



# Maryland Health Benefit Exchange Budget Hearing

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A service of Maryland Health Benefit Exchange

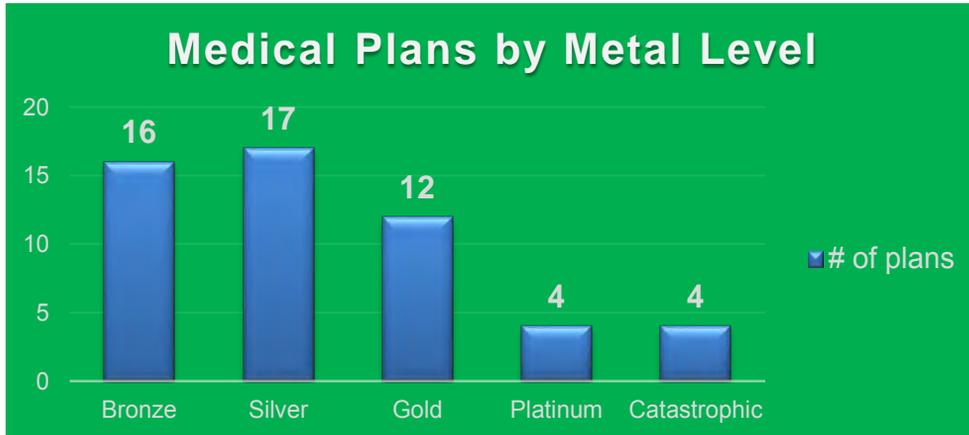
- **General Overview of Maryland Health Benefit Exchange (MHBE)**
- **Overview of MHBE Finances**
- **Response to DLS' Recommended Actions**

## **ENROLLMENT – November 15, 2014 through February 15, 2015**

- 492,210 unique visitors to Maryland Health Connection (MHC) website;
- 274,576 identity-verified accounts;
- 264,245 Marylanders enrolled during open enrollment
  - 119,096 Qualified Health Plans (QHP) enrolled
    - 84,316 Advanced Premium Tax Credit QHP's (71%)
    - 34,780 QHP's without an Advanced Premium Tax Credit (29%)
  - 145,149 Medicaid enrollments

## QUALIFIED HEALTH PLANS OFFERED ON MHC BY CARRIER

Parent Company	# of Plans	Metal Levels
CareFirst CareFirst BlueChoice, Inc. CareFirst of Maryland, Inc. Group Hospitalization and Medical Services, Inc.	15 (15 plans offered last year)	1 catastrophic, 4 bronze, 4 silver, 4 gold, 2 platinum
Kaiser Permanente	10 (9 plans offered last year)	1 catastrophic, 3 bronze, 3 silver, 2 gold, 1 platinum
Evergreen Health Cooperative	12 (9 plans offered last year)	1 catastrophic, 4 bronze, 3 silver, 3 gold, 1 platinum
UnitedHealthcare United Healthcare of the Mid-Atlantic, Inc. All Savers Insurance Company	13 (8 plans offered last year)	1 catastrophic, 4 bronze, 6 silver, 2 gold
CIGNA	3 (0 plans offered last year)	1 bronze, 1 silver, 1 gold
<b>Total</b>	<b>53 (Last year 41 plans were offered)</b>	

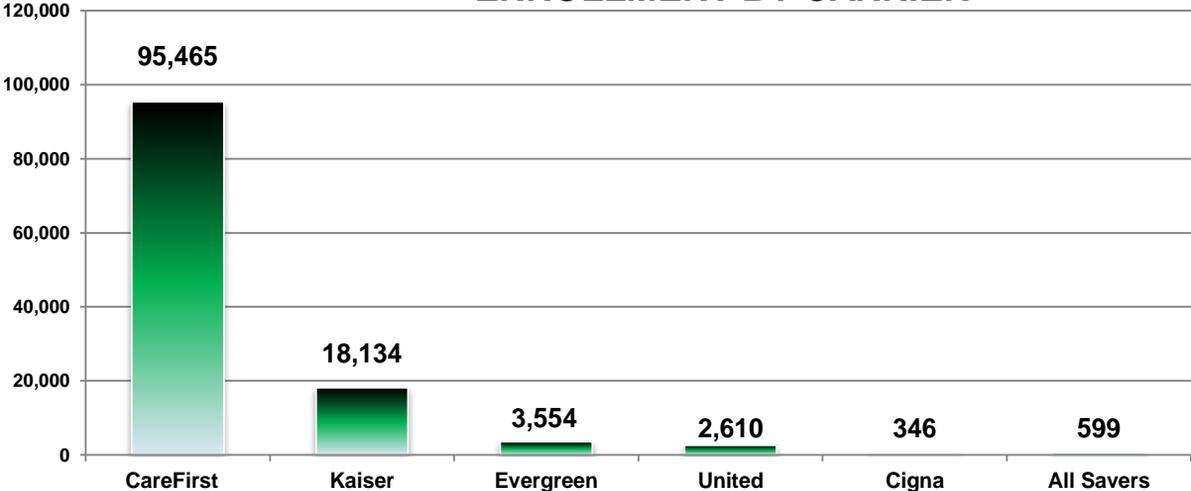


- **All include embedded pediatric dental**
- **38 plans offer statewide coverage**
- **Types:** PPO 7; POS 10; HMO 28; EPO 8

Metal levels correspond to the plan actuarial value:  
 Bronze = 60% (+/- 2%)      Silver = 70% (+/- 2%)  
 Gold = 80% (+/- 2%)      Platinum = 90% (+/- 2%)

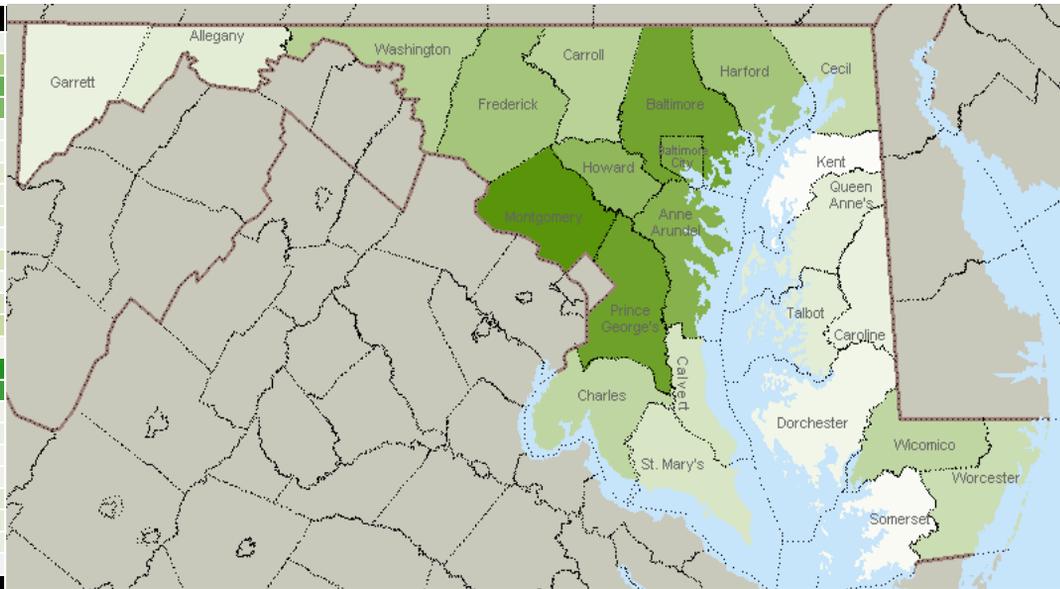
# PLAN SELECTION FOR QUALIFIED HEALTH PLANS OFFERED ON MHC

## ENROLLMENT BY CARRIER

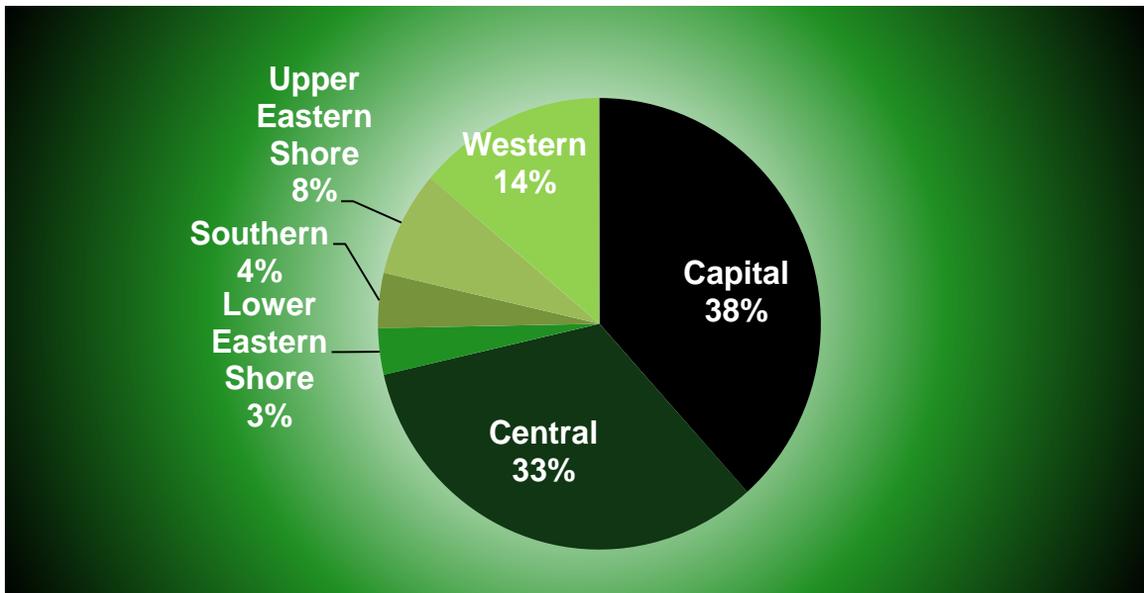


## ENROLLMENT FOR QUALIFIED HEALTH PLANS & MEDICAID by Region

COUNTY	TOTAL
Allegany	2,076
Anne Arundel	19,924
Baltimore	36,635
Baltimore City	30,641
Calvert	2,553
Caroline	1,545
Carroll	5,308
Cecil	3,935
Charles	5,109
Dorchester	1,410
Frederick	8,635
Garrett	1,458
Harford	8957
Howard	13393
Kent	776
Montgomery	55442
Prince Georges	45954
Queen Annes	1685
Saint Marys	2728
Somerset	1019
Talbot	1664
Washington	5541
Wicomico	4591
Worcester	3160
Out-of-State	106
<b>TOTAL</b>	<b>264,245</b>

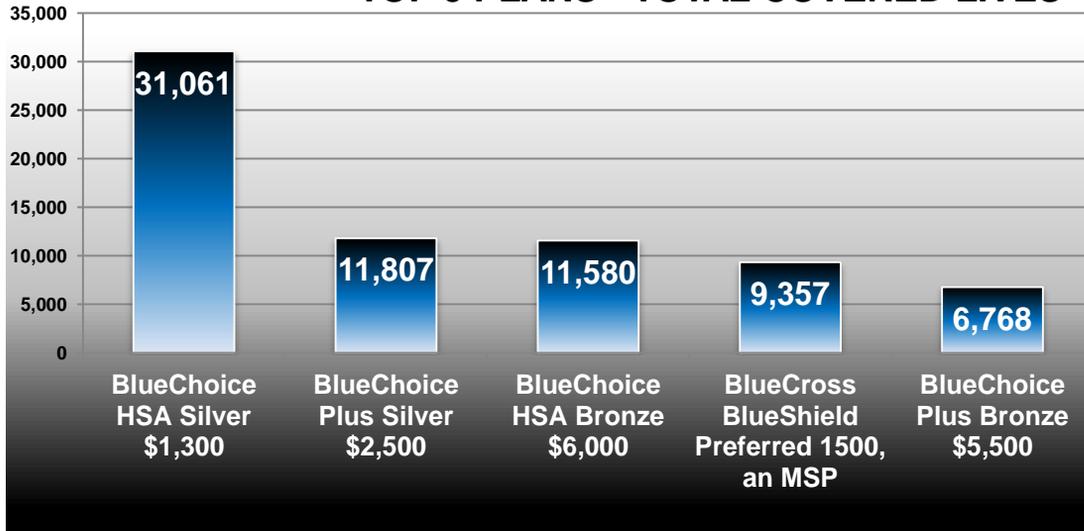


## ENROLLMENT FOR QUALIFIED HEALTH PLANS & MEDICAID by Region



## PLAN SELECTION FOR QUALIFIED HEALTH PLANS OFFERED ON MHC

### TOP 5 PLANS - TOTAL COVERED LIVES



## CONSUMER ASSISTANCE – Connector Entity Program

- 6 connector entities with local community-based partners
- 200 navigators; 100 assisters



## CONSUMER ASSISTANCE

- **Producers**
  - ❖ 1,142 authorized producers, incl. 36 captive producers;
  - ❖ Broker Renewal Referral Program with 191 participants;
  - ❖ 21,790 QHP enrollments through brokers
- **Application Counselors**
  - 35 Application Counselor Sponsoring Entity organizations
  - ACSEs engage 200+ Certified Application Counselors (CACs)

- Consolidated Services Center (Call Center) Analysis

	Calls Received	Avg Daily Calls Rec'd	Calls Answered	Calls Abandoned	% Abandoned	Average Speed Answer	Service Level	Average Talk Time
November	69,978	2,332	51,813	18,165	26%	4:39	39%	14:29
December	160,983	5,193	100,083	60,900	38%	15:02	29%	19:02
January	121,524	3,920	115,124	6,400	5%	1:30	72%	16:09
February	191,277	6,831	106,634	84,643	44%	17:32	11%	19:02

Budgeted Funding:

- FY15 – \$21.5 million
- FY16 - \$15 million

## **2<sup>nd</sup> Year Milestones:**

- Fully functioning IT system
  
- Increased Coverage Options
  - 2 new carriers (1 medical and 1 dental), and 12 additional plans
  
- Uninsured Rate Dropped
  - According to Gallup poll uninsured rate in Maryland dropped 5.1%

*States With Largest Reductions in Percentage Uninsured, 2013 vs. 2014*

"Do you have health insurance coverage?" (% No)

	<b>% Uninsured, 2013</b>	<b>% Uninsured, 2014</b>	<b>Change in uninsured (pct. pts.)</b>	<b>Medicaid expansion AND state exchange/ partnership in 2014</b>
Arkansas	22.5	11.4	-11.1	Yes
Kentucky	20.4	9.8	-10.6	Yes
Oregon	19.4	11.7	-7.7	Yes
Washington	16.8	10.1	-6.7	Yes
West Virginia	17.6	10.9	-6.7	Yes
California	21.6	15.3	-6.3	Yes
Connecticut	12.3	6.0	-6.3	Yes
Colorado	17.0	11.2	-5.8	Yes
Maryland	12.9	7.8	-5.1	Yes
Montana	20.7	15.8	-4.9	No
New Mexico	20.2	15.3	-4.9	Yes

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## Upcoming Challenges

- Hard to Reach Populations
- Maximizing Transparency and Consumer Decision Support
  - Provider Directory
  - Consumer Checkbook
- Optimizing consumer choice and plan affordability
- Providing Medicaid consumer assistance

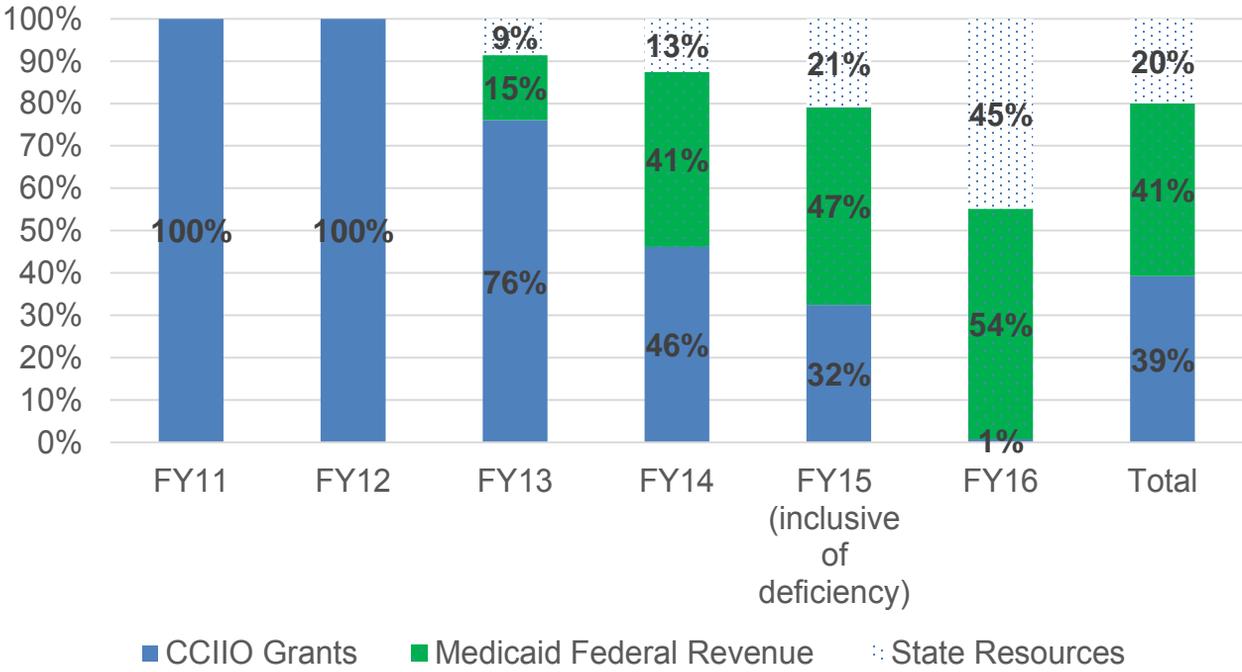
## **Scope of Finance Presentation**

- Transition to State Resources in the middle of Fiscal Year 2015, yet still optimizing federal revenue
- Self Sustainability
- Appropriation Balances as of January 31, 2015
- Strategies to deal with limited State resources in FY2015

## Transition to State Resources

- Per ACA, certain federal support for exchanges ends January 1, 2015.
- Because Maryland's state-based exchange plays a key role for Medicaid, MHBE can still access federal Medicaid support past January 1, 2015; however, General Funds are required to draw down Medicaid federal revenue
- Thus, State resources will represent a greater share of the budget - approximately 45% of funding in FY16 as opposed to 21% in FY15 and 13% in FY14.

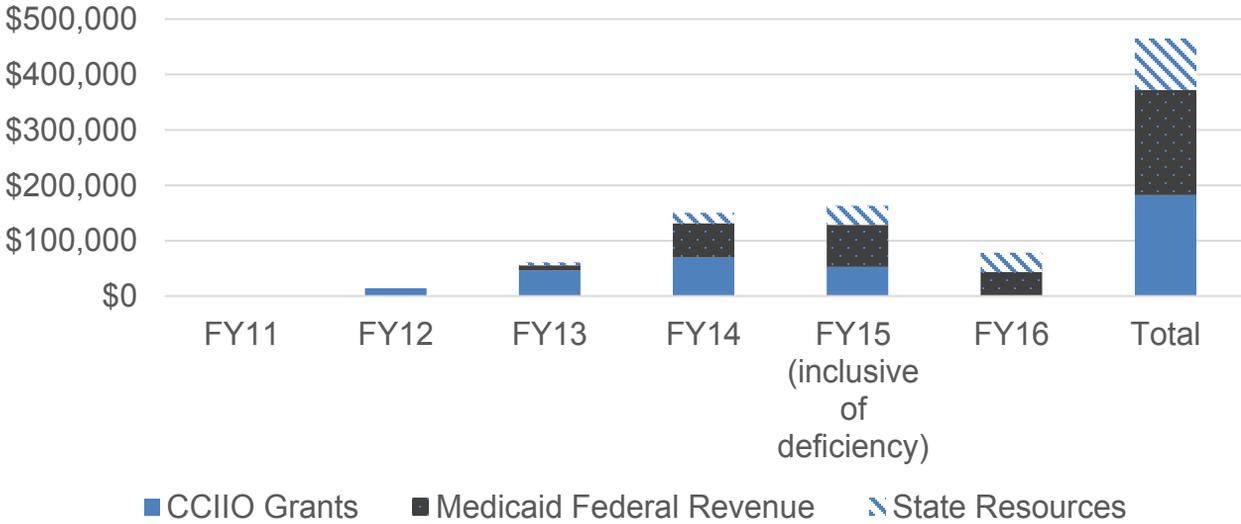
## Exchange Expenditures by Fund Type (%)



## Transition to State Resources but Overall Reduced Expenditures

- Expenditures overall are being reduced in half from FY15 to FY16 (\$162 million to \$78 million).
- Most notably:
  - Call Center expenditures are decreasing from \$21.5 million to \$15 million
  - Connector Entities expenditures are decreasing from \$18 to \$12 million
  - Marketing Expenditures are decreasing from \$4.5 million to \$2.5 million

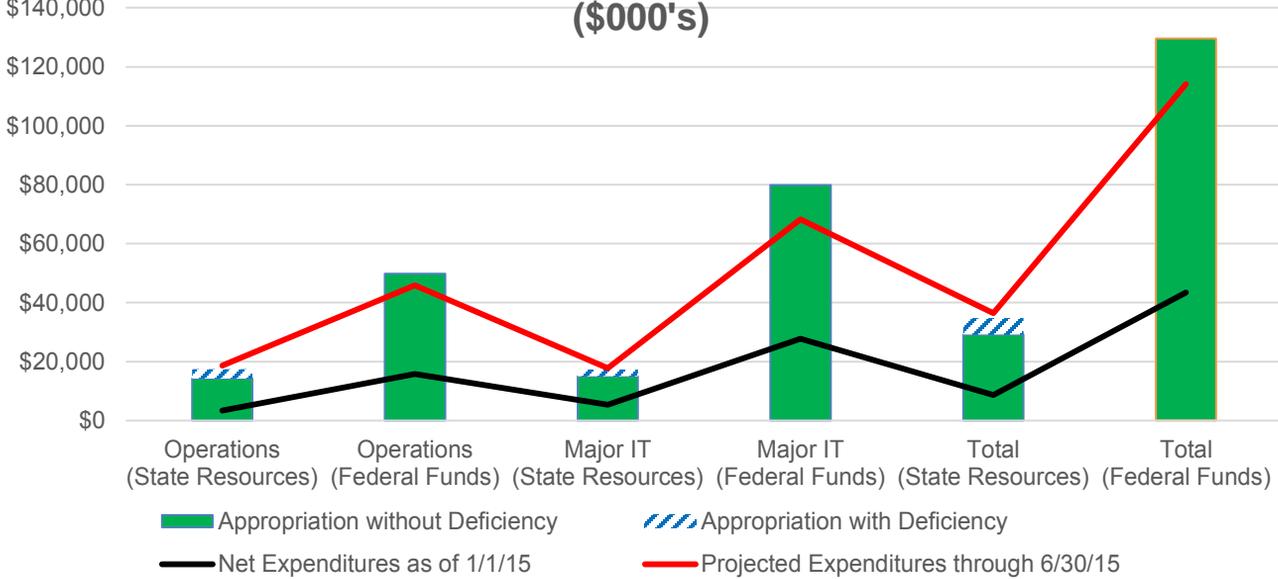
### Exchange Expenditures by Fund Type (\$000's)



## **Self-Sustainability**

- In Fiscal Year 2015, the Exchange is slated to expend \$162 million (\$34 million in State Resources)
- Preliminary estimates indicate that \$15 to \$20 million will come to the State through the existing insurance assessment in calendar year 2014.
- Because the insurance assessment also applies to Medicaid managed care plans, we project approximately \$23 million more in special funds in calendar 2014 due to the implementation of the Affordable Care Act (Rate Stabilization Fund).
- All told, because of the implementation of the Affordable Care Act, the State can anticipate \$38 to \$43 million more in revenue every year, which is line with out year projections for State funded Exchange operations.
- This does not account for the positive externality of reducing uncompensated care in Maryland hospitals, which in turn reduces hospital rates and the long term expenditures of the Maryland Medicaid program and the State employee health insurance plan.

### Fiscal Year 2015 Appropriation Balance as of January 31, 2015 and Projected Spend for Remainder of Fiscal Year 2015 (\$000's)



**Limited State Resources for remainder of Fiscal Year 2015 requires tough choices.**

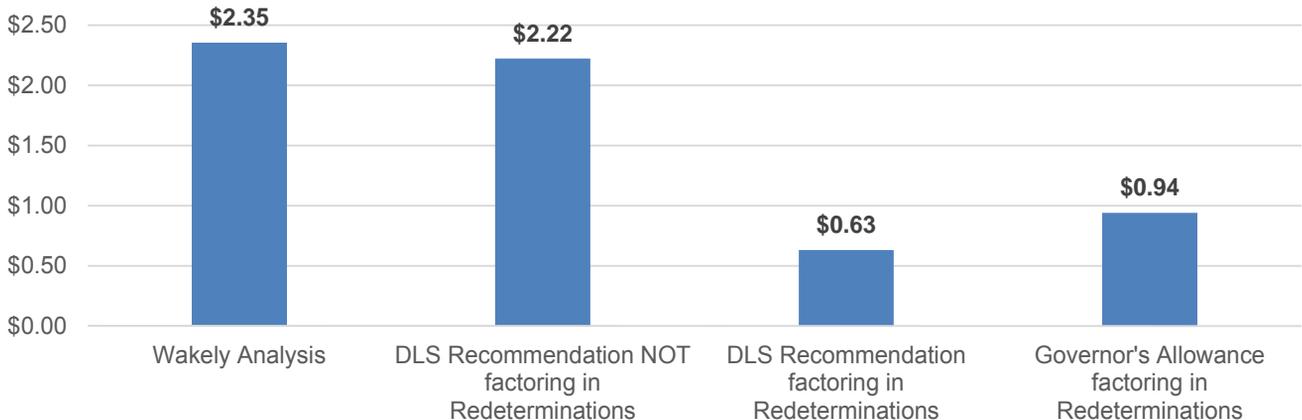
- Strategies already incorporated:
  - Connector Entities, which in FY15 receive \$5 million per quarter will be cut \$1 million in quarter four (April to June)
  - \$3.8 million of a new grant award of \$7.9 million from Consumer Information and Insurance Oversight (CCIIO) will be diverted to cover State QHP expenses
  - Reduced staff in call center over the remainder of the fiscal year
  - New Dental Functionality for the HBX website will be pushed to FY16.
  - Marketing for the remainder of the fiscal year will be cut \$900k
  - Delayed hiring
- Possible Future Strategies to be employed:
  - Reducing existing operational contracts (Call Center, Consumer Assistance, Marketing) further.
  - Utilizing more of the new grant from CCIIO
  - Delay hiring further

- **DLS Recommendation #1** – Strike the following language from the special fund appropriation: “provided that this appropriation shall be reduced by \$1,498,276 contingent upon the enactment of legislation reducing the required appropriation of \$35,000,000.”
  - MHBE concurs with this recommendation in the sense that this language is not necessary given DLS’s Recommendation #3.

- **DLS Recommendation #2** - Reduce the appropriation for connector entities by \$4 million. This reduction still leaves \$8 million for that purpose.
  - MHBE does not concur with this recommendation. The Connector Entities are essential to enrolling many of Maryland's most vulnerable citizens, most notably non-English speakers, individuals without adequate computer access (both rural and urban), and individuals with special needs. While the website has made great strides, consumer assistance will always be needed for these populations.
  - Moreover, the Wakely analysis DLS is citing and DLS' own analysis both fail to account for the fact that the HBX will serve as the portal by which Medicaid redeterminations (approximately 800k individuals) will be redetermined, thereby overstating the Per Member Per Month (PMPM) costs. Factoring this population in, the Per Member Per Month (PMPM) costs will actually be 94 CENTS PMPM – not \$2.40 PMPM the Wakely analysis envisioned and not the \$2.22 PMPM the DLS analysis is recommending.

- DLS Recommendation #2** - Reduce the appropriation for connector entities by \$4 million. This reduction still leaves \$8 million for that purpose.

### Per Member Per Month Costs



- **DLS Recommendation #3** – Reduce the appropriation of the Maryland Health Benefit Exchange by \$1,498,276 in special funds. This action implements the Governor’s proposal as introduced.
  - MHBE concurs with this recommendation.

- **DLS Recommendation #4** - Reduce the appropriation for marketing by \$1 million. This reduction still leaves \$1.6 million for that purpose.
  - MHBE does not concur with this recommendation. The marketing budget has already been substantially reduced, and an additional cut would significantly curtail our ability to ensure that Marylanders, particularly the remaining uninsured who have proven difficult to reach, are informed about the Exchange’s new opportunity for affordable coverage, open enrollment and its deadlines, and the penalty for failing to enroll.
  - For those remaining uninsured, the stakes will be even higher next year, with the penalty increasing to 2.5% of income, or \$695, whichever is greater. Open enrollment will end Jan. 31, before consumers file taxes.
  - Both state and national surveys show that despite enrollment successes, large swaths of the population still lack a basic familiarity with the requirement to purchase insurance, the opportunities afforded by health benefit exchanges, subsidies and other affordability programs, and the tax penalty.
    - A Robert Wood Johnson/Urban Institute survey showed 25% know nothing about the tax penalty, and 30% know nothing about the marketplace or open enrollment deadline.
    - Maryland surveys and focus groups last fall showed consumers in some areas with “absolutely no awareness” of Maryland Health Connection, with this lack of awareness as high as 54% in Western MD.

- **DLS Recommendation #4** - Reduce the appropriation for marketing by \$1 million. This reduction still leaves \$1.6 million for that purpose.
  - MHBE's marketing budget is smaller than other marketplaces, *e.g.* KY - \$11.3 M; IL - \$35 M; NY - \$40.1 M; OR - \$9.9 M; NM - \$6.2; ID - \$4.7 M; CO - \$7.2 M.
  - Target populations' consumption of media highly fragmented, *e.g.* Internet, smartphone apps, radio, T.V., print
  - SHOP just beginning; has had little promotion at formative stage.

- **DLS Inquiry #1** – The agency should comment what the evident popularity of these high-deductible plans means for the core issue of health care affordability
  - MHBE believes that offering high deductible plans is an important component of consumer choice, but their popularity underscores the importance of having effective consumer support to ensure informed decision-making. Consumers must be given the guidance or tools to understand the total likely out-of-pocket costs of a plan choice, which factors in utilization to help consumers understand the implications of choosing a high deductible plan given their particular health needs. High-deductible plans have lower premiums, but we need to provide consumers the tools to understand that premiums are just one part of the story.

- **DLS Inquiry #2** – The agency should comment on plans to move to an integrated system.
  - MHBE is in preliminary discussions with other State agencies about moving to a fully integrated system.