The Honorable Martin O'Malley
Governor
State of Maryland
Annapolis, MD 21401-1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

RE: HB 166, Chapter 2 of the Acts of 2011 - Maryland Health Benefit Exchange Act of 2011

December 23, 2011

Dear Governor O'Malley, President Miller and Speaker Busch:

Pursuant to HB 166, Chapter 2 of the Acts of 2011, the Maryland Health Benefit Exchange is to report its findings and recommendations, including recommendations for further legislative or regulatory action, to the Governor and General Assembly on or before December 23, 2011.

The legislation requires that the Exchange study and make recommendations regarding:

1. The feasibility and desirability of the Exchange engaging in selective contracting and multistate or regional contracting;
2. The rules under which health benefit plans should be offered inside and outside of the Exchange in order to mitigate adverse selection and encourage enrollment in the Exchange;
3. The design and operation of the Exchange's Navigator Program and any other appropriate consumer assistance mechanisms;
4. The design and function of the Small Business Health Options Plan (SHOP) Exchange beyond the requirements of the Affordable Care Act (ACA) to promote quality, affordability, and portability;
5. How the Exchange can become self-sustaining by 2015; and
6. How the Exchange should conduct its public relations and advertising campaign.

Pursuant to the insurance article, section 31-106 (G) of the insurance article, the Board created four advisory committees with more than 60 participating Marylanders.

In consultation with these committees and with data and analysis provided by external consultants, the Board developed the recommendations in the attached report for a successful Exchange.

The Board looks forward to the next steps in consideration of these recommendations, and we thank you for the opportunity to serve Maryland at this special time.

Sincerely,

Joshua M. Sharfstein, M.D.
Chair
Board of the Maryland Health Benefit Exchange

Recommendations for a Successful Maryland Health Benefit Exchange

A Report to the Governor and Maryland General Assembly

Maryland Health Benefit Exchange
December 23, 2011

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Introduction

Maryland's Health Benefit Exchange will provide a marketplace for individuals and small businesses to purchase high quality, affordable health coverage. Because of subsidies through the Affordable Care Act, the Exchange will make health insurance newly accessible to hundreds of thousands of Marylanders.

This report provides recommendations for policies on a wide range of topics to help the Exchange succeed. These topics include six that are specifically mentioned in the Maryland Health Benefit Exchange Act:[1]

1. The feasibility and desirability of the Exchange engaging in selective contracting and multistate or regional contracting
2. The rules under which health benefit plans should be offered inside and outside the Exchange in order to mitigate adverse selection and encourage enrollment in the Exchange
3. The design and operation of the Exchange's Navigator Program and any other appropriate consumer assistance mechanisms
4. The design and function of the Small Business Health Options Plan (SHOP) Exchange beyond the requirements of the Affordable Care Act to promote quality, affordability, and portability
5. How the Exchange can become self-sustaining by 2015
6. How the Exchange should conduct its public relations and advertising campaign

In developing these recommendations, the Exchange Board worked with a broad range of interested Marylanders and teams of experts. We received a tremendous amount of input from four advisory committees, which consisted of stakeholders from the health insurance industry, health care providers and associations, community members and advocates, academia, business owners, consultants, and local government officials. In total, 66 Marylanders served on these committees (Figure 1).

Exchange Timeline

March 23, 2010
President Obama signed the Affordable Care Act into law. The Affordable Care Act requires states to either establish and operate a Health Benefit Exchange by 2014 or participate in a federal Exchange

April 12, 2011
Governor O'Malley signed the Maryland Health Benefit Exchange Act, which established Maryland's Exchange as a public corporation and independent unit of state government

June 3, 2011
Exchange Board held its first meeting

September – November 2011
Advisory Committees met

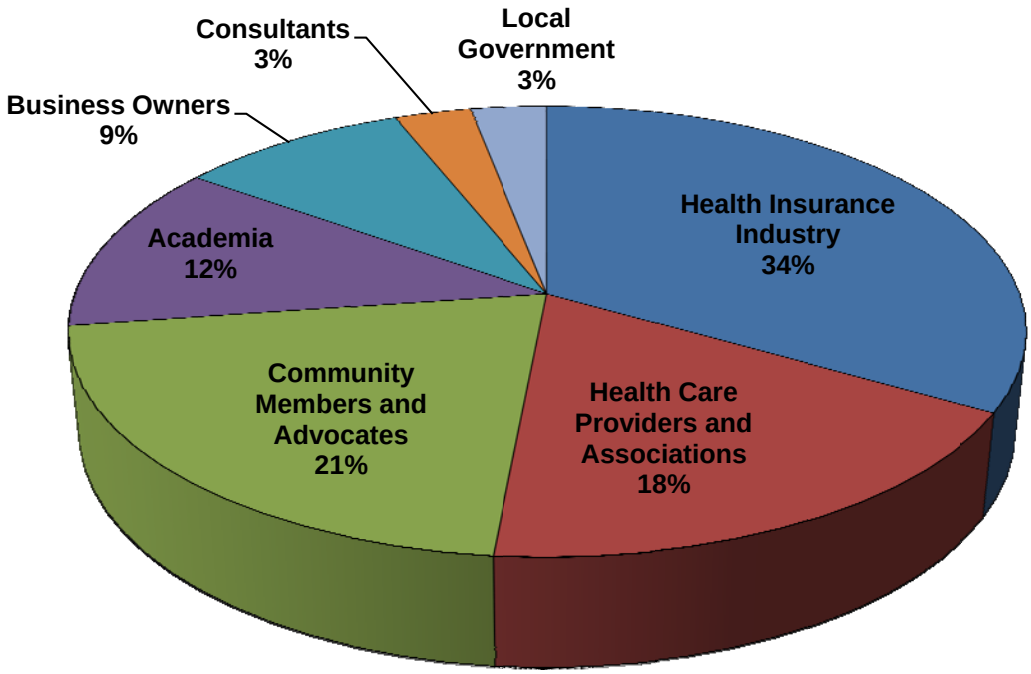
January 1, 2013
Exchange must be certified for operation by the federal government

October 1, 2013
Individuals and groups will begin enrolling in the Exchange

January 1, 2014
The Maryland Health Benefit Exchange will be operational

[1] See Appendix 1 for the relevant text of the Maryland Health Benefit Exchange Act of 2011.

Figure 1. Advisory Committee Membership by Affiliation



The Exchange issued requests for proposals and awarded contracts to consultants to conduct analyses and develop options on each of these six topics between August and November 2011. The consultants were responsible for presenting the advisory committees and the Board with key factors for consideration in their analyses and options for moving forward. The advisory committees, designed as non-voting bodies to facilitate a collaborative process, were responsible for critically examining the options and analyses provided by the study consultants, offering stakeholder perspectives, and providing the Board with Maryland-specific implications of these options.

The advisory committees met a combined total of 22 times between September and November 2011, with all meetings open to the public and with opportunities for public comment. The consultants attended and presented at the committee meetings to engage the advisory committees in discussion. The Executive Director of the Exchange and a Board Liaison designated for each committee attended all committee meetings. See Appendices 2 and 3 for full lists of the Board and advisory committee members, respectively.

Each advisory committee provided the Board with a report summarizing its comments on the assigned consultant studies. All consultant and advisory committee reports were submitted to the Exchange by November 10, 2011, and are included as Attachments A through K. The reports were made available to the public on the Exchange's website, and additional public comment was accepted through written and oral testimony.

We considered all of this input in assessing a wide range of important policy questions. The purpose of this report is to present our recommendations for a successful Exchange.

A number of our recommendations will require legislative action, and we will work with the Administration to identify which require legislative action and to draft appropriate language for each.

Principles for Policy Decisions

Informed by public input, we developed a set of seven principles to create an Exchange that serves the health care needs of Maryland individuals, families, employers and employees. These principles guided our decision making on each of the policy topics.

1. **Accessibility.** The Exchange should reduce the number of Marylanders without health insurance and improve access for all Marylanders.
2. **Affordability.** The affordability of coverage, within the Exchange and within the state, is essential to improving Maryland's health care system and economy.
3. **Sustainability.** The Exchange will need to be sustainable in order to succeed in the long run.
4. **Stability**. The Exchange should promote solutions that respect existing strengths of our state's health care system and promote stability within the Exchange.
5. **Health Equity.** The Exchange should work to address longstanding, unjust disparities in health access and health outcomes in Maryland.
6. **Flexibility.** The Exchange should be nimble and flexible in responding to the quickly changing insurance market, health care delivery system, and general economic conditions in Maryland, while being sensitive and responsive to consumer demands.
7. **Transparency**. The Exchange is accountable to the public, and its activities should be transparent, its services easily available, and its information easily understandable by the populations it assists.

Using the data and options outlined in the advisory committee and consultant reports, we considered how each of our recommendations aligned with these principles.

Pathways

We developed pathways to frame the issues for decision making, to provide a structure for a data-driven analysis of key policy issues, and to provide consistency in our approach across multiple areas.

Each major topic area of study has its own pathway: SHOP, Navigators, public relations and advertising, market rules and risk mitigation, operating model, and financing. In addition to these topics, we developed a pathway on continuity of care for consumers in the Exchange.

Operating Model

The Exchange's operating model is the approach to engaging issuers offering qualified health plans inside the Exchange.[2] An effective model will help the Exchange offer high quality plans to consumers. While the Affordable Care Act outlines a set of minimum standards for issuers contracting with the Exchange, states have the option of developing additional criteria or selectively contracting—options collectively known as "active purchasing" (see box). We analyzed a range of options for health plan certification that included:

- Having no additional standards and contracting with all issuers that meet the Affordable Care Act minimum criteria
- Adding additional requirements to the Affordable Care Act minimum standards but allowing all issuers that meet these requirements to participate
- Selectively choosing to contract with a few issuers for the Exchange

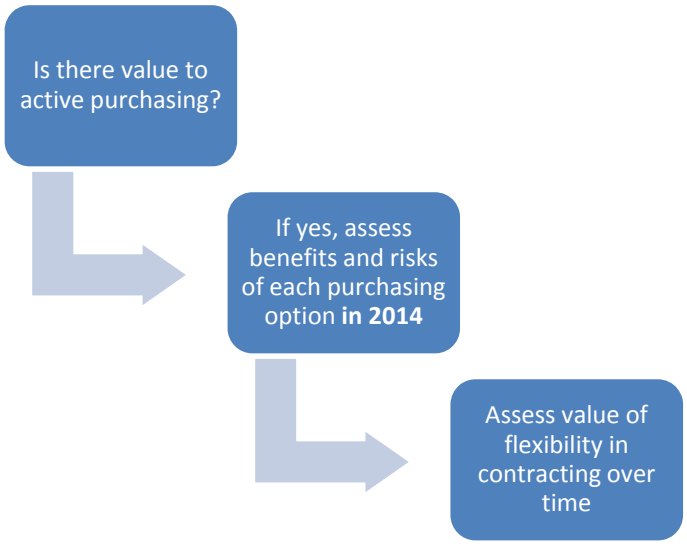
Active purchasing includes a menu of tools that states can use in contracting with issuers in the Exchange.

These tools include developing additional criteria that issuers must meet beyond the Affordable Care Act minimum, selectively contracting with certain issuers, or requiring issuers, as a condition for contracting in the Exchange, to participate in quality improvement programs.

Active purchasing may allow the Exchange to manage competition, negotiate product offerings with insurers, improve quality, and achieve specific long-term goals.

We developed the pathway in Figure 2 as a guide for analyzing these options.

Figure 2. Operating Model Pathway



[2] Qualified health plan is a term defined by the Affordable Care Act and refers to health plans that are certified to be offered in the Exchange. The term issuer refers to the health insurance carriers offering plans in the Exchange. Throughout this report, we use the terms "issuer," "carrier," and "insurer" interchangeably.

KEY INFORMATION: OPERATING MODEL

We identified the following key points in considering these questions:[3]

- **Active purchasing can bring important value to Marylanders**. The value in active purchasing is that, at large levels of enrollment, it would allow the Exchange to have market-wide impact on key goals, such as high quality standards, delivery system reforms, health equity, and cost controls within the health care system.[4]
- **The initial challenge for the Exchange is enrollment, and carrier participation will affect enrollment in the Exchange.** Maryland's individual and small group markets are highly concentrated: one carrier composes 71 percent of the combined markets and five carriers compose 98 percent of the markets.[5] Enrollment may be affected by the extent to which these large carriers participate. Carrier participation, in turn, will depend on the requirements to enter the Exchange.
- **There are certain minimum standards that may be quite important for Marylanders**. For example, Marylanders switching coverage may need certain protections during their transition that can only be assured with additional requirements on participating plans.
- **Over time, as the Exchange grows, it will have more opportunities to use active purchasing strategies to pursue a wide range of goals, such as decreased health care costs**. Active purchasing also provides an opportunity for the Exchange to partner with carriers to achieve its goals and serve as a conduit for change in the future.

DISCUSSION: OPERATING MODEL

We found that active purchasing has significant potential to improve the quality, outcomes, and long-term affordability of health care in Maryland over time. We also recognized that carrier participation is essential to the early success of the Exchange, as enrollment volume drives sustainability and affordability.

In reviewing the contracting options developed by the consultant, we identified a balanced and incremental approach for 2014: having the ability to add requirements above the Affordable Care Act minimum standards but allowing all health plans that meet these requirements to participate. For example, such additional requirements could relate to care transitions (see the Continuity of Care Section). This approach would maximize the growth potential of the Exchange to create a sustainable model while setting a reasonable standard for health plan qualifications.

To ensure that the Exchange remains viable, contracting options should be revisited as the Exchange achieves scale and market leverage over time, and as outside market conditions shift. The advisory committee report indicated that the Exchange should continuously re-evaluate its contracting requirements and have authority to change these requirements as needed.

[3] See Operating Model and Insurance Rules Advisory Committee Report, pp. 5-7 and Wakely Consulting Group Operating Model Report, pp. 5-17.
[4] Wakely Operating Model Report, p.16.
[5] Wakely Operating Model Report, p.13.

As the Exchange matures, flexibility will allow it to respond to the market and use contracting options to further such key principles as quality, affordability, and health equity.

RECOMMENDATIONS: OPERATING MODEL

- The Exchange should have the flexibility to set minimum standards for qualified health plans above the requirements of the Affordable Care Act.
- The Exchange should have the flexibility to modify its approach to contracting over time.

Market Rules and Risk Mitigation

The Exchange's success depends on pooling risk among many Marylanders to keep health care affordable.

The Exchange needs to offer products that attract all kinds of Marylanders, including Marylanders with relatively good health status and low health care costs. If the Exchange attracts only individuals with the highest health care need and costs, then this adverse selection will cause the costs of coverage to spiral beyond affordability (see box).

Adverse selection occurs when a disproportionate number of individuals with higher than average health needs and health costs enroll in a given health plan.

There are three types of adverse selection that Maryland must address:

1. *Market Adverse Selection* occurs when healthy people decide not to purchase insurance or purchase minimum coverage and less-healthy people purchase maximum coverage when they need it.

2. *Exchange Adverse Selection* occurs when less-healthy people purchase coverage through the Exchange and healthy people purchase coverage outside the Exchange.

3. *Insurer Adverse Selection* occurs when less-healthy people disproportionately purchase coverage through a given insurer or insurers and healthy people disproportionately purchase coverage through another given insurer or insurers.

The Affordable Care Act provides states with several strategies to mitigate risk.[6] The Maryland Insurance Administration is leading the state effort in 2012 to design an approach to these strategies. These strategies may not be enough for the Exchange to succeed in pooling risk sufficiently, keeping costs affordable, and maintaining an attractive market for insurers. The Basic Health Plan option for Maryland also has implications for risk in the Exchange.[7]

We analyzed options for the rules under which health benefit plans should be offered inside and outside the Exchange in order to promote a broad risk pool and encourage both carrier participation and member enrollment in the Exchange.

These options include:

- Essential Health Benefits: These are health care services that must be offered by all health plans in the individual and small group markets both inside and outside the Exchange. We evaluated

[6] Commonly referred to as "the 3R's," these strategies are risk adjustment, risk corridors, and reinsurance.

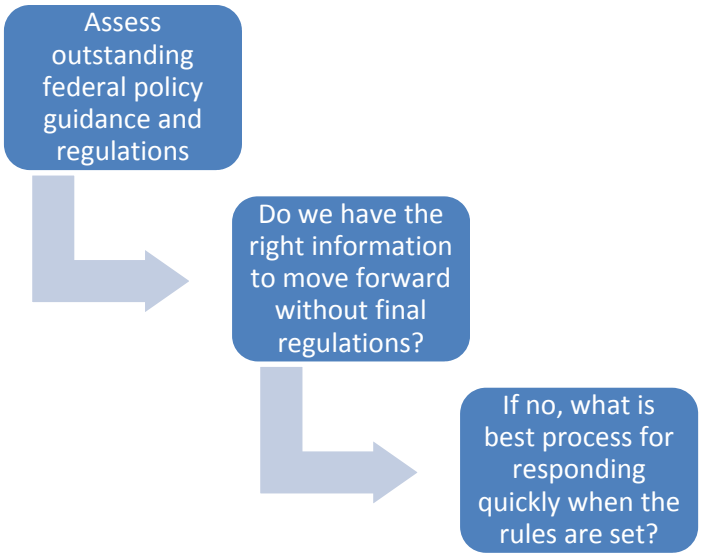
[7] The size of the subsidy-eligible population, and therefore the effect on the overall risk profile of the Exchange, depends in part on whether Maryland pursues the Basic Health Plan. The Basic Health Plan is an option given to states to develop a separate insurance product for individuals with household income below 200 percent of the FPL who are ineligible for Medicaid. Under the Basic Health Plan, the federal government would pay the state 95 percent of the premium tax credits and cost-sharing reductions it would have provided to these individuals in the Exchange. If the state chooses the Basic Health Plan option, eligible individuals may not obtain coverage through the Exchange, thus removing these individuals from the Exchange risk pool.

whether the Exchange should require qualified health plans to cover benefits beyond the essential health benefits mandated by the Affordable Care Act.

- Participation Rules: We evaluated whether issuers offering health plans outside the Exchange should be required to offer health benefit plan(s) inside the Exchange.
- Maryland Health Insurance Plan Funds: We evaluated how these funds should be addressed to mitigate risk.

We developed the pathway in Figure 3 as a guide for considering these options. We also considered an additional issue—the use of funds from the Maryland Health Insurance Plan to mitigate the risk in the individual Exchange.

Figure 3. Market Rules and Risk Selection Pathway



KEY INFORMATION: ESSENTIAL HEALTH BENEFITS

We identified the following key points related to essential health benefits in considering these questions:[8]

- **The Affordable Care Act requires qualified health plans to cover a minimum set of diagnostic, preventive, and therapeutic services referred to as essential health benefits.** Individual subsidies will be based on these essential health benefits; any state mandates over and above these benefits must be paid for by the state.
- **New federal guidance for essential benefits was released by the U.S. Department of Health and Human Services on December 16, 2011.** This guidance provides states with several options for defining the essential health benefits, including basing the essential benefits on common plans offered in the large or small-group markets.[9]

[8] See Operating Model and Insurance Rules Advisory Committee Report, pp. 8-10 and Mercer Report, pp. 12-17.
[9] States may choose one of the following plans on which to base their essential health benefits: one of the three largest small group products, one of the three largest state employee health plans, one of three largest federal employee health benefit plans, or the largest non-Medicaid health maintenance organization plan operating in the state. The plan chosen will become

- **Maryland must have a legally binding benefit package no later than September 30, 2012.** The December 16, 2011, federal guidance requires benefits to be defined by the end of the third quarter two years prior to the implementation of the plan. This means that Maryland must have the essential health benefits defined by September 2012 for the January 1, 2014, implementation.

DISCUSSION: ESSENTIAL HEALTH BENEFITS

The recent federal guidance requires a careful analysis of its implications for Maryland. We will participate in state efforts to determine the best approach for 2014.

RECOMMENDATIONS: ESSENTIAL HEALTH BENEFITS

- The essential benefits package should be settled as early as possible and at the latest by September 30, 2012.

KEY INFORMATION: CARRIER PARTICIPATION

We identified the following key points related to carrier participation:[10]

- **State and federal laws include some standards for plan participation.** The Affordable Care Act requires carriers participating in the Exchange to offer at least one Silver plan and one Gold plan inside the Exchange. Maryland's Exchange Act requires carriers in the Exchange to offer at least one Bronze plan inside and at least one Silver plan and one Gold plan outside the Exchange.[11]
- **Balance inside and outside the Exchange is essential.** The extent to which rules differ inside and outside the Exchange will affect the level of risk inside the Exchange and may lead to adverse selection.[12] Plans offered outside the Exchange do not have to adhere to all of criteria required of plans inside the Exchange.[13] This means that carriers could offer cheaper plans with fewer benefits outside the Exchange, which could draw the healthier population away from the Exchange.[14] This could destabilize the Exchange and lead to spiraling costs.
- **Adverse selection against the Exchange is the single most important reason why Exchanges have failed in the past.**[15] For example, an Exchange in California recently failed when it essentially turned into a high-risk pool. As a result, all measures to address this problem should be seriously considered.

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the benchmark for essential health benefits and will be the only product design that can be offered in the individual and small group markets (exclusive of grandfathered and self-insured products).

[10] See Operating Model and Insurance Rules Advisory Committee Report, pp. 13-17 and Mercer Report, pp. 18-30.

[11] Collectively referred to as "metal levels," the terms Bronze, Silver, Gold, and Platinum refer to Affordable Care Act requirements for health plans offered within the Exchange. The Affordable Care Act specifies actuarial values and out-of-pocket payment limits for each level, and all health plans within the Exchange must adhere to these criteria.

[12] Mercer Report, p. 19.

[13] Mercer Report, p. 19.

[14] Although risk pools must be community rated and pooled both inside and outside the Exchange, they are only required to be so within a specific carrier's pool. Therefore, if a carrier chooses to remain outside the Exchange and draw healthier members, the experience from that plan or plans does not need to be pooled with any membership inside the Exchange, creating higher costs inside than outside.

[15] Blumberg & Pollitz, 2009.

- **Catastrophic plans, available only to individuals under 30 years of age and a specified subset of others represent a significant risk to the Exchange if offered only outside the Exchange.** Because these individuals are more likely to be healthy, if a catastrophic plan is offered only outside the Exchange, it could pull healthy individuals to the external market, and undermine the viability of the Exchange.

DISCUSSION: CARRIER PARTICIPATION

There is no outstanding guidance on carrier participation, and a decision on how to proceed is necessary for planning for the Exchange.

We recognize the significant danger to the Exchange's success if plans operate exclusively outside the Exchange and preferentially attract healthy individuals. We discussed the necessary participation rules for the Exchange to succeed and determined that a reasonable approach would be to require any carrier above a minimum participation threshold that offers products outside the Exchange to participate in the Exchange. Exempting small carriers from this requirement via the minimum participation threshold would reduce the barriers to entry and help attract new carriers into the Maryland market without substantially affecting the Exchange.

After reviewing data on the scale of Maryland insurance plans, we determined that this participation threshold can reasonably be set at an annual small group premium revenue of $20 million for participation in the SHOP Exchange and an annual individual market premium revenue of $10 million.[16] Participation should be defined at the parent company level and all subsidiaries should be required to participate in the Exchange if they participate outside the Exchange. Any carrier offering plans below these thresholds should be permitted to continue to offer exclusively outside the Exchange until it meets these thresholds.

We caution, however, that even exempting small carriers could pose a danger, and the effect of this policy should be assessed over time. The Maryland Insurance Administration should have the authority, in consultation with the Exchange, to change the threshold for plans over time.

We also recognized that catastrophic plans offered only outside the Exchange pose an additional threat to the viability of the Exchange. We determined that any carriers offering a catastrophic plan outside the Exchange should be required to offer plans inside the Exchange.

Therefore, any carrier offering either a catastrophic plan or offering any plans equating to a premium amount above the threshold amount outside the Exchange would be required to participate in the Exchange.

We recognize that the policy of requiring Exchange participation will need to be reassessed in concert with purchasing strategies as the Exchange considers more active purchasing strategies.

[16] At these thresholds, one plan in each market would currently be exempted from the requirement to offer plans in the Exchange.

RECOMMENDATIONS: CARRIER PARTICIPATION

- Carriers above a minimum participation threshold should be required to offer products in the Exchange. The small group minimum participation threshold should be set at $20 million in annual premium revenue, and the individual threshold should be set at $10 million in annual premium revenue.
- Carriers offering a catastrophic plan, as defined by the Affordable Care Act, outside the Exchange should be required to participate in the Exchange
- The Exchange should assess the adequacy of the participation threshold over time. The Maryland Insurance Administration should have the flexibility, in consultation with the Exchange, to adjust the threshold for plans over time.

KEY INFORMATION: MARYLAND HEALTH INSURANCE PLAN FUNDS

We identified the following key points:

- The Maryland Health Insurance Plan currently provides guaranteed-issue health insurance for individuals who have been denied coverage by one or more carriers due to a health condition or who suffer from one of approximately 70 conditions that automatically qualify an individual for the Plan. It currently covers approximately 20,000 high-risk individuals. A recent study by the MHCC found average spending for MHIP enrollees was $9,498 versus $2,548 for individuals in the individual market.[17] It is mostly funded through hospital assessments ($119 million) and premium revenues ($59 million).[18] The assessments offset the cost to individuals by reducing the member premium.
- Without continuing the Maryland Health Insurance Plan assessments into the Exchange, average premiums for individuals in the Exchange may increase substantially. In 2014, Maryland Health Insurance Plan members will merge into the Exchange at the same time the individual market, currently underwritten, will become community-rated. This will lead to a major premium increase for individuals currently in the underwritten market. Without the Maryland Health Insurance Plan funds, Mercer estimates that individuals will experience an average premium increase of 29 percent in 2014. Conversely, Mercer estimates an average of a 2 percent increase if the Maryland Health Insurance Plan funds follow members into the Exchange.[19]

DISCUSSION: MARYLAND HEALTH INSURANCE PLAN FUNDS

We agree with the advisory committee report that Maryland Health Insurance Plan funds should be used to reduce the impact of the cost of care for the high-risk individuals.[20] The Exchange should design a strategy to most effectively use these funds for this purpose.

[17] Maryland Health Care Commission, 2011.
[18] Mercer, p. 49.
[19] Mercer, pp. 50-51.
[20] Operating Model and Insurance Rules Advisory Committee Report, p. 16.

RECOMMENDATIONS: MARYLAND HEALTH INSURANCE PLAN FUNDS

- The Maryland Health Insurance Plan assessments should be allocated to the Exchange for the purpose of risk mitigation.

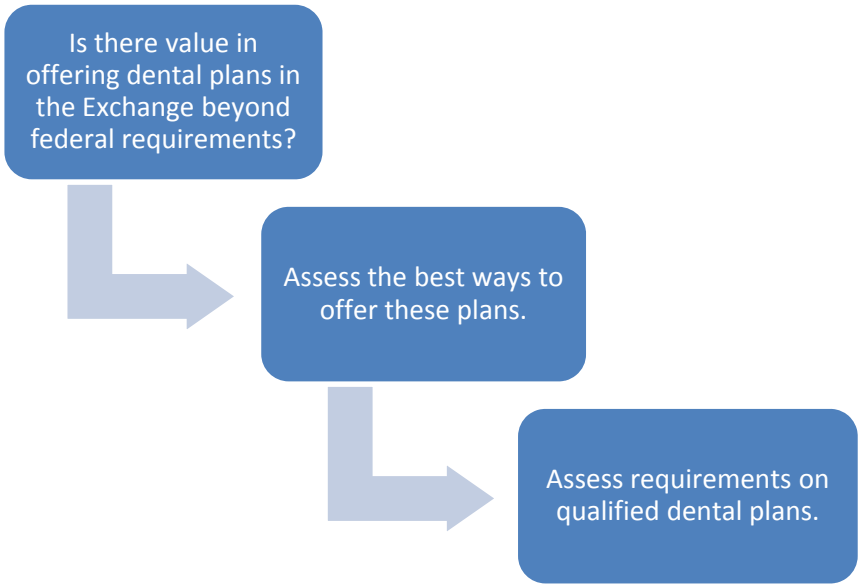
Dental Plans

The Affordable Care Act requires the Exchange to offer pediatric dental services to children and gives states the option to provide additional dental benefits through the Exchange. These benefits must be offered either through a health plan or stand-alone dental plan. We analyzed options for offering dental services in the Exchange beyond this Affordable Care Act requirement. These options include:

- Offering no additional dental services beyond Affordable Care Act requirements
- Offering optional stand-alone dental plans in the Exchange
- Offering optional dental plans that are bundled with health plans

We developed the pathway in Figure 4 as a guide for analyzing the options for offering dental plans within the Exchange.

Figure 4. Dental Pathway



KEY INFORMATION: DENTAL PLANS

We identified the following key points in considering these questions:[21]

- **Oral health is very important to overall health.** The signs and symptoms of disease, lifestyle behaviors, and exposure to toxins can be detected through the mouth; research shows associations between oral disease and chronic disease and adverse pregnancy outcomes.[22]
- **The Affordable Care Act does not define requirements for qualified dental plan certification.** Each state has the primary responsibility of identifying and administering the qualification requirements for dental plans within the Exchange.[23]

[21] See Operations and Insurance Rules Advisory Committee Report, pp. 10-12 and Mercer Report, pp. 31-35.
[22] U.S. Public Health Service, 2000.

- **Access to widespread dental coverage, for both children and adults, is an important objective in Maryland.**[24] Stakeholder interviews and other Maryland-specific data sources supported this objective.[25] The advisory committee report noted concern that Marylanders largely do not have access to preventive dental care.[26]
- **Children's dental access is related to their parents' access.** Children whose parents visit the dentist are significantly more likely to have a dental visit than children whose parents do not visit the dentist.[27]
- **Consumers who purchase dental insurance are used to purchasing it in concert with medical insurance**. Eighty percent of individuals with employer-sponsored health insurance and 30 percent of those with individual insurance purchase dental coverage.[28]
- **Dental coverage is typically offered through stand-alone[29] plans**.[30] The majority of businesses in Maryland with 100 or fewer employees that offer dental coverage purchase through stand-alone plans.[31]
- **Maryland would not have to pay for additional optional dental benefits offered through the Exchange.** Maryland is only responsible for paying for mandatory benefits beyond the essential health benefits.
- **Consumers should receive the same level of oversight and protection for dental plans as they do for medical plans**. Lax certification standards may result in poorer consumer experience.[32]

DISCUSSION: DENTAL PLANS

We find significant value in offering dental plans in the Exchange. Offering these plans would improve access to dental services for Marylanders and provide continuity for families whose children receive dental services through qualified health plans. Because Maryland consumers are currently offered dental plans alongside their medical plans, offering dental plans in the Exchange would be consistent with current options. The advisory committee report noted that optional dental benefits should be offered in the Exchange.

In assessing the best way to offer optional dental plans in the Exchange, we determined that offering both stand-alone dental plans and dental plans that are bundled with health plans would provide the most consistency with current market options.

In the absence of federal requirements for offering dental plans in the Exchange, it is important for Maryland to set standards to ensure the quality of products offered. As noted in the advisory committee report, the Exchange should develop requirements, measurements, and a process for certifying dental plans. As these decisions are not yet finalized for medical plans, it is too early for the

[23] Mercer Report, p.32.
[24] Mercer Report, p. 31.
[25] Mercer Report, pp. 31-32.
[26] Operating Model and Insurance Rules Committee Report, p. 11.
[27] Isong et al., 2010.
[28] Bloom & Cohen, 2010.
[29] Stand-alone plans may be offered by a major medical carrier or a dental-only carrier and refer to plans that only offer dental services.
[30] Operating Model and Insurance Rules Committee Report, p. 11.
[31] Mercer Report, p. 31.
[32] Operating Model and Insurance Rules Committee Report, p. 11.

Exchange to develop specific requirements for dental plans at this time. The standards for both medical and dental plans should be developed simultaneously and aligned.

RECOMMENDATIONS: DENTAL PLANS

- The Exchange should offer both stand-alone dental plans and dental plans that are bundled with health plans as options for consumers to purchase.
- The Exchange should develop requirements for qualified dental plans based on the requirements for qualified health plans at the time the health plan requirements are finalized.

SHOP

Attracting small business participation is important for the viability of the SHOP Exchange. In order to encourage participation, the Affordable Care Act provides tax credits to small businesses for the amount the business spends on insurance premiums for certain employees (see box). But small businesses may only claim tax credits for the first two years following 2014. This highlights the need for the SHOP Exchange to be attractive to small employers.

The amount of the small business tax credit depends on the size of the business, the average wages of employers, and the tax year. The following table displays the amount of the tax credit beginning in 2014.

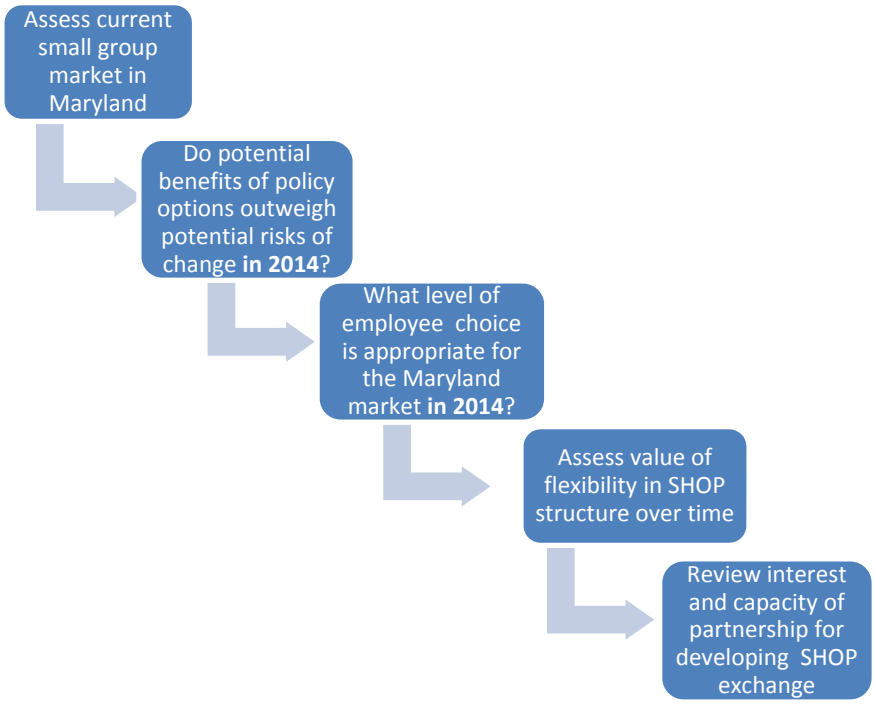
Employees	2014 Average Wage			
	Up to $25,000	$35,000	$45,000	$50,000
Up to 10	50%	30%	10%	0%
15	33%	13%	0%	0%
20	17%	0%	0%	0%
25	0%	0%	0%	0%

We analyzed several options for the design and function of the SHOP Exchange, including:

- Whether the Exchange should merge the individual and small group markets
- Whether the Exchange should expand the small group market to include employers with 51 to 100 employees prior to the Affordable Care Act requirement to do so in 2016
- The appropriate level of employee choice in health plans
- Opportunities for partnerships in developing the SHOP Exchange

We developed the pathway in Figure 5 as a guide for analyzing these options.

Figure 5. SHOP Pathway



KEY INFORMATION: MERGING INDIVIDUAL AND SMALL GROUP MARKETS

We identified the following key points when discussing the merger of the markets:[33]

- **Maryland's small group market is nearly twice as large as its individual market.**[34] Thirty-five to 47 percent of small businesses (45,000) offer health insurance, covering 365,000 individuals.[35] The individual market consists of 186,000 individuals.[3637]
- **The individual and small group markets in Maryland currently have different rating rules**. The individual market is underwritten, meaning insurers may decline to offer coverage to individuals based on their medical history. The small group market offers a guaranteed issue of coverage and uses modified community rating.
- **If the individual and small group markets are merged, whichever market has lower average medical costs would experience a greater rate impact as a result of the merger**.[38] Individually, Mercer estimated the impact of health care reform on the small group market to be about 5 percent, and the impact on the individual market to range from 4 to 40 percent.[39]
- **Under existing law, some small businesses in Maryland self-insure.** Current law allows stop-loss insurance[40] to be sold with a $10,000 specific attachment point and 115 percent of expected claims aggregate attachment point. If premiums become too high, small groups may be more inclined to self-insure when their claims are low and re-enter the guaranteed-issue market when claims get too high, creating adverse selection against the Exchange.
- **Not all carriers participate in both markets.** Therefore, merging the markets would require these carriers to enter a new market.

DISCUSSION: MERGING INDIVIDUAL AND SMALL GROUP MARKETS

We analyzed the potential benefits and risks of merging the individual and small group markets for 2014.

The potential benefit of merging the individual and small group markets in 2014 is that it would create a larger risk pool, which may help decrease premium costs. The consultant's data, however, suggest that both markets appear large enough that merging for critical mass may not be necessary.[41]

We identified significant risks to merging the markets in 2014, including increased premiums, small groups switching to self-insurance, small groups dropping coverage, and forcing some carriers to

[33] See SHOP Advisory Committee Report, pp. 12-14 and Institute for Health Policy Solutions (IHPS) Report, pp. 3-12.
[34] IHPS, p. 4.
[35] IHPS, p. 14.
[36] Mercer, p. 22.
[37] Approximately 34,000 of these individual members are covered by association plans that are issued and delivered outside the state of Maryland. Because these plans are not regulated by the Maryland Insurance Administration, they are not subject to Maryland state mandates. While we are concerned about the impact of association plans on the Exchange, we have not addressed it in this report as more information is needed to fully assess the issue.
[38] IHPS, p. 10.
[39] Mercer, p. 54.
[40] Stop loss refers to reinsurance that protects carriers from high-cost claims for specific individuals.
[41] IHPS Report, p. 10.

participate in both markets. Additionally, merging the two markets in 2014 would create additional uncertainty during a time when the market is undergoing significant changes.

We concluded that the risks exceeded the benefits, and the Exchange should not pursue merging the individual and small group markets at this time. The advisory committee report stated that merging the markets in 2014 would have a negative impact on premium rates, that there is too much uncertainty to merge at this time, and that keeping the markets separate would allow the Exchange to focus on core deliverables without adding potentially disruptive requirements.[42]

As the market stabilizes, this option should be revisited. Preserving the flexibility to modify the structure of the SHOP Exchange is necessary to ensure the long-term viability of the Exchange.

RECOMMENDATIONS: MERGING INDIVIDUAL AND SMALL GROUP MARKETS

- The Exchange should keep the individual and small group markets separate in 2014.
- In 2016, the Exchange should reassess merging the two markets.

KEY INFORMATION: EXPANDING THE SMALL GROUP MARKET

We identified the following key points:[43]

- **The Affordable Care Act requires the Exchange to expand the small group market to include employers with 51 to 100 employees in 2016.**
- **The small and large group markets in Maryland have different rating rules.** The small group market offers a guaranteed issue of coverage and uses modified community rating, while the market for employers with 51 to 100 employees is underwritten.
- **Employers with 51 to 100 employees are more likely to offer coverage and self-insure than the small group market.** Eighty-nine percent of employers with 51 to 100 employees offer health insurance.[44] Interest in self-insurance is growing among employers with 51 to 100 employees.[45]

DISCUSSION: EXPANDING THE SMALL GROUP MARKET

We assessed the potential benefits and risks of this option for 2014.

The potential benefit of expanding the small group market prior to 2016 is that it would increase the size of the risk pool. We are uncertain, however, that this provision will still be a requirement in 2016, and the consultant's analysis found that the current small group market is large enough that expanding is not necessary to obtain the critical mass necessary for stability.[46]

A major risk is that changing the definition of the small group market inside the Exchange would also change the definition outside the Exchange, creating a major impact on the existing market. Additionally, since large groups are underwritten and more likely to self-insure, merging the markets

[42] SHOP Advisory Committee Report, p. 12.
[43] See SHOP Advisory Committee Report, pp. 15-26 and IHPS Report, pp. 14-20.
[44] IHPS, p. 15.
[45] IHPS, p. 17
[46] IHPS, p. 19.

would potentially raise premiums. Making this change in 2014 would create additional uncertainty during a time when the market is undergoing significant changes.

We found that the risks exceeded the benefits. The advisory committee report indicated consensus on retaining the current small group market definition in 2014.

RECOMMENDATIONS: EXPANDING THE SMALL GROUP MARKET

- The Exchange should not expand the small group market to include employers with 51 to 100 employees prior to 2016.

KEY INFORMATION: EMPLOYEE CHOICE

Employee choice is a concept that includes options for employers and employees.

We identified the following key points:[47]

- **Affordable Care Act proposed regulations require the SHOP Exchange to permit employers the option of choosing a metal level and allowing employees to choose a qualified health plan at that level.** The rule does not say employers must use this approach— only that the SHOP Exchange must make this an option to employers.
- **In the current small group market, employers typically offer either a single plan or several plans from one carrier but do not offer plans from multiple carriers.**

DISCUSSION: EMPLOYEE CHOICE

We considered whether there is value in permitting additional employee choice beyond that required by federal rules.

With greater choice, consumers have more options for finding a health plan that meets their needs and to make cost-conscious decisions. But too much choice may also create adverse selection, increased costs for insurers, additional administrative burden to small businesses, and confusion for employees. With too much choice, enrollees may switch to more comprehensive plans as their health needs increase, resulting in adverse selection in the more comprehensive plans. The advisory committee report suggested that the Exchange should limit employee choice for these reasons.[48]

Today, employees in the small group market are either presented with one plan from which to choose, or have the choice of multiple plans within the same carrier. We concluded that providing these options, in addition to the Affordable Care Act-required option, would offer consistency with the outside market and achieve a balance between the risks of too much and too little choice.

As the market stabilizes, this issue should be re-visited. Providing choice within the Exchange may create sustainability for the Exchange. Preserving the flexibility to modify the structure of the SHOP Exchange is necessary to ensure the long-term viability of the Exchange.

[47] See SHOP Advisory Committee Report, pp. 6-11 and IHPS Report, pp. 21-35.
[48] SHOP Advisory Committee Report, p. 6.

RECOMMENDATIONS: EMPLOYEE CHOICE

- The Exchange should offer the federally-required level of employee choice and continue to allow small employers to offer one issuer with one or more qualified health plans in the Exchange.
- The Exchange should re-evaluate employee choice options in 2016.

KEY INFORMATION: OPPORTUNITIES FOR PARTNERSHIPS

We identified the following key points: [49]

- **Producers and third-party administrators provide essential services to most of Maryland's small group market**. Over 90 percent of small employers who purchase insurance do so through insurance producers.[50] The majority of small group coverage is administered through third-party administrators that offer a full range of benefits and payroll services to reduce the administrative burden for small businesses, many of which do not have human resources departments.[51] Third-party administrators also currently offer services to the small group market that the SHOP Exchange will need to offer, such as online plan comparisons, online and paper enrollment, and billing and premium collection.
- **Because of different premium collection, and plan payment operations, separate systems may be needed for the SHOP and individual Exchanges.[52]**
- **Maryland is in the process of evaluating major information technology functions to support the Exchange. SHOP functionality is addressed in a request for proposal, and requirements are currently being developed.**

DISCUSSION: OPPORTUNITIES FOR PARTNERSHIPS

We recognize that small businesses need support for the administration of health benefits, and the SHOP Exchange must be capable of offering this support. The SHOP Exchange must be prepared to provide these services for a high volume of enrollment. We reviewed the interest and capacity for partnerships with existing resources in the state to offer these services in the SHOP Exchange and concluded that there is potential, but further analysis is needed to specify the details of such a partnership.

The Exchange is in the process of procuring a major information technology solution to support enrollment, eligibility, and other additional functions. As the Exchange reviews the requirements, it will take into consideration the capabilities of these potential partners to determine the degree to which it makes sense for Marylanders.

[49] See IHPS Technical Assessment.
[50] Manatt Report, p. 23.
[51] IHPS, p. 11.
[52] IHPS, p. 8.

RECOMMENDATIONS: OPPORTUNITIES FOR PARTNERSHIPS

- The Exchange should analyze options for partnering with existing resources in the state in developing the SHOP Exchange. This analysis and a plan for the partnership should be established before the end of the second quarter of 2012 in order to allow enough time for implementation.

Navigator Program

The Exchange's success depends on reaching hundreds of thousands of previously uninsured Marylanders. Navigators are the organizations and individuals defined by the Affordable Care Act required to provide information and assistance to individuals and small businesses about health plans and enrollment in the Exchange.

The Affordable Care Act requires 1) Exchanges to develop Navigator Programs and 2) Exchanges to offer grants to entities to perform the Navigator functions (see box). The Affordable Care Act and proposed regulations broadly outline the funding requirements, eligibility criteria, duties, and standards of Navigators but the requirements also provide states with significant flexibility in designing their own programs.

Navigators will perform the following functions:

- Conduct public education.
- Distribute fair and impartial information about enrollment into health plans and the availability of tax credits. Such information must acknowledge other health programs.
- Facilitate enrollment in health plans.
- Provide referrals to applicable agencies for enrollees with grievances, complaints, or questions.
- Provide information in a culturally and linguistically appropriate manner.
- Maintain expertise in eligibility, enrollment, and program specifications.

We analyzed options for the design and operations of the Navigator Program, including:

- What functions Navigators should perform
- How Navigators and others who enroll individuals into qualified health plans should be compensated
- How to provide training, certification, and oversight for Navigators

We developed the pathway in Figure 6 to guide this analysis.

Figure 6. Navigator Pathway

KEY INFORMATION: NAVIGATOR PROGRAM

We identified the following key points:[53]

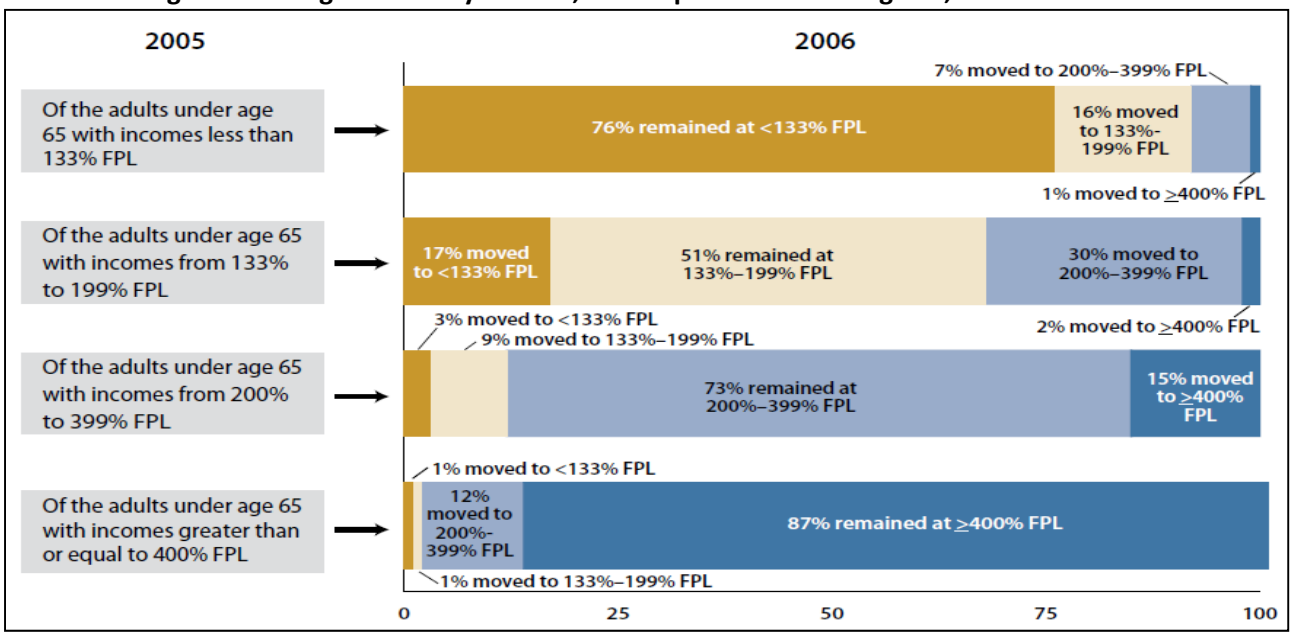
- **The needs of Maryland's individual and small group markets are very different.** Maryland has a strong producer community that provides consumer assistance to over 90 percent of the small group market.[54] Small businesses have unique needs that are addressed by producers, such as weighing plan options against industry dynamics, employer size, demographic and other employee characteristics, cash flow and financing, and overall business philosophy.[55] Producers also provide services to 40 to 50 percent of the individual market.[56] Maryland also has a strong web of support to assist uninsured individuals in obtaining public insurance coverage. State and local agencies, community-based organizations, and safety-net providers assist individuals with understanding and enrolling in public programs.[57] These agencies conduct outreach and education, provide enrollment support, and target vulnerable populations.
- **The Exchange is required to provide a seamless entry into coverage across qualified health plans and Medicaid under the Affordable Care Act's No Wrong Door policy.** The Affordable Care Act and accompanying proposed regulations require eligibility determination, enrollment, and transition between programs, including public programs and the Exchange, to be seamless from the view of the consumer.

[53] See Navigator and Enrollment Advisory Committee Report, pp. 5-15 and Manatt Health Solutions Report, pp. 13-17, 22-34, 38-41, 45-64.
[54] Manatt, pp. 25-26.
[55] Manatt, pp. 27-28.
[56] Manatt, pp. 27-28.
[57] Manatt, pp. 30-31.

- **Researchers predict high rates of transitions across Medicaid and qualified health plans in the Exchange.**[58] A recent study from the Commonwealth Fund shows that income levels among individuals below 400 percent of the federal poverty level (FPL) frequently change, especially for individuals in the lowest income brackets.[59] Figure 7 presents the Commonwealth Fund's data (from 2005) on income transitions among populations with household income below 400 percent of the FPL.
- **A Navigator Program will benefit from the engagement of individuals and organizations that are based within their communities.** Effective outreach requires cultural and linguistic competence. Many individuals without recent experience in the private insurance market will gain coverage through the Exchange, and they will be more likely to enroll when assisted by someone they trust.
- **The Affordable Care Act and accompanying proposed rules do not define specific requirements for Navigator licensure**. Proposed regulations allow states to prescribe their own certification standards.
- **Navigator functions overlap with some functions requiring producer licensure, but Navigators are not performing all the same functions as producers.** Under existing law, a number of Navigator functions would require a producer's or adviser's license issued by the Maryland Insurance Administration. Navigators will also be performing activities not typically provided by producers, such as assisting individuals with Medicaid eligibility and enrollment.
- **Training for Navigators is needed to protect consumers.** Marylanders should have confidence that Navigators are giving fair and accurate guidance on enrollment, subsidies, and plan selection.
- **The demands on the Navigator program will be intense around the launch of the Exchange.** More than 100,000 Marylanders may need assistance within a span of a few months for enrollment. In light of the scale of the initial outreach effort, training requirements should be reasonably targeted to key areas of competence.

[58] Farley Short et al., 2011; Manatt, p. 53.
[59] Farley Short et al., 2011.

Figure 7. Changes in Family Income, U.S. Population under Age 65, 2005 – 2006



Source: Farley Short et al., 2011, p. 6.

DISCUSSION: NAVIGATOR PROGRAM

In reviewing whether there should be identical individual and SHOP Navigator Programs, we recognized that individuals and small businesses have different consumer assistance needs that require different sets of expertise. We also noted that the advisory committee report supported separate programs and emphasized that it would be difficult for a single Navigator to adequately serve both markets. We concluded that separate programs would be the best way to meet the needs of the different markets.

In reviewing whether the Navigator should be integrated with Medicaid outreach and enrollment, we noted that the Navigator Program is an opportunity for the Exchange to meet Affordable Care Act seamless entry into coverage requirements, to help provide continuity of care for individuals who transition between Medicaid and the Exchange, to provide culturally and linguistically appropriate services, and to leverage federal Medicaid matching funds. There was consensus among advisory committee members and stakeholders that Navigators should perform outreach, eligibility, and enrollment for the newly eligible Medicaid population. We concluded that there should be integration between the Navigator and Medicaid programs.

In reviewing the options for the design of the Navigator Program provided by the consultant, we recognized that leveraging existing consumer assistance resources and infrastructure would cause the least amount of disruption to the current market, make the most efficient use of Exchange funds and meet the statutory regulation to supplement, but not replace, the current market. The consultant developed several models for the SHOP and individual Exchanges that incorporate the services of both producers and community-based organizations. We concluded that the following two models would make the best use of existing resources:

- SHOP Exchange Producer Interface model –In this model, producers would be permitted to sell qualified health plans in the Exchange, but they would not be compensated as Navigators. Instead, they would be compensated directly from carriers.[60] The Exchange would engage Navigators to conduct outreach, serve small businesses who opt not to use a producer, and fill gaps if there is a market failure in the producer distribution channel.
- Individual Exchange Market Integration model – Similar to the SHOP model, producers would be permitted to sell qualified health plans in the Exchange and would be compensated directly by carriers. The Exchange would also engage Navigators who would be responsible for the management of eligibility and enrollment for individuals in both the Exchange and Medicaid.

In these models, the Exchange would contract with Navigators, and producers would be permitted to sell qualified health plans within the Exchange alongside Navigators. Navigators would be compensated through grants from the Exchange and producers would be compensated by insurance carriers. In keeping with the Affordable Care Act requirement, Navigators are not directly or indirectly compensated by insurance carriers in these models, and producer compensation will be comparable inside and outside the Exchange to mitigate the risk that enrollment will be directed away from the Exchange.

When reviewing appropriate certification and licensure requirements for Navigators, we discussed how Navigators will perform critical functions for Marylanders, some of which currently require producer licensure. At the same time, the Navigator will not perform all the functions of a licensed producer, and there will be unique requirements related to their work for the Exchange.

We recognized the importance of achieving a balance between ensuring that there are a sufficient number of Navigators to reach target populations, while maintaining appropriate oversight and consumer protections. We decided that the Exchange should work with interested stakeholders to develop and implement a Navigator certification program for individuals and entities performing Navigator functions. This certification program should be approved by the Maryland Insurance Administration and should focus on topics essential to consumer protection. Navigators who obtain certification from the Exchange should be excluded from producer and adviser licensure requirements. With the ultimate authority resting with the Maryland Insurance Administration, the Exchange and the Maryland Insurance Administration should develop an approach to enforcing these requirements in 2012.

[60] The Affordable Care Act explicitly prohibits Navigators from receiving direct or indirect compensation from insurance issuers.

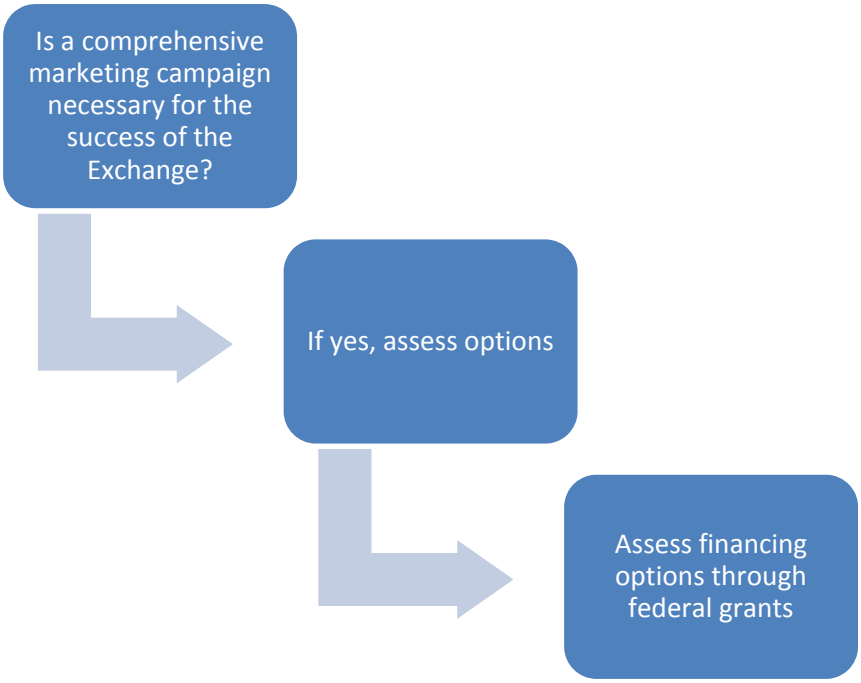
RECOMMENDATIONS: NAVIGATOR PROGRAM

- The Exchange should have separate Navigator Programs for the individual and small group markets.
- The Exchange should work with Medicaid to integrate the Navigator Program with Medicaid outreach and enrollment.
- The Exchange should adopt the Producer Interface Model for the SHOP Exchange and the Market Integration Option for the individual Exchange. These options maintain and utilize the expertise in the existing marketplace to reach the 730,000 uninsured in Maryland.
- The Exchange should develop and implement a certification program, approved by the Maryland Insurance Administration, for individuals who perform certain Navigator functions. Navigators earning certification by the Exchange should be exempt from producer and adviser licensure requirements.
- The Exchange and the Maryland Insurance Administration should develop an enforcement model for Navigator misconduct.

Advertising, Marketing, and Public Relations

The success of the Exchange depends on the volume of people signing up for coverage, and public relations and marketing campaigns have been successful in driving enrollment in health insurance programs. We analyzed the appropriate role and scale of a public relations and advertising campaign to drive enrollment in the Exchange. We developed the pathway in Figure 8 as a guide for analyzing the options to determine the right level of marketing needed to ensure success.

Figure 8. Advertising, Marketing, and Public Relations Pathway



KEY INFORMATION: ADVERTISING, MARKETING, AND PUBLIC RELATIONS

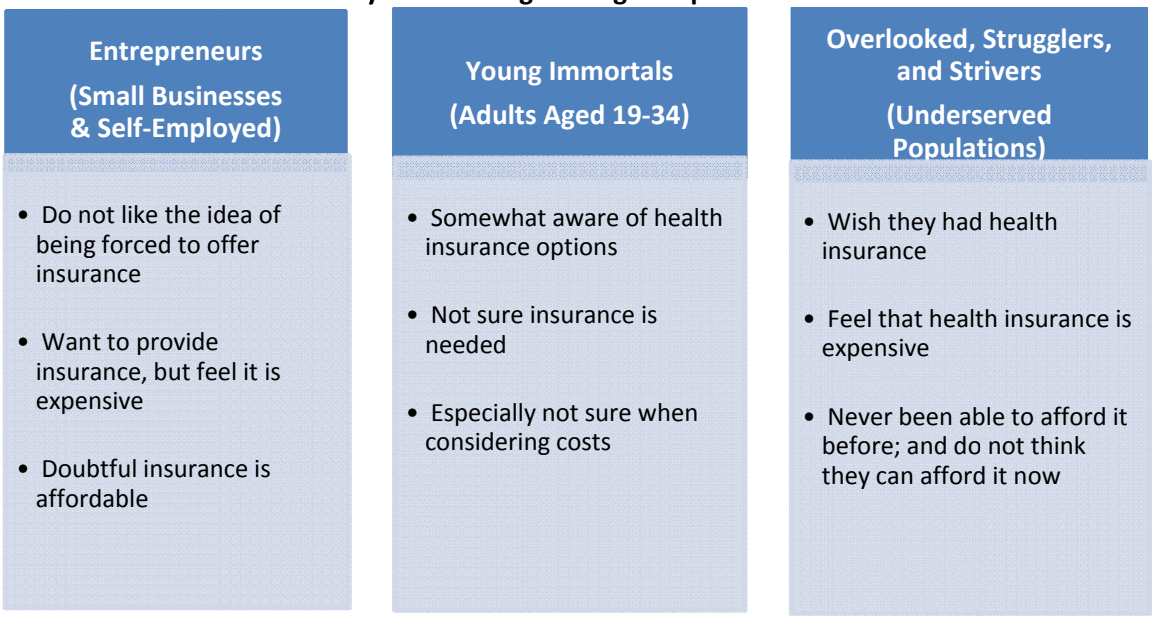
We identified the following key points in considering these questions:[61]

- **The success, viability, sustainability, and affordability of the Exchange depend on having robust enrollment in the Exchange.** The Exchange needs a critical mass of enrollment in order to attract carriers to participate and create a risk pool large enough to keep costs down.
- **A comprehensive, wide-reaching, mass-media marketing campaign is needed to create awareness of the Exchange.** Market research indicates a nationwide lack of awareness and lack of support for health reform.[62] Tracking polls indicate that familiarity with the Affordable Care Act and awareness of the law's key benefits has fallen.[63]
- **A comprehensive, wide reaching mass media campaign is necessary to dispel myths and change perceptions about health care so that people enroll**. Market research found that the

[61] See Navigator and Enrollment Advisory Committee Report, pp. 15-19 and Weber Shandwick Report, pp. 7-20, 23-29, 123-137.
[62] Weber Shandwick, p. 26.
[63] Kaiser Family Foundation, 2011.

Exchange's target populations in Maryland currently have various negative perceptions about health care and health insurance.[64] Figure 9 presents some examples of these negative perceptions.

Figure 9. Negative Perceptions on Health Care and Health Insurance by the Exchange's Target Populations



Source: Weber Shandwick, p. 24.

- **Key aspects of a successful campaign include** establishing a strong brand identity, building support among policymakers and community leaders, developing and disseminating effective messages, mapping all engagement efforts around raising awareness of the Exchange, ultimately motivating Maryland residents to enroll in the Exchange, and launching the campaign as early as June 2012 to ensure awareness of the Exchange by the first open enrollment.[65]
- **A marketing campaign is a requirement to comply with Affordable Care Act and federal grant funding requirements.** Proposed Affordable Care Act regulations state that the Exchange should conduct outreach and education activities beyond Navigators to encourage Exchange participation.[66] Federal Exchange establishment grant funds require a "robust education and outreach program to inform health care consumers about the Exchange and the new coverage options available to them."[67] A comprehensive campaign has wide reach, creates awareness of the value and importance of health insurance, and educates about the requirements under the Affordable Care Act.

[64] Weber Shandwick, pp. 23-24.
[65] Weber Shandwick, pp. 7-8.
[66] U.S. Department of Health and Human Services, p. 12.
[67] Center for Consumer Information and Insurance Oversight, 2011.

DISCUSSION: ADVERTISING, MARKETING, AND PUBLIC RELATIONS

We found that without a strong advertising, marketing, and public relations campaign, the Exchange will fail.

A campaign should be funded through the federal Exchange establishment grant and designed to overcome key myths and drive robust enrollment. It should launch in June 2012, beginning with basic awareness initiatives, and grow more specific to drive enrollment for the first open enrollment in the fall of 2013.

The consultant developed a series of options, based on its successful experience in marketing Massachusetts' health reform effort as well as its experience in Maryland. The Exchange should review these options and determine what is feasible through the federal Exchange Level II Establishment Grant, with a planned application date of March 2012.

RECOMMENDATIONS: ADVERTISING, MARKETING, AND PUBLIC RELATIONS

- The Exchange should use federal grant funds to develop and implement a broad marketing and outreach campaign that not only educates all Marylanders about the value of health insurance and the Exchange, but also drives enrollment into the Exchange.

Financing

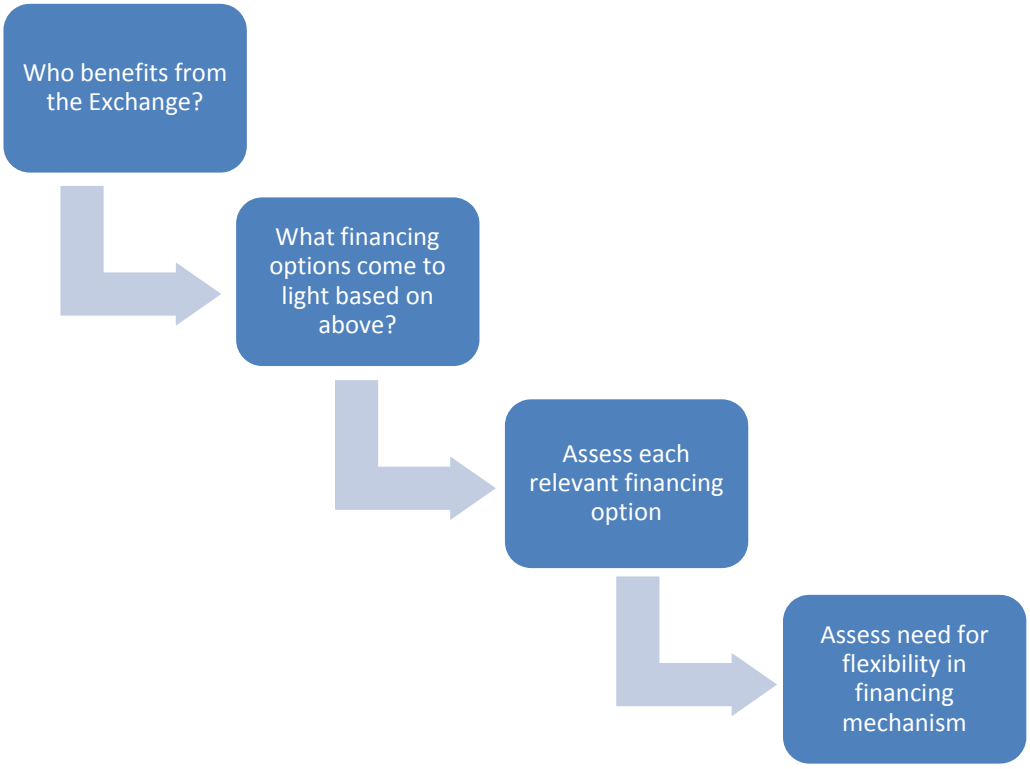
The federal government will fund the Maryland Health Benefit Exchange through grants until 2014. By 2015, the Exchange must be self-sustaining with a mechanism to maintain an adequate level of financing for its ongoing operations.

Funding can take many forms, from narrow assessments such as charging a fee for individuals entering the Exchange, to wide assessments such as state general funds. Options for financing the Exchange include:

- Transaction fees on plans sold in the Exchange
- Advertising on the Exchange web site
- Assessments on issuers participating in the Exchange for their Exchange business
- Assessments on issuers participating in the Exchange for all business
- Assessments on all issuers in the market, regardless of participation in the Exchange
- Replacing or repurposing existing revenue streams
- Broad-based assessments on the health care market
- Tax revenue
- General fund revenues
- A combination approach incorporating more than one funding mechanism

We developed the pathway in Figure 10 as a guide for analyzing these options.

Figure 10. Financing Pathway



KEY INFORMATION: FINANCING

We identified the following key points:[68]

- **The Exchange will provide insurance options to the 730,000 uninsured individuals in Maryland.**[69] Exchange enrollment is estimated to be as much as 170,000 in the first year.[70]
- **The Exchange will benefit all Marylanders.** It will provide a distribution channel for insurance carriers, allow people to more efficiently shop for insurance, access premiums and cost-sharing subsidies, expand insurance coverage, and educate consumers about health insurance.[71] As coverage increases in the state, insurance premium revenue and hospital revenue will likely increase and uncompensated hospital care decrease.[72] Increased coverage in the state may also lead to improved population health, reducing cost over time.[73]
- **Even individuals insured through large employers benefit from having access to the Exchange in the event of losing coverage.**
- **The Exchange needs to have a financing mechanism that is sustainable and reliable.** It must be able to mitigate the risk of a revenue shortfall and support variability in Exchange enrollment during the first few years of operation or in the event of low enrollment.[74]
- **A combination of funding mechanisms creates a more stable approach to funding.** Using several funding mechanisms will spread the revenue requirements over the largest base, providing more stability to the revenue stream.[75] A combination of mechanisms will allow the Exchange to adjust revenue sources and amounts as experience unfolds. [76]
- **Medicaid cost allocation will account for some of the Exchange's funding.** It is estimated that 42 percent of individuals using the Exchange will enroll in Medicaid.[77] Any information technology work that supports eligibility, enrollment, and ongoing functions will be supporting both Medicaid and the Exchange. Similarly, to the extent that administrative and overhead costs associated with the Navigator function (and other overlapping functions) will be shared with Medicaid, costs should be allocated.
- **Because the Exchange does not need to be self-sufficient until 2015, specific decisions on financing are not needed this year.**

[68] See Finance and Sustainability Committee Report, pp. 8-14 and Wakely Financing Report, pp. 8-10, 16-24.
[69] Maryland Health Care Commission, 2011.
[70] Health Care Reform Coordinating Council, 2010.
[71] Wakely Financing Report, p. 20.
[72] Wakely Financing Report, p. 24.
[73] Finance and Sustainability Advisory Committee Report, p. 10.
[74] Wakely Financing Report, p. 20.
[75] Wakely Financing Report, Appendix 4, p. 5.
[76] Wakely Financing Report, p. 26.
[77] Health Care Reform Coordinating Council, 2010.

DISCUSSION: FINANCING

We agreed with the advisory committee report that the Exchange benefits more than those directly related to the Exchange. With more Marylanders covered by health insurance, uncompensated care will decrease, insurance premium and hospital revenue will increase, and with that, health insurance premiums should decrease for all Marylanders.

In reviewing the funding options, we concluded that, because it benefits all Marylanders, the Exchange should be broadly funded. We noted that the early years of the Exchange will be uncertain, and it will be difficult to properly estimate fixed and variable costs. With this uncertainly, we concluded that the foundation of funding for the Exchange should come from a broad-based mechanism with a subset of additional funding coming from transaction fees tied to enrollment within the Exchange. As enrollment stabilizes, the Exchange may depend upon transaction fees to a greater extent.

There are some existing models for broad-based financing of health programs. For example, the Maryland Health Care Commission's funding is derived from four assessments on the health care industry. We do not have a strong preference for one specific type of broad-based financing, but it should be consistent, reliable, and able to scale with the growth of the Exchange.

Because decisions do not need to be made in 2012, we will work with interested parties this year to further define a fair and reasonable approach to supporting the Exchange.

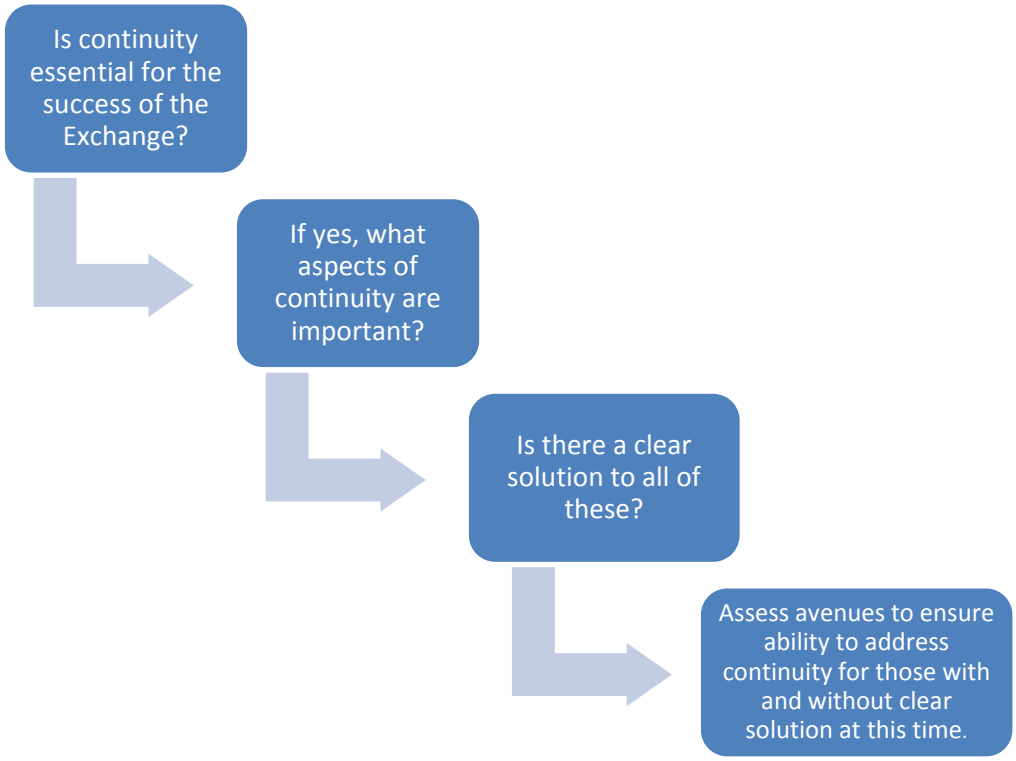
RECOMMENDATIONS: FINANCING

- 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.
- A decision on financing should be made in early 2013.

Continuity of Care

In reviewing all of these policy decisions, we recognized the need to address continuity of care for consumers across all programs. As individuals transition between Medicaid, the Exchange, and the outside commercial market, continuity is important to ensure that individuals receive appropriate, needed care and to avoid unnecessary duplication of services. We developed the pathway in Figure 11 to guide the discussion on continuity of care.

Figure 11. Continuity Pathway



KEY INFORMATION: CONTINUITY OF CARE

We identified the following key points in considering these questions:

- **Duplication of care adds significantly to the cost of care**.[78]
- **Duplication of care creates confusion and frustration** by forcing individuals and their caregivers to retell their information and requiring health care professionals to spend hours on additional paperwork.[79] This frustration may be directed to the Exchange.
- **Both Medicaid managed care organization and commercial provider contracts currently have some language to support care continuity during transitional periods**.

[78] U.S. Department of Health and Human Services, 2011.
[79] U.S. Department of Health and Human Services, 2011.

DISCUSSION: CONTINUITY OF CARE

We realize that this pathway was not a part of the legislatively mandated questions, but the importance of this cannot be ignored. We have an opportunity, with the establishment of the Exchange, to begin taking steps to enhance the insurance experience in Maryland.

In particular, we determined that continuity of care for consumers as they transition between health plans in the Exchange, Medicaid, and the outside market is especially important. Since Medicaid managed care organizations and health plans in the commercial market currently have some requirements for care transitions, we concluded that extending these requirements to the Exchange's health plan certification process is consistent with the current market.

RECOMMENDATIONS: CONTINUITY OF CARE

- The Exchange should require transition of care language in contracts as part of qualified health plan certification and work with Medicaid to promote reciprocal care transition provisions in the managed care organization contracts.

Multi-State and Regional Contracting

The Affordable Care Act allows states to form combined or regional Exchanges, provided that all states agree to the arrangement and the arrangement is approved by the federal government. We examined whether Maryland's Exchange should engage in multi-state or regional contracting. These contracting options include:

- Baseline Contracting – In this option, the Maryland Exchange would participate in the minimum level of multi-state contracting required by the Affordable Care Act: including at least two national plans in the Exchange.
- Supporting Cross-Border Enrollment – In this option, Maryland would adopt health plan certification criteria that encourage and support the ability of participating health plans to support cross-border enrollment.[80]
- Coordinating Qualified Health Plan Certification with Another State – In this option, Maryland would work with a neighboring state to develop joint or reciprocal certification processes, develop consistency in plan offerings across states, or coordinate resources to collaborate on the administrative processes that will support certification, such as data collection of the carrier review process.

KEY INFORMATION: MULTI-STATE AND REGIONAL CONTRACTING

We identified the following key points in considering these options:

- **Most carriers in Maryland currently have cross-border relationships with providers to support members who live out of state but work in Maryland.[81]**
- **There is a certain level of regionalism already built into the structure of the Exchange.** Two national carriers will be selected by the federal government to participate in every Exchange.[82]
- **There are a number of challenges to coordinating health plan certification with other states.** Each state has its own unique infrastructure, and this approach requires states to agree on all key policy decisions as well as technical and tactical implementation decisions.

DISCUSSION: MULTI-STATE AND REGIONAL CONTRACTING

In reviewing these options, we agreed with the advisory committee report that cross-border enrollment is consistent with the current Maryland marketplace.[83] Cross-border enrollment policies should remain in place. We noted that coordinating health plan certification with other states may be difficult to achieve, but if other states are interested in working with Maryland, the Exchange should entertain the option of multi-state contracting. The Exchange should neither be obligated nor prohibited from doing so.

[80] Specifically, this refers to an individual who may be living in another state but who is employed by a small business located in Maryland. This would encourage and allow issuers to contract with providers in neighboring states to ensure coverage for those individuals.
[81] Wakely Operating Model Report, p. 18.
[82] Wakely Operating Model Report, p. 17.
[83] Operating Model and Insurance Rules Advisory Committee, p. 7.

RECOMMENDATIONS: MULTI-STATE AND REGIONAL CONTRACTING

- Current cross-border enrollment policies should remain in place.
- If another state wishes to engage in multi-state contracting with Maryland, the Exchange should have the flexibility to contract with that state, but should not be obligated or prohibited from doing so.

Plan for Fraud, Waste, and Abuse

We discussed the requirements for a program for the detection and prevention of fraud, waste, and abuse within the Exchange.

KEY INFORMATION: PLAN FOR FRAUD, WASTE, AND ABUSE

We identified the following key points:

- **The Exchange must comply with federal and state laws regarding fraud, waste, and abuse**, such as whistleblower protections, federal anti-kickback prohibitions, and confidentiality protections.
- **The Exchange will be subject to audits by both the state and federal government.** The federal government will conduct annual audits of the Exchange and may withhold or cancel payments if it suspects misconduct. The Affordable Care Act allows the federal government to investigate the Exchange's affairs, properties, and records.[84] The Exchange will also be subject to state-level audits, operational reviews, and examinations by the Inspector General and Attorney General.
- **The Exchange needs to develop credibility and trust with the public and its business partners in order to succeed.**

DISCUSSION: PLAN FOR FRAUD, WASTE, AND ABUSE

We found that public and governmental trust and credibility is essential to the success of the Exchange. We agreed with the advisory committee report that the Exchange needs strong fraud, waste, and abuse detection and control mechanisms.[85] The Exchange should develop a full-scale fraud, waste, and abuse detection and prevention program that defines a framework for internal controls, identifies control cycles, conducts risk assessments, documents processes, and implements controls.

RECOMMENDATIONS: PLAN FOR FRAUD, WASTE, AND ABUSE

- The Exchange should develop a full-scale fraud, waste, and abuse detection and prevention program that defines a framework for internal controls, identifies control cycles, conducts risk assessments, documents processes, and implements controls.

[84] Affordable Care Act, Section 1313.
[85] Operating Model and Insurance Rules Advisory Committee Report, p. 15.

Summary of Recommendations

Operating Model

1. The Exchange should have the flexibility to set minimum standards for qualified health plans above the requirements of the Affordable Care Act.
2. The Exchange should have the flexibility to modify its approach to contracting over time.

Market Rules and Risk Mitigation

3. The essential benefits package should be settled as early as possible and at the latest by September 30, 2012.
4. Carriers above a minimum participation threshold should be required to offer products in the Exchange. The small group minimum participation threshold should be set at $20 million in annual premium revenue, and the individual threshold should be set at $10 million in annual premium revenue.
5. Carriers offering a catastrophic plan, as defined by the Affordable Care Act, outside the Exchange should be required to participate in the Exchange.
6. The Exchange should assess the adequacy of the participation threshold over time. The Maryland Insurance Administration should have the flexibility, in consultation with the Exchange, to adjust the threshold for plans over time.
7. The Maryland Health Insurance Plan assessments should be allocated to the Exchange for the purpose of risk mitigation.

Dental Plans

8. The Exchange should offer both stand-alone dental plans and dental plans that are bundled with health plans as options for consumers to purchase.
9. The Exchange should develop requirements for qualified dental plans based on the requirements for qualified health plans at the time the health plan requirements are finalized.

SHOP

10. The Exchange should keep the individual and small group markets separate in 2014.
11. In 2016, the Exchange should reassess merging the two markets.
12. The Exchange should not expand the small group market to include employers with 51 to 100 employees prior to 2016.
13. The Exchange should offer the federally-required level of employee choice and continue to allow small employers to offer one issuer with one or more qualified health plans in the Exchange.
14. The Exchange should re-evaluate employee choice options in 2016.
15. The Exchange should analyze options for partnering with existing resources in the state in developing the SHOP Exchange. This analysis and a plan for the partnership should be established before the end of the second quarter of 2012 in order to allow enough time for implementation.

Navigator Program

16. The Exchange should have separate Navigator Programs for the individual and small group markets.
17. The Exchange should work with Medicaid to integrate the Navigator Program with Medicaid outreach and enrollment.
18. The Exchange should adopt the Producer Interface Model for the SHOP Exchange and the Market Integration Option for the individual Exchange. These options maintain and utilize the expertise in the existing marketplace to reach the 730,000 uninsured in Maryland.
19. The Exchange should develop and implement a certification program, approved by the Maryland Insurance Administration, for individuals who perform certain Navigator functions. Navigators earning certification by the Exchange should be exempt from producer and adviser licensure requirements.
20. The Exchange and the Maryland Insurance Administration should develop an enforcement model for Navigator misconduct.

Advertising, Marketing, and Public Relations

21. The Exchange should use federal grant funds to develop and implement a broad marketing and outreach campaign that not only educates all Marylanders about the value of health insurance and the Exchange, but also drives enrollment into the Exchange.

Financing

22. 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.
23. A decision on financing should be made in early 2013.

Continuity of Care

24. The Exchange should require transition of care language in contracts as part of qualified health plan certification and work with Medicaid to promote reciprocal care transition provisions in the managed care organization contracts.

Multi-State and Regional Contracting

25. Current cross-border enrollment policies should remain in place.
26. If another state wishes to engage in multi-state contracting with Maryland, the Exchange should have the flexibility to contract with that state, but should not be obligated or prohibited from doing so.

Plan for Fraud, Waste, and Abuse

27. The Exchange should develop a full-scale fraud, waste, and abuse detection and prevention program that defines a framework for internal controls, identifies control cycles, conducts risk assessments, documents processes, and implements controls.

Appendix 1. Legislative Text

Maryland Health Benefit Exchange Act of 2011

The Maryland Health Benefit Exchange Act of 2011 requires the Exchange, in consultation with the advisory committees and other stakeholders, to study and make recommendations regarding:

I. The feasibility and desirability of the Exchange engaging in:

   1. Selective contracting, either through competitive bidding or a negotiation process similar to that used by large employers, to reduce health care costs and improve quality of care by certifying only those health benefit plans that meet certain requirements such as promoting patient-centered medical homes, adopting electronic health records, meeting minimum outcome standards, implementing payment reforms to reduce medical errors and preventable hospitalizations, reducing disparities, ensuring adequate reimbursements, enrolling low-risk members and underserved populations, managing chronic conditions and promoting healthy consumer lifestyles, value-based insurance design, and adhering to transparency guidelines and uniform price and quality reporting; and
   2. Multistate or regional contracting.

II. The rules under which health benefit plans should be offered inside and outside the Exchange in order to mitigate adverse selection and encourage enrollment in the Exchange, including:

   1. Whether any benefits should be required of qualified health plans beyond those mandated by the Affordable Care Act, and whether any such additional benefits should be required of health plans offered outside the Exchange;
   2. Whether carriers offering health benefit plans outside the Exchange should be required to offer either all the same health benefit plans inside the Exchange, or alternatively, at least one health benefit plan inside the Exchange; and
   3. Which provisions applicable to qualified health plans should be made applicable to qualified dental plans.

III. The design and operation of the Exchange's Navigator Program and any other appropriate consumer assistance mechanisms, including:

   1. The infrastructure of the existing private sector health insurance distribution system in the state to determine whether private sector resources may be available and suitable for use by the Exchange;
   2. The effect the Exchange may have on private sector employment in the health insurance distribution system in the state;
   3. What functions, in addition to those required by the Affordable Care Act, should be performed by Navigators;
   4. What training and expertise should be required of Navigators, and whether different markets and populations require Navigators with different qualifications;

5. How Navigators should be retained and compensated, and how disparities between Navigator compensation and the compensation of insurance producers outside the Exchange can be minimized or avoided;
6. How to ensure that Navigators provide information in a manner culturally, linguistically, and otherwise appropriate to the needs of diverse populations served by the Exchange, and that Navigators have the capacity to meet these needs; and
7. What other means of consumer assistance may be appropriate and feasible, and how they should be designed and implemented.

IV. The design and function of the Small Business Health Options Plan (SHOP) Exchange beyond the requirements of the Affordable Care Act to promote quality, affordability, and portability, including:

1. Whether it should be a defined contribution/employee choice model or whether employers should choose the qualified health plan to offer their employees;
2. Whether the current individual and small group markets should be merged; and
3. Whether the SHOP Exchange should be made available to employers with 51 to 100 employees prior to 2016, as authorized by the Affordable Care Act.

V. How the Exchange can be self-sustaining by 2015 in compliance with the Affordable Care Act, including:

1. A recommended plan for the budget of the Exchange;
2. The user fees, licensing fees, or other assessments that should be imposed by the Exchange to fund its operations, including what type of user fee cap or other methodology would be appropriate to ensure that the income of the Exchange comports with the expenditures of the Exchange; and
3. A recommended plan for how to prevent waste, fraud, and abuse.

VI. How the Exchange should conduct its public relations and advertising campaign, including what type of solicitation, if any, of individual consumers or employers would be desirable and appropriate.

Appendix 2. Exchange Board Members

Joshua M. Sharfstein, M.D. – Chair

Secretary, Maryland Department of Health and Mental Hygiene

Dr. Joshua M. Sharfstein was appointed by Governor Martin O'Malley as Secretary of the Maryland Department of Health and Mental Hygiene in January 2011.

In March 2009, President Obama appointed Dr. Sharfstein to serve as the Principal Deputy Commissioner of the U.S. Food and Drug Administration, the agency's second highest-ranking position. He served as the Acting Commissioner from March 2009 through May 2009 and as Principal Deputy Commissioner through January 2011.

From December 2005 through March 2009, Dr. Sharfstein served as the Commissioner of Health for the City of Baltimore, Maryland. In this position, he led efforts to expand literacy efforts in pediatric primary care, facilitate the transition to Medicare Part D for disabled adults, engage college students in public health activities, increase influenza vaccination of healthcare workers, and expand access to effective treatment for opioid addiction. Under his leadership, the Baltimore Health Department and its affiliated agencies have won multiple national awards for innovative programs, and in 2008, Dr. Sharfstein was named Public Official of the Year by Governing Magazine.

From July 2001 to December 2005, Dr. Sharfstein served as minority professional staff of the Government Reform Committee of the U.S. House of Representatives for Congressman Henry A. Waxman. Dr. Sharfstein is a 1991 graduate of Harvard College, a 1996 graduate of Harvard Medical School, a 1999 graduate of the combined residency program in pediatrics at Boston Children's Hospital and Boston Medical Center, and a 2001 graduate of the fellowship in general pediatrics at the Boston University School of Medicine.

Darrell Gaskin, Ph.D. – Vice-Chair

Associate Professor, Johns Hopkins Bloomberg School of Public Health

Darrell J. Gaskin is Associate Professor of Health Economics at the Johns Hopkins Bloomberg School of Public Health and Deputy Director of the Hopkins Center for Health Disparities Solutions. He has also served on the faculties of the University of Maryland – College Park and Georgetown University. His primary research interests are healthcare disparities, safety net providers, and access to care and quality of healthcare for Medicaid, minority, uninsured, and other vulnerable populations. His research has been supported by the NIMHD, AHRQ, NICHD, NIA, HRSA-MCHB, The Commonwealth Fund, the Kaiser Family Foundation, and the Robert Wood Johnson Foundation. Dr. Gaskin earned his Ph.D. in health economics at The Johns Hopkins University, a MS degree in economics from the Massachusetts Institute of Technology, and a BA degree in economics from Brandeis University.

Dr. Gaskin has been nationally recognized for his research on the hospital safety net. He was awarded the AcademyHealth 2002 Article-of-the-Year Award for his Health Services Research article entitled, "Are Urban Safety-Net Hospitals Losing Low-Risk Medicaid Maternity Patients?" Dr. Gaskin's research has been published in HSR, Health Affairs, Medical Care Research and Review, Medical Care and Inquiry. Currently, he serves on the Editorial Boards of HSR and Medical Care Research and Review.

Dr. Gaskin's research has been recognized and appreciated by policymakers and advocates. In 2009, he published a chapter on access to care for African Americans in the National Urban League's annual publication, "State of Black America." Among his most recent work is a report released by the Joint Center for Political and Economic Studies that estimates the cost of health disparities to be more than ¼ of a trillion dollars annually. Dr. Gaskin's current research projects explore the relationship between health and healthcare disparities and residential segregation. He resides in Anne Arundel County.

Therese Goldsmith, J.D., M.S.

Commissioner, Maryland Insurance Administration

Therese M. Goldsmith was appointed by Governor Martin O'Malley to serve as Maryland's Insurance Commissioner effective June 13, 2011, for a term ending May 31, 2015. Immediately prior to that appointment, Goldsmith was a Commissioner on the Public Service Commission of Maryland.

Before entering public service, Goldsmith was a partner at the law firm of Hogan & Hartson LLP (now Hogan Lovells). As part of that firm's white collar litigation group, she concentrated her practice on government investigations of alleged health care fraud and abuse, claims brought by the government or private whistleblowers under the federal and state False Claims Acts, and issues arising under HIPAA and state privacy laws. Prior to joining Hogan & Hartson in 2001, she was an associate at the law firm of Venable, Baetjer and Howard, LLP (now Venable LLP). Her practice there focused on federal and state health care regulatory compliance, fraud and abuse investigations, provider reimbursement appeals, rate review matters, medical staff peer review proceedings, licensure board disciplinary actions, patient care issues, and corporate transactions.

Commissioner Goldsmith previously worked as a certified speech-language pathologist, focusing primarily on communication and swallowing disorders resulting from stroke, traumatic brain injury, or other neurological conditions. Most recently, she was the Director of Speech-Language Pathology at the National Rehabilitation Hospital in Washington, D.C., and was a member of the adjunct graduate faculty of Loyola College in Maryland.

Commissioner Goldsmith received her Juris Doctor degree with honors from The University of Maryland School of Law, where she was an articles editor for the Maryland Law Review and was awarded The William Strobel Thomas Prize for the highest scholastic average of the Class of 1998. She earned a Bachelor of Science degree, summa cum laude, and a Master of Science degree from Towson University.

Ben Steffen, M.A.

Acting Executive Director, Maryland Health Care Commission

Ben Steffen serves as the Acting Executive Director of the Maryland Health Care Commission as well as the Director of the Commission's Center for Information Services and Analysis. As Acting Director, he is responsible for Commission programs in hospital and long-term care services, health coverage in the small group market, and health information technology. The Center for Information Services and Analysis has analytic and operational responsibilities for health care practitioner initiatives in the state including development of an All Payer Data Base, the Maryland Trauma Physician Services Fund, and the Patient Centered Medical Home Program. Mr. Steffen serves as a spokesperson for the Commission at

state and national levels on insurance coverage, state health care expenditures, physician work force, physician uncompensated care, and information security.

Before joining the Commission, Mr. Steffen was with Computer Sciences Corporation's health care systems consulting practice. He directed projects focused on hospital spending particularly under Medicare's Prospective System and on hospitals' quality improvement processes. Earlier he served as a budget analyst in the Health, Housing, and Income Security Division of the Congressional Budget Office where he was involved with modeling proposed changes in Medicare and Medicaid programs including reforms that led to the Medicare Prospective Payment System.

Mr. Steffen holds a Master's Degree from American University and has completed post-graduate work at the University Of Michigan.

Georges C. Benjamin, M.D.

Executive Director, American Public Health Association

Georges C. Benjamin, MD, FACP, FACEP(E), Hon FRSPH, is the executive director of the American Public Health Association (APHA), the nation's oldest and largest organization of public health professionals. He previously was the secretary of the Maryland Department of Health and Mental Hygiene, from 1999 - 2002 following four years as its deputy secretary for public health services. For the last 20 years he has been actively practicing public health at the local, state, and national level with expertise in the areas of emergency preparedness, administration, and infectious diseases. Dr. Benjamin serves as publisher of the field's premier journal, the American Journal of Public Health, *The Nation's Health* Newspaper and the APHA's timeless publication on infectious diseases, the Communicable Disease Manual.

Dr. Benjamin is a graduate of the Illinois Institute of Technology and the University of Illinois, College of Medicine. He is board-certified in internal medicine and a fellow of the American College of Physicians. He also is a Fellow Emeritus of the American College of Emergency Physicians; an honorary fellow of the Royal Society of Public Health; a Fellow of the National Academy of Public Administration; and a member of the Institute of Medicine of the National Academies. He resides in Montgomery County.

Jennifer Goldberg, J.D., LL.M.

Assistant Director of Advocacy for Health Care Law and Elder Law, Maryland Legal Aid Bureau

Jennifer Goldberg is the Assistant Director of Advocacy for Health Care and Elder Law for the Maryland Legal Aid Bureau. Since joining Maryland Legal Aid in 2001, she has focused her practice on public benefits, disability issues, and elder law. She has represented low-income clients in a wide range of civil matters, including Medicaid, Social Security and SSI, nursing home and assisted living, home and community based services, food stamps, unemployment, consumer, landlord-tenant, subsidized housing, and home ownership cases. Her current work involves health care reform's impact on low income and vulnerable populations, improving access to long term services and supports, and optimizing legal services for older adults. She also provides leadership and support to advocates in Maryland Legal Aid's 13 offices across the state serving low-income clients in health care and elder law matters. Ms. Goldberg serves on the Maryland State Bar Association Elder Law Section Council and the Maryland Access Point Advisory Board. She is a regular presenter at national, state and local conferences, including those of the National Health Law Program, National Aging and the Law Conference, National Legal Aid and Defender Association, and Maryland Partners for Justice.

Before joining Maryland Legal Aid, Ms. Goldberg worked as a supervising attorney and teaching fellow at Georgetown University Law Center in its Domestic Violence Clinic, where she was also a Georgetown Women's Law and Public Policy Fellow. She served as law clerk to the Honorable Mark L. Wolf in the United States District Court, District of Massachusetts. Ms. Goldberg earned a J.D. magna cum laude from Harvard Law School and a LL.M. in advocacy from Georgetown University Law Center. Ms. Goldberg received her bachelor's degree summa cum laude from Harvard and Radcliffe Colleges. She resides in Howard County.

Enrique-Martinez-Vidal, M.P.P.

Vice President, AcademyHealth and Director, State Coverage Initiatives

Enrique Martinez-Vidal is Vice President for State Policy and Technical Assistance at AcademyHealth. He is also the director of State Coverage Initiatives, a national program of the Robert Wood Johnson Foundation, which provides timely, experience- and research-based information and technical assistance to state leaders in order to help them move health care reform forward at the state level.

From 2008 to 2010, he was the project director for the State Quality Improvement Institute, a Commonwealth Fund-sponsored learning collaborative and technical assistance project that assisted states with developing and implementing sustainable quality improvement strategies.

Previously, Mr. Martinez-Vidal was the deputy director for performance and benefits at the Maryland Health Care Commission, an independent state agency. There he was responsible for the oversight of Maryland's small group insurance market reforms; the annual evaluation of Maryland's mandated health insurance benefits; the collection and public dissemination of quality and performance information for hospitals, nursing homes, and health plans; providing primary assistance on all legislative issues; and working on numerous other projects related to the affordability of health care, quality improvement, and patient safety.

Mr. Martinez-Vidal was also formerly a policy analyst with the Maryland Department of Legislative Services staffing the House Economic Matters Committee for five years. He has a B.A. in political science and international studies from Dickinson College and a master's degree in public policy from Georgetown University. He resides in Montgomery County.

Thomas S. Saquella, M.A.

Former President, Maryland Retailers Association

Mr. Saquella served as President of the Maryland Retailers Association for 25 years before retiring in July, 2010. MRA, consisting of members at some 1400 locations in Maryland, is the retail community's major statewide trade association in Maryland.

In addition to overseeing the administration of a variety of membership service programs and public relations and media activities, Mr. Saquella served as the chief spokesman and representative for the retail industry before state government.

Prior to joining MRA, Mr. Saquella served for over 11 years as the Executive Assistant and Chief of Staff to the Maryland Secretary of Economic and Community Development where he developed many of Maryland's economic development and housing programs. In all, Mr. Saquella worked with the

Maryland General Assembly for 37 sessions before his retirement in 2010, and he has served on a number of government boards and commissions.

Mr. Saquella was a recognized leader in the Maryland business community. He sat on numerous business and industry committees including: Board of Directors of the Better Business Bureau, former co-chair and member of the Legislative Committee (25 years) and various issue committees of the Maryland Chamber of Commerce, Chair and member of the Advisory Council of the Maryland Business for Responsive Government (24 years), and the Small Employer Legislative Coordinating Council. He also participated in numerous business legislative coalitions including Co-Chair of the Alliance for Customer Choice for Electric Supply and Services (ACCESS) that in 1999 successfully pushed for electric restructuring in Maryland.

He served on the boards of Goodwill Industries of the Chesapeake (and chaired Goodwill's Public Policy Committee), Maryland Council of Economic Education, Maryland Coalition for Financial Literacy, Queen Anne's County Economic Development Commission, and he chaired the United Way of Central Maryland's Legislative Committee.

Mr. Saquella received his B.A. Degree in government from LaSalle University in Philadelphia and a Master's Degree from George Washington University. He was a commissioned officer in the U.S. Army and served in Vietnam. He resides in Queen Anne's County.

Kenneth S. Apfel, M.P.A.

Professor of Practice, University of Maryland School of Public Policy

Kenneth S. Apfel joined the faculty at the University of Maryland's School of Public Policy in fall 2006 as Professor of the Practice. His teaching and research interests are in public management and leadership, as well as in social policy, with a particular focus on aging, health care, and retirement issues.

Before joining the School, Mr. Apfel served as the Sid Richardson Chair in Public Affairs at the University Of Texas LBJ School Of Public Affairs. Prior to that, he served as Commissioner of the Social Security Administration from 1997 until his term ended in January 2001. He was the first Senate-confirmed Commissioner of Social Security after SSA became an independent agency and the new Cabinet-level position was authorized by Congress. Previously, he had served as Associate Director for Human Resources at the Office of Management and Budget, and as Assistant Secretary for Management and Budget at the U.S. Department of Health and Human Services. Before he joined the Clinton Administration, Mr. Apfel worked for two decades in the area of social policy, as legislative director to Senator Bill Bradley, as the Senator's chief staff person for federal social and budget policy, as staff for the U.S. Senate Budget Committee, and as a Presidential Management Intern at the U.S. Department of Labor.

Mr. Apfel received his bachelor's degree from the University of Massachusetts, Amherst, in 1970; a master's degree in rehabilitation counseling from Northeastern University in 1973; and a master's degree in public affairs from the LBJ School of Public Affairs in 1978. He is an elected Fellow of both the National Academy of Public Administration and the National Academy of Social Insurance, and recently served as the Chair of both Boards. He is also a longstanding Board member of the Center on Budget and Policy Priorities in Washington, DC.

Rebecca Pearce, M.B.A. – Executive Director

Maryland Health Benefit Exchange

Rebecca Pearce is the Executive Director of the Maryland Health Benefit Exchange. She began serving this role in September 2011.

Ms. Pearce has been in the health insurance field for over nine years. She began her career in product development at CareFirst BlueCross BlueShield in Owings Mills, Maryland where she was responsible for the growth and viability of each product and/or segment in the market. As the Director of the small group market, she worked with the Maryland Health Care Commission to modify the comprehensive standard health benefit plan benefits to stay within statutory requirements. Ms. Pearce then moved to Kaiser Permanente to manage the Medicare Advantage product nationally. Most recently, she was the Director of Benefits Administration where she was responsible for negotiating and implementing benefit exceptions for major national companies throughout the Kaiser Permanente organization. She also helped to develop Kaiser Permanente's national preventive benefit package as required by the Affordable Care Act.

Ms. Pearce has her undergraduate degree from Washington University in St. Louis and her M.B.A. from the University of Maryland, College Park. She resides in Baltimore County.

Appendix 3. Advisory Committee Members

Operating Model and Insurance Rules Advisory Committee

Co-Chairs
Uma Ahluwalia (Montgomery County Department of Health and Human Services)
Jonathan Anders (Allegeant - Accountable Care Solutions)

Members
Salliann Alborn (Community Health Integrated Partnership, Inc.)
Virginia Anderson (Maryland Dental Action Coalition)
Paul Berman (Psychologist in private practice)
Vincent DeMarco (Maryland Citizen's Health Initiative)
Laura Howell (Maryland Association of Community Services)
Kendall Hunter (Kaiser Foundation Health Plan of Mid-Atlantic States)
Aaron Kaufman (Community Advocate)
Cristina Meneses (Public Health Law Network)
John Miller (MidAtlantic Business Group on Health)
Paul Nicholson (Adventist HealthCare)
Mark Sucoloski (Riggs, Counselman, Michaels & Downes)
Tequila Terry (DentaQuest)
Sally Tyler (American Federation of State, County and Municipal Employees)
Susan Wood (School of Public Health and Health Services, The George Washington University)
Kevin Yang (CareFirst BlueCross BlueShield)
Charles Yarborough (Lockheed Martin Corp.)

Board Liaison
Therese Goldsmith

SHOP Advisory Committee

Co-Chairs
John Fleig (United Healthcare)
Bradley Herring (Johns Hopkins Bloomberg School of Public Health)

Members
Shawn Brashears (Kelly & Associates Insurance Group)
Kenneth Capone (People On the Go)
Lee Diemer (BenefitMall)
Jon Frank (Jon S. Frank & Associates, Inc.)
Manny Hidalgo (Latino Economic Development Corporation)
Kindra Ingram (Align Spine Health Center, LLC)
Eric King (The Crab Shanty)
Mary Kivlighan (University of Maryland, College Park School of Public Health)
Marilyn Koss (Koss Benefits Financial & Insurance Services)
Cindy Otley (CareFirst BlueCross BlueShield)
Camilla Roberson (Public Justice Center)
Bill Scarafia (St. Mary's County Chamber of Commerce)
William Simmons (Group Benefit Services)

Board Liaison
Thomas Saquella

Navigator and Enrollment Advisory Committee

Co-Chairs
Leigh Cobb (Advocates for Children & Youth)
Toby Gordon (Johns Hopkins University, Carey Business School)

Members
Nancy Bond (The Coordinating Center for Home and Community Care, Inc)
Christopher Culotta (CareFirst BlueCross BlueShield)
Michael Cumberland (Keller Stonebraker Insurance)
Cynthia Demarest (Maryland Physicians Care)
Jay Duke (Waring-Ahearn Insurance Agency, Inc.)
Mary Lou Fox (Maryland Women's Coalition for Health Care Reform)
Stephanie Golden (Golden & Cohen, LLC)
Thomas Grote (Aetna)
Floyd Hartley (Advocate)
Yngvild Olsen (Baltimore Substance Abuse System, Inc.)
Richard Reeves (United Healthcare)
Alma Roberts (Baltimore Healthy Start, Inc.)
Jan Ruff (MAXIMUS Health Services)
Deborah Trautman (Johns Hopkins Medicine)
Cassandra Umoh (Self-employed, consultant)
Ellen Weber (University of Maryland School of Law)

Board Liaison
Jennifer Goldberg

Finance and Sustainability Advisory Committee

Co-Chairs
Nathan Brown (Community Advocate)
Dushanka Kleinman (University of Maryland School of Public Health)

Members
Russ Causey (CMD Outsourcing Solutions, Inc.)
Matt Celentano (Maryland Citizens' Health Initiative)
Alvin Helfenbein (Helfenbein Insurance Agency, Inc.)
Julia Huggins (CIGNA HealthCare)
Sheila Mackertich (Baltimore HealthCare Access)
Michael McHale (Hospice of the Chesapeake, Inc.)
Miguel McInnis (Mid-Atlantic Association of Community Health Centers)
John O'Donnell (Washington Area New Automobile Dealers Association)
Leni Preston (Maryland Women's Coalition for Health Care Reform)
Stephanie Reid (Carroll Hospital Center)
Mike Robbins (Maryland Hospital Association)
Tara Ryan (Pharmaceutical Research and Manufacturers of America)
Randolph Sergent (CareFirst BlueCross BlueShield)
Jagdeep Singh (Prince George's Hospital & Laurel Regional Hospital)
Ronald Wineholt (Maryland Chamber of Commerce)

Board Liaison
Ben Steffen

Key References

Advisory Committee Reports

Finance and Sustainability Advisory Committee. (2011, November 15). *Report to the Maryland Health Benefit Exchange Board.* Baltimore, MD: Maryland Health Benefit Exchange. Retrieved from http://dhmh.maryland.gov/healthreform/exchange/pdf/nov15/FinalFinancingAdvisoryCommittee.pdf. **See Attachment A for the full report.**

Navigator and Enrollment Advisory Committee. (2011, November 8). *Report to the Maryland Health Benefit Exchange Board.* Baltimore, MD: Maryland Health Benefit Exchange. Retrieved from http://dhmh.maryland.gov/healthreform/exchange/pdf/nov15/FinalNavigatorAdvisoryCommittee.pdf. **See Attachment B for the full report.**

Operating Model and Insurance Rules Advisory Committee. (2011, November 15). *Report to the Maryland Health Benefit Exchange Board.* Baltimore, MD: Maryland Health Benefit Exchange. Retrieved from http://dhmh.maryland.gov/healthreform/exchange/pdf/OperationsAdvisoryCommitteeReportFinal.pdf. **See Attachment C for the full report.**

SHOP Advisory Committee. (2011, November 15). *Report to the Maryland Health Benefit Exchange Board.* Baltimore, MD: Maryland Health Benefit Exchange. Retrieved from http://dhmh.maryland.gov/healthreform/exchange/pdf/nov15/FinalSHOPAdvisoryCommittee_2.pdf. **See Attachment D for the full report.**

Consultant Studies

Institute for Health Policy Solutions. (2011, November 9). *Final report – Analysis of key Maryland SHOP-related policy options.* Washington, DC. Retrieved from http://dhmh.maryland.gov/healthreform/exchange/pdf/nov15/FinalSHOPExchangeIHPS_1.pdf. **See Attachment E for the full report.**

Institute for Health Policy Solutions. (2011, November 14). *Technical assessment of private sector capacity*. Washington, D.C. , DC. Retrieved from http://dhmh.maryland.gov/healthreform/exchange/pdf/nov15/FinalSHOPTechAssess.pdf. **See Attachment F for the full report.**

Manatt Health Solutions. (2011, November 6). *Study of navigator program and consumer assistance.* , DC. Retrieved from http://dhmh.maryland.gov/healthreform/exchange/pdf/nov15/FinalNavigatorReportManatt.pdf. **See Attachment G for the full report.**

Mercer Government Human Services Consulting. (2011, November 8). *Report of market rules and risk selection for state of Maryland: Maryland Health Benefit Exchange.* Atlanta, GA: Mercer Health and Benefits, LLC. , DC. Retrieved from http://dhmh.maryland.gov/healthreform/exchange/pdf/FinalMDStudyofMarketRules-and-RiskSelectionReport.pdf. **See Attachment H for the full report.**

Wakely Consulting Group. (2011, November 7). *Maryland Health Benefit Exchange: Financing the exchange consultant report.* Boston, MA. , DC. Retrieved from http://dhmh.maryland.gov/healthreform/exchange/pdf/nov15/FinalFinancingReportWakely.pdf **See Attachment I for the full report.**

Wakely Consulting Group. (2011, November 8). *Maryland Health Benefit Exchange: Exchange operating model consultant report.* Boston, MA. , DC. Retrieved from http://dhmh.maryland.gov/healthreform/exchange/pdf/FinalExchangeOperatingModelVendorReport.pdf. **See Attachment J for the full report.**

Weber Shandwick. (2011, November). *Final report: Public relations and advertising consultant study: Maryland Health Benefit Exchange.* Baltimore, MD. , DC. Retrieved from http://dhmh.maryland.gov/healthreform/exchange/pdf/nov15/FinalAdvertisingReportWeber.pdf. **See Attachment K for the full report.**

Other References

Bloom, B., & Cohen, R. (2010 June). *Dental insurance for persons under age 65 Years with private health insurance: United States, 2008.* Washington, D.C.: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/databriefs/db40.pdf.

Center for Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services. (2011, November 29). *Cooperative agreement to support establishment of state-operated health insurance exchanges; announcement type: Amended.* Retrieved from http://apply07.grants.gov/apply/opportunities/instructions/oppIE-HBE-11-004-cfda93.525-cidIE-HBE-11-004-012241-instructions.pdf.

Health Care Reform Coordinating Council. (2010, July 26). *Interim report*. Retrieved from http://dhmh.maryland.gov/healthreform/html/interimreport.html.

Blumberg, L., & Pollitz, K. (2009, April 1). *Health Insurance Exchange: Organizing health insurance marketplaces to promote health reform goals.* Washington, D.C.: Urban Institute. Retrieved from http://www.urban.org/UploadedPDF/411875_health_insurance_marketplaces.pdf.

Farley Short, P., Swartz, K., Namrata, U., and Graefe, D. (2011, May). *Realizing health reform's potential: Maintaining coverage, affordability, and share responsibility when income and employment change*. The Commonwealth Fund Pub. 1503. Retrieved from http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/May/1503_Short_maintaining_coverage_affordability_reform_brief.pdf.

Isong, I., Zuckerman, K., Rao, S., Kulthau, K., Winickoff, J., & Perrin, J. (2010, February 1). Association between parents' and children's use of oral health services. *Pediatrics*. DOI: 10.1542/peds.20091417. Retrieved from http://pediatrics.aappublications.org/content/early/2010/02/01/peds.2009-1417.full.pdf+html

Kaiser Family Foundation. (2011, August). *Public opinion on health care issues.* Retrieved from http://www.kff.org/kaiserpolls/upload/8217-F.pdf.

Maryland Health Care Commission. (2011, January). *Health insurance coverage in Maryland: Through 2009.* Retrieved from http://mhcc.maryland.gov/health_insurance/insurance_coverage/insurance_report_2009_20110120.pdf.

U.S. Department of Health and Human Services. (2011, July 15). Federal Register Vol. 76, No. 136. Retrieved from http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf.

U.S. Department of Health and Human Services. (2011, March). Report to Congress: National strategy for quality improvement in health care. Retrieved from http://www.healthcare.gov/law/resources/reports/quality03212011a.html.

U.S. Public Health Service. (2000). *Oral health in America: A report of the Surgeon General.* Washington, D.C.: U.S. Department of Health and Human Services. Retrieved from http://silk.nih.gov/public/hck1ocv.@www.surgeon.fullrpt.pdf.

Kaiser Family Foundation. (2011, August). *Public opinion on health care issues.* Retrieved from http://www.kff.org/kaiserpolls/upload/8217-F.pdf.

List of Attachments

A. Finance and Sustainability Advisory Committee Report

B. Navigator and Enrollment Advisory Committee Report

C. Operating Model and Insurance Rules Advisory Committee Report

D. SHOP Advisory Committee Report

E. Institute for Health Policy Solutions SHOP Report

F. Institute for Health Policy Solutions SHOP Technical Assessment

G. Manatt Health Solutions Navigator Report

H. Mercer Government Human Services Consulting Market Rules and Risk Selection Report

I. Wakely Consulting Group Financing Report

J. Wakely Consulting Group Operating Model Report

K. Weber Shandwick Public Relations and Advertising Report