PROJECT NARRATIVE:

PLANNING FOR THE MARYLAND HEALTH BENEFIT EXCHANGE

The State of Maryland ("Maryland") plans to operate a statewide Health Benefit Exchange ("Exchange") beginning in 2013. Funding is requested for specific personnel and projects connected with the planning and establishment of the Exchange, building on work previously completed or in progress. At the conclusion of the grant period, Maryland will submit a final report to the Department of Health and Human Services ("HHS") detailing an implementation plan for the Exchange including, but not limited to, goals, objectives, responsible parties, costs, timeframes, and milestones.

BACKGROUND RESEARCH

The analytic groundwork for this Exchange was laid in 2006-2007, when the Maryland Health Care Commission ("Commission") developed and modeled a proposal, known as the Maryland Plan, for an exchange to promote transparency and choice, deliver subsidies, merge funding streams, and adjust risks in the individual and small group markets. The concept of individual responsibility was a key element of the Plan, which featured strong penalties for remaining uninsured if affordable coverage was available.[1]

Maryland has carried out other research and activities relevant to the establishment of an Exchange: state specific analyses of insurance coverage[2] and health care expenditures[3];

[1] The Report on Policy Options is found at http://mhcc.maryland.gov/legislative/healthpolicyoptions_0108.pdf Detailed modeling of the proposal performed by John Sheils of the Lewin Group is found at http://mhcc.maryland.gov/health_insurance/costcovimpacts.pdf. Brief descriptions of these and other key Maryland reports are found in Attachment 1.

[2] http://mhcc.maryland.gov/health_insurance/insurance_coverage/insurance_report_thru_2007.pdf This is a biennial report. The next report will be issued in December 2010 and help inform subsequent planning and economic modeling.

[3] http://mhcc.maryland.gov/health_care_expenditures/hcec10/report.pdf

extensive experience with claims analysis using commercial, Medicaid, and Medicare claims databases[4]; an all-payer hospital rate setting system,[5] including a hospital discharge database with cost information; a long history of public reporting of health plan quality[6] using HEDIS, the CAHPS Health Plan Survey, and eValu8 measures; and initial efforts to improve price transparency for hospital services and for health plan benefits and premiums.

Governor O'Malley established the Maryland Health Reform Coordinating Council[7] by Executive Order on March 24, 2010. The Council includes members of the executive and legislative branches of government and is responsible for coordinating the state actions to implement PPACA. The Council has established Workgroups in six areas of special concern.[8] Each Workgroup is responsible for outlining issues, engaging the public, gathering and analyzing public comment, conducting focused research, and developing options for consideration by the Coordinating Council. The Entry to Coverage Workgroup and the Exchange and Insurance Markets Workgroup are of particular importance to this grant; their co-chairs have been meeting to coordinate efforts and to develop this grant application. Workgroup reports are due to the Coordinating Council in November; in late December the Council will provide recommendations to the Governor and General Assembly in December regarding actions necessary in the 2011 and 2012 sessions of the General Assembly.

Our expectation is that the General Assembly will pass legislation during the 2011 session that establishes the governance for a statewide Exchange. The Board of the Exchange will be asked to provide specific legislative recommendations for the 2012 session that may

[4] http://mhcc.maryland.gov/health_care_expenditures/mcdb.html
[5] Murray, Robert: Setting Hospital Rates To Control Costs And Boost Quality: The Maryland Experience. Health Affairs, September/October 2009; 28(5): 1395-1405.
[6] http://mhcc.maryland.gov/hmo/compreport_021010.pdf
[7] http://www.healthreform.maryland.gov/index.html
[8] http://www.healthreform.maryland.gov/workgroups/index.html

restructure the non-group and small group markets and will provide whatever additional authorities are needed for efficient operation of the Exchange.

Maryland's intensive Exchange planning effort will extend through the summer of 2011, will continue and expand the open process and active stakeholder involvement set in motion by the Council, will feed directly into an implementation process, and will enable Maryland to implement a successful health insurance exchange in 2013. Specifically, the planning process, consisting of projects funded through this federal planning grant and projects funded through state funds, is designed to provide both the operational infrastructure and the analysis essential to 1) support the policy decisions that must be made during the first 6-9 months that the governance of the Exchange is in existence, 2) develop an implementation plan, and 2) guide the preparation of Maryland's grant application for implementation funding. Our grant proposal reflects the following key principles:

- **Rely on Maryland's preexisting strengths, existing data, and extensive health care reform planning process already underway;**
- **Focus most of the initial federal grant funding on the effort requiring the greatest lead time -- information technology;**
- **Fund a core staff for the planning and implementation of the Exchange;**
- **Fund a comprehensive outreach and communications strategy to reach the public in general and small businesses in particular; and**
- **Fund through both federal grant and state resources targeted efforts that will inform later deliberations of the Exchange Board.**

Because Maryland's application relies heavily on existing data, policy analyses, and economic modeling and on health care reform planning processes currently underway, we have

provided in footnotes the urls for key reports that demonstrate our efforts past and present, rather than attaching multiple large files to this grant application. We have also provided one paragraph descriptions of these reports in Attachment 1.

STAKEHOLDER INVOLVEMENT

A substantial part of the initial stakeholder involvement has been addressed with the creation of the Coordinating Council and the two Council workgroups that are particularly relevant to the Exchange: the Exchange and Insurance Markets Workgroup and the Entry into Coverage Workgroup. Deliberations of the Outreach and Education Workgroup will also provide vital stakeholder input to shape the Exchange's outreach and education efforts. In addition to the Coordinating Council's website, the Council operates a listserv with over 800 organizations and individuals receiving information, and a comment process that has received 160 public comments from individuals, organizations and coalitions. The Council and workgroup process will assure appropriate involvement of and input from key stakeholder groups that will help shape recommendations for General Assembly action beginning next January. A partial list of active participants in the planning process is found in Attachment 2.

The greater challenge lies in engaging the general public. The communications strategy will need to provide accurate information about how health care coverage will change, and in particular, how the Exchange will offer a seamless entry point into public and private coverage across the income spectrum, choices for all those purchasing insurance through the Exchange in the individual and small group markets, and subsidies for low to middle income families purchasing individual market coverage. While the experience in Massachusetts is a very helpful guide to promoting coverage in the individual market, Maryland, like all states, has different features that influence the message and its delivery. Additionally, no one has much experience

in successfully marketing an exchange similar to a SHOP Exchange to small employers and their employees.

We are requesting funding in the amount of $78,400 for a contract to plan a comprehensive outreach and communications strategy to reach the public in general and small businesses in particular. One of the lessons from reform efforts in Massachusetts and other states is that a comprehensive outreach and communications strategy is essential to effective implementation. The other lesson is that small business participation in exchanges has been quite limited. This contract will include funding for market research to identify features of an exchange that would appeal to small business owners and employees. The contract would also address access issues for individuals with disabilities. The outreach and communications plan would be implemented through later grants.

PROGRAM INTEGRATION

The most substantial program integration task will be to create a seamless process for an individual or small employer to obtain information about public and private health care coverage options and costs, to choose among coverage options, and to enroll in appropriate coverage. The fundamental policy and organizational challenges in creating this integrated eligibility and enrollment system are being addressed through the Maryland Health Care Reform Coordinating Council. Simplified eligibility standards for public programs or for subsidies, standardized benefit descriptions, tiered cost-sharing, and other PPACA provisions will help simplify the eligibility, choice, and enrollment process for the consumer, but the infrastructure to support this seamless consumer experience does not currently exist. **We request funding for those substantial infrastructure integration challenges in the Technical Infrastructure section.**

The transition from underwriting in the individual market to guaranteed issue and modified community rating, the successful integration of Maryland's high risk pool (the third largest in the nation before expanding to include the federal high risk pool for the state) with the individual market, and the question of whether the small group and individual markets should be merged to enhance employee choice are known planning challenges. The impact of these changes on premiums in the individual and small group market – and steps that may mitigate these effects on premiums – require study. The challenges include not only the integration of programs to create seamless coverage, but also the protection of these programs from adverse selection resulting from coverage available outside the regulated Maryland insurance market.

Maryland will fund a study to answer these questions. A modification of the Commission's actuarial contract with Mercer (a letter of interest is attached) will examine:

- Changes in premiums in the individual and small group markets in 2014, when adverse selection risks are greatest because of minimal personal responsibility penalties and the migration of individuals currently covered by the Maryland Health Insurance Program (our high risk pool) into the individual market;
- The likely effects of merging the individual and small group markets, were that action desirable for policy reasons;
- The extent of erosion in the small group market due to 1) association plans, 2) self-insurance using low attachment point stop-loss insurance, and 3) the use of Section 125 plans plus wage enhancements to enable employees to purchase in the individual market; and
- Steps Maryland might take (beyond the reinsurance, risk corridors, and risk adjustment provisions of PPACA) to mitigate adverse consequences of reform.

RESOURCES AND CAPABILITIES

Maryland is fortunate to have both public and private sector capabilities to address many of the challenges posed by health care reform. In the public sector, long-standing working relationships exist among key agencies, including the Department of Health and Mental Hygiene (DHMH, which includes the Medicaid program), the Department of Human Resources (responsible for most of the current eligibility system), the Maryland Insurance Administration (responsible for insurance regulation and consumer protection), the Commission (responsible for policy analysis and for benefit design in the small group market), the Health Services Cost Review Commission (responsible for the hospital all-payer system), the Office of the Attorney General (responsible for consumer protection), and the Department of Budget and Management. These agencies and the key legislative committees involved in health care reform are represented on the Health Care Reform Coordinating Council, chaired by the Lieutenant Governor and the Secretary of Health and Mental Hygiene. These agencies have generated much of the information and policy analysis necessary to guide reform, and are actively involved in major public reporting, quality improvement, practice transformation, and payment reform initiatives.

In the private sector, the major universities provide public policy and public health expertise. The state also has several large third party administrators with well-developed information infrastructures that have played very active roles in marketing, enrollment, billing, and the administration of COBRA coverage and the Partnership subsidy.[9] Representatives of businesses, associations, hospitals, health professionals, carriers, brokers, disease specific

[9] The capabilities of these Maryland third party administrators were assessed in a recent consultant's report by Jonathan Gruber and Bob Carey. The report emphasized that several existing TPAs could provide infrastructure for the Exchange, but that overarching policy and governance would be essential to represent the public interest. http://www.naifanet.com/230000//A%20Health%20Insurance%20Exchange%20for%20Maryland%20%2D%20Comparing%20MA%20to%20MD%2Epdf).

advocacy organizations, and the general public are actively involved in the State's deliberations and in promoting a range of reform proposals at the state level.[10]

However, the state planning and implementation activities required by PPACA are of unprecedented scale and complexity and will require dedicated staff. **We are requesting funding to hire core staff to coordinate planning of the Exchange in the amount of $186,826.85, including fringe and travel to federal meetings.** A program manager with health policy background will administer the federal planning grant, develop any necessary RFAs for grant activities, oversee contracts funded under the grant, and draft a comprehensive implementation and staffing plan for the Exchange. A health policy analyst with strong writing skills will be hired to work with the program administrator. Understanding that the Exchange will operate like a business, core staff will ideally have business and/or insurance background. The staff will be housed in and administrative support and supervision will be provided by the Department of Health and Mental Hygiene. Policy guidance will be provided by an advisory committee composed of the co-chairs of the Exchange and Insurance Markets Workgroup and the Entry to Coverage Workgroup. Furthermore, the full Coordinating Council will be regularly apprised of their efforts.

We anticipate that this core staff will be brought under the Exchange itself once the Exchange is established as a legal entity. The initial organizational chart and position descriptions for these individuals are in Attachment 3. No grant support is sought for existing agency staff.

GOVERNANCE

One of the challenges of governance of an Exchange is assuring responsiveness and accountability while providing some degree of insulation from the political process. This partial

[10] See Attachment 2 for a partial list of participants in the Council's planning processes.

insulation is essential for the Governing Board to make the difficult decisions that will be necessary to help bring the continuing escalation of health care costs under control. Maryland has a number of examples of independent and semi-independent agencies that combine a degree of independence with special personnel and procurement authorities that will be essential if this Exchange is to be operating in 2013.

The issues of governance will be examined over the coming six months, with legislation establishing the exchange governance expected in the 2011 session of the General Assembly. No federal grant funding is requested for these activities, since they are already underway with state support.

FINANCE

Two issues are of primary importance: accountability and sustainability. Accountability for the expenditure of federal grant funds is in place – both DHMH and the Commission have experience managing federal grants and have auditing systems and external auditing contracts in place. Longer term accountability issues connected with the operation of the exchange will most appropriately and efficiently be developed by the governance and executive direction of the Exchange. The accounting and auditing challenges will be heavily dependent on the functions of the exchange and whether these are carried out largely within a government agency or through contracts with outside entities.

Financial sustainability after 2014 is required, but the specific financing mechanisms are to be determined. Financing models, including appropriate fees for basic Exchange functions such as enrollment and Navigator services and the future role of and fees for health insurance producers need to be addressed in the course of this planning year. In particular, future sustainability will require an early examination of the practical implementation of the principle

that the premium must be the same inside and outside the Exchange. No federal grant funding is requested; these issues will be addressed by the core staff, the Department of Health and Mental Hygiene, and the Exchange Board.

TECHNICAL INFRASTRUCTURE

As outlined in the Background section, we believe our greatest challenge lies in developing the infrastructure necessary for program integration – and in particular, in the information technology infrastructure needed to operate an Exchange that offers comprehensive information and seamless entry into coverage through effective interfaces with the Maryland Medicaid program, our state eligibility determination processes, federal eligibility verification processes, and commercial market enrollment and billing processes.

The eligibility system for Medicaid and other social service programs in Maryland, like that in many states, is based on old technology. There will need to be a careful assessment of the options for Maryland to achieve seamless integration of Medicaid eligibility and premium credits though the Exchange. Attachment 4 portrays two models of integration: "seamless entry" into public or private health insurance coverage and "no wrong door" entry into public programs (Medicaid and social services). Part of the planning challenge is to develop the front end program for seamless entry into health insurance coverage so that it also can support "no wrong door" policies and the existing social services eligibility process.

Similarly, an assessment of options for eligibility, enrollment, and back office functions for enrollment into Exchange products is essential. Attachment 5 presents a simplified flow chart of the health insurance eligibility determination and enrollment process; the tasks that are not performed by existing systems but must be performed by the new Exchange front end are indicated in red.

Third party administrators in Maryland already perform many of the functions that the Exchange would be required to perform – although not with a public interface. It will therefore be vital to assess the ability of existing private sector entities to expand their capabilities to handle eligibility determination, referral, and enrollment. And finally, the Federal government itself is developing capabilities that will influence state choices, including the public web portal HealthCare.gov and a possible single query point for income, citizenship, and "legally-present" verification.

We plan to contract with an appropriate information technology consultant firm that can evaluate existing capabilities, assess options, develop recommendations, and develop an RFP for services essential to the exchange. Contracting will be expedited by using Maryland's competitive CATS-II task order RFP process. The consultant will:

- Assess current public sector technological capabilities, including the ability to manage the eligibility determinations for Medicaid, for other social welfare programs, and for the Partnership program, the ability to enroll eligible individuals in the appropriate public sector programs, and the ability to refer to commercial coverage when appropriate;
- Assess current private sector technological capabilities for which the Exchange might contract, including the ability to provide well-organized information about coverage options, benefit designs, and premiums; obtain applications and information essential to determine eligibility; enroll individuals in commercial coverage; and handle back office tasks that may be part of an effective exchange;
- Assess technology solutions that may be available from the federal government, including eligibility verification and insurance benefit and pricing information;

- Assess whether the existing public or private sector capacity could be adapted for online public access to facilitate eligibility determination, choice of coverage, application, and enrollment (since existing information infrastructure primarily serves either government agency personnel or insurance agency personnel);
- Assess the specific options for connecting an eligibility determination system with other components of the Exchange and address the following questions:
    - What are the advantages and disadvantages of the following options: procure, install, and expand other commercially available eligibility systems; expand the current private insurance systems to include eligibility and appropriate direct transfer of information to the public information systems; or develop an integrated system de novo?
    - Should the system retain integration with eligibility determination for other social welfare programs or is it more feasible and desirable to develop (at least initially) a separate eligibility process for public and private insurance coverage, emphasizing integration across types of insurance coverage?
    - Which systems can most easily develop a front end interface for consumers, Navigators, brokers, and human resources staff, providing both the enrollment logic and a display of available coverage options (including benefits, premiums, and cost sharing, if any)?
    - What will be required to interface with federal income and citizenship eligibility verification processes?
- Develop the RFP for eligibility system expansion or acquisition (or for a complete Exchange system, including front end for the full range of users).

We are requesting funding for this contract in the amount of $734,000. A more detailed description of the tasks that will be incorporated into the Task Order RFP is found in the attached Information Infrastructure Planning Contractor Workplan and Timeline.

BUSINESS OPERATIONS

Business operations are heavily dependent on the organizational structure, location, and governance of the Exchange; on decisions regarding the relationship of the Exchange subsidy eligibility system to the Medicaid/SCHIP eligibility system and the eligibility system for other social welfare programs; and on recommendations for the technological infrastructure of the Exchange, which is in turn dependent on emerging federal infrastructure, standards, and services. As these become clearer over the grant period, the program administrator (and later in the grant year, the Exchange administration) will develop specific plans for business operations, including a detailed Gantt chart or timeline.

Maryland's agencies have substantial experience performing functions relevant to the business operations of the exchange, including merging public subsidies with private premium contributions, reviewing insurance rates, assessing and reporting on plan quality, operating call centers for a range of health coverage programs, planning and implementing information systems, operating separate personnel and procurement systems for small, independent agencies, and auditing both quality and financial data from carriers. The Exchange will draw on this expertise. Dedicated funding is therefore not being sought.

For the Exchange to be most effective in assisting consumers and most successful in attracting participants, it will have to develop one additional business function: assisting consumers in the difficult task of comparing the value of different health plans and making purchasing decisions. The Commission will fund the development of a health benefit plan

comparison tool that will estimate total premium and cost sharing amounts at different levels of total expenditure.

REGULATORY OR POLICY ACTIONS

The Interim Report of the Maryland Health Reform Coordinating Council[11], and in particular, the 209 page Appendix E of that report, sets forth in detail the many sections of PPACA that either require or invite state legislative or regulatory action. The Coordinating Council's comprehensive planning effort will continue as planned, using state funding. The most immediate results of the existing planning efforts have been 1) legislative and regulatory actions to bring state law into agreement with the early insurance market reforms in PPACA and 2) the passage of legislation authorizing the Maryland Health Insurance Plan to operate the federal high risk pool in Maryland. The session beginning in January 2011 is expected to address the organizational structure and governance of the Exchange. **No federal funding for this effort is requested, since these activities are already underway with state funding.**

CONCLUSION

Funding requests included in this planning grant reflect immediate, essential, high priority planning efforts that are vital to the ultimate success of the Exchange but are not otherwise supported by Maryland's existing health care reform planning process. This grant funding will support the development of Maryland's comprehensive plan for implementation of the exchange, positioning Maryland both to apply for the Exchange implementation grant next year and to implement the Exchange successfully in 2013.

In summary, Maryland will fund the following activities:

[11] http://healthreform.maryland.gov/interimreport.html

- Ongoing Maryland-specific studies of public and private health insurance coverage and health care expenditures;
- Studies required to ascertain whether to merge the individual and small group markets and whether to provide additional protection against adverse selection once both individual and small group products are guaranteed issued and modified community rated;
- Development of governance options for the successful operation of the Exchange; and
- Development of operational plans and a sustainable business model for the Exchange.

Maryland is requesting that this grant provide funds to:

- Assess Maryland's existing information technology infrastructure, identify programmatic needs, and develop an information technology implementation plan to provide both front end access for consumers, Navigators, and Medicaid staff to determine eligibility, choose coverage, and enroll, and backroom infrastructure to conduct the day to day activities of the Exchange;
- Hire initial staff to oversee activities under this grant and to develop a comprehensive implementation plan for the Exchange; and
- Plan a comprehensive outreach and communications strategy to reach the public in general and small businesses in particular.

At the end of the grant period, Maryland will present HHS with the results of the state funded and grant funded projects in a report detailing an implementation plan for the Exchange including, but not limited to, goals, objectives, responsible parties, costs, timeframes, and milestones.