Study of Governance Options: A Report to the Governor and Maryland General Assembly

Maryland Health Benefit Exchange

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Executive Summary

Introduction

The Affordable Care Act (ACA) allows states to establish their exchanges as either governmental agencies or nonprofit entities.[1] While the ACA and corresponding regulations delineate the minimum functions and requirements for exchanges, they afford states considerable flexibility in designing their governance structures. The Maryland Health Benefit Exchange (MHBE) was established in 2011 as a public corporation and a unit of the state government.[2] Recognizing that Maryland should revisit some of its early policy decisions surrounding the MHBE's establishment, the MHBE Act of 2012 requires the MHBE to study and report on "whether the Exchange should remain an independent public body or should become a nongovernmental, nonprofit entity."[3] In accordance with this requirement, the MHBE submits this report to the Governor and the Maryland General Assembly.

Requirements for Government Agencies and Nonprofits

As a unit of Maryland state government, the MHBE is subject to many provisions of the Finance and Procurement, State Government, State Personnel and Pensions, and General Provisions Articles. Some of these requirements include compliance with the Open Meetings Act, the Public Information Act, the Public Ethics Law for state employees, the Administrative Procedures Act provisions related to rulemaking, and procurement requirements. All of these requirements promote the MHBE's public transparency as a state agency. Nonprofit entities, on the other hand, are generally not subject to these requirements, although the Maryland Court of Appeals has found that nonprofits deemed to be performing government functions are subject to the state Open Meetings Act.[4]

The MHBE is currently financed through appropriations from the state General Fund and funds from the 2 percent premium tax on all insurance policies in the state. Nonprofit entities, on the other hand, are generally not funded through the state budget; instead, they rely on fees, grants, donations, and other private gifts or charitable contributions to sustain their operations. A nonprofit's relationship with other entities is largely contractual, and any oversight ability, unless formally specified in statute, is therefore set by the particular provisions of the contract. Similarly, a nonprofit is not required to abide by the procurement laws of a state.

Thus, if the MHBE changed its governance structure to a nonprofit entity, it would not be subject to most of the public transparency and state agency procurement requirements described above, which would result in a loss of transparency. Further, the MHBE would have to change its funding structure.

[1] ACA § 1311(d) (42 U.S.C. § 18031(d)).
[2] Insurance Article, § 31-102(b), Annotated Code of Maryland.
[3] Section 6, Chapter 152, 2012 Laws of Maryland.
[4] *City of Baltimore Dev. Corp. v. Carmel Realty Assoc.* 395 Md. 299, 910 A.2d 406 (2006).

Impact on Medicaid

A key function of the MHBE is to provide a single, streamlined application and eligibility determination process for all insurance affordability programs—Medicaid, the Children's Health Insurance Program (CHIP), and advanced premium tax credits and cost-sharing reductions for qualified health plans (QHPs). In order to accomplish this, the Maryland Department of Health and Mental Hygiene (DHMH) was required to submit a Medicaid state plan amendment delegating authority for Medicaid eligibility determinations for income-based coverage groups to the MHBE. Under the state plan amendment approved by the Centers for Medicare & Medicaid Services (CMS) and federal regulations, this eligibility determination process must be delegated to "an exchange that is a government agency."[5]

If the MHBE became a nonprofit entity, then it would no longer qualify as a government agency as required under this regulation and by the state plan amendment, and DHMH would not be able to delegate Medicaid eligibility determinations to the MHBE. DHMH would then have to file a new state plan amendment with CMS to withdraw the delegation of Medicaid determinations to the MHBE. Becoming a nonprofit would compromise the MHBE's single, streamlined application process and would adversely impact consumers. Further, it would result in a large financial and administrative burden on both DHMH and the MHBE to redesign the Medicaid eligibility determination system.

Other States

Only two state-based exchanges—Colorado and Hawaii—currently operate as nonprofits. The other 12 state-based exchanges—including Maryland—operate as governmental entities (some as state agencies and others with a range of quasi-governmental structures). The MHBE conducted interviews with and performed background research on four other state-based exchanges:

- Colorado, which is a nonprofit exchange
- Hawaii, which currently operates as a nonprofit exchange but is moving to the federally facilitated marketplace
- Washington, which currently operates as a quasi-governmental exchange but is considering becoming a state agency
- Connecticut, which is a quasi-governmental exchange

Key findings from these interviews and background research include the following:

- Related to contracting and procurement, nonprofit and non-state agency exchanges have greater flexibility in contracting and procurement. They are generally not required to abide by state procurement laws, but many voluntarily do so.
- One of the nonprofit exchanges is not allowed to make Medicaid eligibility determinations, so its system is not integrated. The other nonprofit exchange maintains two different online user portals for Medicaid and QHP enrollment.

[5] Maryland State Plan Amendment, Transmittal Number 13-0023-MM4 (June 18, 2014).

- Nonprofit and non-state agency exchanges reported some tensions in their interactions with other state agencies.
- Related to public transparency, three of the four states interviewed are generally required to abide by state public meeting and information disclosure requirements. One nonprofit exchange voluntarily abides by these requirements.
- Some of the nonprofit and non-state agency exchanges are not covered by their state's immunity laws and must purchase their own liability insurance.

Stakeholder Input

The MHBE also sought input from its Standing Advisory Committee (SAC), which includes stakeholders representing carriers, providers, and consumer advocacy organizations. SAC members unanimously agreed that the MHBE should remain an independent agency. The SAC stated that the MHBE recovered from technical problems during the first open enrollment and is currently functioning well, so they did not see a need to change. Further, members commented that changing to a nonprofit would be very expensive, disruptive to consumers, and could jeopardize the MHBE's financial sustainability. Finally, members were concerned that changing to a nonprofit would compromise the MHBE's public transparency.

Recommendation

For the reasons outline above, the MHBE recommends that it remain an independent public body at this time.

Introduction

The Maryland Health Benefit Exchange (MHBE) Act of 2012 requires the MHBE to study and report on "whether the Exchange should remain an independent public body or should become a nongovernmental, nonprofit entity."[6] In accordance with this requirement, the MHBE submits this report to the Governor and the Maryland General Assembly.

This report first provides background information on federal requirements for exchanges, followed by a description of the MHBE's current governance structure and the Maryland laws by which the MHBE must abide as a public body. The report then presents a description of the requirements for nonprofits, the experience of exchanges in a sample of other states, and the impact of the MHBE's governance structure on Medicaid. The report concludes with stakeholder input and recommendations on governance options.

Federal Exchange Requirements

ACA

Under the Affordable Care Act (ACA),[7] states have the option to establish a health benefit exchange that "facilitates the purchase of qualified health plans (QHPs)" and establishes a Small Business Health Options Program (SHOP).[8] If a state does not establish an exchange, then the U.S. Department of Health and Human Services (HHS) will operate a federally facilitated marketplace (FFM) in that state.[9] A state-based exchange must be a governmental agency or a nonprofit entity.[10]

The ACA defines the minimum functions an exchange must perform:[11]

- Certifying QHPs
- Providing a telephone hotline
- Maintaining a website with standardized comparative information on QHPs for consumers
- Assigning a rating for each QHP
- Using a standardized format for presenting QHPs in the exchange
- Informing individuals of eligibility requirements for Medicaid and the Children's Health Insurance Program (CHIP), and enrolling individuals into these programs if the exchange determines that an individual is eligible

[6] Section 6, Chapter 152, 2012 Laws of Maryland.
[7] Pub. L. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (Mar. 30, 2010).
[8] ACA § 1311(b)(1) (42 U.S.C. § 18031(b)(1)).
[9] ACA § 1321(c) (42 U.S.C. § 18041(c)); 45 CFR§ 155.105(f).
[10] ACA § 1311(d) (42 U.S.C. § 18031(d)).
[11] ACA § 1311(d)(4) (42 U.S.C. § 18031(d)(4)).

- Establishing and making available online a calculator to determine the actual cost of coverage after the application of any premium tax credit or cost-sharing reduction
- Exempting an individual from the mandate if the individual meets certain requirements
- Sending—to the Secretary of the Treasury—a list of exempt individuals and employees eligible for a premium tax credit because either their employer did not provide essential minimum coverage or the coverage was unaffordable
- Providing employers with the name of each employee who is eligible for a premium tax credit because either the employer did not provide essential minimum coverage or the coverage was unaffordable
- Establishing a Navigator program

In order to assist states with exchange establishment, HHS awarded grants to states.[12] These grants were limited to assisting states with the establishment of an exchange and have not been awarded after January 1, 2015.[13] After this date, a state-based exchange must be self-sustaining through assessments on participating insurers or other funding methods.[14]

Regulations

Federal regulations provide more detailed requirements regarding the establishment of state-based exchanges.[15] To receive approval from HHS, a state-based exchange must be able to perform the minimum functions under the ACA and corresponding regulations, comply with information reporting requirements, and cover the entire geographic area of the state.[16] The required functions include providing consumer assistance; performing eligibility determinations for participation in the exchange, including eligibility for any premium tax credits and cost-sharing reductions; and facilitating enrollment. State-based exchanges must also make determinations for exemption from the individual mandate, perform SHOP operations, and certify QHPs.

Under federal regulations, where the exchange is an independent state agency or a nonprofit entity, the state must ensure that there is a clearly defined governing Board.[17] The Board must be administered under a formal, publicly adopted operating charter or by-laws, hold regular public meetings, represent consumer interests, and ensure that the majority of the voting Board has relevant experience.[18] The exchange must have and make available a set of guiding governance principles, as well as implement procedures for disclosure of financial interest by Board members.[19] The exchange must regularly consult with stakeholders, including consumers, individuals experienced with health insurance enrollment, advocates, small business owners,

[12] ACA § 1311(a) (42 U.S.C. § 18031(a)).
[13] ACA § 1311(a)(4) (42 U.S.C. § 18031(a)(4)).
[14] ACA § 1311(d)(4) (42 U.S.C. § 18031(d)(5)).
[15] The Exchange Establishment Rule is published at 45 CFR Part 155.
[16] 45 CFR § 155.105(b).
[17] 45 CFR § 155.110(c).
[18] Id.
[19] 45 CFR § 155.110(d).

Medicaid and CHIP agencies, public health experts, providers, large employers, insurance issuers, and agents and brokers.[20]

A state must ensure that its exchange "has sufficient funding in order to support its ongoing operations beginning January 1, 2015" because federal grants will no longer be awarded for state-based exchange establishment.[21] States may generate funding for exchange operations through various methods, including user fees on participating insurers.[22] Beyond these minimum requirements, HHS affords states considerable flexibility in designing the governance structure of their exchanges.

MHBE Background

Maryland Health Benefit Exchange Statute

Under Maryland law, the MHBE was established as a public corporation and a unit of the state government.[23] The purpose of the MHBE is to reduce the number of the uninsured, facilitate the purchase of QHPs, and assist qualified employers in facilitating the enrollment of their employees into QHPs.[24] The MHBE is required to assist individuals with accessing public programs, premium tax credits, and cost-sharing reductions, as well as supplement the individual and small group insurance markets outside the exchange.[25]

The MHBE has a nine-member Board of Trustees, which includes the Secretary of the Maryland Department of Health and Mental Hygiene (DHMH), the Insurance Commissioner, and the Executive Director of the Maryland Health Care Commission.[26] The Governor appoints three members who represent the interests of employers and consumers and may have public health expertise, and three members with knowledge and expertise with health insurance, health plan administration, health care finance, or public health.[27] The Board members should not be affiliated with a carrier, an insurance producer, a third-part administrator, a managed care organization, or any person contracting directly with the MHBE.[28] A member's duties are to serve the public interest of the individuals and qualified employers seeking coverage through a QHP and ensure the sound operation and fiscal solvency of the MHBE.[29] The Board has the authority to appoint an Executive Director to act as the chief administrative officer and direct, administer, and manage the operations of the MHBE.[30]

An MHBE fund was established for the operation and administration of the exchange and the state reinsurance program.[31] The fund consists of user fees or assessments collected by the

[20] 45 CFR § 155.130.
[21] 45 CFR § 155.160(b).
[22] 45 CFR § 155.160(b)(1).
[23] Insurance Article, § 31-102(b), Annotated Code of Maryland.
[24] Insurance Article, § 31-102(c), Annotated Code of Maryland.
[25] Id.
[26] Insurance Article, § 31-104(b), Annotated Code of Maryland.
[27] Insurance Article, § 31-104(b), Annotated Code of Maryland.
[28] Insurance Article, § 31-104(d), Annotated Code of Maryland.
[29] Insurance Article, § 31-104(j), Annotated Code of Maryland.
[30] Insurance Article, § 31-105, Annotated Code of Maryland.
[31] Insurance Article, § 31-107(b), Annotated Code of Maryland.

exchange, revenue from the premium tax, revenue from the Maryland Health Insurance Plan (MHIP) fund, money awarded through grants, and any other source accepted for the benefit of the fund.[32] The fund may only be used for the operation and administration of the MHBE and the state reinsurance program, with separate accounts for each.[33] Money from the distribution of the premium tax should only be used for the exchange.[34] The premium tax is imposed on all new and renewal gross direct premiums or each person subject to the tax.[35] User fees should be imposed in a manner that is transparent and broad-based and does not exceed reasonable projections regarding the amount necessary to support the MHBE.[36] For fiscal year 2015, the state should appropriate at least $10 million from the premium tax to the MHBE fund and $35 million for each following fiscal year.[37] These funds may only be used for the purpose of the operation and administration of the MHBE.[38] If the amount available from the premium tax is insufficient to meet the actual expenditures for operations and administration of the MHBE, then the Governor may provide additional funding through a deficiency appropriation.[39]

Under Maryland law, the MHBE must perform at a minimum all functions required by the ACA.[40] In addition to these minimum functions, the MHBE should allow carriers to offer a qualified dental or vision plan through the exchange, and provide initial, annual, and special enrollment periods.[41] The MHBE must also establish a SHOP through which qualified employers can purchase insurance for their employees, carry out a plan to provide appropriate assistance for consumers seeking to purchase QHPs, and conduct a public relations and advertising campaign.[42] The MHBE should also conduct processes to determine eligibility for premium tax credits, reduced cost-sharing, and individual responsibility requirement exemptions.[43]

When contracting with carriers to provide QHPs, the MHBE should seek to achieve a robust and stable environment and decrease the number of uninsured residents.[44] The MHBE may use alternative contracting options and active purchasing strategies to increase the affordability and quality of care for consumers, which may include pursuing objectives such as high standards of care, continuity of care, delivery system reforms, and health equity.[45] The MHBE should consider the importance of sufficient enrollment and carrier participation and its progress in meeting its objectives when employing contracting strategies.[46] From 2014 to 2016, the MHBE should allow any QHP meeting the MHBE's minimum standards to be offered in the exchange;

[32] Insurance Article, § 31-107(e), Annotated Code of Maryland.
[33] Insurance Article, § 31-107(f),(g), Annotated Code of Maryland.
[34] Insurance Article, § 31-107(g)(3), Annotated Code of Maryland.
[35] Insurance Article, §§ 6-102; 6-103.2, Annotated Code of Maryland.
[36] Insurance Article, § 31-118, Annotated Code of Maryland.
[37] Insurance Article, § 31-107.2(a), Annotated Code of Maryland.
[38] Insurance Article, § 31-107.2(b), Annotated Code of Maryland.
[39] Insurance Article, § 31-107.2(c), Annotated Code of Maryland.
[40] Insurance Article, § 31-108, Annotated Code of Maryland.
[41] Insurance Article, § 31-108(b)(2),(3),(6), Annotated Code of Maryland
[42] Insurance Article, § 31-108(b)(13),(19),(20), Annotated Code of Maryland
[43] Insurance Article, § 31-108(b)(17), Annotated Code of Maryland.
[44] Insurance Article, § 31-110(a), Annotated Code of Maryland.
[45] Insurance Article, § 31-110(b), Annotated Code of Maryland.
[46] Insurance Article, § 31-110(c), Annotated Code of Maryland.

beginning in 2016, the MHBE may also employ alternative contracting options and active purchasing strategies.[47]

The MHBE is authorized to enter into agreements or memoranda of understanding (MOUs) with another state to develop joint or reciprocal certification processes, develop consistency in QHPs offered across states, and coordinate resources for administrative processes necessary to support QHP certification and other exchange functions.[48] The MHBE is authorized to operate or oversee the operation of a transitional reinsurance program in consultation with the Maryland Health Care Commission and with the approval of the Insurance Commissioner.[49]

Current MHBE Operational Structure

Currently, the MHBE executive office comprises seven senior staff positions:[50]

- The Executive Director directs, administers, and manages all MHBE operations. This position is responsible for providing leadership and direction, formulating strategic objectives for Board input, overseeing the entirety of the Exchange's activities, and working closely with senior staff and the Board to define and execute the MHBE's mission.
- The Deputy Executive Director works with the Executive Director to set, manage, and measure the achievement of strategic priorities for the MHBE; maintains effective relationships and communication with key stakeholders; and directs staff cooperation on cross-agency policy and operational initiatives.
- The Chief Financial Officer (CFO) oversees all financial aspects of the MHBE, including managing grant funding, the legislative budget process, and procurement.
- The Director of Policy reviews and synthesizes federal and state regulations, identifying implications for the MHBE, and develops strategies to remain compliant. The Director of Policy also researches and analyzes issues, monitors trends, and represents the MHBE in the state legislative process.
- The Chief Compliance Officer (CCO) manages MHBE compliance with federal and state privacy and other laws and regulations; develops and manages the fraud, waste, and abuse plan; develops MHBE standards for staff training and compliance; and manages enforcement procedures.
- The Chief Operating Officer (COO) oversees consumer assistance, plan services, administrative services, human resources, and consumer appeals functions.
- The Director of Marketing and Strategic Initiatives is responsible for shaping the public image of the MHBE and oversees the marketing and outreach, training, and digital communications functions.

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[47] Insurance Article, § 31-110(d),(e), Annotated Code of Maryland.
[48] Insurance Article, § 31-109(a), Annotated Code of Maryland
[49] Insurance Article, § 31-117(c), Annotated Code of Maryland.
[50] See MHBE Organizational Chart, August 21, 2015, Appendix 1.

- The Chief Information Officer (CIO) is responsible for all information technology functions for the MHBE.

The MHBE also has three Assistant Attorneys General assigned to it, with one service and lead counsel.

MHBE Requirements as a Maryland State Agency

Units of Maryland state government are generally subject to all provisions under the State Finance and Procurement, State Government, and State Personnel and Pensions Articles. They are also subject to many of the General Provisions Article sections. The MHBE is explicitly subject to several provisions under these articles, a few which are highlighted in this section of the report.[51]

Title 3 of the General Provisions Article, known as the Open Meetings Act (OMA), requires public bodies, or the functional equivalent of public bodies, to meet in open sessions.[52] The OMA further requires that adequate notice about the time and location of public meetings be provided to individuals.[53] The OMA dictates how minutes must be documented for the open and closed sessions of meetings.[54] General Provisions Article Title 4, the Public Information Act, lays out the process by which state agencies are to respond to requests for information by the public. Under Title 5 of the General Provisions Article, the Maryland Public Ethics Law requires that state employees not have a financial interest, or other conflicts of interest, with matters in which they participate. The Law also requires certain employees to file financial disclosure statements, stating any employee interests in property, business, any gifts received by those doing business with the state, and any other income earned.[55]

Title 12, Subtitle 4 of the State Finance and Procurement Article requires exempt units of government to have written policies and procedures related to procurement, including the methods of advertising and procurement to be used, goals (including minority business enterprise participation) to be achieved, and the approval process for each procurement.[56]

State Government Article Title 10, Subtitle 1, contains the Administrative Procedure Act's provisions related to rulemaking. All proposed rules must go through a legal sufficiency and public comment process. This subtitle prescribes the number of days required in between each step in the rulemaking process.[57] State Personnel and Pensions Article, Title 5, Subtitle 3, provides rights to whistleblowers in the executive branch of Maryland government.

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[51] See Insurance Article, § 31-103(a), Annotated Code of Maryland.
[52] See General Provisions Article §3-102, Annotated Code of Maryland.
[53] General Provisions Article §3-102(c), Annotated Code of Maryland.
[54] General Provisions Article §3-104, Annotated Code of Maryland.
[55] General Provisions Article, Title 5, Annotated Code of Maryland.
[56] State Finance and Procurement Article, §12-401, Annotated Code of Maryland.
[57] State Government Article, §10-112, Annotated Code of Maryland.

Requirements of Nonprofits

Maryland and federal law set general requirements for all nonprofits under the Corporations and Associations Article, though Maryland does not have a specific nonprofit incorporation law. In order to be designated as a nonprofit, an organization must first draft bylaws, select a board of directors, elect officers, file articles of incorporation with the State Department of Assessments and Taxation (SDAT), hold an organizational meeting, and file the requisite documentation to obtain tax-exempt status from the Internal Revenue Service (IRS) and SDAT.[58] A mission statement is also required to obtain state and federal tax exemption.[59]

By-laws should contain provisions related to the functions of the board of directors, including the purpose and powers, the designation of officers, the schedule of annual and other regular meetings, and the method by which the meetings will take place. The bylaws should also contain conflict of interest policies.

Nonprofit entities are generally not funded through the state budget and instead rely on fees, grants, donations, and other private gifts or charitable contributions to sustain their operations. A nonprofit's relationship with other entities is largely contractual, and any oversight ability, unless formally specified in statute, is therefore set by the particular provisions of the contract. Similarly, a nonprofit is not required to abide by procurement laws of a state, including any special considerations for minority business enterprises.

While best practices encourage nonprofits to provide public access to the affairs of a nonprofit,[60] these types of entities are generally not required to abide by any state laws governing transparency, such as open meeting laws. In Maryland, however, the Court of Appeals has found that a nonprofit deemed to be performing government functions is subject to the state OMA.[61] Further, the OMA explains that a multi-member body created by state statute is subject to the Act.[62]

A nonprofit created through legislation may be subject to some state government procedures and may also be exempt from others.

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[58] Corp. and Assoc. Art. §§ 2-102, 2-103, and 2-106 to 2-109, Annotated Code of Maryland.
[59] See Non-Profit Organizations, available at http://www.sos.state.md.us/charity/Non-Profit.html.
[60] See Standards for Excellence: An Ethics and Accountability Code for the Nonprofit Sector, Maryland Association of Nonprofit Organizations, *available at:* http://standardsforexcellenceinstitute.org/dnn/Portals/0/Repository/MD%20Codebook.9cbd8b52-cbde-4506-a25b-6407e71efc4f.pdf.
[61] *City of Baltimore Dev. Corp. v. Carmel Realty Assoc.* 395 Md. 299, 910 A.2d 406 (2006).
[62] General Provisions Art., §3-301 (h)(1), Annotated Code of Maryland.

Experiences in Other States

Only two state-based exchanges—Colorado and Hawaii—currently operate as nonprofits. The other 12 state-based exchanges—including Maryland—operate as governmental entities (some as state agencies and others with a range of quasi-governmental structures). The MHBE reviewed legislative and policy documentation and conducted interviews with four other state-based exchanges with nonprofit and quasi-governmental governance structures.

Nonprofits

The MHBE researched and interviewed Colorado and Hawaii, the only two states with nonprofit governance structures.

Colorado

On June 1, 2011, the Colorado governor signed SB11-200 into law, which established the Colorado Health Benefit Exchange as a nonprofit unincorporated public entity.[63] The Colorado exchange is governed by a 12-member Board of Directors, with 9 voting members and 3 nonvoting, ex officio members.[64] Members may serve a maximum of two terms. The three ex officio members are the Executive Director of the Department of Health Care Policy and Financing, the Insurance Commissioner, and the Director of the Office of Economic Development and International Trade.[65] The governor appoints five voting members to the Board, with no more than three members from the same political party.[66] The president of the Senate, the minority leader of the Senate, the speaker of the House of Representatives, and the minority leader of the House of Representatives each appoint one voting member.[67] Under the statute, all voting members of the Board should have experience in areas related to establishing an exchange, such as health insurance coverage, health care finance, health benefits administration, or information technology.[68] The people making the appointments must coordinate to ensure that there is a broad representation of skill sets.[69] The majority of voting Board members should not be directly affiliated with the insurance industry, and no members should be state employees.[70]

Under Colorado law, the Board has all of the powers and duties necessary to establish the exchange.[71] The Board appoints an executive director to administer the exchange, creates an initial operation and financial plan, and applies for federal establishment grants.[72] The Board must also create technical and advisory groups as needed, provide an annual report to the governor and general assembly on the planning and establishment of the exchange, and review

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[63] 2011 Colo. Sess. Laws 1073
[64] Colo. Rev. State. § 10-22-105(1)(a)
[65] Colo. Rev. State. § 10-22-105(1)(c)
[66] Colo. Rev. State. § 10-22-105(1)(a).
[67] Id.
[68] Colo. Rev. State. § 10-22-105(1)(b).
[69] Id.
[70] Id.
[71] Colo. Rev. State. § 10-22-106(1).
[72] Id.

the internet portal for the exchange.[73] In establishing the exchange, the Board should consider the desirability of structuring the exchange as one entity that includes two underlying entities to operate the individual and SHOP exchanges, the appropriate size of the small employer market, the unique needs of rural Colorado residents, and the affordability and cost of purchasing health insurance.[74] The Board may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities; it may also create a separate program that shares resources and infrastructure with the exchange to offer ancillary products.[75] The Board may also enter into agreements with the department of personnel to authorize administrative judges to hear and decide matters arising from eligibility and other determinations made by the exchange.[76] The Board does not have the authority to promulgate rules and cannot duplicate or replace the duties—including rate approval—of the insurance commissioner.[77] The Board should foster a competitive marketplace for insurance and not solicit bids or engage in the active purchasing of insurance.[78]

Colorado Interview

The MHBE received a written response to a list of interview questions from Colorado. Colorado explained that the exchange's establishing legislation was a bipartisan bill that had broad stakeholder support, including business groups, consumer advocates, brokers, and insurance companies. Stakeholders supported a non-governmental entity, which led to the creation of the exchange as a public, nonprofit entity that is an instrumentality of the state. Meetings of the Board are subject to Colorado's open meetings and records laws. Public and stakeholder input is solicited and encouraged to promote transparency.

Colorado provided a list of their revenue sources, with estimates of the funds received for the fiscal year ending June 30, 2015:

- Marketplace administrative fee: $7.3 million
- Broad market carrier assessment: $18 million
- Carrier tax-deductible donations: carriers can donate up to $5 million each year
- Grants: $2.5 million from the Colorado Health Foundation for the navigator program for July 2015 through June 2016
- CoverColorado reserves: $14 million

The exchange may also receive funding through other revenues and Medicaid reimbursement. The exchange is currently working with the Colorado Department of Health Care Policy and Financing (HCPF), which administers the state Medicaid program, and the Centers for Medicare & Medicaid Services (CMS) to determine the Medicaid cost allocation methodology for both historical and future costs. Colorado noted that the marketplace administrative fee, which is

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[73] Id.
[74] Id.
[75] Colo. Rev. State. § 10-22-106.
[76] Id.
[77] Colo. Rev. State. § 10-22-104.
[78] Id.

applied to all plans sold through the exchange, was set at 1.4 percent of premiums for 2015 and 3.5 percent for 2016. The broad market carrier assessment, which is carried over from CoverColorado, was set at $1.25 per member per month for 2015, and was raised to $1.80 for 2016. The exchange increased the marketplace administrative fee and the carrier assessment fee in order to meet the increase in volume to ensure sustainability, adequate capital, operation reserves, and system and staffing stability.

Colorado explained that the exchange and Medicaid have a shared system that makes one determination for insurance affordability programs. There are two different online user portals an applicant can access to receive a determination—one portal lies on the state side, and the other is housed on the exchange. Whether an applicant enters through the state side or the exchange, he or she is eventually routed to one shared application, which is technically housed on the state side. Exchange staff worked closely with HCPF and the state's Office of Information Technology in developing system business requirements, testing, training, and back office operations. The exchange is looking to improve its relationship with counties because, in Colorado, the county human services departments handle eligibility determinations for applications not submitted online and online applications that did not receive a real-time eligibility response. The exchange continues to work with HCPF and the counties on coordinated training and a refined referral process to ensure that the customer experience is smooth from application to enrollment.

Colorado explained that the Board complies with federal procurement requirements related to the expenditure of federal grant funds under a comprehensive procurement policy adopted by the Board. The procurement policy further describes thresholds for Board approval of contracts using non-federal funds, including provisions for sole-source procurements, procurement of professional services, required contractual provisions, and recurring low-dollar procurements. These requirements stem from prudent administrative and record-keeping needs but are not specifically required by law or regulation. Colorado's enabling marketplace statute does not anticipate legislative approval of procurements. Board members, officers, and employees of the exchange are not liable for an act or omission when acting in an official capacity, in good faith, without the intent to defraud.

Colorado noted that an advantage of its nonprofit governance structure is that it promotes transparency and public input. It also allows for Board expertise in a variety of subject areas, including individual health insurance coverage, small employer health insurance, health care finance, administration and provision of health care delivery systems, consumer navigation and assistance, health care economics, and information technology. Disadvantages include the limited ability to obtain Board input quickly and the statutory requirements for Board membership that may create inherent conflicts of interests.

Hawaii

Senate Bill 1348, enacted on July 11, 2011, created the Hawaii Health Connector as a private, nonprofit entity. The bill states that the Connector is not "subject to laws or rules regulating rulemaking, public employment, or public procurement."[79] The Connector is audited yearly by

[79] Hawaii S.B. 1348 (2012) §2

the state auditor, who submits the results of the audit to the insurance commissioner.[80] The Connector's Board of directors is then required to submit the results to the legislature as part of an annual report.[81]

The Connector may receive funding through contributions, grants, endowments, fees, or gifts—in cash or otherwise—from public and private sources, which include corporations, businesses, foundations, individuals, and other sources.[82] The Connector can charge user fees or assessments to participating health or dental issuers and can otherwise generate funding to support operations.[83] The statute explicitly states that funds received by the Connector will not be held or administered by the state of Hawaii.[84]

The Board of directors includes 15 members appointed by the governor with consent of the state senate. Board membership reflects geographic and stakeholder diversity, with members representing consumers, employers, insurers, and dental benefit providers.[85] Further, the members shall have expertise in financial, health care, information technology, organizational management, and nonprofit industries.[86] All employees serve at the pleasure of the Board and are not state staff.[87]

Hawaii Interview

The MHBE conducted a telephone interview with Hawaii. Hawaii's exchange was established as a nonprofit entity because the legislature was concerned that it would be difficult to quickly establish an exchange under the state's procurement process. The Connector is funded through issuer fees, federal grants, and a small legislative appropriation. Hawaii has been unable to solicit funding or resources from out of state because of technical problems with the Connector's system during the first year and concerns about the Connector's sustainability due to Hawaii's small uninsured population. While the Connector is not required by law to follow public procurement requirements, the Connector voluntarily adopted Hawaii's sunshine statute and procurement requirements. These requirements include holding public monthly Board meetings and posting procurements online. Contracts over $100,000 require Board approval, and the Connector must inform the Board of contracts under $100,000. There are no specific immunity laws for the Connector.

Regarding the relationship with the state's Medicaid agency, only a state agency in Hawaii can make Medicaid eligibility determinations, so the Medicaid system makes the eligibility determinations and then sends that information to the Connector's system. Originally, the Medicaid eligibility determinations were built into the Connector's system, but due to technical changes, the Medicaid determinations have to be done separately.

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[80] Id. at §2(d).
[81] Id. at §2(e).
[82] Id. at §3.
[83] Id.
[84] Id.
[85] Id. at §4
[86] Hawaii S.B. 1348 (2012) §4.
[87] Id. at §5

A disadvantage of the Connector's nonprofit governance structure is the institutional tension between the Connector as a non-state agency and the other state agencies. There are several differences between the exchange and state agencies that lead to friction. The only extra step the Connector must take because it is a nonprofit is that Medicaid must make the Medicaid eligibility determination; the rest of the Connector's operations are not impacted by its nonprofit status.

Quasi-Governmental

The MHBE also interviewed two states with quasi-governmental governance structures: Connecticut and Washington.

Connecticut

On July 1, 2011, the Governor signed SB921[88] into law, which established the Connecticut Health Insurance Exchange as "a body politic and corporate, constituting a public instrumentality and public subdivision of the state."[89] Under Connecticut law, the exchange should not be construed to be a department, institution, or agency of the state.[90] The powers of the exchange are vested in a Board of Directors. Before June 19, 2013, the Board consisted of 12 voting members and 2 non-voting members;[91] after June 19, 2013, the Board consisted of 11 voting members and 3 non-voting members.[92] The Board members are appointed as follows:

- The Governor appoints two members, one with expertise in individual health insurance coverage and one with expertise in small employer health insurance coverage
- The President Pro Tempore of the Senate appoints one member with expertise in health care finance
- The Speaker of the House of Representatives appoints one member with expertise in health care benefits plan administration
- The Majority Leader of the Senate appoints one member with expertise in health care delivery systems
- The Majority Leader of the House of Representative appoints one member with expertise in health care economics
- The Minority Leader of the Senate appoints one member with expertise in health care access issues for self-employed individuals
- The Minority Leader of the House of Representations appoints one member with expertise regarding barriers to individual health care coverage
- The Commissioner of Social Services, the Secretary of the Office of Policy and Management, and the Healthcare Advocate serve as ex-officio, voting members

[88] Public Act 11-53
[89] Conn. Gen. Stat. §38a-1081(a).
[90] Id.
[91] Conn. Gen. Stat. §38a-1081(b)(1)(A).
[92] Conn. Gen. Stat. §38a-1081(b)(1)(A).

- The Insurance Commissioner, the Commissioner of Public Health, and the Commissioner of Mental Health and Addiction Services serve as ex-officio, nonvoting members

Board members may not be affiliated with an insurer, insurance producer or broker, health care provider, or a health or medical clinic while serving on the Board. These restrictions also apply to exchange employees.[93] Board members may not be health care providers unless the member receives no compensation for giving services as a provider and has no an ownership interest in a professional health care practice. After the governor appoints the initial chief executive office (CEO) of the exchange based on Board recommendations, the Board will appoint subsequent CEOs.[94] The CEO is responsible for administering the exchange's programs and activities in accordance with the policies and objectives established by the Board.[95]

The goal of the exchange is to reduce the number of uninsured individuals, assist individuals and small employers with the purchase of health insurance coverage, and offer easily comparable and understandable information about health insurance options.[96] The Board is authorized to have perpetual successions as a body politic and corporate and to adopt bylaws for the regulation of its affairs and the conduct of its business.[97] The Board may charge assessments or user fees to carriers that are capable of offering a QHP and impose interest and penalties on carriers for delinquent payments of such assessments or fees.[98]

Connecticut Interview

The MHBE conducted a telephone interview with the Connecticut Health Insurance Exchange. Connecticut's exchange is not part of the executive branch. Connecticut chose a quasi-governmental governance structure so the exchange could be established quickly and could have greater flexibility (because it would not be subject to all state procurement requirements and processes). The exchange is subject to some contracting standards, but not all of the contracting processes, and is able to use sole source contracts.

Connecticut's exchange receives no funding from the state; it is funded through assessments on all carriers licensed to sell in the individual, small group, or dental plan markets. The exchange chose to use a market assessment on carriers inside and outside the exchange rather than a user fee so that the assessment would be applied fairly to all carriers and prevent discrimination. The exchange also receives minimal funds for providing assistance to other states and some federal grants. Since the exchange has an integrated Medicaid eligibility system, it receives a cost allocation for Medicaid eligibility determinations from the Department of Social Services, which makes up a large part of the exchange's funding.

For any policies or procedures that affect the public, the exchange must follow notice and public comment procedures. Proposed policies or procedures are announced during a Board meeting and are then available online for public comment for 30 days. If the public comments require

[93] Conn. Gen. Stat. §38a-1081(e)(1)(A).
[94] Conn. Gen. Stat. §38a-1081(d)(1).
[95] Conn. Gen. Stat. §38a-1081(d)(2).
[96] Conn. Gen. Stat. §38a-1083(b).
[97] Conn. Gen. Stat. §38a-1083(c)(1).
[98] Conn. Gen. Stat. §38a-1083(c)(7).

extensive revision, then the policies or procedures will go before the Board and will then be available for public comment for a second time. If the public comments only require minimal changes, then the proposed policy or procedure will be approved by the Board. The exchange is subject to the state's freedom of information law and must follow public meeting requirements. The exchange convenes advisory committees to receive stakeholder input.

The exchange generally does not need Board or legislative approval for contracts and, unlike state agencies, is not subject to attorney general or budget committee review. The exchange must receive Board approval for contracts more than $5,000. It is subject to anti-discrimination requirements and some executive orders. The exchange does not have sovereign immunity and, as a result, purchases liability insurance.

There was friction between the exchange and Medicaid when they were working together to develop the software for the exchange system because of the differing perspectives that come from serving different populations. Medicaid allocates part of its funding to the exchange, and Medicaid funding has become more important since federal grants have ended. While the exchange's enabling legislation allows the acceptance of gifts, this rarely happens.

An advantage of Connecticut's quasi-governmental governance structure is that the exchange can quickly execute contracts. It can be both a disadvantage and an advantage that the exchange does not receive state funding. Connecticut did not feel that its governance structure has any strong advantages or disadvantages compared with other governance structures.

Washington State

The Washington State Health Benefit Exchange Act created the state's exchange as a "self-sustaining public-private partnership that is separate and distinct from the state."[99] The exchange is governed by an 11-member Board. Two members—the Insurance Commissioner and the Administrator of the Health Care Authority—serve as ex-officio in a non-voting capacity. Eight voting members are appointed by the governor, who selects them from lists of nominees created by the two largest caucuses in the House and Senate. The Exchange Act states that the Board must include members who have demonstrated expertise in employee benefits, as a health economist or actuary, in small business, and in health consumer advocacy. A ninth Board member is appointed as the chair and votes only in cases in which there is a tie. Voting members of the Board may not be legislators or employees of the state or its political subdivisions. Individuals whose participation would benefit their own financial interest may not be appointed as members.

The exchange and the Board are only subject to the state's open meetings and public records acts; the Exchange Act explicitly states that it is not subject to other laws or regulations generally applicable to state agencies.[100] The Act also creates a Health Benefit Exchange account, in which all premium taxes, assessments, and any grant funds received must be deposited.[101]

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[99] Wash. Rev. Code §43.71
[100] Id. at §43.71.020(6)
[101] Wash. Rev. Code. at §43.71.060

Washington State Interview

The MHBE conducted a telephone interview with the Executive Director of the Washington Health Benefit Exchange. Washington established a quasi-governmental exchange because the legislature wanted bipartisan support. This decision was motivated by past experience. That is, in 1993, health reform legislation failed in Washington due to a lack of bipartisan support. The legislature also wanted the exchange to be under some governmental control but outside the government so that the exchange would not be affected by elections, state budget problems, and government shut-downs. The exchange is only subject to public meeting and disclosure requirements, so it is more of a private entity than a public one. The legislature only mandates that the exchange consult one committee, the Standing Advisory Committee, but the exchange convenes seven or eight stakeholder groups to receive input from the public.

The legislature required the exchange to submit a report in 2012 that identified possible sources of funding. The legislature then selected three funding sources: a 2 percent premium tax, Medicaid cost allocation, and a carrier supplement. Carriers supported using the 2 percent premium tax because it existed before the exchange and did not require additional payment. The exchange set the carrier supplement for 2016 at $7.40; in 2015, it was $4. The exchange receives Medicaid funds, but because it is not a state agency, it cannot receive money directly from the legislature, so it receives Medicaid funds from the Health Care Authority through a contract. The exchange works closely with the Department of Social and Health Services, which houses the Medicaid eligibility determination system, and the Health Care Authority, which oversees the medical Medicaid program. Medicaid eligibility determinations are integrated into the exchange system. Four months ago, a shopping function for Medicaid plans was added to the exchange system.

The exchange follows general procurement procedures, including a request for proposal process for large contracts, such as the call center and the navigator program. The exchange notifies the Board of potential contracts and will consider the Board's input. However, only the exchange has the authority to approve contracts because the Board members are connected to the community, which could cause conflicts of interest. As a quasi-governmental entity, the exchange can completely outsource the call center and does not need to use state employees, which gives the exchange greater flexibility. The exchange does not have the authority to promulgate rules, but it can make policy decisions. The enabling legislation includes immunity for the Board, though immunity for other aspects of the exchange is uncertain. As a result, the exchange purchased separate liability insurance. The exchange also has the support of the attorney general's office.

Being a quasi-governmental entity gave the exchange greater flexibility in the beginning; it was able to establish itself faster without state restrictions. The exchange was also able to quickly adjust the staffing at the call center to meet demand during and after open enrollment and was not affected by the gubernatorial election or state budget problems. Now that the exchange is established, being outside of the state agencies is a disadvantage because it is difficult for the exchange to be a vendor of the Health Care Authority. Among the four entities working together—the exchange, the Insurance Commission, the Health Care Authority, and the Department of Social and Health Services—there are three different governance structures. Having three structures can be challenging, so the exchange must work carefully with these

agencies to address any challenges. There is currently discussion in Washington regarding whether the exchange should become a state agency.

Impact on Medicaid

A key function of exchanges is to provide a single, streamlined application and eligibility determination process for all insurance affordability programs—Medicaid, CHIP, and advanced premium tax credits and cost-sharing reductions for QHPs. In order to accomplish this, DHMH was required to submit a Medicaid state plan amendment delegating authority for Medicaid eligibility determinations for income-based coverage groups to the MHBE. The state plan amendment, approved by CMS, delegates this eligibility determination process to "an exchange that is a government agency."[102] DHMH retains oversight of the MHBE's Medicaid eligibility determinations and must ensure that the MHBE complies with all federal and state laws, regulations, policies, and guidance covering the Medicaid program. Further, under federal regulation, a Medicaid agency "may delegate authority to make eligibility determinations or to conduct fair hearings under this section only to a government agency which maintains personnel standards on a merit basis."[103]

If the MHBE became a nonprofit entity, then it would no long qualify as a government agency as required under this regulation and by the state plan amendment, and DHMH would not be able to delegate Medicaid eligibility determinations to the MHBE. DHMH would then have to file a new state plan amendment with CMS to withdraw the delegation of Medicaid determinations to the MHBE. Becoming a nonprofit would compromise the MHBE's single, streamlined application process and would adversely impact consumers. Further, it would result in a large financial and administrative burden on both DHMH and the MHBE to redesign the Medicaid eligibility determination system.

Stakeholder Input

The MHBE sought input from its Standing Advisory Committee (SAC) on whether it should remain an independent agency or become a nonprofit entity. The SAC includes members representing carriers, providers, and consumer advocacy organizations. The MHBE provided the SAC with the opportunity to submit verbal comments during the September 8, 2015 meeting, as well as written comments. During the September 8 meeting, the SAC unanimously agreed that the MHBE should remain an independent agency, for several reasons. SAC members commented that, because the MHBE recovered from technical problems during the first open enrollment and is currently functioning well, they do not see a need to change the governance structure. Further, members commented that it would be very expensive and disruptive for the MHBE to become a nonprofit entity. Many members said that being an independent agency makes the MHBE more transparent, especially regarding procurement, and this transparency would be lost if the exchange became a nonprofit. Members expressed concern that if the exchange became a nonprofit, then it could affect the funding the MHBE receives from the state and jeopardize the MHBE's financial stability.

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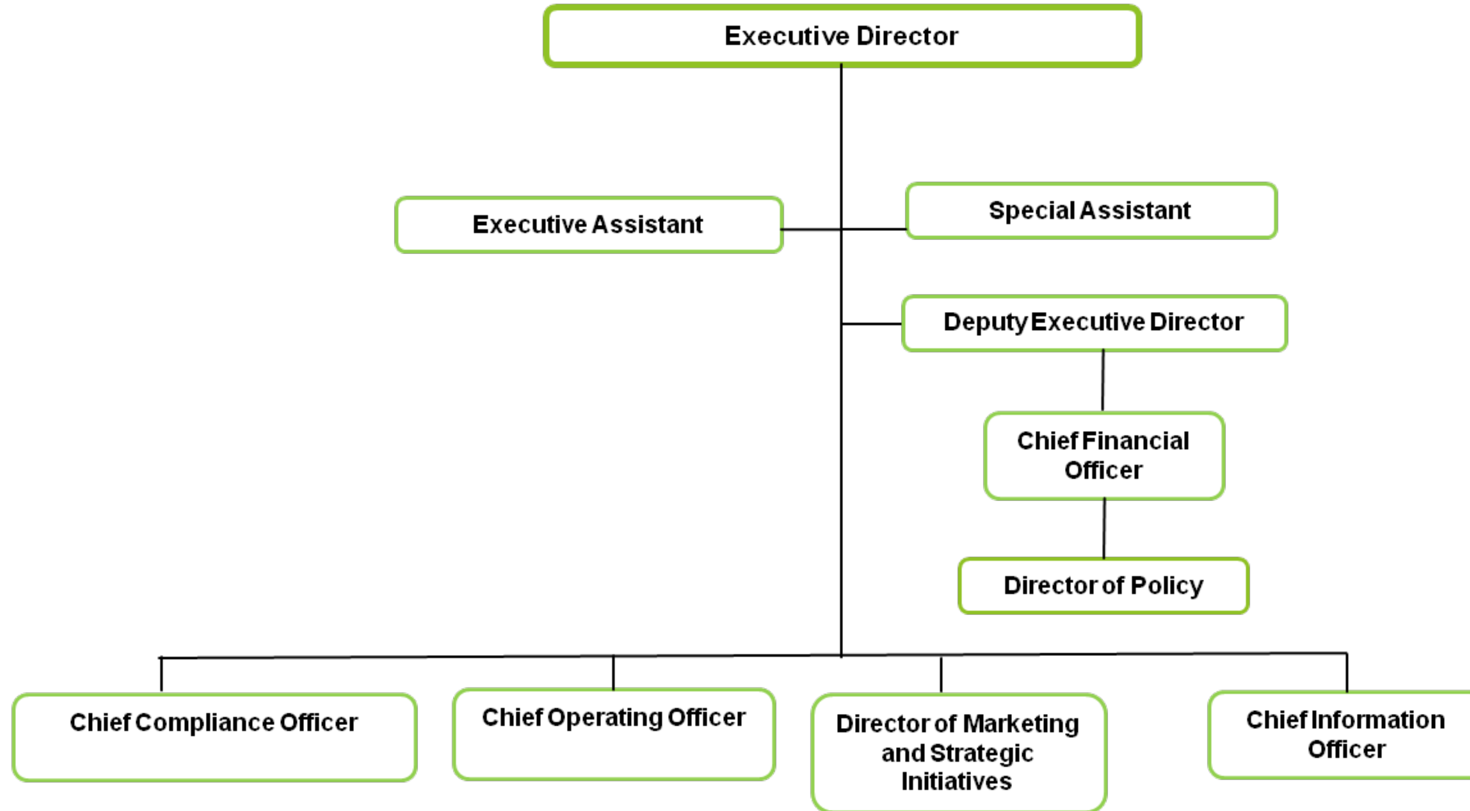
[102] Maryland State Plan Amendment, Transmittal Number 13-0023-MM4 (June 18, 2014).
[103] 42 CFR § 431.10(c)(2).

One SAC member submitted written comments. These written comments reaffirmed the SAC discussion described above, recommending that the MHBE remain an independent agency. See Appendix 2 for the full text of these written comments.

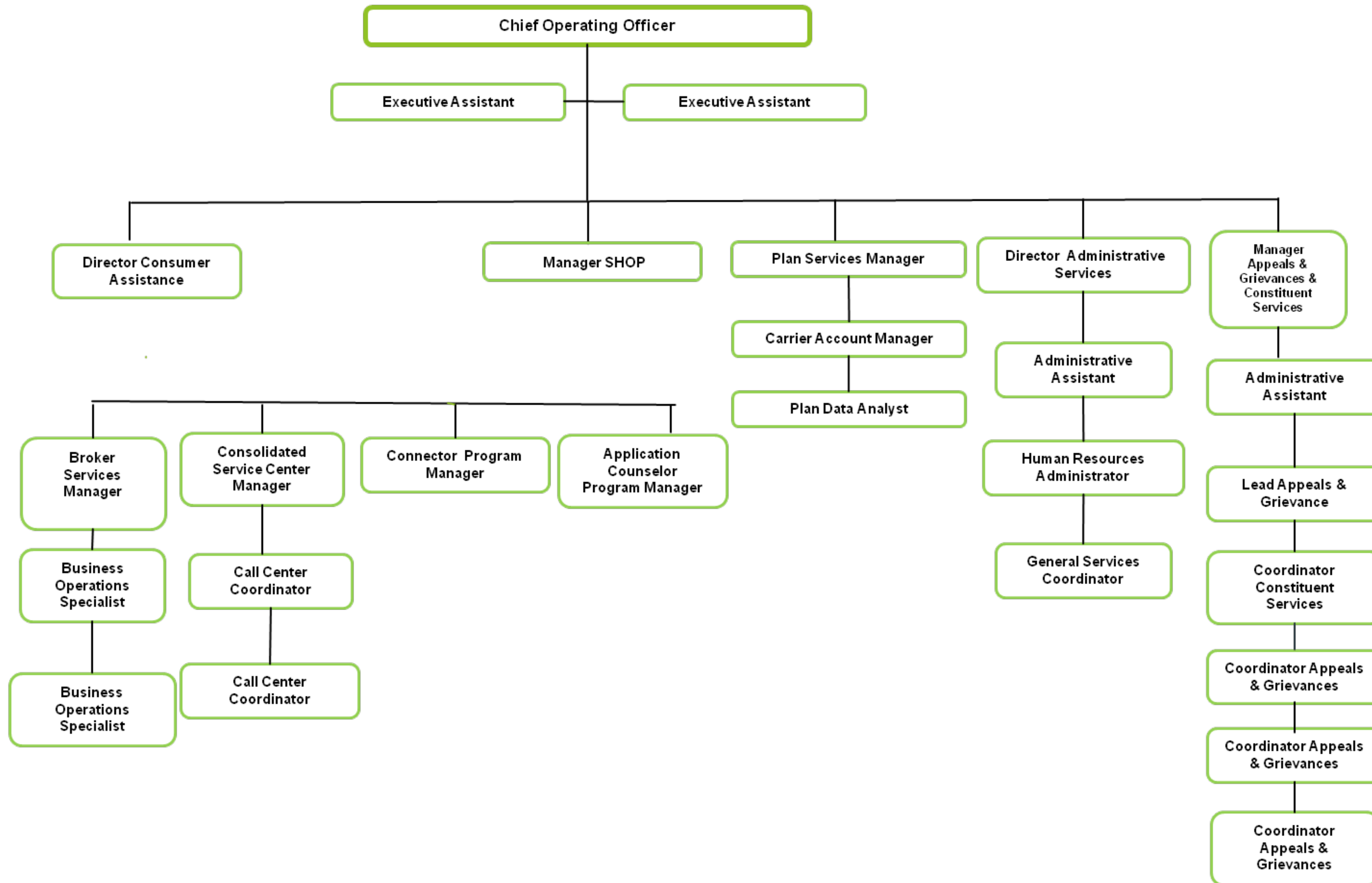
Governance Structure Options and Recommendation

The statute offers the MHBE two options: remain an independent public body or change to a nonprofit entity. Based on the findings presented throughout this report, the MHBE recommends that it remain an independent public body. This option was unanimously preferred by the SAC and is in line with the governance structure of most other state-based exchanges. This option also maintains the integrity of the single, streamlined application and eligibility determination process for Medicaid, CHIP, and QHPs. If the MHBE became a nonprofit entity, then it would no longer qualify as a government agency, as required by CMS, and DHMH would not be able to delegate Medicaid eligibility determinations to the MHBE. This would adversely impact consumers and result in a large financial and administrative burden for both DHMH and the MHBE to redesign the Medicaid eligibility determination system. Further, the MHBE has made considerable effort over the past year to strengthen the oversight, management, and transparency of its procurement process. The MHBE would lose this public transparency if it became a nonprofit entity because it would not be subject to many of the state's procurement and transparency requirements. Finally, if the MHBE became a nonprofit entity, then it would have to change its funding structure.

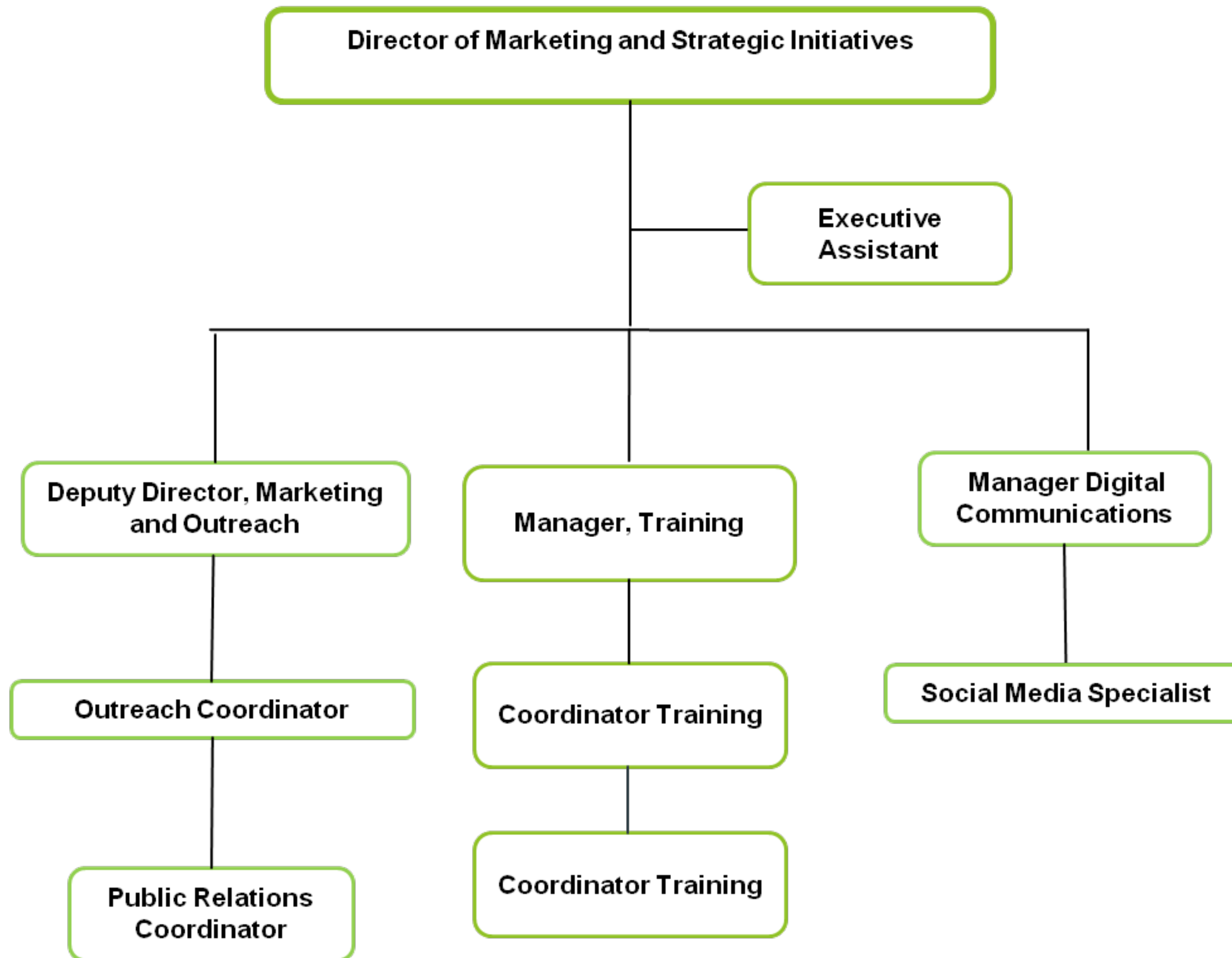
Appendix 1. Organizational Chart



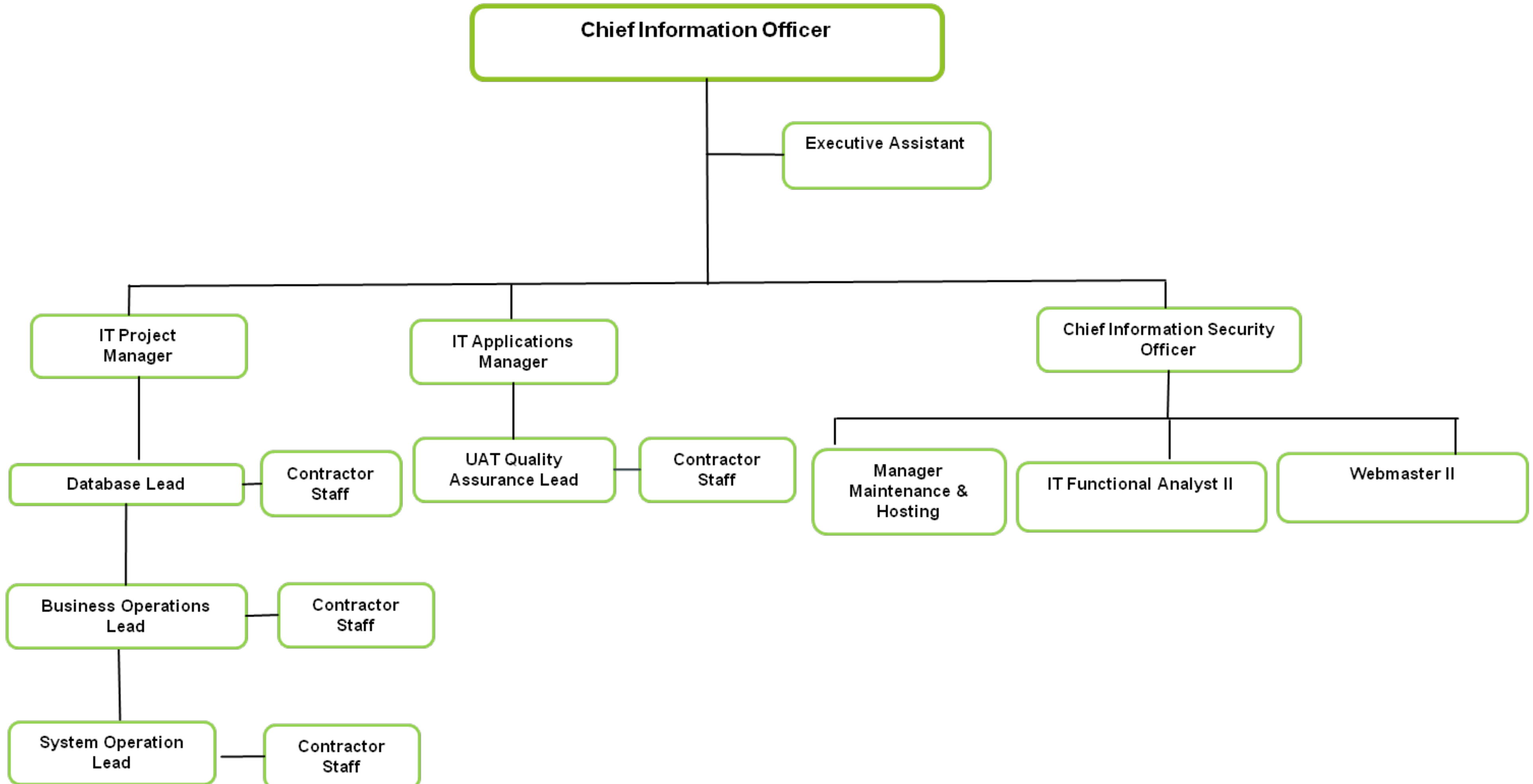
Maryland Health Benefit Exchange Operations



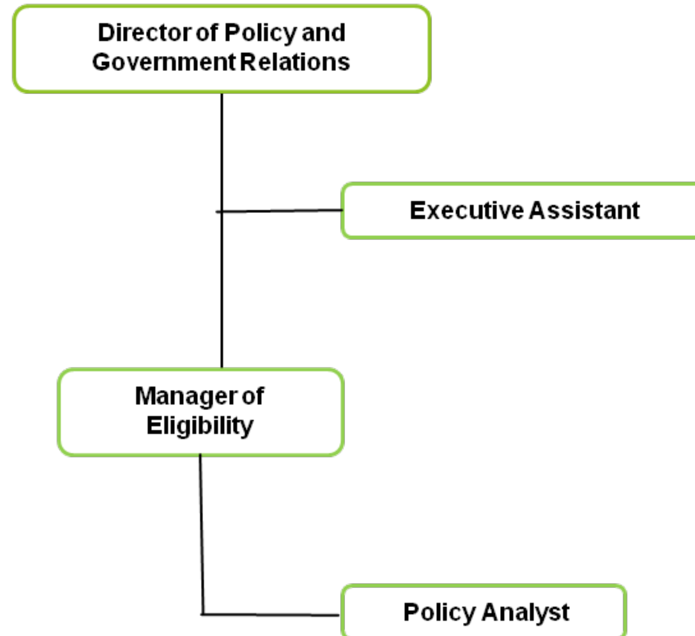
Maryland Health Benefit Exchange
Marketing and Strategic Initiatives



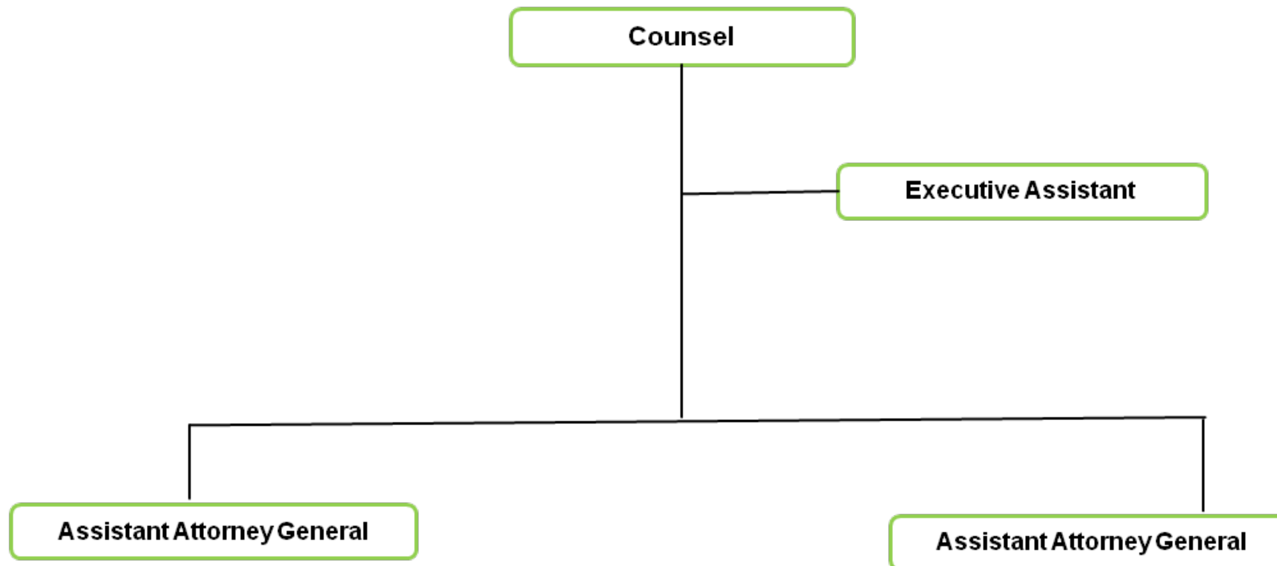
Maryland Health Benefit Exchange
Information Technology



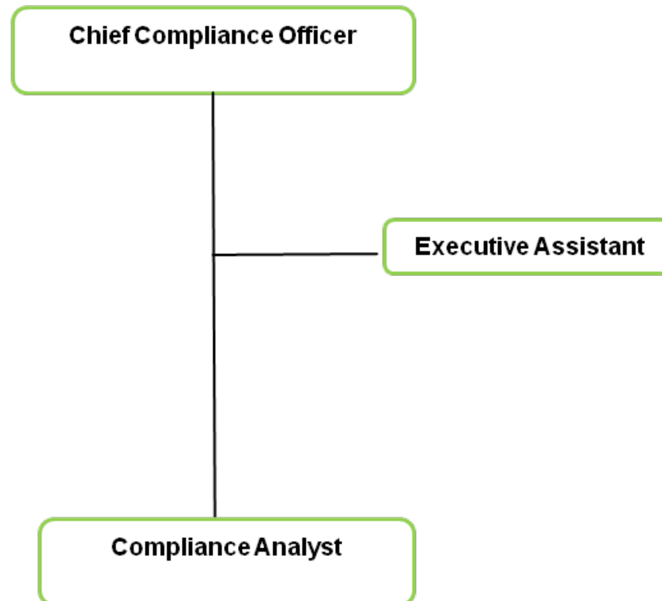
Maryland Health Benefit Exchange
Policy and Government Relations



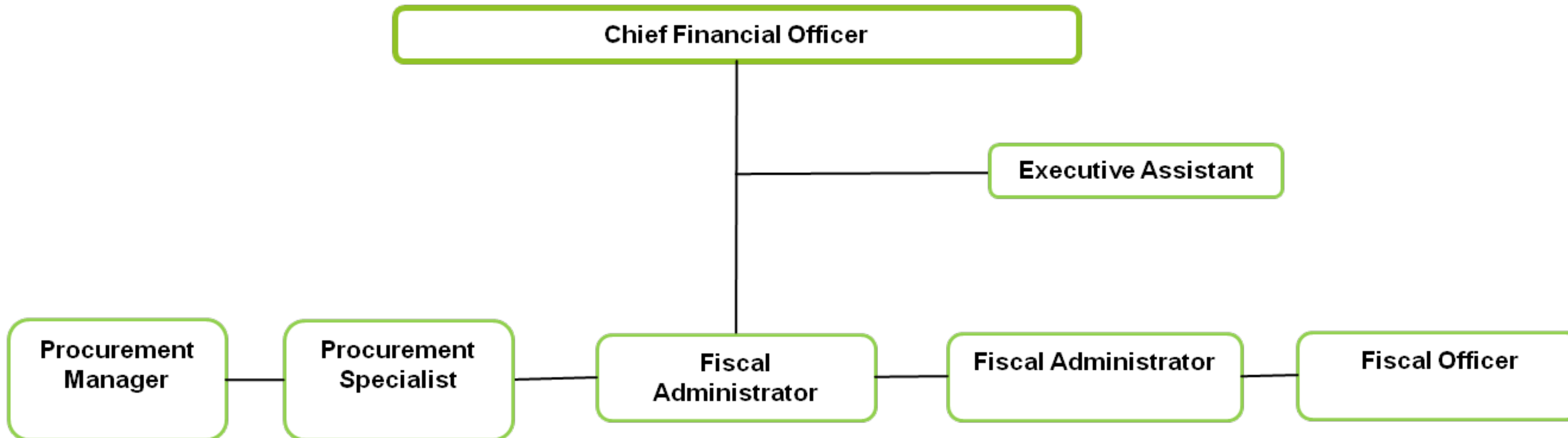
Maryland Health Benefit Exchange
Legal



Maryland Health Benefit Exchange
Compliance



Maryland Health Benefit Exchange
Budget, Finance and Procurement



Appendix 2. SAC Written Comments

The MHBE received the following written comments from committee member Vincent DeMarco of Maryland Citizens' Health Initiative and the Health Care for All! Coalition

October 15, 2015

Comments on Maryland Health Benefit Exchange Governance

On behalf of the Maryland Citizens' Health Initiative and the Health Care for All! Coalition

The Maryland Health Benefit Exchange Act of 2012 requires the Exchange, in consultation with the Standing Advisory Committee, to study and report on whether it should remain an independent public body, or shift to becoming a nonprofit entity.

The Maryland Citizens' Health Initiative, and the Health Care for All Coalition strongly believe that the MHBE should remain an independent public body.

To change the governance structure could potentially disrupt stability that has finally become an ongoing reality. To shift from the current governance arrangement at this point could also stunt the growth of the relatively new Exchange. Remaining with the current governance structure will also provide transparency to consumers as the market expands.

We are thankful for the opportunity to briefly comment on this important issue and are available for further discussions.

Sincerely,

Vincent DeMarco, President, Maryland Citizens' Health Initiative
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