for the small group market) funds medical expenditures, while the balance funds issuer administrative expenses and margin. Of the at least 85 percent of premium revenue dedicated to medical expenditures, approximately 37 percent is paid to hospitals, 27 percent is paid to physicians and other professional providers, while the balance is dedicated to prescription drugs and other provider types.[6] The majority of funds expended to finance premiums take the form of pass-through payments to providers. Because regulatory fees and taxes are not included in issuer MLR calculations, increasing these amounts will serve to increase plan premiums rather than reduce administrative expenses or, in all likelihood, plan margins. Similarly, fees and taxes placed onto providers will for the most part be passed back to payers in the form of higher rates. These higher rates will also make their way into higher premiums. In general, placing an assessment on any one area of the health care market will ultimately affect the upstream source of market revenue: individuals, employers, and, in the case of subsidized enrollment, the U.S. Treasury.

While generally true that financing the Exchange via the insured health care market taps the same source regardless of how it is applied, there are additional important features and considerations related to provider-based revenue mechanisms, particularly in Maryland where hospital rates for all payers are set by the state's Health Service Cost Review Commission (HSCRC). In many states, hospital expenses related to uninsured individuals go unpaid, appearing either as provider bad debt or as uncompensated charity care. In these states, the expansion of coverage provides a benefit to hospitals through a reduction in these uncompensated costs. In Maryland, the costs of uncompensated hospital care are incorporated into the all-payer rate setting process. This means that hospitals are compensated for the free care they provide; these costs are borne on a pro rata basis by their other payers – both commercial and government. Thus, while the burden shifted via the rate setting process on other payers may decline as a result of increased coverage, the net impact to hospitals will arguably be lower than in other states without similar funding mechanisms already in place. Nonetheless, there are clear benefits to hospitals of expanded insurance coverage, for example, hospitals may be able to decrease their subsidies of physician coverage for the uninsured.

[6] www.statehealthfacts.org "Distribution of Health Care Expenditures by Service by State of Residence, 2009". Kaiser Family Foundation. Last accessed September 19, 2012

One important difference between assessing provider revenue rather than fully insured premium revenue is the opportunity to expand the base beyond the insured market to capture revenue from self-insured employers and public payers. Tapping into revenue from these other payers can potentially greatly expand the base for assessment, allowing a lower overall impact to insurance costs by spreading the assessment more broadly. The rationale for including these revenue streams could be that while these groups do not benefit directly from increased coverage or its associated revenue dollars, their rates have historically supported hospital uncompensated care payments. Since the amount of uncompensated care is anticipated to decline, the same payments can now support the MHBE; in other words, these groups will be no worse off. Whether an assessment for this purpose would be possible under the current Medicare waiver, however, is not clear at this time.

Maryland already employs several different methods for raising revenue from the health care industry, meaning that if this path was selected, there may already be administrative infrastructure in place that can be used to support the MHBE. Adopting such an approach could help minimize challenges associated with creating a new assessment and provide administrative, cash flow, or lead time benefits.

Table 2: Summary of Existing Maryland Assessments

Existing Assessment	Collecting Agency	Key Features
Insurance Premium Tax[7]	MIA	• 2% tax on all insurance premiums written in Maryland (including life, property, casualty, and health) • Tax receipts from HMOs and MCOs support Rate Stabilization Fund, which finances Medicaid expenditures. Receipts from other lines support state general fund • Returns filed and payments collected quarterly • Total collections in FY 2011: $288.4 million to the General Fund and $106.7 million to the Rate Stabilization Fund
MIA Assessment[8]	MIA	• Assessment paid by insurers to support operations of the MIA • Total value of the assessment established annually based upon anticipated agency funding needs; carriers contribute pro rata share based upon market share • Assessment collected annually, due in August • Expected collections for 2013: $12.4 million, of which

[7] "FY 2013 Budget Hearing". Maryland Insurance Administration. (March 7, 2012)
[8] Dialogue with Maryland Insurance Administration and Fiscal Year 2011 Annual Report of the Maryland Insurance Administration

		health insurers will be responsible for $4.9 million • Separate assessment supports Appeals and Grievances unit of MIA
HSCRC Assessment[9]	HSCRC	• Assessment paid by hospitals to support operation of HSCRC • Assessment rate based upon anticipated agency funding needs; hospitals contribute rate of revenue. Rate is constantly adjusted to meet budget needs with 10% cushion. Rebate is returned to hospitals if assessment exceeds anticipated needs. • Assessment collected monthly with hospital revenue report • Total collection is FY 2011: $4.9 million
MHCC Assessment[10]	MHCC	• Assessment paid by hospitals insurers, nursing homes, and occupational boards to support MHCC operations; • Total value of assessment determined annually based upon anticipated agency funding needs. Amount assessed to each group based on portion of efforts MHCC dedicates to each group. Portions for each group determined every four years • Assessment on each member of group determined by specified formula • Total expected collection for FY 2013: $11.7 million
Uncompensated Care Assessment[11]	HSCRC	• Assessment paid through hospital rate setting system to cover uncompensated care costs • Rate of assessment is statewide average uncompensated care rate, determined annually. Assessment funds pass-through account to balance hospitals above or below state average • Assessment collected monthly with hospital revenue report • Total uncompensated care funded through rating system in FY 2010: $926 million
MHIP Assessment[12]	HSCRC	• Assessment paid by hospitals to fund MHIP, which serves the State's high risk insurance pool. One of four

[9] "Fiscal Year 2011, Report to the Governor" The Maryland Health Services Cost Review Commission
[10] "FY 2013 Budget Presentation to the Legislature". The Maryland Health Care Commission
[11] "Fiscal Year 2011, Report to the Governor" The Maryland Health Services Cost Review Commission
[12] Harris, R. "Analysis of the FY 2013 Maryland Executive Budget: Maryland Health Insurance Plan" (2012)

		revenue sources for MHIP • Assessment rate is 1% of hospital net revenues • Collected monthly • Total collections in FY 2011: $113 million

BROAD-BASED INSURANCE REVENUE MODEL (E.G. ASSESSMENT ON INSURED PREMIUM REVENUE)

Exchange Value Relationship	This model reflects the overall value of the ACA and the Exchange in bringing additional insured residents into the market and better facilitating the shopping experience.
Market Impact	This model would benefit the Exchange by reducing the incentive for carrier non-participation by eliminating any potential price or administrative cost advantage to non-participation (should the exchange move to an active purchaser model).
Impact to Exchange Enrollees	This funding mechanism is invisible to enrollees, in that it is spread across the entire health care market inside and outside the Exchange.
Variability of Revenue Yield	Relative to QHP-based revenue models, this approach further expands the base for assessment, allowing for a lower overall assessment rate and greater stability in the revenue stream.
Collection Timing and Cash Flow	The Exchange would most likely wish to align this collection process with existing insurance premium based collection processes operated by the MIA. This would likely result in a quarterly collection process. A broad based assessment such as this could by initiated prior to the period of Exchange enrollment (e.g., in 2013), allowing it to finance Navigator grant funding as well as to provide additional start-up or reserve capital to mitigate first-year revenue uncertainty.
Administrative Ease	Because the MIA currently operates an insurance assessment process, incorporating an Exchange assessment into the existing

process would likely be relatively simple and administratively cost effective.

Lead Time to Alter

Working under the assumption that this model would leverage existing MIA processes, the timeline for establishing the Exchange assessment would be tied to the current MIA assessment timeline. The assessment is performed based on MIA's fiscal year. Assessment level to meet budget needs is determined in March-April. Assessment notices are sent to carriers in July and MIA expects to collect its full annual fee in August. An alteration to the assessment would likely coordinate with this timeline and any changes for the Exchange would potentially be restrictive due to the coordination required with the broader market and other dependent processes.

BROAD-BASED PROVIDER REVENUE ASSESSMENT (E.G., HOSPITAL, PHYSICIAN, AND ANCILLARY REVENUE)

Exchange Value Relationship

This approach recognizes the broader value of the Exchange and its role in expanding coverage to the health care industry as a whole.

Market Impact

Each assessment could bring its own effect on the market. For example, an increase in licensing fees could discourage health professionals from coming to Maryland. It is also not known whether an assessment on hospital rates for this purpose is possible under Maryland's Medicare waiver.

Impact to Exchange Enrollees

This funding mechanism is invisible to enrollees, in that it is spread across the entire health care market.

Variability of Revenue Yield

While retaining its basis in the health care industry, this method would further broaden the assessment base to include public and self-insured markets, lowering the overall assessment rate and providing much greater stability and predictability to the revenue stream.

Collection Timing and Cash Flow	Existing assessments by MHIP and HSCRC occur on a monthly basis, but MHCC's assessment is done annually. If the Exchange follows current processes and assesses a percentage of hospital revenue, collection will likely be done on a monthly basis.
Administrative Ease	Because HSCRC administers the rate setting system and performs assessment collection, collaboration with HSCRC would likely result in significant administrative ease.
Lead Time to Alter	Working under the assumption that this model would leverage existing HSCRC processes, a change in assessment rate would likely be performed on an annual basis. Assessment rates for MHIP and uncompensated care are determined annually, but HSCRC adjusts its assessment to fund operations throughout the year. HSCRC holds monthly meetings and likely has the ability to adjust rates on a monthly basis, but an assessment rate change on hospital revenue is likely done annually.

Broad-based or Public Funding Sources

This revenue model would create a broad-based funding stream that is not linked specifically to health industry revenue sources, but would involve broader public support to finance the Exchange's operating costs.

As noted previously in this report, the MHBE will create a number of types of public value for the state of Maryland, and will also be required to provide specific services to the residents of Maryland, such as its role in granting certificates of exemption to the individual responsibility requirement. These processes are required by statute, and provide direct value to the residents of Maryland. Other functions, while not directly attributable to the general public, create value to users who may avail themselves of the services. These functions include: (i) an easy to use web portal for plan comparisons; (ii) information regarding individual and small business benefits and obligations under the ACA; (iii) a trust-worthy source of information regarding health insurance; and (iv) information on health insurance carriers cost and quality initiatives.

During the Joint Committee meeting on July 20th, 2012, Wakely Consulting was asked to specifically consider the implications of leveraging a tobacco tax. While we do not endorse any single revenue model for this report, we consider such an assessment a good example of a broad-based public funding source, as the purpose of the tax is to improve the overall health of the population. While such an initiative is not the primary goal of the MHBE, the Exchange is expanding access to health insurance and by disseminating cost and quality data on health

insurance carriers, is hoping to influence and improve the overall efficiency and quality of the health care market. There is also a strong precedent in states, including Maryland, of funding health programs through a tobacco and cigarette tax. In addition, studies on Medical Expenditure Panel Survey (MEPS) data have shown that those who are uninsured are more likely to be smokers than those who have private insurance, 33.7% compared to 20.3% respectively.[13]

BROAD-BASED PUBLIC FUNDING SOURCE (EX. CIGARETTE TAX)

Exchange Value Relationship	Adopting this approach entails recognition of the Exchange's value as a public good.
Market Impact	No disruption to the Exchange.
Impact to Exchange Enrollees	This funding mechanism is invisible to enrollees, in that it is spread across a specific tax base.
Variability of Revenue Yield	This model provides the broadest revenue source, spreads revenue requirements over the largest base, and provides the greatest degree of certainty to the revenue stream (depending on the basis of the fee or tax).
Collection Timing and Cash Flow	Similar to the broad-based assessment on the health care industry, it is likely that collections for this revenue source would be annually, and will require close coordination with applicable state agencies such as the State Treasurer and Comptroller. Depending on the flexibility of the state, the Exchange could work out a monthly payment schedule or front-load the revenue yield at the beginning of the state fiscal year.
Administrative Ease	Although the state budgeting and fiscal year basis will require a long lead time in the budget development and justification for funding, this funding mechanism should be administratively easy to

[13] Carper, K. and Machlin, S. "Statistical Brief 101: Variations in Smoking by Selected Demographic, Socioeconomic, Insurance, and Health Characteristics, United States, 2003" Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, October 2005.

	implement. The MHBE will likely be working closely with the state to identify and justify its revenue needs and will develop a payment schedule with the state that will echo the collection frequency of the tax.
Lead Time to Alter	Changes to this type of an assessment will be limited and updated on an infrequent basis. Depending on the appropriation process, the MHBE could request annually a lesser or greater percentage of the total tax yield, but the Exchange will be competing with other state needs for this funding source should it request an increase in funding. An alternative approach would be to develop a dedicated funding stream to fund MHBE operations.

Ability to Repurpose Existing Assessments

The ACA will result in many changes in the health care market in Maryland; most notably through the expansion of insurance coverage and the reduction in uncompensated care. To the extent that these changes impact the level of funding yielded through existing market assessments or the required use of these funds, there may be an opportunity to repurpose a portion of an existing funding stream to help support the Exchange. Specifically, a reduced demand for funds paired with a stable revenue source, or a stable demand for funds paired with increased collections, may yield a "windfall" that can be captured to support the Exchange.

Our analysis of existing market assessments in Maryland suggests that such an approach is not a likely option for the MHBE. This is the case for two primary reasons. The first reason has to do with timing. Were such an opportunity to occur, it would become apparent over time as enrollment increased from 2014 and beyond. The Exchange's financing needs, however, are more immediate. The organization cannot wait to evaluate the economic impact of ACA implementation to identify and select a financing opportunity.

The second reason is related to the nature of and use of existing health care assessments. The majority of existing assessments are tightly linked to a specific use of funds that is not anticipated to decline with ACA implementation: the state insurance premium tax is devoted to supporting the Medicaid budget, while the assessments to finance the operations of the MIA, the MHCC, and the HSCRC are calculated annually to finance the operating budgets of these agencies.

The state's two hospital-based assessments similarly do not seem to present funding opportunities. While uncompensated care is expected to decline under the ACA, due to the nature of the state's rate setting system, this will not present an opportunity for hospitals to increase revenues. Hospitals that provide uncompensated care are reimbursed for these costs

through regulated hospital rates that are paid by all payers. The uncompensated care rate is based on expected future levels of uncompensated care. This rate will likely be adjusted downward if uncompensated care is expected to decline due to ACA.

Similarly, the assessment to subsidize the MHIP program may not provide a ready vehicle to finance the Exchange. These funds are currently used to protect the existing non-group insurance price structure by segregating the cost for high-risk individuals. Under the ACA, an analogous function will be performed under the temporary reinsurance program, which will reimburse non-group issuers for costs incurred by high-risk individuals. This program will be supported by a new funding stream, with contributions from both self-insured and fully insured premiums. In addition, the State is evaluating using the MHIP assessment for further risk mitigation.

Financing Model Options for Consideration

As highlighted in the previous section, Maryland has a wide range of options when it comes to selecting a revenue source. In addition to evaluating each individual option, the Joint Committee further must determine whether the state should pursue a revenue model that applies an assessment to a single source or market, or that utilizes a revenue model that raises funds from a combination of different revenue bases. The first approach, or "Single Market Approach," is a methodology that applies the same assessment across an entire market, with the key decision being what market to assess. The second approach, or "Hybrid Approach," would combine revenue streams from different markets. This Hybrid Approach introduces a higher level of complexity, but is more consistent with the perspective of the MHBE Board of Directors, as well as the recently enacted Maryland Health Benefit Exchange Act of 2011, which encouraged the consideration of a transaction and broad-based revenue model for the Exchange.

In order to facilitate the Joint Committee's evaluation of different revenue models, this section first quantifies the required rate of assessment required to finance the anticipated level of Exchange expenditures. The assessment rate is expressed as the percentage of the relevant revenue base (insurance premium, provider revenue, or tax receipts) needed to finance Exchange operations. As noted previously in this report, for simplicity in applying the methodological concepts, we are using the total average cost of exchange operations over the period 2015 through 2017.

Next, it provides a conceptual framework that may help the Committee weigh potential options for combining revenue models across different markets. Our focus on the potential to combine financing mechanisms is based upon two primary factors: (1) the Legislature clearly indicated that the Exchange board should consider a combination of revenue options (both narrowly focused as well as broad-based) when selecting a preferred financing model; and (2) the results

of our assessment suggest that assessing a single market is less likely to mitigate the potential downside risk in pursuing a single, stand-alone financing option.

To focus our discussion, we began by narrowing the range of potential models to discuss. For example, one revenue model we do not recommend Maryland pursue is to fund the MHBE solely through an assessment on Issuers of QHP exchange membership. Based on our estimate of expense levels of the MHBE, as well as expected enrollment take-up, the average assessment on Exchange premiums over the 2015 through 2017 timeframe would be approximately 6%. We believe this level of assessment is large enough to create a market distortion, in that carriers may be incented to direct business outside the Exchange. In addition, the uncertainty of expected enrollment levels creates an unreasonable amount of variability regarding actual premium yield, and thus an ongoing solvency concern for the Exchange.

Conversely, funding the MHBE purely through a public fee is another option we do not recommend pursuing. While this type of financing mechanism eliminates a significant amount of variability in actual premium yield, it requires a long lead-time in budget development, is less flexible than alternative models, and requires a high degree of inter-agency coordination and communication. At least during the initial ramp-up phase of the Exchange, when there will be a number of uncertainties regarding enrollment, premium levels, enrollee purchasing patterns, member retention and administrative spending, a solely public fee model would be too static and inflexible.

Single Market Approach

The Single Market Approach would apply a uniform percentage across an entire market. This model would provide a steady and reliable revenue stream for the MHBE due to the size of the markets to be assessed. From an implementation perspective, the Single Market Approach is relatively straightforward, can leverage existing processes in the state such as MIA revenue collection infrastructure, and depending on the timing of implementation, could provide cash flow to fund the Navigator function prior to the start of operations on January 1, 2014.

Key Assumptions:

Estimated denominator base used to quantify the percentage assessment necessary to fund Exchange operations.

	2015
Total MHBE Operating Costs - Average	$ 42,000,000
Combined Non-group & Small Group Premium Revenue	$ 2,936,173,431
Large Group Premium Revenue	$ 3,545,534,074
Provider Revenues (Hospital-only used as Proxy)	$ 15,091,683,229

For the public fee, we utilized a tobacco tax, or more precisely a cigarette tax, as a proxy for the implementation of such a fee. The availability of public data specific to Maryland with which to determine the total estimated sales revenue to quantify the percentage necessary to fund the MHBE operating cost made this a convenient selection, but the concepts and considerations are similar to other broad-based public fees or taxes that may be considered.

	2015
Cigarette Sales Revenue	$ 861,840,000
Number of Cigarette Packs Sold	199,500,000

Results:

As summarized in Table 3, the greater the scale of a particular market, the lower the assessment rate must be in order to raise the required level of revenue from that market. Each of the rows, or markets, noted below is a stand-alone in that the assessment is not cumulative. For example, to offset the MHBE operating expense by assessing the Combined Non-group and Small Group Premium Revenue, the assessment percentage would need to be 1.43%. To offset the operating cost solely from the Large Group Premium Revenue, the assessment percentage would be 1.18%.

Table 3: Percent of Assessment Base Required to Offset Exchange Expenses

Market or Entity Being Assessed	2015
Combined Non-group & Small Group Premium Revenue	1.43%
Large Group Premium Revenue	1.18%
Provider Revenues (Hospital-only used as Proxy)	0.28%

In analyzing the cigarette tax, we used two metrics to present the results. One metric is the underlying sales revenue, not inclusive of the cigarette tax to present an order of magnitude, and comparable to the insurance premium and provider revenue noted above. The result is that 4.87% of cigarette sales would be necessary to offset the operating expense of the MHBE, or approximately $0.21 per pack of cigarettes.

	2015
Assessment Amount as % of Cigarette Sales Revenue	4.87%
Assessment Amount per Pack of Cigarettes	$0.21

Hybrid Approach

In the Hybrid Approach, revenue from multiple markets would jointly contribute to financing the operations of the Exchange. If such an approach is pursued, an important additional consideration relates to how the relative contribution of funds should be allocated to different revenue streams. Several factors will likely bear on this decision, including the relative share of each revenue base, as well as the perceived value of the Exchange to each market. An additional method for considering this decision is to pair types of Exchange expenditures with revenue sources that best offset the related Expense.

In this framework, a key concept to consider is the difference between variable and fixed cost components. Variable costs represent scalable, transaction-based expenses of the MHBE; in other words, the expense items that will increase as enrollment increases, and decrease as enrollment declines. Fixed costs, on the other hand, do not scale with enrollment. They represent longer-term, stable costs elements that will not increase with enrollment (and will also not decrease if enrollment is lower than expected.)

A funding mechanism that is static and predictable in nature, such as a broad-based provider or public fee, may be well-suited to offset the Exchange's fixed costs, but may not be well-suited to offset the organization's variable costs – particularly in the early years when enrollment may be unpredictable and/or fluctuate considerably. Conversely, a revenue mechanism that is more sensitive to insurance market enrollment, such as an assessment on QHP issuer revenue, may better offset the Exchange's variable costs, but may not sufficiently offset the Exchange's fixed costs at low enrollment levels.

A model that combines different financing mechanisms will be more administratively complex, and may require more frequent recalibration, due to the greater number of underlying variables subject to change. However, a model that more directly links Exchange cost elements to the appropriate revenue stream may provide a revenue mix that both more effectively addresses the organization's total revenue needs and recognizes its multi-faceted value proposition.

In the section below, we have provided a breakdown of expected Exchange operating costs by fixed and variable components as well as a few options for offsetting these costs. While we are still analyzing and determining with staff of the MHBE percentage of cost fixed and variable, we below the percentages noted below are reasonable estimates at this time.

The three different variations of a hybrid approach presented below provide a representation of the logic behind hybrid models. Due to the statutory language in Maryland, which provides for carriers above certain enrollment levels to participant in the Exchange if they want to offer in the non-group and small group markets outside the exchange, we have used the total combined non-group and small group premium revenue. However, in the absence of this

language, the logic behind the Hybrid Approach is that variable cost would be offset by Issuers of QHP enrollment.

As mentioned previously, there are numerous permutations and variations in how different revenue streams could be combined. The three included here are for illustrative purposes to provide the Joint Committee with specific models for consideration.

Key Assumptions:

	2015
Total MHBE Operating Costs	$ 42,000,000
Total Fixed Costs (64%)	$ 26,880,000
Total Variable Costs (36%)	$ 15,120,000

Estimated denominator base used to quantify assessment necessary to fund Exchange operations (same assumptions as Single Market Approach).

	2015
Total MHBE Operating Costs	$ 42,000,000
Non-group & Small Group Premium Revenue	$ 2,936,173,431
Large Group Premium Revenue	$ 3,545,534,074
Provider Revenues (Hospitals used as Proxy)	$ 15,091,683,229

	2015
Cigarette Sales Revenue	$ 861,840,000
Number of Cigarette Packs Sold	199,500,000

Results:

Variation #1

	2015	
Revenue Source	**Assessment**	**Revenue generated**
Combined Non-group & Small Group for Variable Costs	0.51%	$ 15,120,000
Large Group for Fixed Costs	0.76%	$ 26,880,000
Total		$ 42,000,000

Variation #2

	2015	
Revenue Source	**Assessment**	**Revenue generated**
Combined Non-group and Small Group for Variable Costs	0.51%	$ 15,120,000
Providers (Hospital-only used as Proxy) for Fixed Costs	0.18%	$ 26,880,000
Total		$ 42,000,000

Variation #3

	2015	
Revenue Source	**Assessment**	**Revenue generated**
Combined Non-group and Small Group for Variable Costs	0.51%	$ 15,120,000
Cigarette Sales Revenue for Fixed Costs	3.12%	$ 26,880,000
Total		$ 42,000,000

Appendix

Exhibit 1: Implementation Timeline – MHBE Budgetary Cycle and User Fee Development

The following timeline is intended to provide a guideline and approximate dates when the MHBE will need to develop its operating budget. This timeline was created assuming the MHBE will be conforming to a fiscal year ending June 30th budgetary cycle.

The development of the annual budget will establish the revenue requirements necessary for self-sustainability, and will need to be completed in a timeframe to allow for the implementation of the chosen revenue model. Some important observations resulting from this timeline are as follows:

1. Regardless of the revenue model chosen, the exchange will have to deal with a relatively long lead time between the development of its budget and the actual start of the budget year – this will create additional imprecision and uncertainty regarding revenue needs;

2. The operating budget will likely need to be developed a full 18 months prior to the mid-point of the budget year in question;

3. If using a broad-based or public fee revenue model that is tied to the state fiscal year basis, there is the potential of receiving funds prior to the start of operations on January 1, 2014. Helpful in funding Navigator costs prior to January 1, 2014; and

4. If a public fee model is implemented, will need to work with the state to determine a funds flow schedule that will allow the exchange to meet its ongoing obligations.

Timeframe: Start-up period (December 2012 – June 2013)

Budget Task(s)	Mths to Mid-pt of Budget Year	Dec '12	Jan '13	Feb '13	Mar '13	Apr '13	May'13	Jun '13
Update CY 2014 Budget Assumptions:	18	X						
• Refine expense assumptions & revenue needs • Model enrollment take-up and estimated revenue yield • Identify vendor contracts renewing or escalation terms								
Finalize CY 2014 Budget Update	16			X				
• Determine level of assessment(s) required to support 2014								
Budget Approval Process	15				X			
• Exchange BOD approves CY 2014 Budget • If cigarette-type tax, notify State Comptroller, etc. • If Insurance Premium tax, notify Carriers • Incorporate into QHP Certification Specifications								
Beginning of State Fiscal Year	11							
• Refresh 2014 Budget • If assessment adjustment required, notify carriers								
Begin Receiving broad-based revenue from State (i.e Cig Tax)	10							
• Funds can be used for Navigator Grant Funding								
Begin Open Enrollment Period	8							
Refresh CY 2014 Budget	6							

Timeframe: First half of Fiscal Year 2014 (July 2013 – December 2013)

Budget Task(s)	Mths to Mid-pt of Budget Year	Jul' 13	Aug' 13	Sep' 13	Oct' 13	Nov' 13	Dec' 13
Update CY 2014 Budget Assumptions:	18						
• Refine expense assumptions & revenue needs • Model enrollment take-up and estimated revenue yield • Identify vendor contracts renewing or escalation terms							
Finalize CY 2014 Budget Update	16						
• Determine level of assessment(s) required to support 2014							
Budget Approval Process	15						
• Exchange BOD approves CY 2014 Budget • If cigarette-type tax, notify State Comptroller, etc. • If Insur Premium tax, notify Carriers • Incorporate into QHP Certification Specifications							
Beginning of State Fiscal Year	11	**X**					
• Refresh 2014 Budget • If assessment adjustment required, notify carriers							
Begin Receiving broad-based revenue from State (i.e Cig Tax)	10		**X**				
• Funds can be used for Navigator Grant Funding							
Begin Open Enrollment Period	8				**X**		
Refresh CY 2014 Budget	6						**X**

Timeframe: Second half of Fiscal Year 2014 (December 2013 – June 2014)

Budget Task(s)	Mths to Mid-pt of Budget Year	Dec '13	Jan '14	Feb '14	Mar '14	Apr '14	May'14	Jun '14
Start New Budget Cycle - 2015								
Update/Refine CY 2015 Budget Development	18	X						
• Refine expense assumptions & revenue needs • Model enrollment take-up and estimated revenue yield • Identify vendor contracts renewing or escalation terms								
Finalize CY 2015 Budget Update	16			X				
• Determine level of assessment(s) required to support 2015								
Budget Approval Process	15				X			
• Exchange BOD approves CY 2015 Budget • If cigarette-type tax, notify State Comptroller, etc. • If Insur Premium tax, notify Carriers • Incorporate into QHP Certification Specifications								
Beginning of State Fiscal Year	11							
• Refresh 2015 Budget • If assessment adjustment required, notify carriers								
Begin Receiving broad-based revenue from State (i.e Cig Tax)	10							
• Funds can be used for Navigator Grant Funding								
Begin Open Enrollment Period	9							
Refresh CY 2015 Budget	6							

Timeframe: First half of Fiscal Year 2015 (July 2014 – December 2014)

Budget Task(s)	Mths to Mid-pt of Budget Year	Jul' 14	Aug' 14	Sep' 14	Oct' 14	Nov' 14	Dec' 14
Start New Budget Cycle - 2015							
Update/Refine CY 2015 Budget Development	18						
• Refine expense assumptions & revenue needs • Model enrollment take-up and estimated revenue yield • Identify vendor contracts renewing or escalation terms							
Finalize CY 2015 Budget Update	16						
• Determine level of assessment(s) required to support 2015							
Budget Approval Process	15						
• Exchange BOD approves CY 2015 Budget • If cigarette-type tax, notify State Comptroller, etc. • If Insur Premium tax, notify Carriers • Incorporate into QHP Certification Specifications							
Beginning of State Fiscal Year	11	**X**					
• Refresh 2015 Budget • If assessment adjustment required, notify carriers							
Begin Receiving broad-based revenue from State (i.e Cig Tax)	10		**X**				
• Funds can be used for Navigator Grant Funding							
Begin Open Enrollment Period	9				**X**		
Refresh CY 2015 Budget	6						**X**

Exhibit 2: Financing Model Assumptions

Revenue Base	2015	Assumptions
Total Maryland Earned Premiums in Non-Group Market	$ 654,213,697	Non-group premium levels for 2010 sourced from Mercer Consulting report. 2015 - 2017 figures based on Wakely calculated projections
Total Maryland Earned Premiums in Small-Group Market	$ 2,281,959,734	Small-group premium levels for 2010 sourced from Mercer Consulting report. 2015 - 2017 figures based on Wakely calculated projections
Total Maryland Earned Premiums in Large Group Market	$ 3,545,534,074	Large-group premium levels for 2010 sourced from Maryland Insurance Administration. 2015 - 2017 figures based on Wakely calculations
Maryland Hospital Revenues	$ 15,091,683,229	Maryland hospital revenue for net patient regulated services for 2010 sourced from HSCRC annual report. 2015-2017 figures based on Wakely calculations
Cigarette Sales Revenue	$ 861,840,000	FY 2011 figure, held constant for 2015 modeling
Number of Cigarette Packs Sold	199,500,000	FY 2011 figure, held constant for 2015 modeling

Financing Model Sources:

Boonn, A. "State Cigarette Tax Rates, Date of Last Increase, Annual Pack Sales & Revenues, and Related Data". Campaign for Tobacco-Free Kids (July 6, 2012).

Carlson, C. (2011). Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans. Milwaukee, WI: Oliver Wyman.

Fakhraei, S. H. (2012). Maryland health care reform simulation model: Detailed analysis and methodology. Baltimore, MD: The Hilltop Institute, UMBC.

"Fiscal Year 2011, Report to the Governor" The Maryland Health Services Cost Review Commission

"General Obligation Bonds: State and Local Facilities Loan of 2012, First Series" State of Maryland

"Report of Market Rules and Risk Selection for the State of Maryland, Maryland Health Benefit Exchange". Mercer Health & Benefits LLC, Government Human Services Consulting, (November 8, 2011).

MIA Annual Maryland Health Benefit Plans Report, 2010

Wakely
Consulting Group

Analysis for Financing the Maryland Health Benefit Exchange – Budget Supplement

Wakely Consulting Group

October 31, 2012

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Contents

Executive Summary

This report has been prepared as a result of a Request for Proposals dated May 23, 2012 issued by the Maryland Health Benefit Exchange (MHBE) for Detailed Analysis for Financing the MHBE, and subsequent proposal and award of work to Wakely Consulting Group (Wakely). The preparation of this report is intended to inform the joint legislative-executive committee (Joint Committee), which, per the Maryland Health Benefit Exchange Act of 2012, is required to make recommendations regarding Exchange financing and self-sustainability to the Governor and General Assembly by December 1, 2012.

Wakely developed this report as a supplement to the previously released Wakely report titled "Detailed Analysis for Financing the Maryland Health Benefit Exchange" dated September 19, 2012. That report provided a qualitative analysis and discussion of the value of the Exchange to identified market segments, as well as a detailed assessment of exchange financing models and revenue options for the Joint Committee's consideration. For modeling and discussion purposes, a total exchange operating expense of $42 million was estimated, which was not Maryland specific. This supplemental report provides an analysis and assessment of the MHBE specific administrative budget, including operating assumptions and detailed expense estimates for the years 2015 through 2017.

The underlying scale of MHBE enrollment, which is a significant driver of overall operating expense, is expected to average approximately 198,000 over the three-year period. Estimated year-end total enrollment is 177,080, 196,234, and 221,433 for the years 2015, 2016, and 2017 respectively. Enrollment in the MHBE is expected to be heavily weighted toward the non-group market segment with an average year end enrollment split of 95% non-group and 5% small group. The enrollment figures above assume that the state will not be implementing a Basic Health Program, which is an optional program for states to develop for individuals who are below 200% of the Federal Poverty Level and ineligible for Medicaid or CHIP. As this population would otherwise be exchange eligible, the implementation of a Basic Health Program would significantly reduce the overall enrollment scale of the MHBE and require a recalibration of the budget assumptions.

The operating budget of the MHBE for the calendar year ended 2015, 2016, and 2017 is estimated to be $34,916,005, $33,883,502, and $32,917,018 respectively. On a total per member per month (PMPM) basis, the estimated cost for the same time frame is $16.75, $14.66, and $12.64 respectively. Based on the assumptions and estimates utilized for the budget build-up, we believe this budget reflects an appropriate and reasonable level of fiscal conservatism, while at the same time compares favorably to exchange budget data in other states, and benchmark data developed by Wakely using publicly available data from the Massachusetts Health Connector.

Exchange Budget Development Methodology

A key element of assessing revenue model options is to first estimate the level of expenses that must be supported by the chosen revenue stream. To assist the Maryland Health Benefit Exchange (MHBE) with this task, we have developed a three year budget estimate covering the years 2015 through 2017. This three year budget, or financial planning document, provides the MHBE with a tool with which to assess estimated expenses in the context of enrollment scale along with exchange design and functionality. When supplemented with benchmark data, this document provides an important yardstick with which to gauge the reasonableness of expected spending relative to the administrative scale of the Exchange. Although our analysis projects expenditures through 2017, the primary focus of this budget exercise is on 2015, which is the year during which the MHBE must become fully financially self-sustaining, transitioning from Federal grant funding to a state-based revenue stream.

Working closely with the staff of the MHBE, we relied upon many assumptions and details from the MHBE's Level Two Establishment Grant submission, which included expected spending through 2014, to forecast expenses for the period 2015 through 2017. Actual contracts or known costs were incorporated when available, and for projected expenses, we utilized a combination of market data, benchmark cost, and industry knowledge to formulate an overall budget plan (see Exhibit 2 – Key Budget Assumptions). Additional analyses were performed to corroborate new functions required of the MHBE such as Appeals & Grievances, Reinsurance administration, premium billing for non-group, and the Navigator function. An additional element of the budget we estimated, but recommend a future follow up analysis, is the breakout of costs as fixed or variable. This is an important aspect in managing the MHBE, and further research and analyses, as well as finalization of key contracts and policy decisions will need to occur in order to refine this aspect of the budget development.

An important financing element in developing the Exchange's total operating budget is the portion of expenses that should be allocated to the Maryland Department of Health and Mental Hygiene's Medicaid program (Medicaid). The Medicaid program is expected to utilize certain functions performed by the Exchange, such as the web portal, and eligibility determination and enrollment, and will therefore be responsible for a pro-rata share of the expenses associated with those functions.

For the start-up phase of the MHBE, the Level Two Establishment Grant detailed the specific functions and total estimated expense to be shared between the Exchange and Medicaid. For this phase, the cost allocation methodology resulted in an allocation of 58% to the MHBE and 42% to Medicaid. As the MHBE transitions from its start-up phase to ongoing operations beginning in 2015, a different allocation methodology needs to be developed and applied to applicable expenses to properly reflect Medicaid's evolving utilization of Exchange functions. Wakely, working closely with the MHBE staff and personnel from the state's Medicaid program,

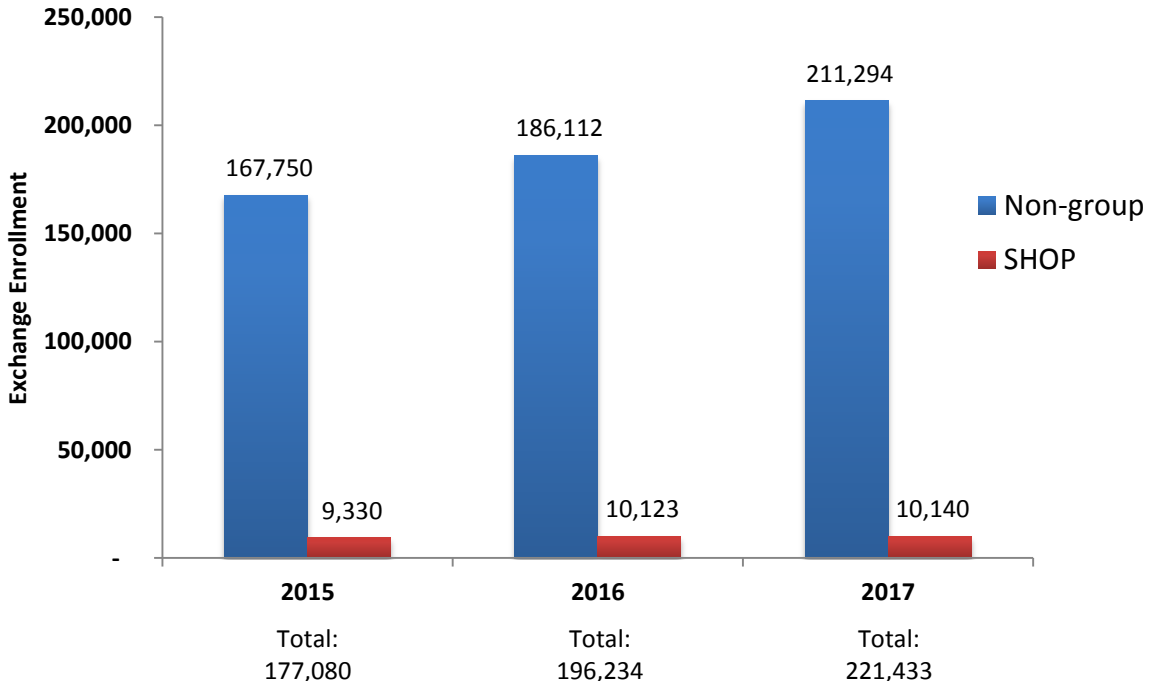
has developed a preliminary cost allocation methodology for ongoing operational expenses. The result is an allocation of 25% to the MHBE and 75% to the Medicaid program. Consistent with the approach taken for the Level Two Establishment Grant, the cost allocation is not applied to all expenses, but only to those expenses in which the function will be shared between the MHBE and the Medicaid program. The MHBE will continue to work closely with state's Medicaid program and is planning to consult with a cost allocation consultant to further refine the allocation methodology.

Note: All budget figures reflected in this report are exchange-specific. Expense assumptions have been developed as either exchange-specific, or total shared cost, and allocated to Exchange and the Medicaid program consistent with the cost allocation methodology.

Exchange Budget Analysis

An important element of the MHBE budget development is expected enrollment scale. Total estimated year end enrollment of the Exchange is anticipated to be 158,535 in 2014, growing to 221,433 by year end 2017 (a 39.7% increase over this time frame)[1]. Over the three-year period 2015 through 2017, total year-end membership is estimated to be 177,080, 196,234, and 221,433 respectively.[2] Total enrollment is expected to be disproportionately from the individual market, with approximately 95% of the total for each of the three years attributable to the non-group market.

Figure 1: Estimated Exchange Enrollment

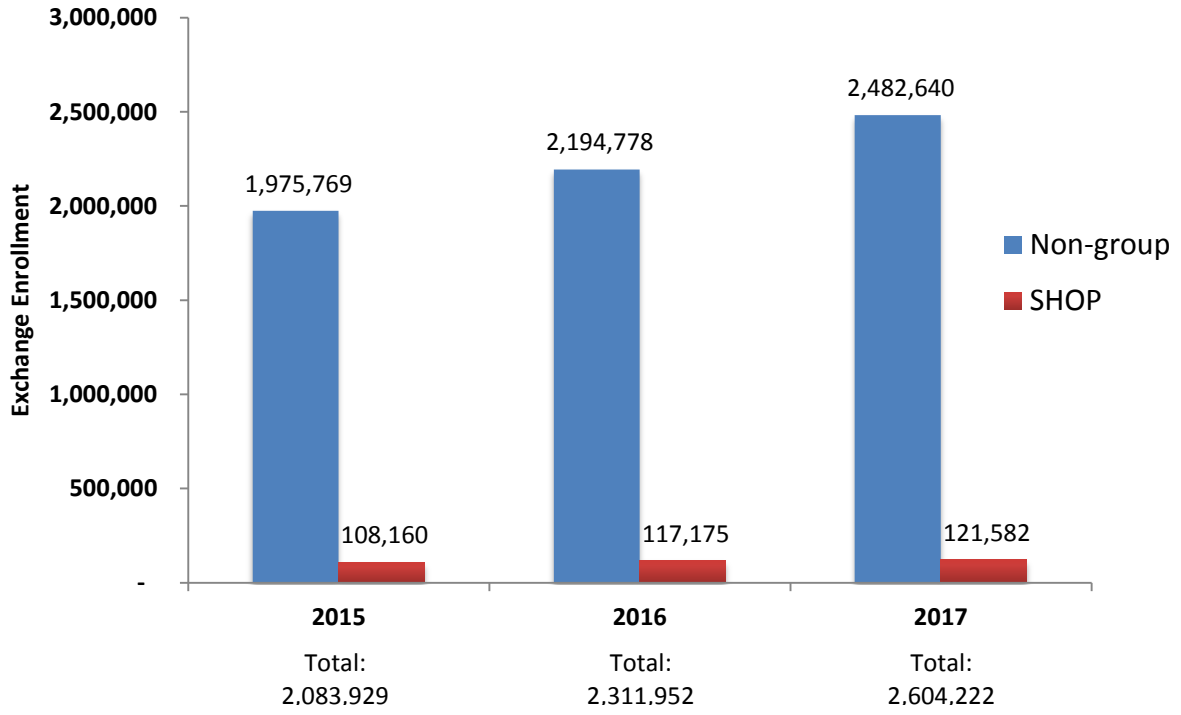


In order to calculate PMPM cost, Wakely developed a membership model that takes into account assumptions regarding the rate of monthly enrollment take-up, separately for the non-group and small group markets. The resulting estimates for member months are 2,083,929 for 2015, 2,311,952 for 2016, and 2,604,222 for 2017.

[1] Fakhraei, S. H. (2012). *Maryland health care reform simulation model: Detailed analysis and methodology.* Baltimore, MD: The Hilltop Institute, UMBC.

[2] Exchange Enrollment estimates in The Hilltop Institute report were determined on a fiscal year basis. Wakely converted these figures to be represented on a calendar year basis.

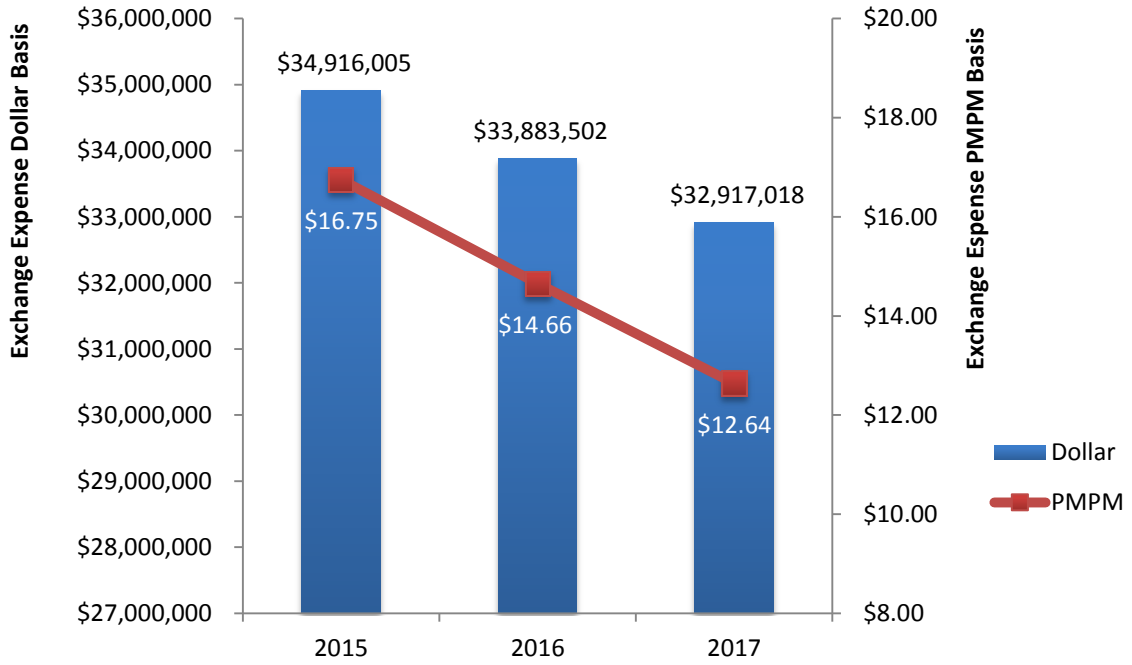
Figure 2: Estimated Exchange Member Months



The total Exchange spending for the three year period 2015, 2016, and 2017 are estimated to be $34,916,005, $33,883,502, $32,917,018 respectively. Over the same period, expenses on a per-member-per-month (PMPM) basis for 2015, 2016, and 2017 are estimated to be $16.75, $14.66, and $12.64 respectively. The decreasing estimated PMPM cost reflects the increase in membership during this time frame and underscores the positive impact on PMPM, or unit cost, resulting from greater enrollment scale. Membership scale will be the single biggest contributor to operating the MHBE on a cost-effective basis and will be an important variable in refining and updating the budget on a go-forward basis.

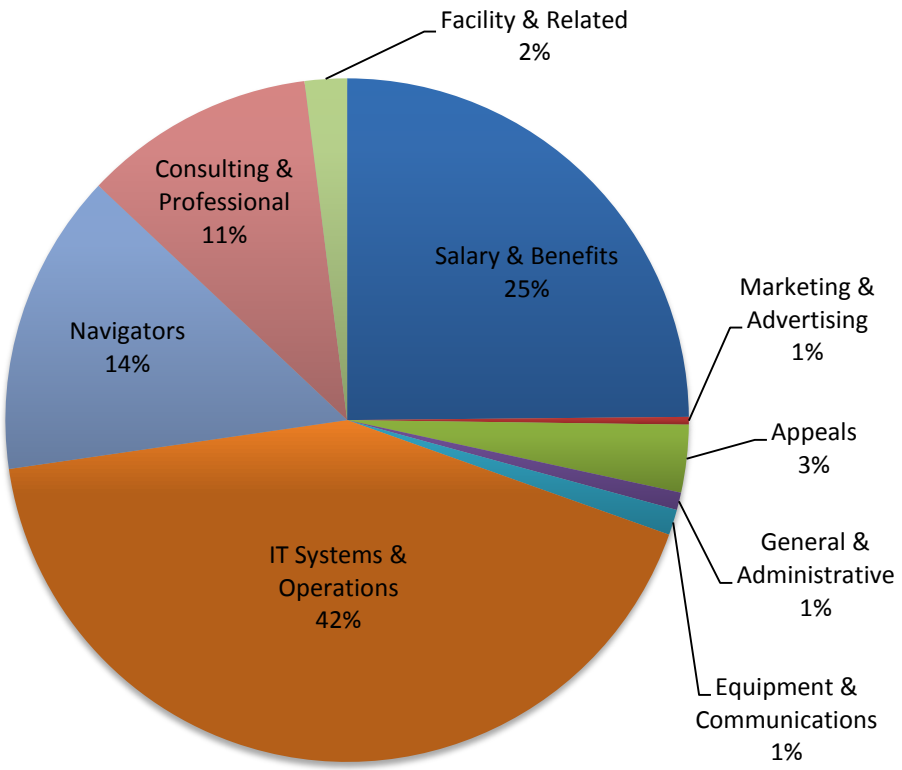
When considering the functions required of the MHBE per the ACA and subsequent Federal guidance and regulations, the total estimated operating cost on a per-member-per-month (PMPM) basis over the three-year period appears reasonable. While it is difficult to compare directly with benchmark data due to differences in scale and functions, we did perform a high level comparison to the one Exchange operating that is most analogous to the MHBE; the Massachusetts Health Connector. Analyzing 2017, which is the year in which the MHBE will have scale comparable to the 2012 level of the Health Connector, the MHBE will be operating at $12.64 PMPM compared to the Health Connector's 2012 budget of $13.07 PMPM.

Figure 3: Total Exchange Expenses – Dollar Basis & PMPM



When analyzing 2015 detailed spending categories, total Exchange cost is primarily concentrated in two spending line items, Staffing and IT Systems & Operations, with approximately 25% of the total estimated spending due to salaries and benefits, and another 42% attributable to IT Systems & Operations.

Figure 4: Maryland Health Benefit Exchange Expense Breakout - 2015



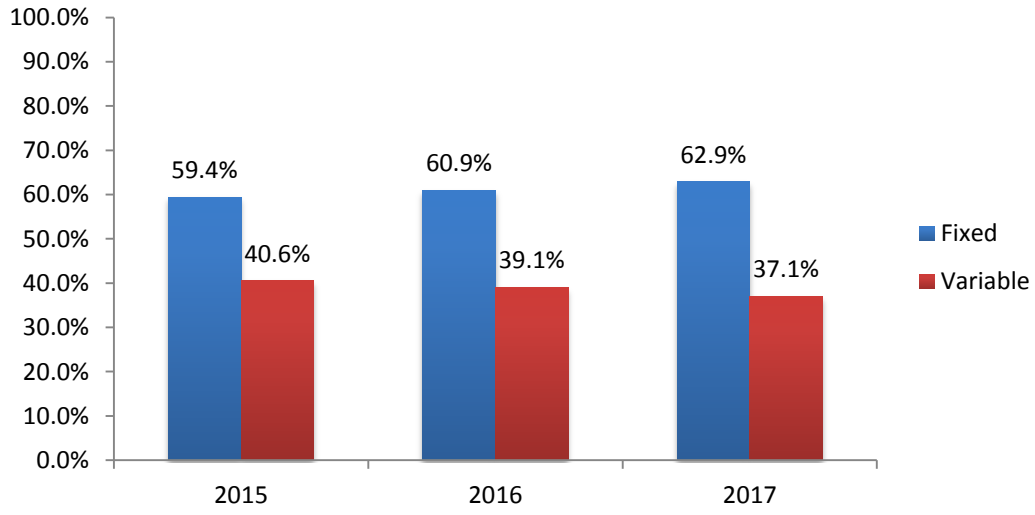
Staffing is expected to remain relatively constant over the three year period, with a hiring plan that targets 70 full time equivalents (FTE's) by the end of 2015. Most of the staff is concentrated in the functional areas of Operations, Information Technology, and Communications & Outreach. The approximate number of staff in each of these three areas is expected to be 15, 10, and 10 respectively. The budget estimate assumes significant use of third-party vendors, meaning that costs for IT Systems & Operations primarily represent vendor costs related to operating and maintaining the primary business and operating systems of the MHBE. Expenses included in this line item include software, hardware and staffing costs for call center operations, premium billing and collections, the eligibility determination rules-engine, website maintenance, and cost to operate specific functions applicable to the small business health options program (SHOP) for small businesses. Other categories rounding out the total spending include Consulting & Professional Services, Marketing & Advertising, including Navigators, Appeals and Grievances, and Other Administrative costs.

A notable expenditure missing from the total is the cost of broker commissions. At this time, the MHBE is considering a policy in which brokers are paid directly by the carriers. Under this approach, although broker commissions will be paid for applicable Exchange enrollees, the

MHBE will not be part of the financial transaction, and therefore will not need to include estimates for such costs when determining assessments.

Finally, Wakely has classified each detailed expense line as either a fixed, variable or semi-variable cost. Understanding the underlying cost structure and determining how much of the total expected spending will flex with membership is an important aspect of exchange budgeting. This element of the budgeting process is especially relevant when assessing revenue options, as the greater the percentage of the total cost is fixed, the more vulnerable the Exchange becomes financially to revenue models that are based solely on enrollment take-up. For 2015, approximately 59% of the total expected exchange spending is identified as fixed. This figure considers that a number of the IT and Operational systems such as call center, premium billing and collections, and eligibility determination rules-engine have both a fixed and variable component. For 2016 and 2017, the total percentage of expenses considered fixed is about 61% and 63% respectively. While we believe the fixed/variable percentage splits are reasonable, as the MHBE gets closer to the beginning of operations, and further refinement of actual contracts, the percentage split will need to be recalculated.

Figure 5: Maryland Health Benefit Exchange: Fixed and Variable Costs 2015-2017 Percentage of Total Cost



Appendix

Exhibit 1: Exchange Budget Summary

	Calendar Year - Dollar Basis		
	CY 2015	CY 2016	CY 2017
Salary & Benefits	$ 8,676,568	$ 8,269,742	$ 8,435,137
Marketing & Advertising	$ 126,558	$ 115,177	$ 83,800
Navigators	$ 5,000,000	$ 4,000,000	$ 3,000,000
Consulting & Professional	$ 3,831,313	$ 3,920,364	$ 3,920,693
Equipment & Communications	$ 421,734	$ 625,114	$ 429,824
General & Administrative	$ 288,400	$ 297,052	$ 305,964
Facility & Related	$ 696,265	$ 724,611	$ 753,008
Appeals	$ 1,115,982	$ 1,149,461	$ 1,183,945
IT Systems & Operations	$ 14,759,186	$ 14,781,981	$ 14,804,648
Total	**$ 34,916,005**	**$ 33,883,502**	**$ 32,917,018**

	Calendar Year - PMPM Basis		
	CY 2015	CY 2016	CY 2017
Salary & Benefits	$ 4.16	$ 3.58	$ 3.24
Marketing & Advertising	$ 0.06	$ 0.05	$ 0.03
Navigators	$ 2.40	$ 1.73	$ 1.15
Consulting & Professional	$ 1.84	$ 1.70	$ 1.51
Equipment & Communications	$ 0.20	$ 0.27	$ 0.17
General & Administrative	$ 0.14	$ 0.13	$ 0.12
Facility & Related	$ 0.33	$ 0.31	$ 0.29
Appeals	$ 0.54	$ 0.50	$ 0.45
IT Systems & Operations	$ 7.08	$ 6.39	$ 5.68
Total	**$ 16.75**	**$ 14.66**	**$ 12.64**

Exhibit 2: Key Budget Assumptions for 2015 - 2017

Expense Category	Type of Expense	Assumptions
Salary & Benefits	Fixed	Approximately 70 full time employees throughout the budget period and a factor-based benefit load of 40.66%. Included a 2% annual inflation factor for salaries. Decreasing level of indirect cost after 2014, as MHBE transitions from federal funding.
Marketing & Advertising	Fixed/Variable components	Includes most spending between $80,000 and $130,000 for select expenses from advertising campaign, digital marketing, promotional materials, and other forms of outreach.
Navigators	Variable	Includes estimated Exchange spending between $3,000,000 and $5,000,000 to support Navigator activities. As Exchange enrollment increases from 2015 to 2017, Navigator efforts will decrease and therefore required spending is assumed to decrease. Estimate based on comparable information from community based organizations and subject matter experts familiar with previous Massachusetts Navigator-related experiences.
Consulting & Professional	Fixed/Variable components	Primarily related to expected spending for IT Consultants to work with System Integrator on system updates and modifications, as well as cost to administer a state-based reinsurance program in compliance with the ACA. Other estimates include costs for the hiring of professional services such as auditing, legal, actuarial, and banking services. Estimated annual inflation of 3% applied.
Equipment & Communications	Mostly Fixed	Most significant expenditure is for IT support services related to the administrative infrastructure of the Exchange of $250,000. Remainder of expense line includes repurchase of items such as computers/laptops, software, telephones and continued expenses for internet, email, mobile phone service agreements.
General & Administrative	Mostly Variable	Includes estimates for general office supplies, staff travel, professional liability insurance for management and staff, and stakeholder/outreach meetings. Most significant expense is from in-state

		and out-of-state travel at $200,000.
Facility & Related	Fixed	Primarily includes annual office space rent and utilities of about $700,000. A 4% annual inflation rate was applied to rent based on proposed lease agreement. Includes the repurchase of office equipment, including copiers. Office furniture is included in lease agreement and repurchase of furniture is not assumed for 2015 – 2017.
Appeals	Semi-fixed	Includes the hiring of contract support from HEAU and the AG's office to administer the eligibility appeals and certificates of exemption from the individual responsibility requirement. Also includes space, phones, and supplies to support their roles, based on 2% of staffing costs.
IT Systems & Operations	Semi-Fixed	Includes estimated cost for development and maintenance and operations of key Exchange processes such as Eligibility determination, premium billing and collections, web portal, and member call center. Most significant expenses are related to Call Center and Eligibility Determination & Enrollment of about $15 million and $17 million, respectively. Estimates include a combination of actual contracts when available, or projections using industry knowledge, benchmarks, and subject matter experts working with the Exchange.

Summary of Public Comment on the Analysis of Financing Options for the Maryland Health Benefit Exchange

Appendix C

Organization	Summary
America's Health Insurance Plans	• AHIP supports an approach to financing the MHBE that incorporates more than one revenue base because this would ensure that stakeholders who benefit from the exchange will contribute to its financial viability. • However, AHIP believes that health plans offered outside the exchange should be exempt from any assessments or fees charged to finance the MHBE. • AHIP recommends that assessments or fees should be limited to the minimum amount necessary to pay for the administrative costs and expenses incurred in the operation of the MHBE.
CareFirst BlueCross BlueShield	• CareFirst supports a broad-based approach to funding that includes all stakeholders who ultimately benefits from the MHBE. • CareFirst continues to believe that the All-Payer Rate System provides the best way to finance the MHBE. If this is not a viable option, any assessment on carriers should be broad enough to ensure that plans sold on or off the exchange will not be placed at a competitive disadvantage. • CareFirst also believes that the MHBE should recoup some expenses from stakeholders other than carriers or providers. For example, the Medicaid program will realize administrative efficiencies and should assist with expenses, and navigator entities and producers receiving licensing, training, and certification should cover the costs associated with those services. • Finally, CareFirst does not believe that carriers would realize any significant cost savings if the MHBE were to expand its functions beyond those required by regulation and suggests that all post-sale customer service should be performed by the applicable carrier.
Delta Dental	• Delta Dental suggests that the application of an assessment on health plans should be done in proportion to the percentage of premium collected for coverage sold on the exchange. They contend that a flat fee or per-enrollee fee would disproportionately add to the administrative costs of stand-alone dental plans. • Delta Dental opposes assessments on health plans outside the exchange and believes that exempting these plans from assessments would protect the affordability of coverage outside the exchange.
Maryland Citizens' Health Initiative	• Maryland Citizens' Health Initiative supports the use of a tobacco tax as a revenue source for funding the MHBE. • Maryland Citizens' Health Initiative contends that unlike other revenue sources, a tobacco tax increase would have the added public health benefit of reducing teen smoking and saving health care costs. • Maryland Citizens' Health Initiative urges support of their proposal for a one dollar per pack increase in the state tax on cigarettes, with a comparable increase in the tax on other tobacco products, with part of the revenue to be used to fund the MHBE.
Johns Hopkins	• Johns Hopkins opposes the use of a provider tax to partially or fully fund the annual administrative budget of the MHBE. • Johns Hopkins contends that the use of a hospital provider tax could be problematic because Maryland is already close to the federal provider tax cap of 6%, and the State's continued reliance on provider taxes threatens Maryland's ability to maintain the "all-payor" waiver for hospital services.

Maryland Hospital Association	• The Maryland Hospital Association opposes the use of a hospital provider tax as a tool to finance the MHBE because of the impact of adding assessments would have on Maryland's "all-payor" system and Medicare waiver. • The Maryland Hospital Association contends that 1) the "all-payor" system cannot afford any additional costs not directly associated with providing care for patients in a hospital system; 2) there is no evidence to suggest that hospitals will benefit financially from the expansion in coverage; and 3) other stakeholders, such as the State's Medicaid program, will benefit from the MHBE and that financing should be shared accordingly.
Maryland Women's Coalition for Health Care Reform	• The Coalition supports the hybrid model proposed in the analysis that would utilize three funding sources: combined non-group and small group assessments for variable costs; provider assessments for fixed costs; and an additional broad-based tax that would not adversely affect the ability of vulnerable and special populations to access affordable health care and would be specifically designated for the MHBE funding. • The Coalition believes that the MHBE financing model should 1) encourage participation by the broad health care industry and all consumers; 2) address sustainability, stability, and flexibility; 3) support health equity through accessibility and affordability; and 4) promote transparency by providing access to all information relating to the cost of their health insurance. • The Coalition suggests that a determination on funding mechanisms should be guided by a full understanding of the MHBE budget—particularly the funding of the navigator programs.
MedStar Health	• MedStar Health opposes the use of a hospital provider tax as one of the funding streams to finance the MHBE. • MedStar Health believes that an additional provider tax would increase hospital rates, making it difficult for the Maryland to meet the required test for maintaining the State's Medicare waiver. • MedStar Health is also concerned about the impact that adding a provider tax may have on current discussions with the Centers for Medicare and Medicaid Services regarding the Medicare waiver.
United Concordia Companies, Inc.	• United Concordia supports Hybrid Approach Variation #3 of the Wakely analysis because it spreads the cost of funding the MHBE over both the health insurance industry and industries, such as the tobacco industry, that impact the health of Marylanders. • As a second preference, United Concordia supports Hybrid Approach Variation #2 because it spreads the cost of funding the Exchange among others, such as hospitals, who have a stake in promoting the health of Marylanders. • If a model is approved that assesses QHP issuers only, United Concordia contends that a proportionate assessment on stand-alone dental plans (rather than a flat per-member per-month fee) is important for ensuring the fair treatment of stand-alone dental plans.
UnitedHealthCare	• UnitedHealthCare believes that those who do not participate in the exchange, such as health plans sold outside the exchange, should not be required to pay for its operation. • UnitedHealthCare would not object to using a sin tax (for example, on cigarettes) as an additional source of funding for the MHBE. • UnitedHealthCare believes that assessments 1) should not be based on premium amount, but rather on a per member cost in order to ensure that all consumers are treated equally; 2) should be considered a state tax or assessment and should be excluded from health plan administrative costs for calculating medical loss ratios; 3) should be defined no less than twelve months in advance and adjusted prospectively; and 4) should be limited to the minimum amount necessary to pay for operating the MHBE. • UnitedHealthCare recommends that all funds collected should include a transparent plan as to how the funds will be allocated.