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 those 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 Qualified Health Plans (QHPs); 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 QHP 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 QHP 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 QHP 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 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 QHPs 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.