

# ASSESSING THE IMPACT OF HEALTH CARE REFORM IN MARYLAND



DEPARTMENT OF LEGISLATIVE SERVICES JANUARY 2017

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# **Assessing the Impact of Health Care Reform in Maryland**

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**Department of Legislative Services  
Office of Policy Analysis  
Annapolis, Maryland**

**January 9, 2017**

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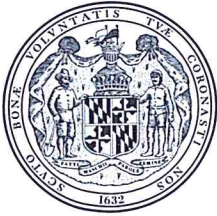
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DEPARTMENT OF LEGISLATIVE SERVICES  
OFFICE OF THE EXECUTIVE DIRECTOR  
MARYLAND GENERAL ASSEMBLY

Warren G. Deschenaux  
Executive Director

January 9, 2017

The Honorable Thomas V. Mike Miller, Jr., President of the Senate  
The Honorable Michael E. Busch, Speaker of the House of Delegates  
Members of the Maryland General Assembly

Ladies and Gentlemen:

The attached report, titled *Assessing the Impact of Health Care Reform in Maryland*, provides preliminary analysis of the impact of the federal Patient Protection and Affordable Care Act (ACA) in Maryland, focusing on coverage, access to care, and cost. The report provides a brief background on the major provisions of the ACA and implementation efforts in Maryland, explores changes in health insurance coverage and the number of uninsured in Maryland, reviews data regarding changes to individuals' access to health care, and details the cost of implementing the ACA and the impact on consumer spending. The report concludes with a discussion of the future of the ACA, including efforts to repeal and replace the ACA and the potential fiscal and health policy impact on Maryland.

The report was prepared by Patrick D. Carlson, Jennifer B. Chasse, Lindsey D. Holthaus, and Linda L. Stahr. Katylee M. Cannon, Kamar Merritt, Maureen R. Merzlak, and Brett A. Ogden provided administrative support. Your questions and comments are welcomed.

Sincerely,

A handwritten signature in blue ink, appearing to read "Warren G. Deschenaux".

Warren G. Deschenaux  
Executive Director

WGD/JBC/km



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## Executive Summary

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In 2010, the federal Patient Protection and Affordable Care Act (ACA) was enacted. Major features of the law include (1) an individual mandate; (2) the establishment of health benefit exchanges; (3) the provision of federal premium and cost-sharing subsidies for individuals and families with incomes between 133% and 400% of federal poverty guidelines (FPG); (4) an employer mandate for employers with more than 50 full-time employees; (5) an allowance for states to expand Medicaid to individuals with incomes up to 138% FPG; and (6) significant changes to private insurance including guaranteed issuance and renewal regardless of preexisting conditions, coverage for children up to age 26 on a parent's policy, limits on premium rate variations, a ban on lifetime limits, and a restriction on annual limits.

Since passage of the ACA, Maryland has brought State health insurance laws into compliance with federal consumer protections, standardized the premium rate review and approval process, established the Maryland Health Benefit Exchange (MHBE), expanded Medicaid, provided for the transfer of individuals formerly covered by the Maryland Health Insurance Plan (MHIP) (Maryland's former high-risk insurance pool) to other coverage, and repealed MHIP.

Based on review of available data and analysis, the Department of Legislative Services finds that, to date, Maryland has observed a significant increase in health care coverage through the expansion of Medicaid (291,000 individuals) and establishment of MHBE (142,872 individuals), and a corresponding decrease in the uninsured rate by more than one-third.

The Medicaid expansion has been the primary driver of coverage gains, while MHBE enrollment has been smaller than anticipated. Only about one-third of individuals eligible to enroll in MHBE did so in 2015. Most individuals enrolled in a qualified health plan offered through MHBE have qualified for a federal advanced premium tax credit (APTC).

Among private-sector employers in Maryland, offer rates for health insurance have remained steady at about 98% for large employers since 2010. However, among small employers, offer rates continued a downward trend that began prior to the ACA. The percentage of employees who enroll in coverage offered has also generally declined, particularly among small employers.

Maryland's uninsured rate declined from 10.1% in 2012 to 6.7% in 2015 and is lower than the national rate (9.4% in 2015). The uninsured rate decreased for all races/ethnicities but remained highest for Hispanic/Latino individuals (23.6% in 2015). The uninsured rate also decreased for all age groups, particularly ages 45 to 54, but remains highest among ages 26 to 34.

Reductions in the uninsured rate were further observed for nearly all income categories except those with incomes greater than 400% FPG, which remained at 2%. The uninsured rate declined the most among individuals with lower incomes. The uninsured rate decreased from 7% to 4% for the native born population, from 12% to 6% for naturalized citizens, and from 45% to 33% for noncitizens.



Data available for Maryland from national sources shows that access to health care has improved with the expansion of access to health insurance coverage. Maryland generally compares favorably with the nation as a whole on measures of access.

The percentage of Marylanders who could not afford to see a doctor in the past 12 months fell from 12.1% in 2010 to 10.1% in 2014. Maryland ranked eighth best among the states on this measure. The percentage of Marylanders who needed but did not get medical care due to cost fell from 7.0% in 2011 to 2.8% in 2014, while the percentage of Marylanders who last visited a doctor for a routine checkup two or more years ago dropped from 10.5% in 2010 to 9.1% in 2014.

In 2014, Maryland ranked thirty-third (with fifty-first being the best) among the 50 states and the District of Columbia on the percentage of adults without a usual place of medical care, with the State's 14.6% comparing favorably with the national rate of 17.3%. Emergency department use remained relatively stable following the expansion of health coverage in 2014.

Implementation of the ACA in Maryland to date has largely been funded with federal dollars, including expansion of Medicaid and establishment of MHBE. However, State expenditures have begun to increase as the federal matching rate for Medicaid declines and MHBE has become self-sufficient. The State's share of the Medicaid expansion in fiscal 2017 is estimated at \$69.6 million. Under the ACA, the State's share will increase to 10% (\$350.2 million) by fiscal 2021. The total general fund appropriation to MHBE from fiscal 2011 to 2017 is \$136.5 million.

As the number of uninsured Marylanders has declined, the State has realized savings in the amount of hospital uncompensated care (UCC). As a percentage of gross patient hospital revenue, UCC declined from 7.65% in fiscal 2009 to 4.69% in fiscal 2015. From fiscal 2013 to 2015, hospital UCC costs declined by 2.55 percentage points, equivalent to approximately \$311 million.

Consumer costs have generally increased within MHBE for the individual exchange. From 2014 to 2017, premiums increased by 55% for individuals aged 21 and 40 purchasing a CareFirst (BlueChoice) Silver Plan. For individuals aged 60 purchasing the same plan, premiums increased by 52%. Costs did not increase to that extent across all insurers participating in MHBE, and in some cases, premiums decreased.

Premiums for employer-sponsored insurance (family coverage) increased by 20% from 2011 to 2016, compared with 31% from 2006 to 2011. The share of employees enrolled in high-deductible health plans with a savings option grew by eight percentage points from 2014 to 2016, moderating the rise in premiums. The percentage of private-sector employees enrolled in a plan with a deductible rose from 51.6% to 83.0%. The average deductible per employee increased by 162.9% for single coverage and 156.4% for family coverage.

For many years, critics of the ACA have sought to repeal it and called for alternatives, contending that the ACA has proven costly and detrimental to the health insurance market and the economy. Common concerns are that the law has increased premiums and deductibles, resulted in narrow provider networks for plans offered on the exchanges, increased taxes to fund implementation, and

imposed costs on employers to comply with the law. Substantial revision or repeal of the ACA is anticipated given the results of the U.S. presidential and congressional elections.

A number of congressional proposals to replace the ACA have been offered, most recently by U.S. House Speaker Paul D. Ryan. The Ryan Proposal would eliminate the individual mandate, replace the current income-based APTCs with a new tax credit for individuals regardless of income, and expand the use of high-deductible “catastrophic” health plans paired with tax-free health savings accounts. President-elect Donald J. Trump has indicated support for these changes but would like to preserve the ban on preexisting condition limitations and the provision that allows young adults to remain on their parents’ policies until age 26.

While details are uncertain, repeal or substantial amendment of the ACA and adoption of alternative reforms could have a tremendous impact on Maryland and will require the General Assembly to consider significant financial and policy decisions.

If enhanced federal funding is repealed, Maryland must decide whether to maintain and how to fund the Medicaid expansion. In the absence of enhanced federal funding, the net cost to Maryland will be \$1.27 billion in fiscal 2018, rising to \$1.50 billion in fiscal 2022. Additionally, loss of an enhanced matching rate for the Maryland Children’s Health Program would increase general fund spending by an estimated \$68.0 million in fiscal 2018, \$72.8 million in fiscal 2019, and \$19.5 million in fiscal 2020.

The State will also need to decide whether to continue MHBE and, if

maintained, how to continue funding MHBE. State law mandates an annual appropriation of at least \$35 million to support MHBE.

Repeal of the ACA could have a profound impact on the Maryland all-payer model contract that governs hospital rate setting. If the ACA is repealed, Maryland could eventually lose the model contract, putting in jeopardy \$2.3 billion in Medicare and Medicaid payments to Maryland hospitals per year. If the model contract continues, the State could have difficulty meeting its obligation to limit annual growth in all-payer hospital per capita revenue and limit Medicare per beneficiary hospital cost growth due to increased UCC.

The State has adopted a number of changes to insurance law to conform with and implement the ACA. Repeal or significant revision of the ACA may require the State to rollback and alter a number of these provisions to harmonize State requirements on carriers. State legislation also repealed a number of provisions of insurance law obsolete under the ACA that may need to be reestablished, such as standards governing medical underwriting by insurers, if allowed under reforms adopted at the federal level.

Given the results of the election, substantial revision or repeal of the ACA is anticipated. The change in leadership in Washington underscores the importance of monitoring legislative and policy initiatives under consideration at the federal level, such as the Ryan Proposal, in light of the potentially significant impact that a change in federal health policy could have on the State.



# Chapter 1. Introduction and Background

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## Overview

As the number of individuals without health insurance rose in the 2000s, policymakers sought methods to expand access to health care and reduce the number of uninsured. Several states, including Maryland, took incremental approaches to expanding coverage, including Medicaid expansions and subsidies for small employers and the working poor. In 2010, the federal Patient Protection and Affordable Care Act (ACA) was enacted as a national effort to address access to coverage. With full implementation now in place for three years, this report provides an analysis of the impact to-date of health care reform efforts in Maryland using available national and State data.

**Chapter 1** of this report provides brief background on the major provisions of the ACA and implementation efforts in Maryland. **Chapter 2** explores changes in health insurance coverage in Maryland since implementation of the ACA, including enrollment in Medicaid and the Maryland Health Benefit Exchange (MHBE), the availability of employer-sponsored insurance, and changes in the number and composition of the uninsured population. **Chapter 3** reviews data regarding changes to individuals' access to health care following the first year of full implementation of the ACA. **Chapter 4** details the cost of implementing the ACA in Maryland, including State spending on health care reform efforts, reductions in hospital uncompensated care in Maryland under the ACA, and the impact on consumer spending. **Chapter 5** discusses the future of the ACA, including efforts to repeal and replace the Act and the potential fiscal and policy consequences on Maryland.

## The Federal Patient Protection and Affordable Care Act

The ACA, enacted on March 23, 2010, aimed to expand health care coverage, control health care costs, and improve the health care delivery system. Major features of the law include:

- ***Individual Mandate:*** Most U.S. citizens and legal residents must have qualifying health coverage or pay a tax penalty. In 2016, the penalty is the greater of \$695.00 per adult plus \$347.50 per child, up to a maximum of \$2,085.00 per family, or 2.5% of family income in excess of the 2015 income tax filing thresholds (\$10,300 for a single person and \$20,600 for a family). In 2017, the penalty will increase according to inflation.
- ***Establishment of Health Benefit Exchanges and Premium and Cost-sharing Subsidies:*** States had the option to establish marketplaces (either State-based or federally facilitated) to enable the purchase of health insurance, with federal premium and cost-sharing subsidies for individuals and families with incomes between 133% and 400% of federal poverty guidelines (FPG).

- ***Employer Mandate:*** Employers with more than 50 full-time employees that do not offer insurance or do not offer insurance that is affordable to their lower income employees must pay a penalty or provide vouchers to lower income employees to purchase coverage through an exchange.
- ***Expansion of Medicaid:*** Individuals younger than age 65 with incomes up to 133% FPG (based on modified adjusted gross income) are eligible for Medicaid with significantly enhanced federal funding.
- ***Small Business Tax Credits:*** Small employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees may qualify for a tax credit of up to 50% of the employer's contribution if the employer contributes at least 50% of the total premium cost.
- ***Changes to Private Insurance:*** A number of changes make it easier to obtain insurance and protect patients including guaranteed issuance and renewal for individual and small employer plans regardless of preexisting conditions, coverage for children up to age 26 on a parent's policy, a ban on lifetime limits, a restriction on annual limits, and coverage of certain preventive services without cost sharing.
- ***Changes to Medicare Prescription Drug Benefits:*** Several provisions make Medicare prescription drug coverage more affordable. Copayments are phased down to 25% by 2020, and the Medicare Part D "donut hole" (a coverage gap where beneficiaries are required to pay the full cost of their medications, even while they continue to pay premiums) is fully phased out by 2020.

## **Implementation Efforts in Maryland**

Since the ACA became law, Maryland has been actively working to implement related reforms. Through executive action and legislation enacted beginning in 2011, Maryland established the Maryland Health Care Reform Coordinating Council and the Governor's Office of Health Care Reform, brought the State's health insurance laws into compliance with new federal consumer protections, and standardized the health insurance premium rate review and approval process. Maryland also established MHBE to develop and operate the Individual Exchange and the Small Business Health Options Program Exchange, established a funding stream for MHBE, expanded Medicaid coverage for low-income individuals, provided for the transfer of Maryland Health Insurance Plan (MHIP) members to other coverage and the dissolution of MHIP, and established a time-limited State Reinsurance Program for 2015 and 2016.

## **Maryland Health Benefit Exchange**

As 1 of 17 states that initially elected to operate a state-based health benefit exchange, Maryland established MHBE to help individuals and small employers and their employees shop for affordable health insurance. Individuals with household incomes between 100% and 400% FPG may be eligible for advanced payments of the federal premium tax credit. Individuals enrolled in a qualified health plan may also be eligible for cost-sharing reductions. Maryland Health Connection, the name of the State's insurance marketplace, went live in October 2013.

## **Expansion of Medicaid**

The ACA expanded Medicaid coverage, but under a 2012 U.S. Supreme Court ruling, the decision to adopt the expansion was left to each individual state. Maryland (along with 31 other states including the District of Columbia) chose to adopt the Medicaid expansion per Chapter 159 of 2013. Effective January 1, 2014, Medicaid eligibility was expanded to adults younger than age 65 with family or household incomes up to 133% FPG and former foster care adolescents up to age 26. ACA altered the definition of modified adjusted gross income to add an additional 5% income disregard, effectively changing the threshold to 138% FPG. Thus, Medicaid was expanded to nearly all individuals younger than age 65 with incomes up to 138% FPG. The Medicaid expansion was 100% federally funded for the first three years (calendar 2014 through 2016). Federal funding declines to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and subsequent years.



## Chapter 2. Health Insurance Coverage

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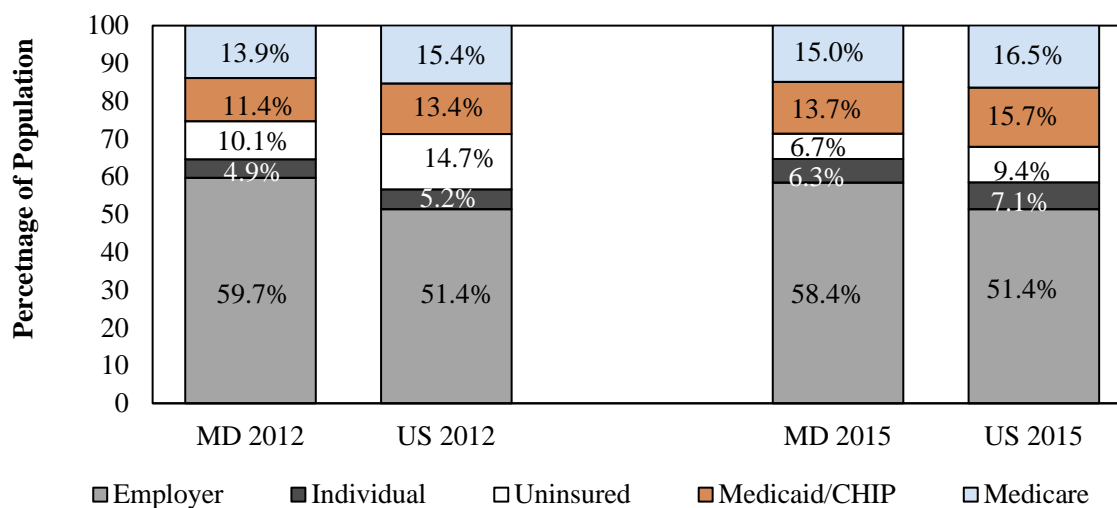
When the federal Patient Protection and Affordable Care Act (ACA) was enacted in 2010, a major goal of the Act was to extend health coverage to 47 million uninsured individuals nationwide, including the more than 700,000 uninsured individuals in Maryland. Now nearly seven years after enactment and three years of full implementation, Maryland has observed a significant increase in health coverage through the expansion of Medicaid, the extension of health insurance coverage through the Maryland Health Benefit Exchange (MHBE), and other reforms. When considering the number of individuals enrolled in Medicaid under the ACA expansion and in qualified health plans offered through MHBE, the number of individuals with ACA-related coverage in 2016 exceeds 400,000. This increase in coverage has contributed to a significant decrease in the uninsured rate in the State.

### Overview of Health Coverage in Maryland

In Maryland, individuals generally obtain health insurance through one of three sources: (1) employer-sponsored coverage; (2) private coverage purchased directly from a health insurance carrier; or (3) public health insurance programs provided by the State or federal government. As shown in **Exhibit 2.1**, based on an analysis of *American Community Survey* (ACS) data by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, Maryland's uninsured rate declined from 10.1% in 2012 (before full implementation of the ACA in 2014), to 6.7% in 2015, a 33.6% decline.



**Exhibit 2.1**  
**Health Insurance Coverage by Type for Maryland and the United States**  
**All Ages**  
**Calendar 2012, 2015**



CHIP: Children's Health Insurance Program

Note: Data in file reflects noninstitutional population. These figures vary slightly from those reported later in the report, which are taken directly from data from the *American Community Survey* as reported by the U.S. Census Bureau. Furthermore, actual Maryland Medicaid enrollment figures were significantly higher than those indicated here, with 16.4% of Marylanders enrolled in Medicaid in fiscal 2012 and 20.8% enrolled in fiscal 2015.

Source: State Health Access Data Assistance Center analysis of the *American Community Survey*

Maryland's comparatively lower uninsured rate is attributable in part to the State having a higher percentage of individuals insured by their employer (in 2015, 58.4% in Maryland compared with 51.4% nationally). A smaller percentage of the State's population has coverage through a private health insurance plan offered to individuals. However, based on SHADAC's analysis of ACS data, this percentage increased from 4.9% in 2012 to 6.3% in 2015, consistent with the national trend.

The most noteworthy change in coverage contributing to the lower uninsured rate in Maryland is the increase in the percentage of individuals covered by Medicaid. ACS data indicates that, in Maryland, the percentage of individuals enrolled in Medicaid increased from 11.5% in 2012 to 13.7% in 2015, a 19.0% increase. The Department of Legislative Services notes that survey estimates significantly undercount Medicaid enrollment compared with actual

administrative counts. Thus, ACS figures are substantially lower than actual enrollment figures. Actual enrollment data indicate that both a higher percentage of Marylanders are enrolled in Medicaid than are reflected in ACS responses, and the percentage of individuals enrolled has grown by a greater amount than indicated in ACS data. More specifically, the percentage of Marylanders enrolled in Medicaid grew from 16.4% in fiscal 2012 to 20.8% in fiscal 2015, a 27.0% increase. This figure is projected to increase to 21.2% in fiscal 2017. The percentage of individuals with Medicaid coverage nationally increased as well (from 13.4% in 2012 to 15.7% in 2015). Maryland also experienced an increase in the percentage of individuals who have Medicare coverage, from 13.9% in 2012 to 15.0% in 2015, consistent with the national increase and indicative of the aging population.

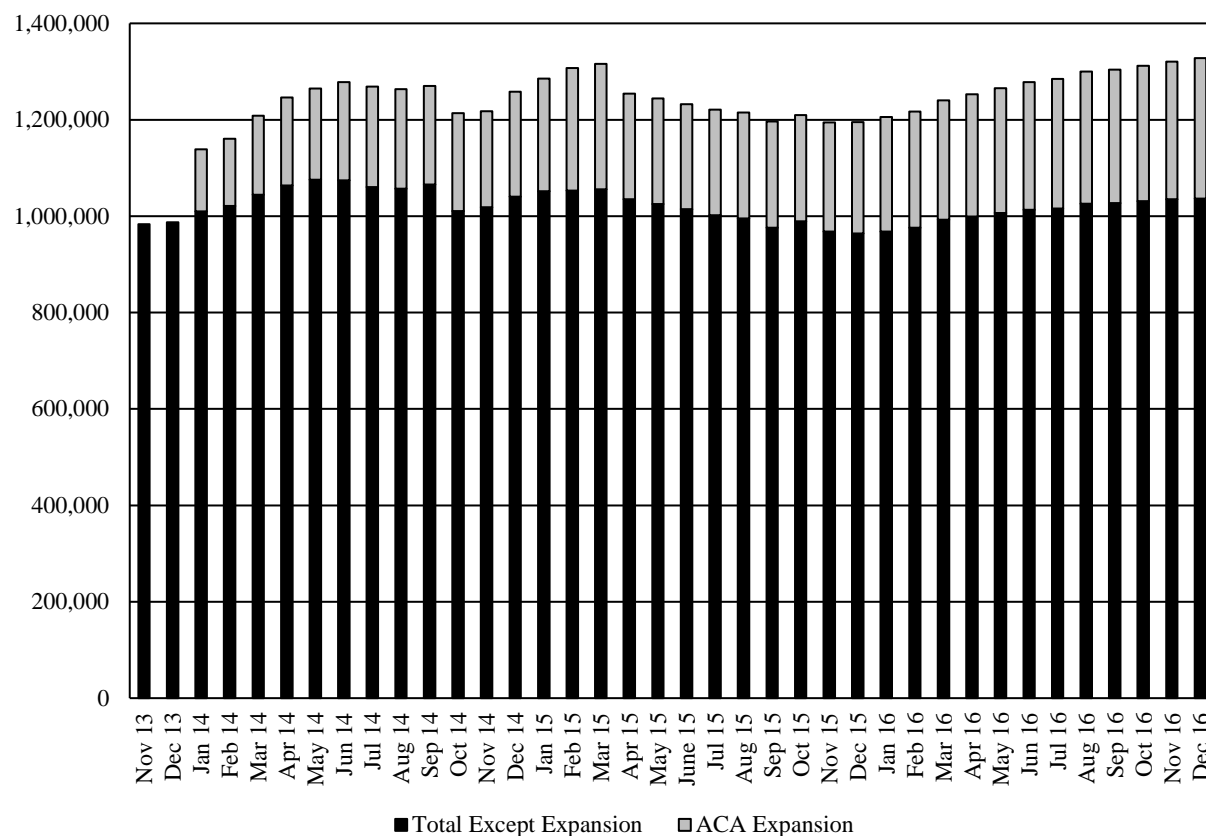
## Enrollment in Medicaid

As noted above, the State has experienced a significant increase in the number of individuals enrolled in Medicaid since the expansion of coverage under the ACA. Beginning January 1, 2014, Medicaid eligibility was expanded to include adults younger than age 65 with family or household incomes up to 133% of federal poverty guidelines (FPG) based on modified adjusted gross income (effectively, 138% FPG) and former foster care adolescents up to age 26.

**Exhibit 2.2** shows the number of individuals enrolled in Medicaid and the Maryland Children's Health Program (MCHP) by month from November 2013 to December 2016 and includes enrollment for the ACA expansion population and the population that has coverage under other traditional Medicaid eligibility categories (*e.g.*, children, pregnant women, elderly or disabled individuals, and low-income parents). Overall enrollment in Medicaid has grown to more than 1.3 million as of December 2016, which includes 291,000 individuals who have coverage under the ACA expansion. This enrollment figure exceeds an estimate made by the Hilltop Institute in 2014 that approximately 120,000 individuals in the State would enroll in Medicaid under the ACA expansion by 2016.

Medicaid enrollment reached 1.32 million in March 2015, with more than 260,000 individuals covered under the ACA expansion, but then dropped beginning in April 2015 when enrollees eligible for coverage based on income were required to reenroll in the new MHBE eligibility and enrollment system at their annual eligibility redetermination. The transition from a primarily paper-based process to a web-based, phone-assisted process resulted in a drop in total Medicaid enrollment that continued for much of 2015, reaching a low point of 1.2 million in November 2015. However, enrollment stabilized in December 2015 and has grown steadily to reach 1.33 million in December 2016. ACA expansion enrollment also declined sharply from 260,000 in March 2015 to a low of 219,000 in April 2015 with the commencement of the new eligibility redetermination process but has since rebounded to 291,000 in December 2016, a new peak enrollment level for the expansion population.

**Exhibit 2.2**  
**Average Monthly Enrollment in Medicaid and the**  
**Maryland Children's Health Program**  
**November 2013 – December 2016**



ACA: Federal Patient Protection and Affordable Care Act

Source: Department of Legislative Services

The enrollment of 291,000 individuals under the Medicaid ACA expansion has been the main source of coverage and primary driver of reducing the number of uninsured in Maryland. This impact is consistent with the experience of other states that elected to expand their Medicaid programs under the ACA. According to the U.S. Census Bureau in 2015, states that expanded Medicaid had lower uninsured rates among nonelderly adults than other states. In expansion states, the uninsured rate decreased from 12.8% in 2013 to 7.2% in 2015. In nonexpansion states, the uninsured rate decreased from 16.9% in 2013 to 12.3% in 2015. As noted above, based on SHADAC's analysis, Maryland's uninsured rate decreased from 10.1% in 2013 to 6.7% in 2015.

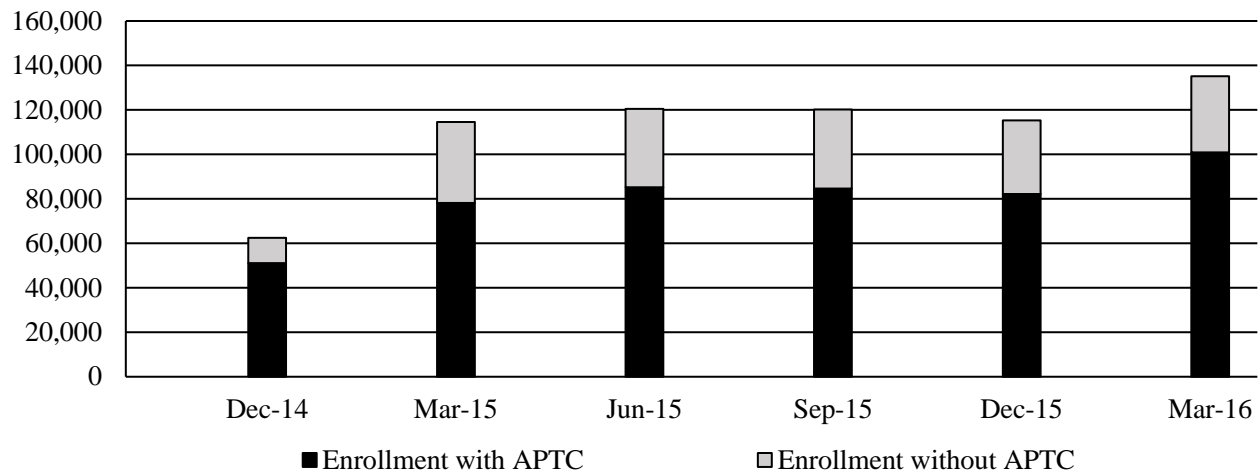
## **Enrollment in the Maryland Health Benefit Exchange**

The ACA aimed to extend health insurance coverage by establishing health insurance marketplaces through which consumers can compare qualified health plans (QHP) offered by private health insurance carriers and, for those eligible, obtain advanced premium tax credits (APTC) and cost-sharing subsidies to reduce the cost of coverage. MHBE's Maryland Health Connection (MHC) provides health insurance coverage through the Individual Exchange and the Small Business Health Options Program (SHOP) Exchange. After experiencing difficulty in enrolling individuals during its first open enrollment period, MHC has since observed a modest increase in the number of individuals enrolled in QHPs. As of September 2016, 142,872 individuals were enrolled in a QHP offered through MHC. SHOP has also experienced modest enrollment since its launch in April 2014. As of June 2016, the most recent data available, 119 groups had enrolled through the SHOP, covering about 1,000 individuals.

### **Individual Exchange Enrollment**

At the launch of MHC in October 2013, problems with the information technology (IT) system prevented consumers from creating accounts and enrolling in coverage, resulting in low enrollment during the open enrollment period (October 2013 through March 2014). QHP enrollment improved in 2015 after MHBE's decision to replace its original IT platform and use a platform from Connecticut. As shown in **Exhibit 2.3**, QHP enrollment increased significantly during the second open enrollment period (November 2014 through February 2015), with 114,559 individuals enrolled in coverage in March 2015. Enrollment then experienced modest growth during the third open enrollment period (November 2015 through January 2016), with 115,297 individuals enrolled in December 2015 and 135,208 individuals enrolled in March 2016.

**Exhibit 2.3**  
**Qualified Health Plan Enrollment**  
**December 2014 – March 2016**



APTC: advanced premium tax credit

Note: Enrollment figures reflect individuals who have paid their premiums and have an active policy as of the specified date. Active policyholders include those who have paid for the current month and individuals who may be in a grace period for nonpayment.

Source: Centers for Medicare and Medicaid Services

Most QHP enrollees have qualified for an APTC, with the largest proportion of enrollees receiving an APTC in December 2014 (82%), and the lowest proportion receiving an APTC in March 2015 (68%). More than 70% of QHP enrollees received an APTC in June 2015 and in the reporting periods that followed, with 75% of enrollees receiving an APTC in March 2016. Internal Revenue Service data for tax year 2014 (the most recent data available) indicate that the APTC was claimed on a total of 26,230 Maryland tax returns. In total, these credits were valued at \$63.9 million.

While enrollment in QHPs through MHBE has grown, a Kaiser Family Foundation (KFF) analysis of marketplace enrollment data and the estimated number of potential QHP enrollees suggests that there are a significant number of individuals who are eligible to enroll in a QHP, but who remain uninsured. KFF's estimate includes all individuals eligible for tax credits, as well as other legally residing individuals who are uninsured or purchase non-group coverage, have incomes above Medicaid/MCHP eligibility levels, and who do not have access to employer-sponsored coverage. According to KFF, approximately 394,000 Marylanders were eligible to enroll in a QHP in 2015.

As shown in **Exhibit 2.4**, the State's QHP enrollment of 135,208 in March 2016 represents just one-third (34%) of the estimated number of potential enrollees. Based on the percentage of potential enrollees actually enrolled, Maryland ranked eleventh among the 17 states with state-based or federally supported state-based marketplaces. The federally facilitated marketplaces had a total enrollment of just under 8.0 million (42% of the estimated potential enrollment in those states). Overall, a total of 11.1 million individuals were enrolled in marketplace plans nationwide, constituting 40% of an estimated 27.4 million potential marketplace enrollees.

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**Exhibit 2.4**  
**Marketplace Enrollment as a Share of Potential Marketplace Enrollment**  
**March 2016**

	<u>Total Enrollment</u>	<u>Estimated Number of Potential Enrollees</u>	<u>% of Potential Enrollees Enrolled</u>
<b>State-based Marketplaces</b>			
Massachusetts	207,121	353,000	59%
District of Columbia	17,666	31,000	58%
Idaho	94,270	187,000	51%
California	1,415,428	2,986,000	47%
Oregon	131,167	284,000	46%
Vermont	27,883	60,000	46%
Rhode Island	35,583	86,000	41%
Nevada	79,876	225,000	36%
New Mexico	47,497	133,000	36%
Connecticut	102,917	292,000	35%
<b>Maryland</b>	<b>135,208</b>	<b>394,000</b>	<b>34%</b>
Kentucky	74,640	248,000	30%
Washington	158,245	580,000	27%
Hawaii	13,313	52,000	26%
Colorado	108,311	486,000	22%
Minnesota	74,060	330,000	22%
New York	224,014	1,036,000	22%
<b>Federally Facilitated Marketplaces</b>	<b>7,970,718</b>	<b>19,154,000</b>	<b>42%</b>
<b>United States</b>	<b>11,081,330</b>	<b>27,438,000</b>	<b>40%</b>

Source: Kaiser Family Foundation

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The KFF analysis suggests that Maryland may be underperforming in enrolling individuals in QHPs when compared with some states with state-based marketplaces, such as Massachusetts and California, and the federally facilitated marketplaces overall. While the underperformance may indicate a need for improved outreach and enrollment efforts by MHBE, other factors may be contributing to the lower rate of enrollment in QHPs. A February 2015 KFF analysis estimating the number of individuals eligible for financial assistance indicated that 225,000 (49%) of the potential marketplace enrollees in Maryland were eligible for APTCs. Massachusetts and California, two states that have enrolled a larger share of potential enrollees in marketplace plans, were estimated to have a larger percentage of potential enrollees eligible for APTCs, at 57% and 58%, respectively. Nationally, an estimated 62% of potential marketplace enrollees were eligible for APTCs. Maryland's lower enrollment rate may, therefore, be attributable to the State having a lower percentage of potential enrollees eligible for APTCs.

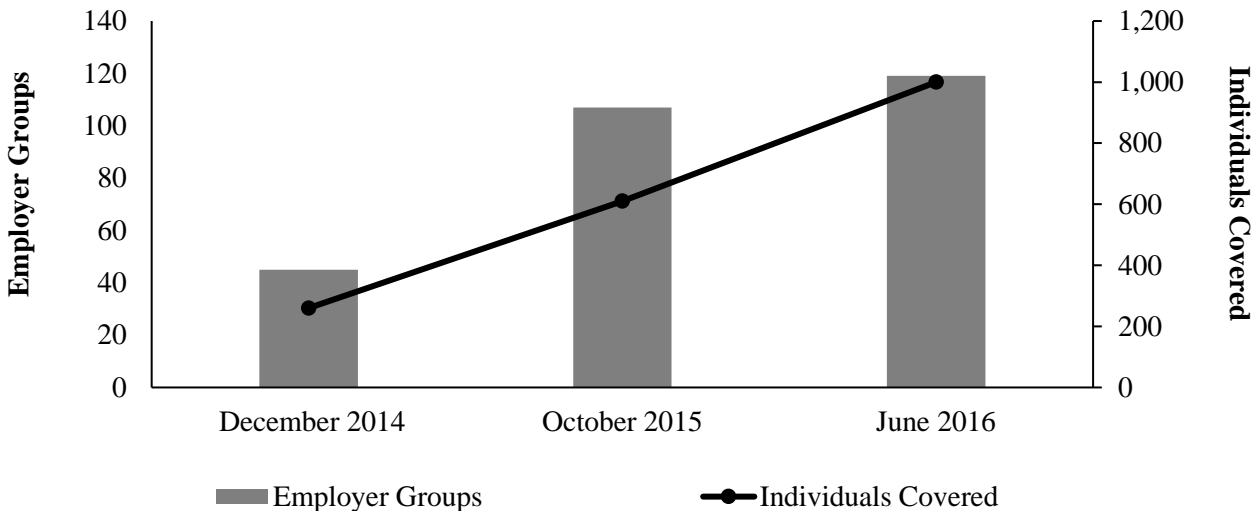
### **Small Business Health Options Exchange Enrollment**

Maryland is among 17 states that elected to operate their own SHOP exchange through which small businesses with 50 or fewer employees may enroll in QHPs. Small businesses that employ 25 or fewer employees and have an average annual salary of \$50,000 or less qualify for a federal tax credit to offset the cost of purchasing coverage. Enrollment in QHPs offered on the SHOP exchange has been low for the first three years of operation, a trend observed in other states.

MHBE launched SHOP in April 2014, allowing small businesses to enroll through a paper-based process. Beginning in January 2015, MHBE partnered with three selected third-party administrators (TPAs) to allow employers and employees to access their enrollment application and account information through a website. In August 2015, the functionality of SHOP expanded further with the introduction of an employee choice option for plan selection. An employer has two options for plan selection. Under the employer choice option, the employer picks one insurance company and employees can choose any plan offered by that insurer. Under the employee choice option, the employer picks the metal level that will be open to employees, and employees can then choose a plan at that metal level from any insurer that will be open to employees. In July 2016, MHBE selected Benefit Mall to serve as the sole administrator of SHOP, a decision that establishes just one online portal for SHOP enrollment instead of the three separate portals that had been maintained by the three TPAs. In 2017, 11 carriers will offer QHPs through SHOP.

The Hilltop Institute at the University of Maryland, Baltimore County had projected that more than 8,000 employees of small businesses would enroll in QHPs through SHOP in its first year. However, as shown in **Exhibit 2.5**, only 45 employers enrolled in 2014 covering about 260 individuals. Enrollment grew modestly in the subsequent years of operation, with 107 employers enrolled in 2015 covering about 610 individuals, and 119 employers enrolled in 2016 covering about 1,000 individuals. Eighty-three percent of the groups enrolled in June 2016 had fewer than 10 employees and 12% had fewer than 20 employees.

**Exhibit 2.5**  
**Enrollment in the Small Business Health Options Program**  
**December 2014, October 2015, and June 2016**



Source: Maryland Health Benefit Exchange

Low enrollment in SHOP is not unique to Maryland. The federal Centers for Medicare and Medicaid Services reported in May 2015 that about 11,000 employers were enrolled in SHOP plans nationwide, covering about 85,000 individuals – substantially less than the 1 million individuals estimated to enroll through SHOP in 2015 by the Congressional Budget Office. Nationally, SHOP enrollment amounts to less than 1% of the small group insurance market. The reason for low enrollment in Maryland’s SHOP exchange remains unclear. However, one potential factor is that the federal tax credit is claimed with less frequency in high-cost areas of the country where salaries are higher, such as in Maryland. If access to the federal tax credit is a main advantage for purchasing coverage through SHOP and a sizeable number of small firms in Maryland do not qualify for the federal tax credit, small employers may be electing to purchase coverage elsewhere.

### **Enrollment in Private Health Insurance**

Maryland has historically had greater employer-sponsored health care coverage for individuals. Nearly 60% of Marylanders receive health insurance through an employer compared with about 50% of individuals nationally. In addition to an individual mandate to purchase insurance, the ACA included an employer mandate to encourage employers to continue providing



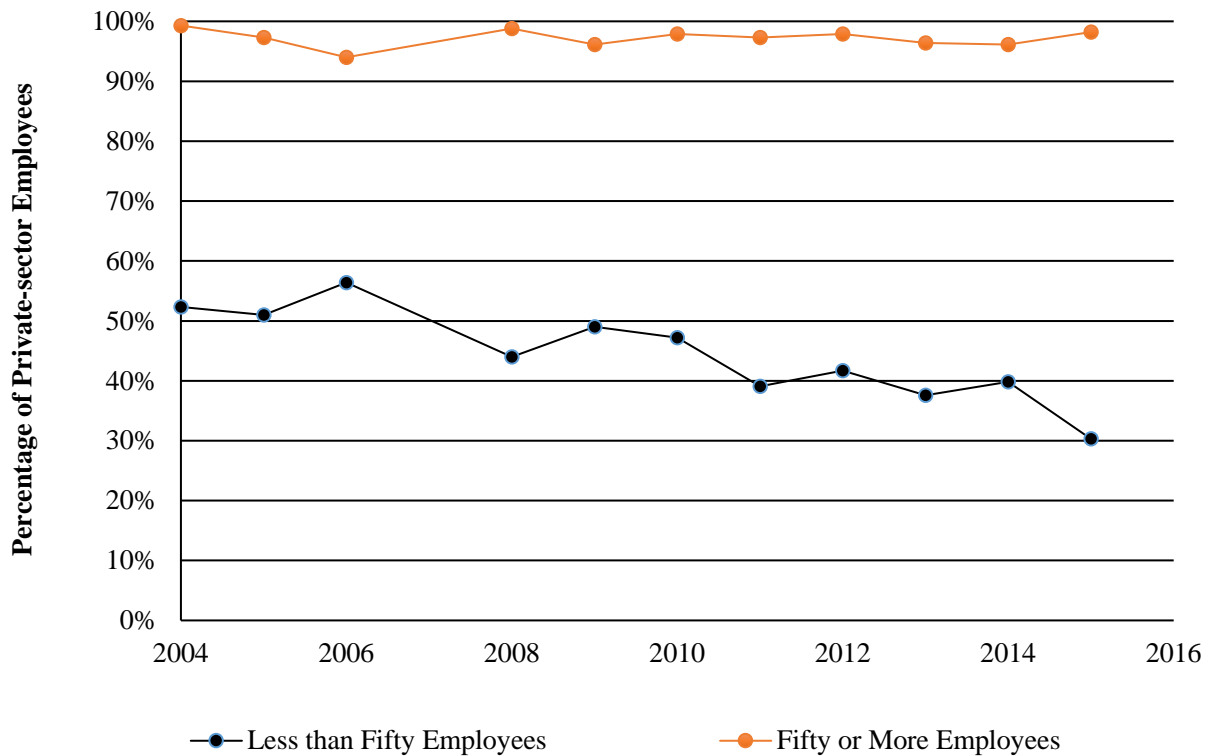
insurance once the exchanges began operating. The mandate requires employers with 50 or more full-time employees or part-time equivalents to provide health insurance coverage or face a penalty. However, if small employers choose to provide coverage, they must offer plans that meet ACA specifications for the small group market (including coverage of essential health benefits) and they must satisfy the ACA's general requirements to be affordable and provide at least minimum value to employees. If an individual does not have access to employer-sponsored insurance, a policy can be purchased in the individual market.

### **Health Insurance Offer Rates by Employers**

**Exhibit 2.6** shows health insurance offer rates (the percentage of private-sector employers offering health insurance benefits to their workers) in Maryland by firm size from calendar 2004 to 2015. Among larger employers (50 or more employees), health insurance offer rates have held steady at around 98.0%. The rate is highest for employers with 1,000 or more employees (100.0%). However, health coverage offers among smaller employers (fewer than 50 employees) have continued to decline. From 2010 to 2015, offer rates for small employers fell from 47.2% to 30.3%. This downward trend began prior to enactment of the ACA in 2010, including the employer mandate, which became effective in 2015. However, there was a large drop from 2014 to 2015, where the percentage of private-sector small employers offering health care coverage fell 24.0% from 39.8% to 30.3%. Employers with fewer than 10 employees had the lowest offer rates in 2015, at 21.8%. Employers with between 10 and 24 employees had an offer rate of 57.2%.

One potential factor contributing to the downward trend in offer rates for small employers is the APTC. Smaller employers may find that employees eligible for the APTC with incomes between 133% and 400% FPG can get subsidized coverage through MHBE that will be as, if not more attractive, than coverage provided by the employer. Employers can provide tax-excluded health coverage to attract employees, where the same money spent on salaries would be taxable, but for employees earning less than 400% FPG, it may be beneficial for the employer to have employees purchase a subsidized plan through MHBE. Additionally, small businesses often pay more for employee health benefits because they lack the buying power of large employers.

**Exhibit 2.6**  
**Percentage of Private-sector Employers in Maryland**  
**Offering Health Care Coverage by Firm Size**  
**Calendar 2004-2016 (Est.)**

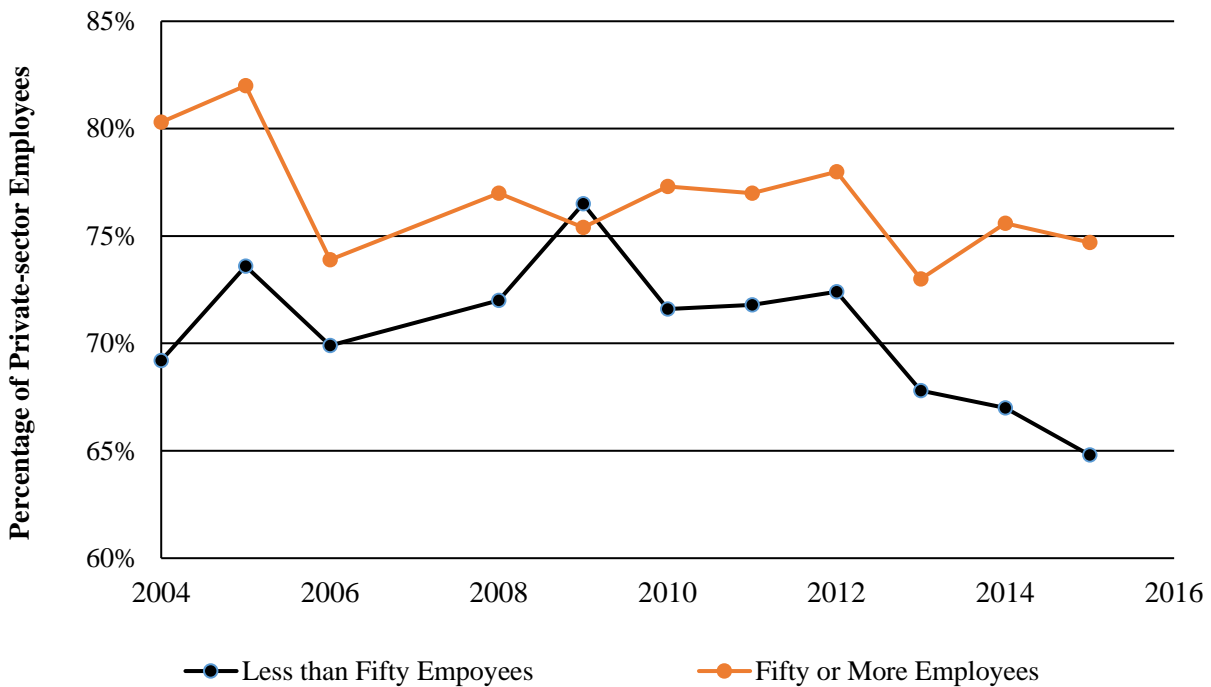


Source: *Medical Expenditure Panel Survey – Insurance Component*, Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends

## Health Care Coverage Take-up Rates by Employees

**Exhibit 2.7** shows employee take-up of health care coverage (the percentage of employees who enroll in coverage offered) by firm size in Maryland. With the exception of 2009, take-up rates at smaller employers (50 or fewer employees) has been lower than at larger employers (50 or more employees). From the enactment of the ACA in 2010 until 2012, take-up of health insurance by employees increased slightly for all sized firms. Since 2012, employee take-up of health insurance in smaller employers has decreased from 72.4% to 64.8% in 2015, and take-up in larger employers decreased from 78.0% to 74.0%. As noted above, the availability of the APTC may contribute to the decline in take-up rates among employees at smaller employers.

**Exhibit 2.7**  
**Percentage of Private-sector Employees**  
**Enrolled in Health Care Coverage in Maryland by Firm Size**  
**Calendar 2004-2015**

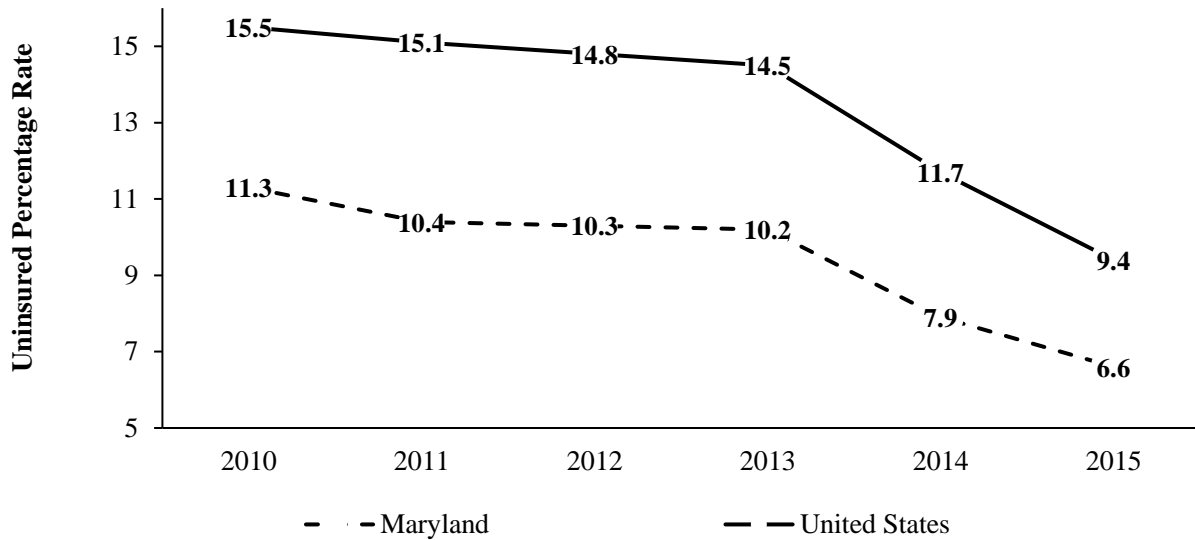


Source: *Medical Expenditure Panel Survey – Insurance Component*, Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends

## The Uninsured

Maryland has experienced a significant decrease in the number of uninsured residents since 2010, when the first ACA reforms went into effect. As shown in **Exhibit 2.8**, the uninsured rate in the State has dropped from 11.3% (641,000) in 2010 to 6.6% (389,000) in 2015 based on data reported by the U.S. Census Bureau. The most significant drop occurred in 2014 and 2015, the first two years of full ACA implementation, including MHBE and the Medicaid expansion. The uninsured rate in Maryland dropped from 10.2% (593,000) in 2013 to 6.6% (389,000) in 2015. Nationwide, the uninsured rate fell from 15.5% in 2010 to 9.4% in 2015. As in Maryland, the United States experienced the most significant drop in its uninsured rate in 2014 and 2015, with a drop of 5.1 percentage points during that time period.

**Exhibit 2.8**  
**Uninsured Rate: United States and Maryland**  
**Calendar 2010-2015 (All Ages)**

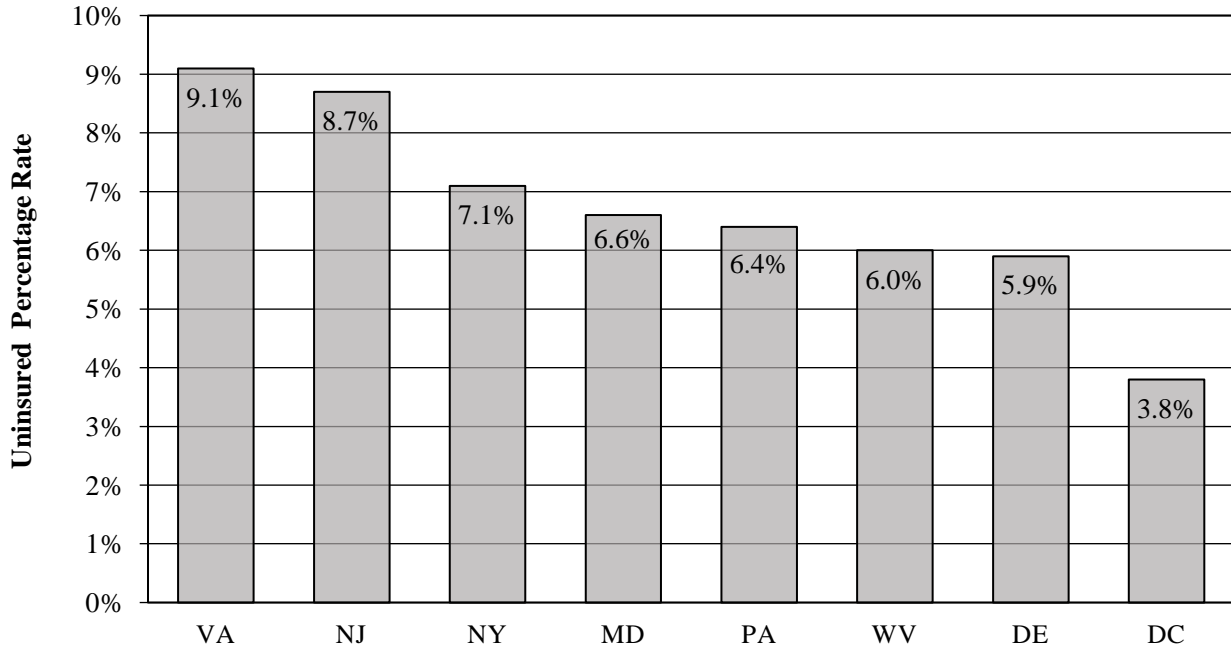


Source: U.S. Census Bureau (*American Community Survey*)

Maryland's uninsured rate of 6.6% in 2015, as reported by the U.S. Census Bureau, is somewhat lower than the average uninsured rate of 7.2% for states that expanded Medicaid eligibility and substantially lower than the average uninsured rate of 12.3% for states that did not expand Medicaid eligibility. The State's 3.6 percentage point drop in its uninsured rate from 2013 to 2015 represents a 35.0% reduction in the number of uninsured, less than the overall 44.0% reduction in the uninsured rate observed in states that expanded Medicaid, but larger than the 27.0% reduction in the uninsured rate observed in states that did not expand Medicaid.

Maryland's uninsured rate of 6.6% ranks near the middle among states in the mid-Atlantic region. As shown in **Exhibit 2.9**, the State's uninsured rate for 2015 is similar to Pennsylvania (6.4%), higher than the District of Columbia (3.8%), and lower than Virginia (9.1%), a state that has not expanded Medicaid eligibility under the ACA.

**Exhibit 2.9**  
**Uninsured Rate: Mid-Atlantic States**  
**Calendar 2015 (All Ages)**



Source: U.S. Census Bureau (*American Community Survey*)

The uninsured rate in Maryland varies by geographic area, from a low of 1.8% in parts of Harford County (North and West) – Bel Air Town, Fallston, and Jarrettsville, to a high of 22.8% in parts of Prince George’s County (Northwest) – College Park and Langley Park. This high rate is likely attributable to the large Hispanic population and the number of noncitizens, particularly in Langley Park. As discussed later in this chapter, these populations are both more likely to be uninsured. According to the U.S. Census Bureau, in Langley Park, 76.6% of the population are Hispanic, 58.5% are noncitizens, and 53.8% are uninsured. In College Park, only 7.9% of residents are uninsured.

**Exhibit 2.10**  
**Uninsured Rate in Maryland by Public Use Microdata Area**  
**Calendar 2015 (All Ages)**



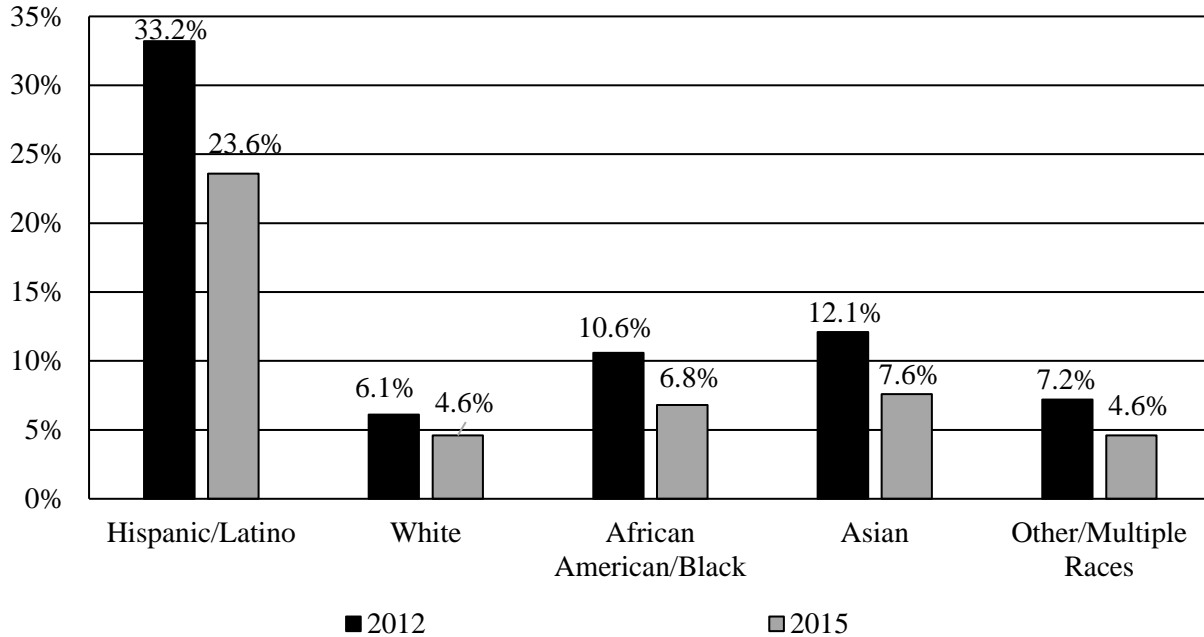
Note: A Public Use Microdata Area (PUMA) is a geographic unit used by the U.S. Census Bureau. Each PUMA contains at least 100,000 people. PUMAs do not overlap. There are 2,378 PUMAs in Maryland based on the 2010 census.

Source: U.S. Census Bureau (*American Community Survey*)

### Uninsured Rates by Race and Ethnicity

According to U.S. Census data, the uninsured rate decreased for all races/ethnicities between calendar 2012 and 2015, as shown in **Exhibit 2.11**. The rate declined by more than one-third for individuals who identified as African American/Black, Asian, and Other/Multiple Races. However, while the uninsured rate was reduced by 29.0% for Hispanic/Latino individuals, almost one-quarter (23.6%) of this population remained uninsured in 2015. Under current law, noncitizens and certain categories of legal immigrants are ineligible for coverage under Medicaid or to purchase a QHP through MHBE, which likely contributes to higher uninsured rates for the Hispanic/Latino population.

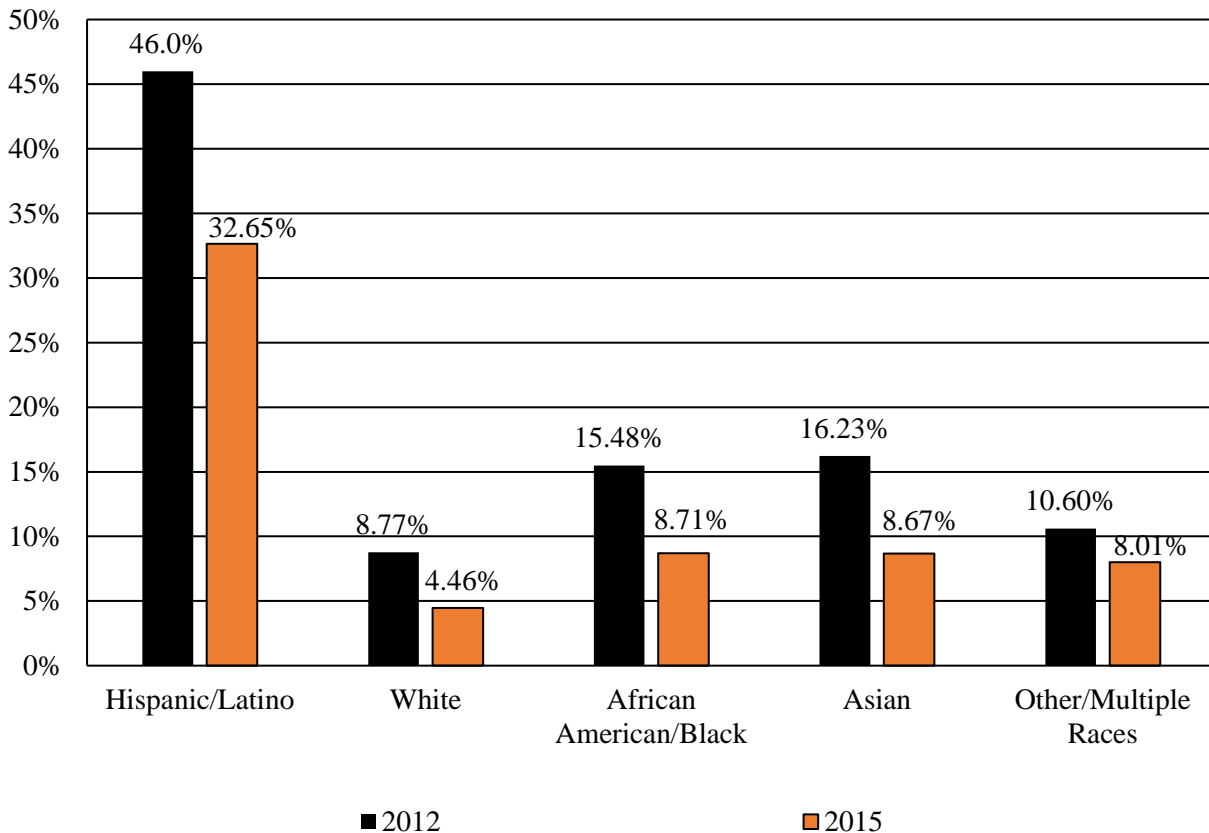
**Exhibit 2.11**  
**Maryland's Uninsured Rate by Race/Ethnicity (All Ages)**  
**Calendar 2012 vs. 2015**



Source: Department of Legislative Services; U.S. Census Bureau (*American Community Survey*)

Children and individuals older than age 65 are insured at a higher rate due to MCHP, which insures children up to 300% FPG (compared to Medicaid for adults, which covers up to, effectively, 138% FPG), and Medicare, which is available to most individuals age 65 and older. When looking at all ages, the insured rate is lower due to more children and individuals age 65 and older having insurance from these programs. The uninsured rate is higher for adults ages 18 to 64. As shown in **Exhibit 2.12**, the uninsured rate by race/ethnicity for Maryland adults is much higher than the rate for all ages, with 32.65% of the Hispanic/Latino population and 8.71% of the African American/Black population uninsured in 2015.

**Exhibit 2.12**  
**Maryland's Uninsured Rate by Race/Ethnicity (Ages 18-64)**  
**Calendar 2012 vs. 2015**



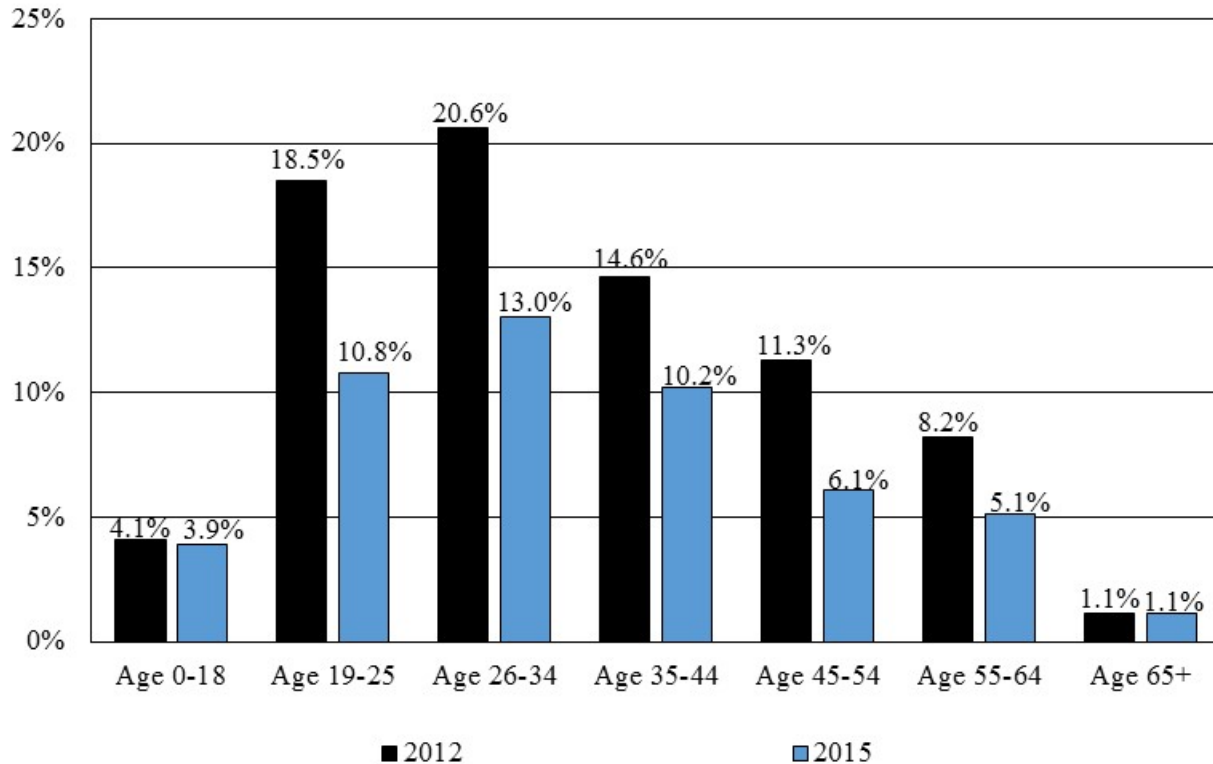
Source: Department of Legislative Services; U.S. Census Bureau (*American Community Survey*)

### Uninsured Rates by Age and Poverty Level

From calendar 2012 to 2015, the uninsured rate decreased for all age groups. As shown in **Exhibit 2.13**, the age group with the greatest percentage decrease in the uninsured population was ages 45 to 54. The age group 19 to 25 saw the second greatest percentage decrease. The uninsured rate remains highest among ages 26 to 34. The ACA provision permitting dependents to remain on their parents' insurance plan until their twenty-sixth birthday is a potential factor contributing to the higher rates for this group, as young adults phase out of their parent's coverage. Additionally, as this age group is younger, more individuals may be healthier and opt out of buying coverage until needed.



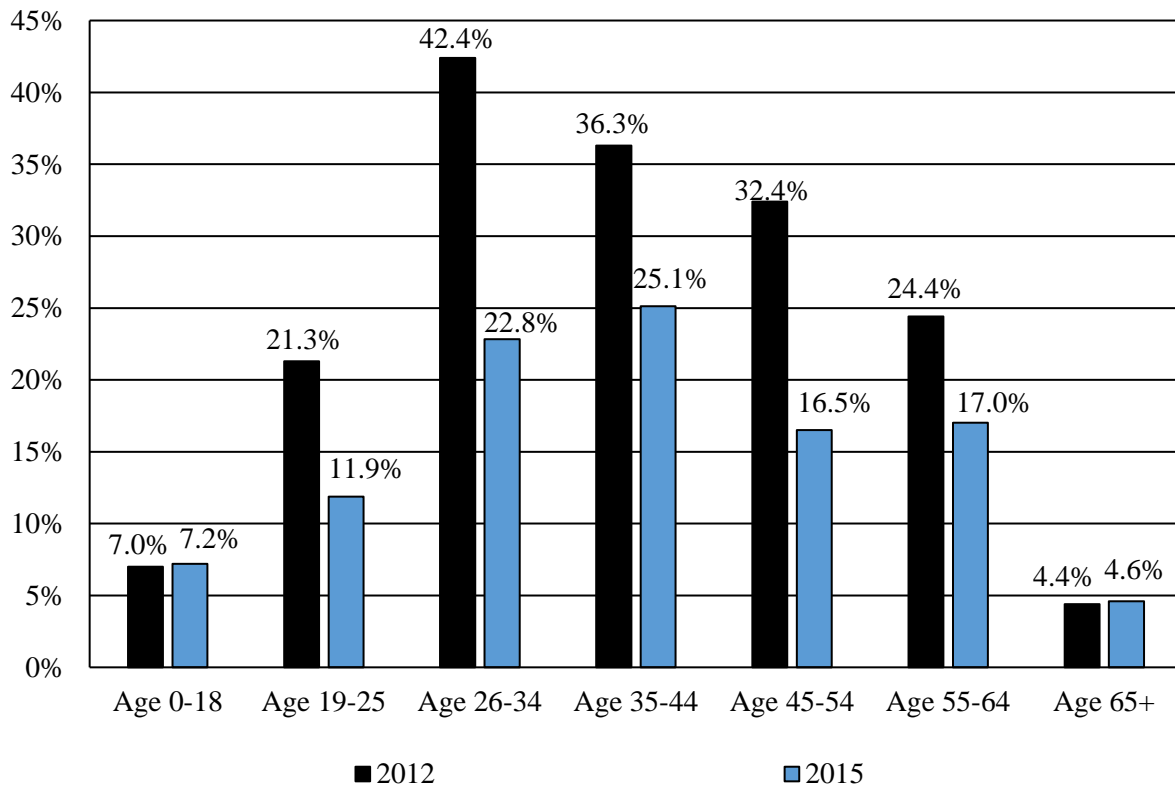
**Exhibit 2.13**  
**Maryland's Uninsured Rate by Age (All Ages)**  
**Calendar 2012 vs. 2015**



Source: Department of Legislative Services; U.S. Census Bureau (*American Community Survey*)

**Exhibit 2.14** shows the uninsured rate by age category for individuals with household incomes up to 138.0% FPG. Given the expansion of Medicaid eligibility to 138.0% FPG (based on calculation of modified adjusted gross income), it is not surprising that the uninsured rate declined significantly for adults at this income level (children were already generally eligible for coverage). The largest decrease in the uninsured rate for individuals in this income level was among ages 26 to 34, which decreased from 42.0% in 2012 to 22.8% in 2015. For ages 35 to 44 at this income level, 25.1% remained uninsured in 2015.

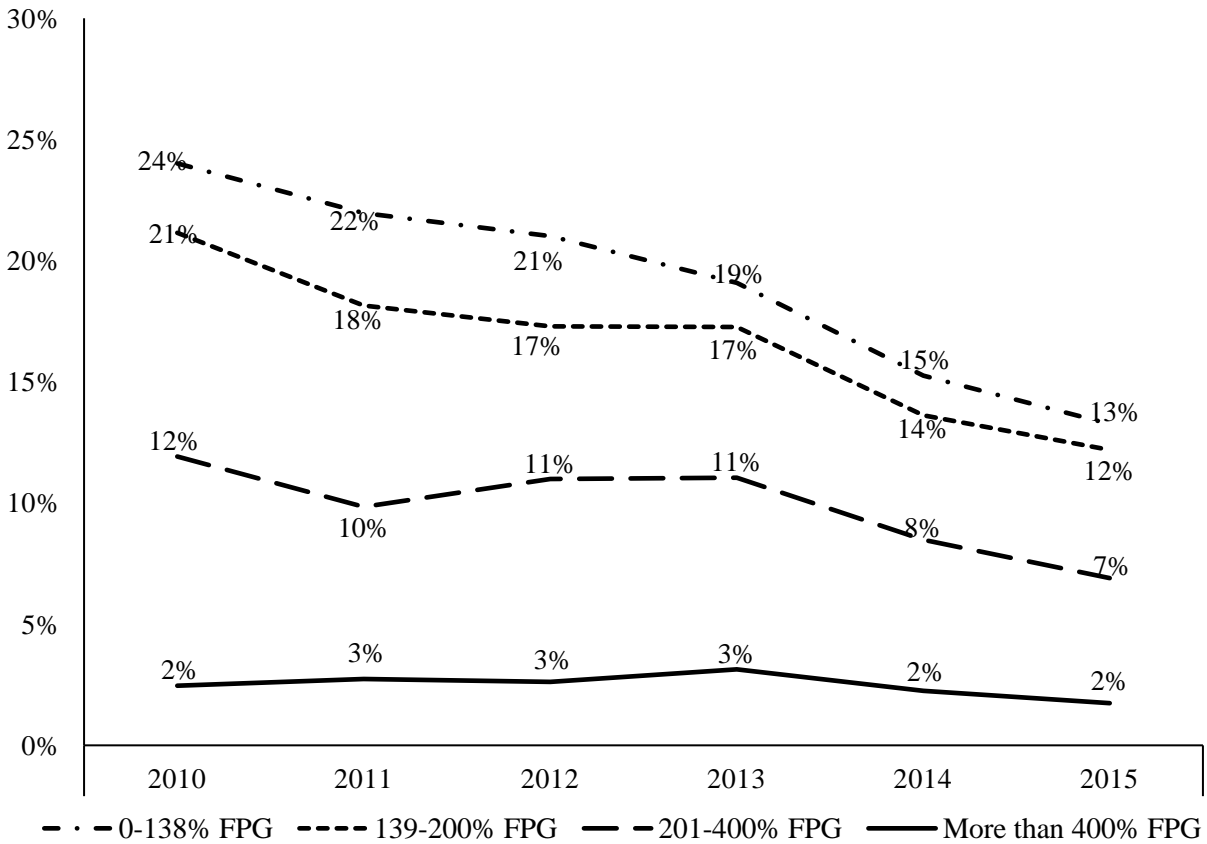
**Exhibit 2.14**  
**Maryland's Uninsured Rate for Individuals with Household Incomes**  
**Less Than 138% of Federal Poverty Guidelines by Age**  
**Calendar 2012 vs. 2015**



Source: *State Health Access Data Assistance Center analysis of the American Community Survey*

**Exhibit 2.15** shows the uninsured rate for Marylanders by poverty level from calendar 2010 to 2015. Reductions in the uninsured rate were observed for nearly all income categories except those with incomes greater than 400% FPG, which remained at 2%. However, while the uninsured rate declined the most among individuals with lower incomes (including 46% for individuals with incomes up to 138% FPG, largely due to the Medicaid expansions), the uninsured rates among these lower income categories remain the highest: 13% of individuals with incomes up to 138% FPG (though many may be eligible for Medicaid); 12% of individuals with incomes between 139% and 200% FPG; and 7% individuals with incomes between 201% and 400% FPG remained uninsured in 2015.

**Exhibit 2.15**  
**Maryland’s Uninsured Rate for Individuals by Federal Poverty Guidelines**  
**Calendar 2010-2015**

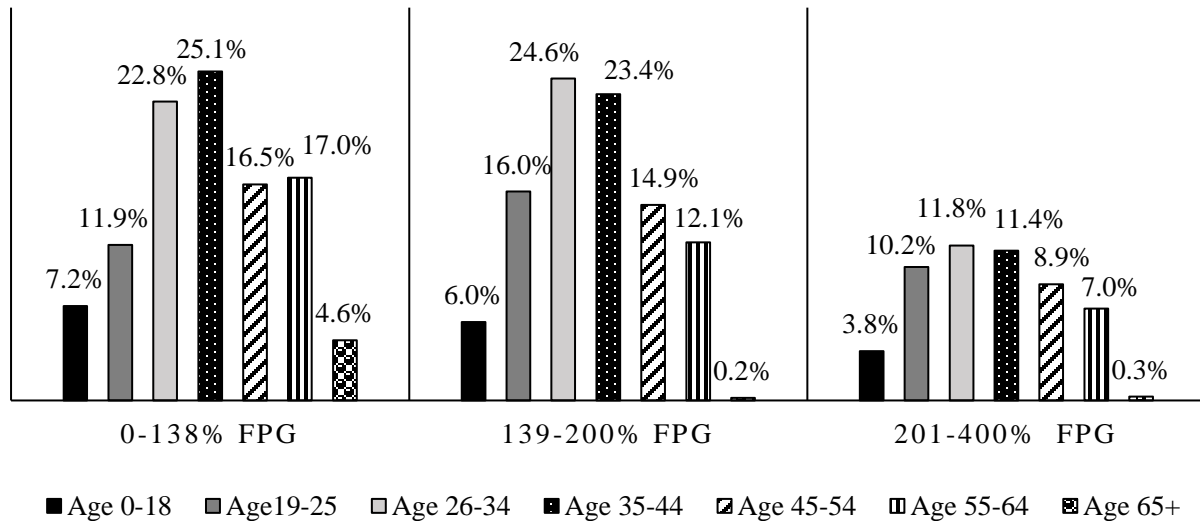


FPG: federal poverty guidelines

Source: State Health Access Data Assistance Center analysis of the *American Community Survey*

When examining the uninsured rate by poverty level and age, as shown in **Exhibit 2.16**, the highest uninsured rate in 2015 (25.1%) was for individuals with incomes below 138.0% FPG who were ages 35 to 44. This rate was closely followed by individuals with incomes between 139.0% and 200.0% FPG who were ages 26 to 34, for which the uninsured rate was 24.6% in 2015.

**Exhibit 2.16**  
**Maryland's Uninsured Rate by Poverty Level and Age**  
**Calendar 2015**



Source: State Health Access Data Assistance Center analysis of the *American Community Survey*

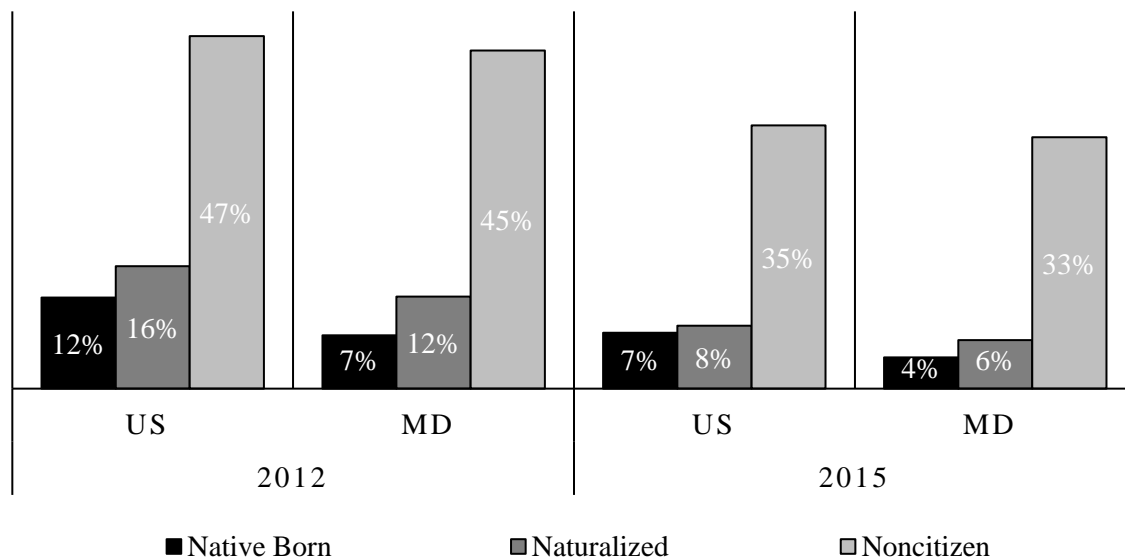
### Uninsured Rates by Citizenship Status

Noncitizens are largely limited to purchasing private coverage outside of MHBE. Certain immigration statuses qualify an individual to purchase through MHBE including: lawful permanent resident (green card holder), asylees, refugees, Cuban/Haitian entrants paroled into the United States, battered spouse/child/parent, temporary protected status, deferred enforced departure, non-immigrant status (such as H-1B, H-2A, H-2B), student visas, U visa, and T visa. Noncitizens are not eligible for Medicaid, but may receive Emergency Medicaid, which includes labor and delivery services. Once an individual becomes a legal resident, there is a five-year waiting period to receive Medicaid. Individuals residing in Maryland on student or temporary work visas are not eligible for Medicaid. During this five-year waiting period, legal residents can buy a QHP through MHBE and may qualify for financial assistance based on their income.

Insurance coverage for immigrants differs by citizenship status. **Exhibit 2.17** shows the uninsured rate by citizenship status (native born, naturalized, or noncitizen). An immigrant may become a “naturalized” citizen after being a permanent legal resident for at least five years (three years if a spouse of a U.S. citizen) or have qualifying service in the U.S. Armed Forces and meeting other eligibility requirements. Noncitizen includes both legal residents (documented

noncitizens) and undocumented immigrants. A legal resident includes those with a green card, visa, or other legal status who has not become a naturalized citizen. The exhibit shows that native born citizens were more likely to be insured than naturalized citizens and naturalized citizens were more likely to be insured than noncitizens.

**Exhibit 2.17**  
**Maryland's Uninsured Rate by Citizenship Status (All Ages)**  
**Calendar 2012 vs. 2015**



Source: State Health Access Data Assistance Center analysis of the *American Community Survey*

From 2012 to 2015, the uninsured rate decreased from 7% to 4% for native born citizens and from 12% to 6% for naturalized citizens. The uninsured rate among noncitizens fell from 45% to 33%. Since the noncitizen population contains both undocumented immigrants and legal residents, it is likely that the uninsured rate is higher for noncitizens due to their ineligibility for Medicaid (most naturalized citizens will qualify for Medicaid if they have been a permanent resident for five years). Undocumented immigrants are also ineligible to purchase a QHP through MHBE. Noncitizens may be more likely to have characteristics related to being uninsured, including being male, young, single, and having lower education and income. They may also work in jobs that do not provide health insurance coverage.

## Chapter 3. Access to Care

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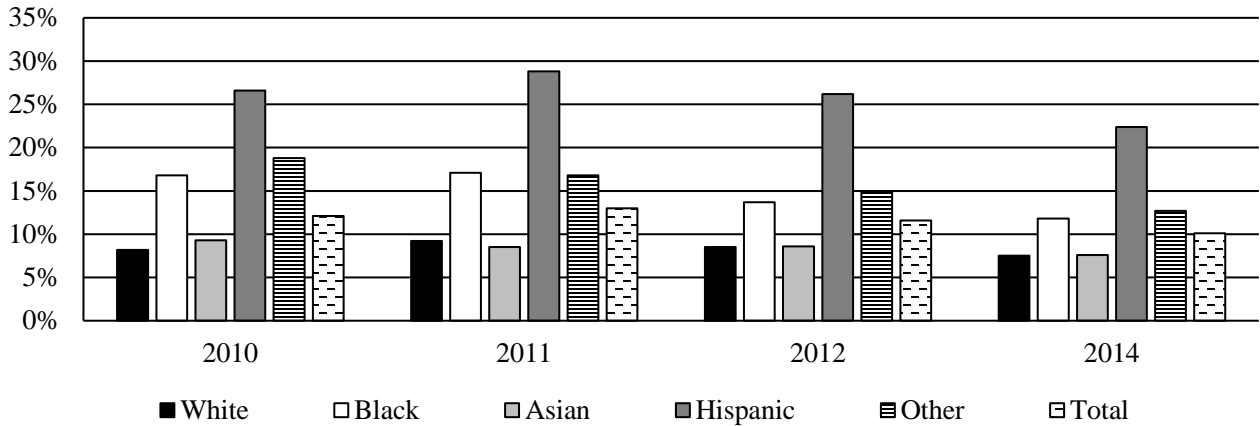
Having health care coverage makes it easier for individuals to access health care when they need it. The National Center for Health Statistics found that:

- adults with health insurance coverage for more than a year were more likely to have a usual place for medical care than those with any period of noncoverage;
- adults insured for more than a year were more likely to have visited a doctor or other health care professional during the past year than those with any period of noncoverage;
- adults with any period without health insurance in the past year were more likely to have had an unmet medical need due to cost than those with coverage for more than a year; and
- adults with health insurance coverage for more than a year were more likely to have been vaccinated to protect against the flu than those with any period of noncoverage.

To assess any initial impact of expanded coverage under the federal Patient Protection and Affordable Care Act (ACA), the Department of Legislative Services sought measures that reflect access to care. Although State-level data does not allow a comparison on these access measures between those who have coverage and those who do not, data available for Maryland from national sources shows that access to health care has improved with the expansion of access to health coverage in 2014. Maryland generally compares favorably with the nation as a whole on measures of access.

The most recent access to care data available at the publication of this report was for 2014 (the first year of full implementation of the ACA) and thus may not reflect full implementation of the ACA. As shown in **Exhibit 3.1**, the percentage of Marylanders who could not afford to see a doctor in the past 12 months fell from 12.1% in 2010 to 10.1% in 2014. The percentage for Black and Hispanic Marylanders, while still higher than the percentage for Whites, dropped considerably over the time period from 16.8% to 11.8% for Blacks; and from 26.6% to 22.4% for Hispanics. In comparison, the percentage for Whites fell from 8.2% to 7.5%. Maryland ranked eighth best among the states on this measure.

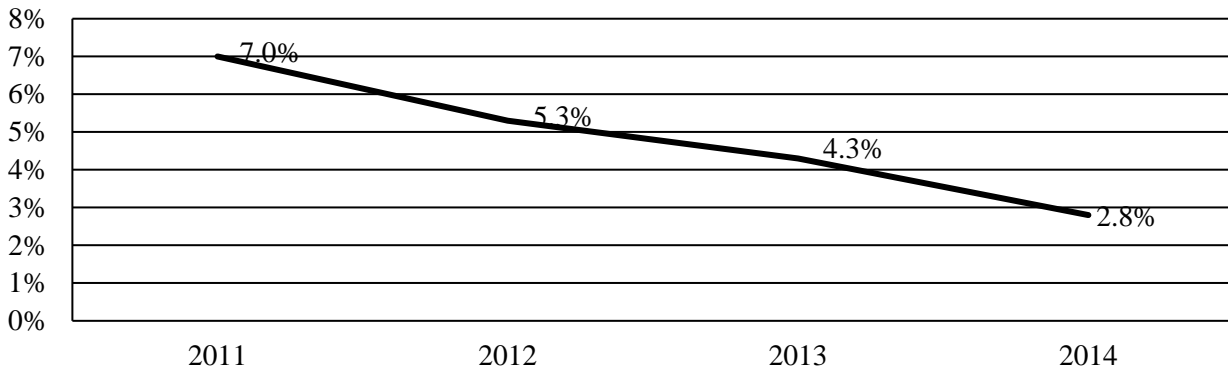
**Exhibit 3.1**  
**Percentage of Marylanders Who Could Not Afford to See a Doctor in the Past 12 Months**  
**Calendar 2010-2012 and 2014**



Source: Maryland Behavioral Risk Factor Surveillance System

As shown in **Exhibit 3.2**, the percentage of Marylanders who needed but did not get medical care due to cost fell from 7.0% in 2011 to 2.8% in 2014.

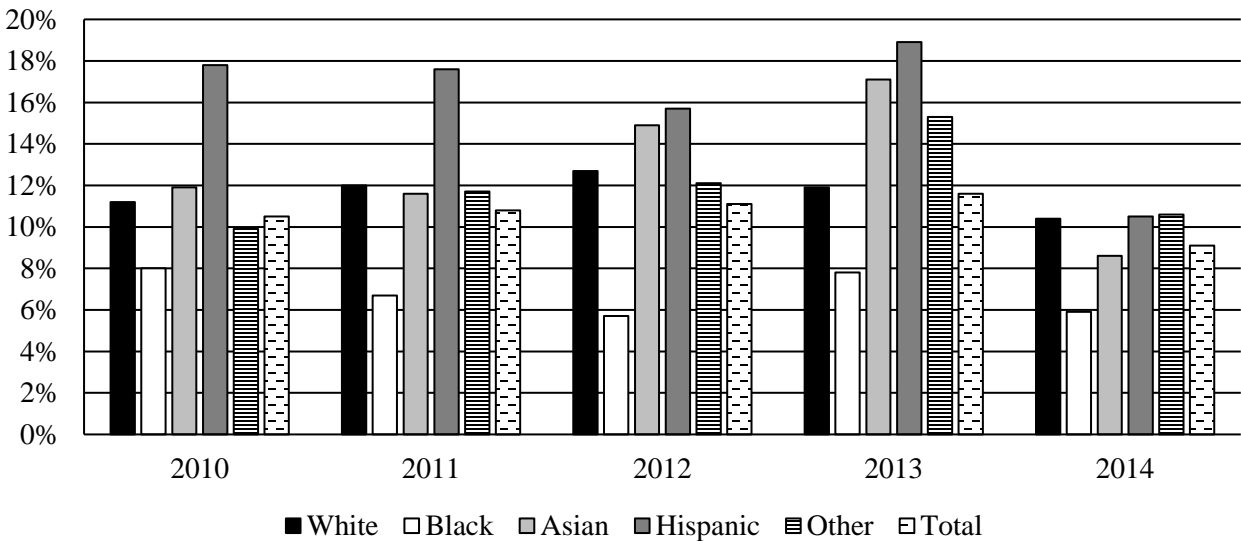
**Exhibit 3.2**  
**Percentage of Marylanders Who Needed But Did Not Get Medical Care Due to Cost in Past Year**  
**Calendar 2011-2014**



Source: State Health Access Data Assistance Center analysis of *National Health Interview Survey* data, National Center for Health Statistics

As shown in **Exhibit 3.3**, the percentage of Marylanders who last visited a doctor for a routine checkup two or more years ago dropped from 10.5% in 2010 to 9.1% in 2014. Again, the percentage for Black and Hispanic Marylanders dropped considerably over the time period: from 8.0% to 5.9% for Blacks; and from 17.8% to 10.5% for Hispanics. The percentage for Whites dropped from 11.2% to 10.4%.

**Exhibit 3.3**  
**Percentage of Marylanders Who Last Visited a Doctor for a**  
**Routine Checkup Two or More Years Ago**  
**Calendar 2010-2014**



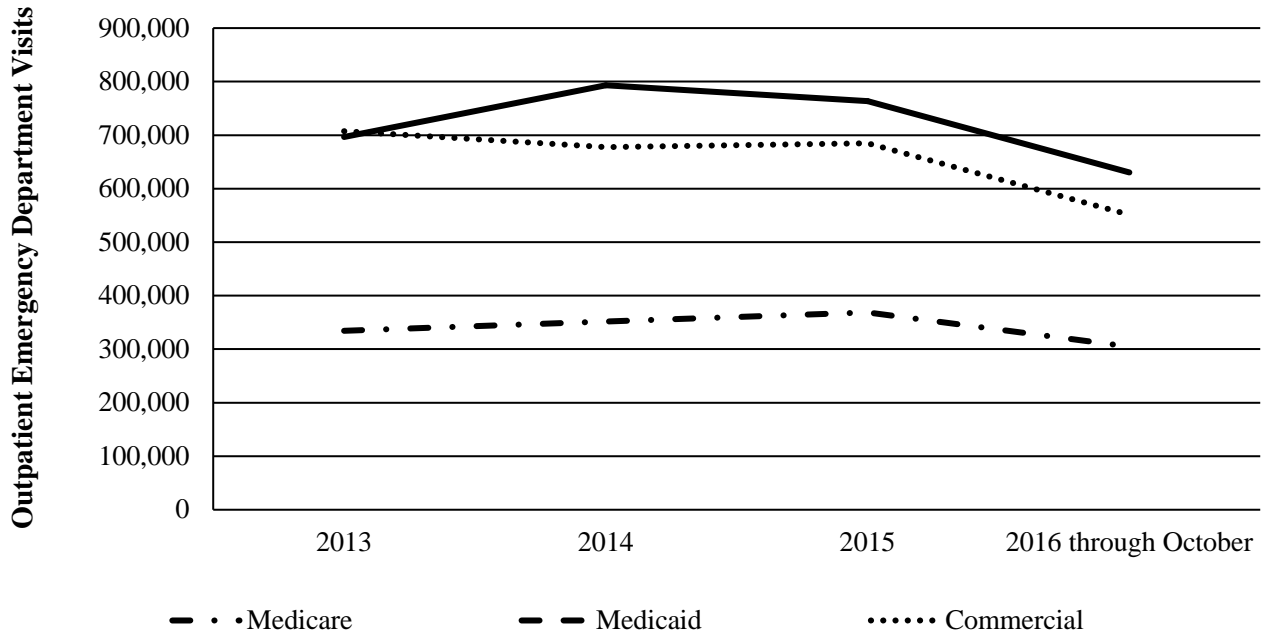
Source: Maryland Behavioral Risk Factor Surveillance System

In 2014, according to the Kaiser Family Foundation, Maryland ranked thirty-third (with fifty-first being the best) among the 50 states and the District of Columbia on the percentage of adults without a usual place of medical care, with the State’s 14.6% comparing favorably with the 17.3% for the United States as a whole.

As shown in **Exhibit 3.4**, emergency department use remained relatively stable following the expansion of health care coverage in 2014.



**Exhibit 3.4**  
**Emergency Department Visits by Payer**



Source: Health Services Cost Review Commission

## Chapter 4. Cost

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Implementation of the federal Patient Protection and Affordable Care Act (ACA) in Maryland to date has largely been funded with federal dollars, including expansion of Medicaid and establishment of the Maryland Health Benefit Exchange (MHBE). However, State expenditures have begun to increase as the federal matching rate for Medicaid declines and MHBE has become self-sufficient. As the number of uninsured Marylanders has declined, the State has realized savings in the amount of hospital uncompensated care. Consumer spending has also been impacted. This chapter describes State spending on health care reform efforts and the impact on consumer spending in Maryland.

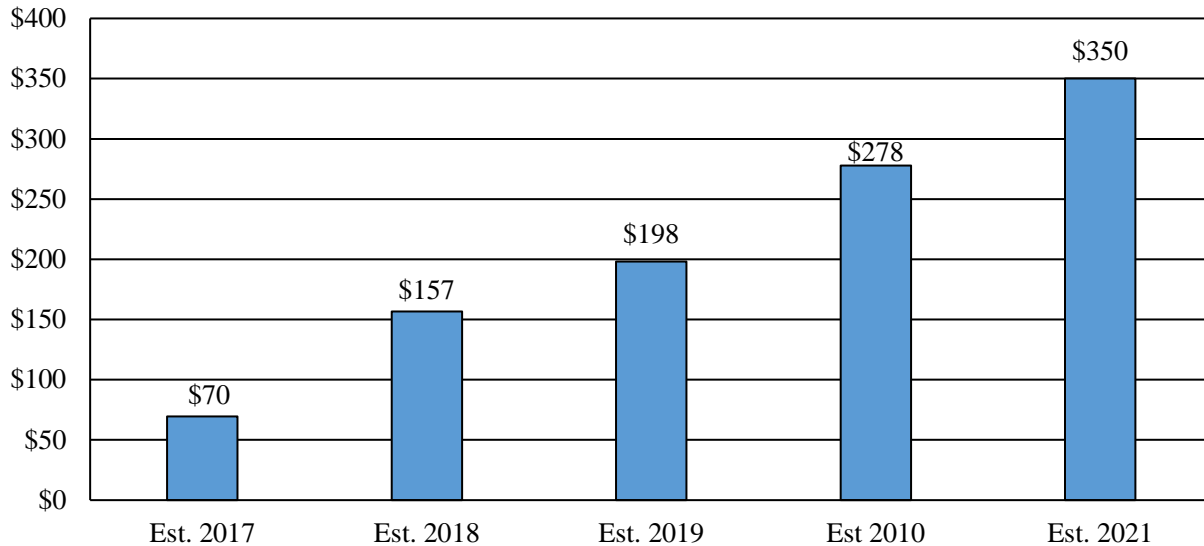
### State Spending on Health Care Reform Efforts

#### Medicaid

A central provision of the ACA is the expansion of Medicaid. Effective January 1, 2014, Medicaid coverage was extended to individuals with incomes up to 138% of federal poverty guidelines (FPG). As discussed in Chapter 2, nearly 291,000 Marylanders have been covered under the Medicaid expansion. Most significantly, the expansion was 100% federally funded for the first three years (calendar 2014 through 2016). Federal funding declines to 95% in 2017, and will continue to decline as follows: 94% in 2018; 93% in 2019; and 90% in 2020 and subsequent years. Maryland's traditional federal matching rate for Medicaid is 50%.

In fiscal 2014 through 2016, Maryland's Medicaid expansion covered between 130,000 and 260,000 individuals at no cost to the State. Fiscal 2017 is the first budget year to include State support for the ACA expansion population: 5% of total expenditures for the six months beginning January 1, 2017. As shown in **Exhibit 4.1**, the State's share of expenditures in fiscal 2017 is estimated at \$69.6 million. Over the next several years, the State's responsibility for the expenses of ACA expansion population will gradually increase to 10%, fully phasing in by fiscal 2021. By fiscal 2021, the Department of Legislative Services estimates that State spending on the Medicaid expansion population will be \$350.2 million. Total spending on Maryland's ACA Medicaid expansion is projected to be \$2.8 billion in fiscal 2017, increasing to \$3.5 billion by fiscal 2021.

**Exhibit 4.1**  
**Estimated State Spending on the Medicaid Expansion Population**  
**Fiscal 2017-2021 Est.**  
**(\$ in Millions)**



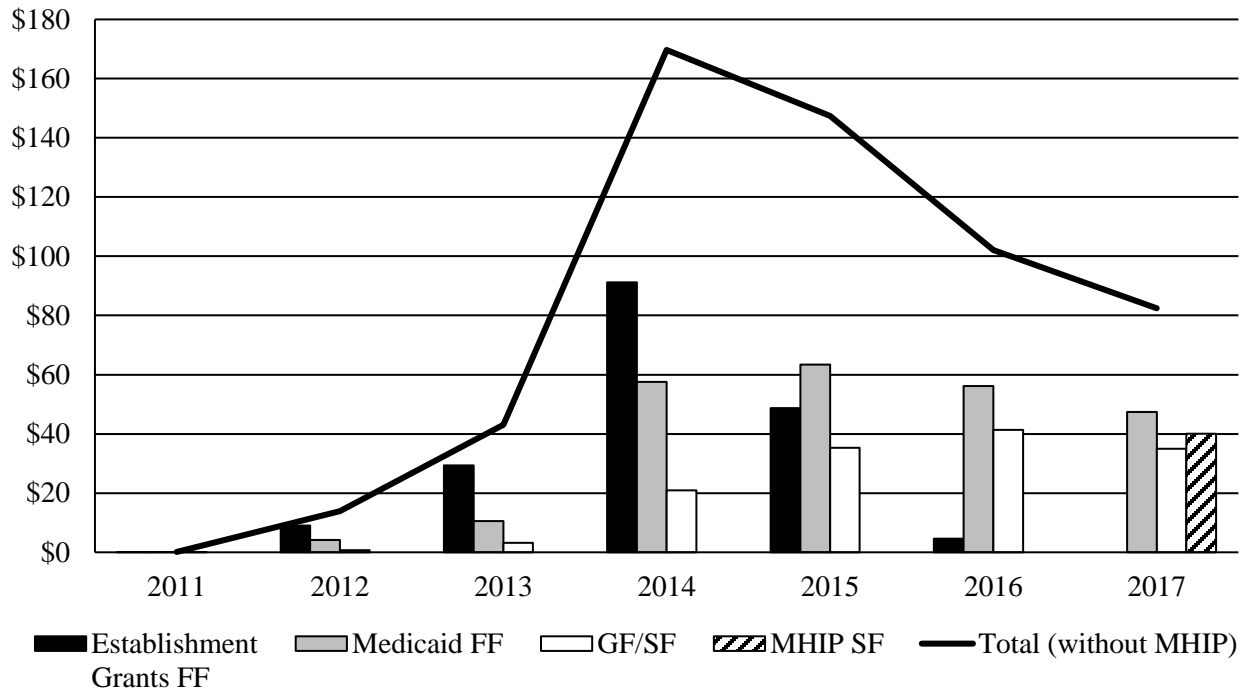
Note: Data includes both somatic and behavioral health expenditures.

Source: Department of Legislative Services

### Maryland Health Benefit Exchange

Current law mandates an annual appropriation of at least \$35.0 million to the MHBE Fund to support MHBE beginning in fiscal 2016. It should be noted that, under the ACA, state-run exchanges were required to be self-sufficient (have a dedicated funding stream) by 2015. The special funds devoted to MHBE are a diversion of revenues derived from a tax on all insurance premiums. The total general fund appropriation to MHBE from fiscal 2011 to 2017 is \$136.5 million. The federal fund appropriation is \$422.3 million; thus, a total of \$558.8 million was spent on MHBE over a six-year period. **Exhibit 4.2** shows spending by fund source from 2011 to 2017 on MHBE. Money from the Maryland Health Insurance Plan (MHIP) Fund was transferred to the MHBE Fund for the purpose of supporting the State Reinsurance Program.

**Exhibit 4.2**  
**Spending on the Maryland Health Benefit Exchange by Fund Source**  
**Fiscal 2011-2017**  
**(\$ in Millions)**



FF: federal fund  
 GF: general fund  
 MHIP: Maryland Health Insurance Plan  
 SF: special fund

Source: Maryland Health Benefit Exchange; Department of Legislative Services

### Reduction in Hospital Uncompensated Care

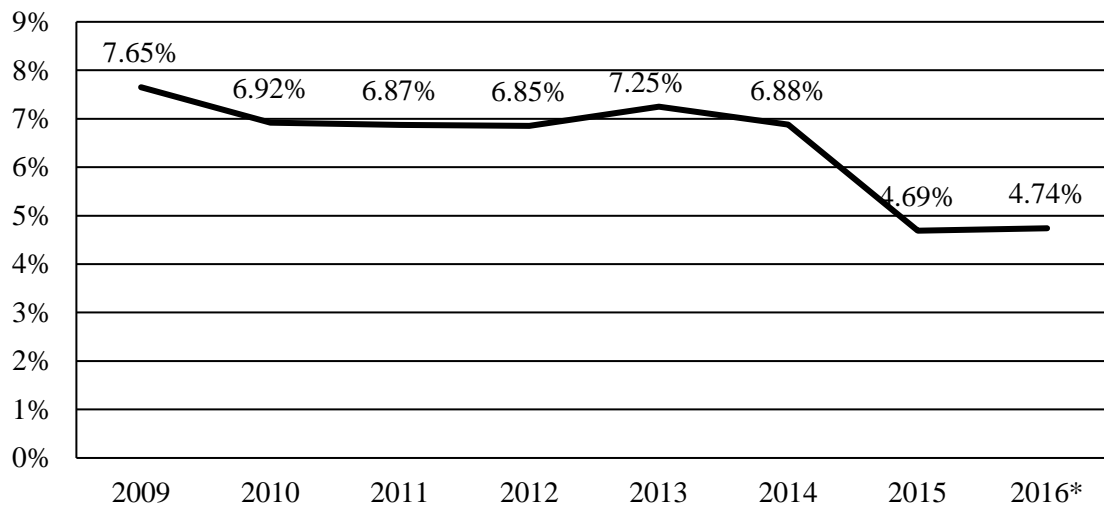
Since it first began setting rates, the Health Services Cost Review Commission (HSCRC) has recognized the cost of uncompensated care (UCC) within Maryland’s unique hospital rate-setting system. As a result, patients who cannot pay for care are still able to access hospital services, and hospitals are credited for reasonable levels of UCC provided to those patients.

Under the current HSCRC policy, UCC is funded by a statewide pooling system in which regulated Maryland hospitals draw funds from the pool if they experience a greater than average

level of UCC and pay into the pool if they experience a less than average level of UCC. This ensures that the cost of UCC is shared equally across the hospitals in the system.

The expansion of health care coverage under the ACA means that individuals whose hospital care previously would have been paid for through the UCC pool now get their care paid for by Medicaid or private health insurance. HSCRC has adopted a conservative approach to determining the UCC percentage in hospital rates since the ACA was implemented. Based on historical experience with the Maryland Primary Adult Care Program population (which received a limited Medicaid benefit package), HSCRC reduced the UCC rate from an anticipated rate of 7.23% to 6.14% of gross patient revenue for rate year 2015. Using the actual experience of the Medicaid expansion population for calendar 2014, HSCRC further reduced the UCC rate to 5.35% for rate year 2016. **Exhibit 4.3** shows hospital UCC as a percentage of gross patient revenue from rate year 2009 through 2016.

**Exhibit 4.3**  
**Hospital Uncompensated Care as a Percentage of Gross Patient Revenue**  
**Rate Year 2009-2016**



\* 2016 data is unaudited.

Source: *Health Services Cost Review Commission Final Recommendations for the Uncompensated Care Policy for 2017*, approved on June 8, 2016. Data source is *Hospital Annual Financial Audited Cost Reports, RE Schedule*.

As shown in Exhibit 4.3, actual UCC experience was lower than the 6.14% HSCRC projected for rate year 2015. UCC as a percentage of hospital gross patient revenue declined from 7.65% in fiscal 2009 to 4.69% in fiscal 2015. From 2013 to 2015, hospital UCC costs declined by

2.55 percentage points, equivalent to approximately \$311 million. The declines ranged from -0.42% to -14.16% across Maryland hospitals. On June 8, 2016, HSCRC approved the use of the 4.69% UCC rate experienced in fiscal 2015 as the UCC rate for 2017. Unaudited hospital data for rate year 2016 show a UCC rate of 4.74%, indicating that UCC seems to have stabilized.

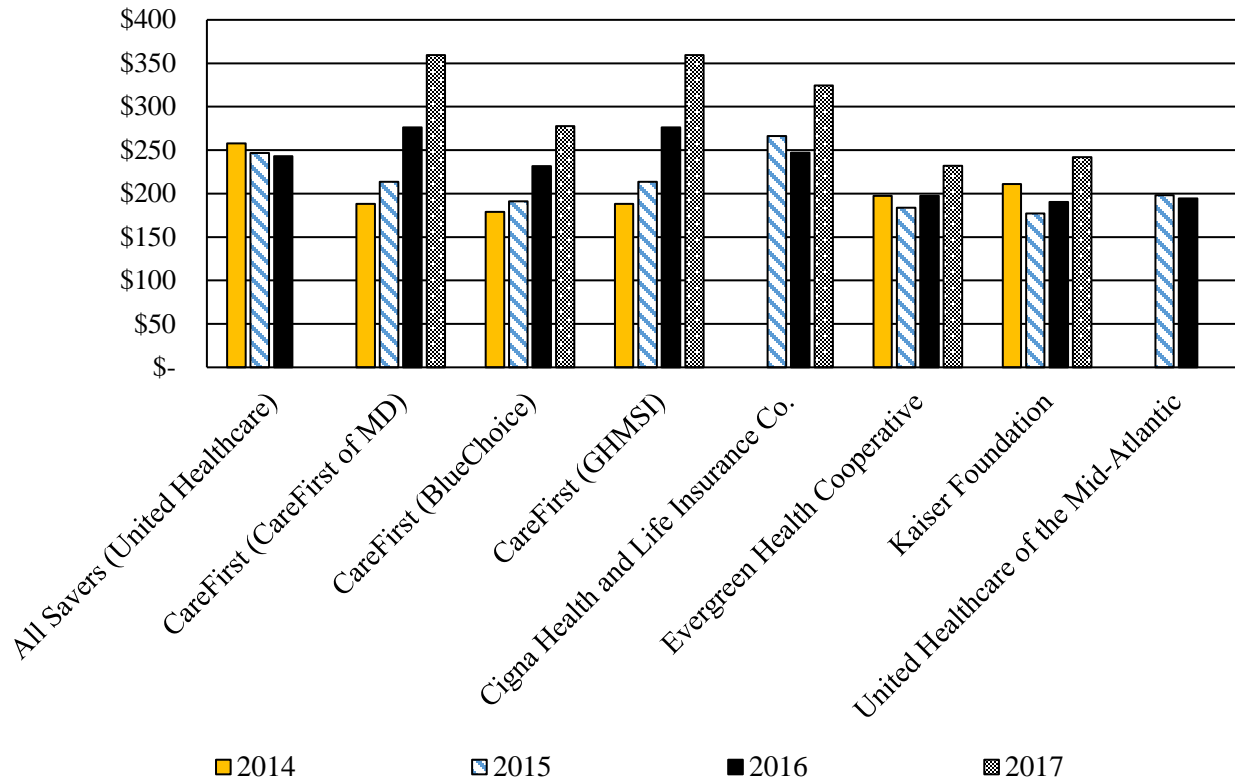
## **Consumer Spending Post-health Care Reform**

Consumers in Maryland can purchase private insurance either through their employer, through MHBE, or individually from a health insurance carrier or through an insurance broker. There are two types of spending on health care for consumers: the cost to have insurance (the premium); and the cost to use insurance (deductibles, coinsurance, and copayments). The cost to use insurance varies by insurer and plan type. Particularly in the individual insurance market, the lower the premium, the higher the deductibles, coinsurance, and copayments. Plans with lower premiums usually have lower actuarial values (how much the insurer pays) and the consumer has to pay more of the out-of-pocket costs. These plans also have higher deductibles (the amount the consumer must contribute before the insurance will pay). In 2016, for plans sold on the individual insurance market, the out-of-pocket maximum could be no more than \$6,850 for an individual plan and \$13,700 for a family plan before any marketplace subsidies.

### **Premiums for Insurance Purchased by Individuals**

Instability in Maryland's individual insurance market has required consumers to shop carefully for a health plan that meets both their health care needs and budget. The number of carriers participating in the individual market has fluctuated from six in 2014 to eight in 2015 and 2016 and down to five in 2017. Three of these carriers are under the CareFirst umbrella. As shown in **Exhibits 4.4, 4.5, and 4.6**, the lowest-cost silver plan (which pays an estimated 70% of medical costs) for an individual offered by each carrier in the Baltimore metro area varies widely by age and carrier. Although Evergreen Health Cooperative Inc. had the lowest approved rates for 2017, the Maryland Insurance Administration announced on December 8, 2016, that Evergreen plans will not be available in the individual market for the 2017 plan year. As a result, Kaiser has the lowest-priced silver plan among the five remaining carriers.

**Exhibit 4.4**  
**Baltimore Metro Area Approved Monthly Rate Examples**  
**Lowest-priced Silver Plan – Age 21**  
**2014-2017**

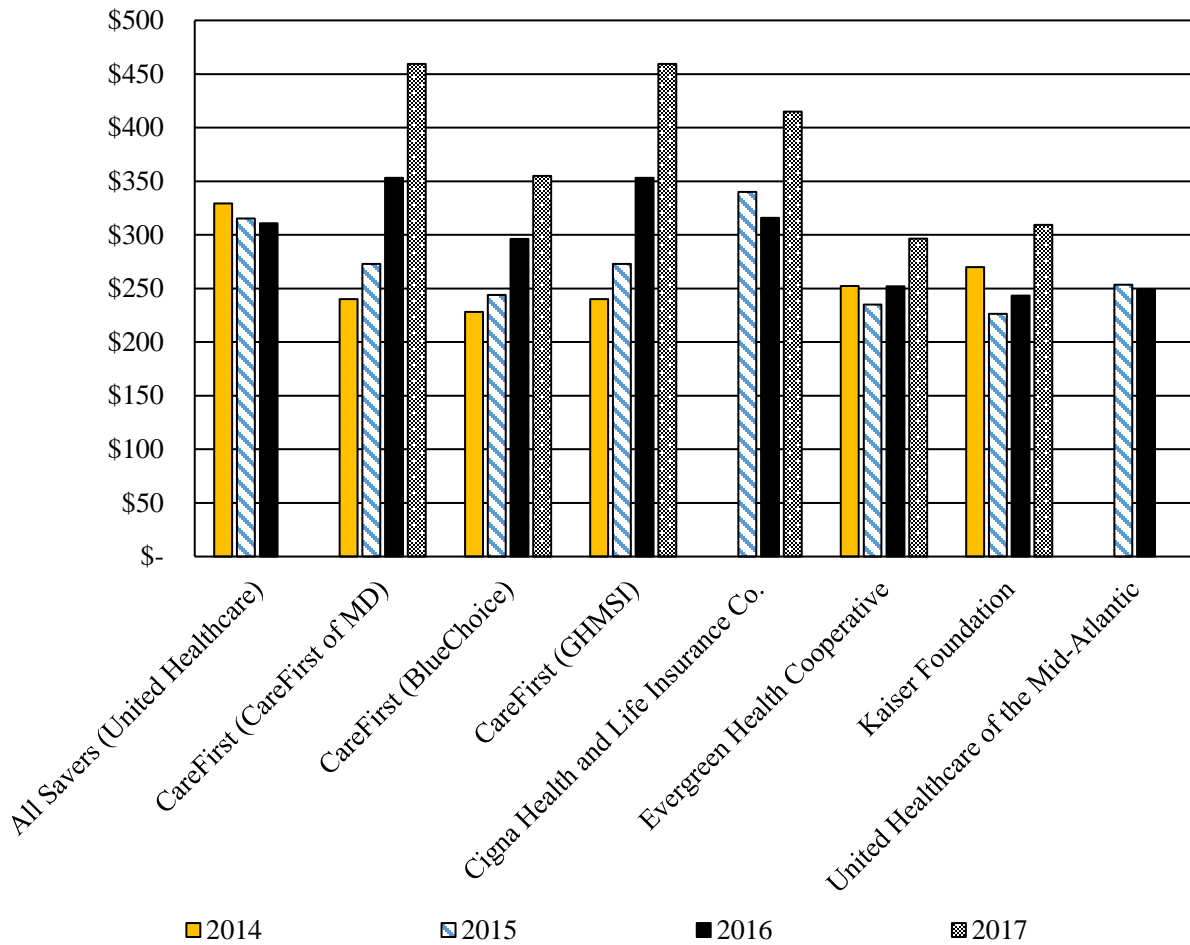


GHMSI: Group Hospitalization and Medical Services, Inc.  
 MD: Maryland

Note: Despite approved rates, Evergreen plans are not available in 2017.

Source: Maryland Insurance Administration

**Exhibit 4.5**  
**Baltimore Metro Area Approved Monthly Rate Examples**  
**Lowest-priced Silver Plan – Age 40**  
**2014-2017**



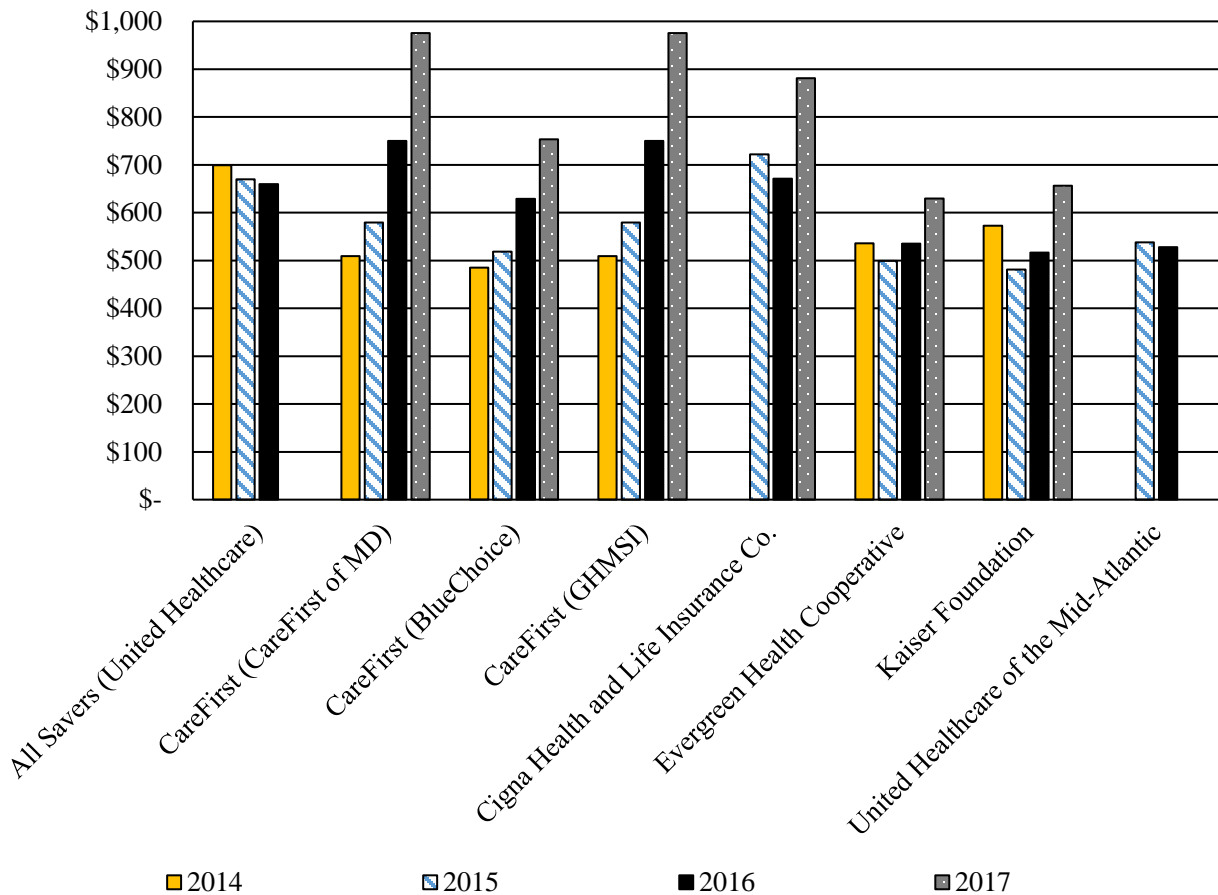
GHMSI: Group Hospitalization and Medical Services, Inc.  
 MD: Maryland

Note: Despite approved rates, Evergreen plans are not available in 2017.

Source: Maryland Insurance Administration



**Exhibit 4.6**  
**Baltimore Metro Area Approved Monthly Rate Examples**  
**Lowest-priced Silver Plan – Age 60**  
**2014-2017**



GHMSI: Group Hospitalization and Medical Services, Inc.  
 MD: Maryland

Note: Despite approved rates, Evergreen plans are not available in 2017.

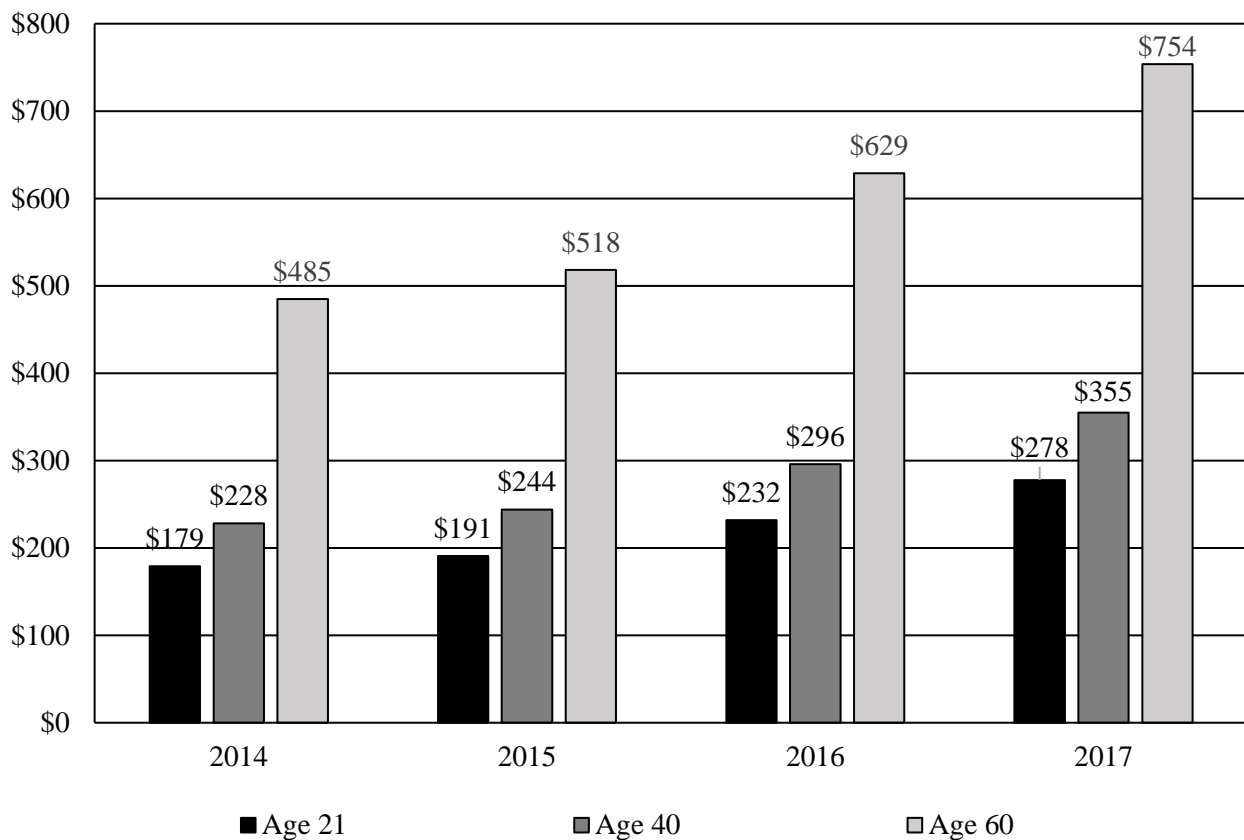
Source: Maryland Insurance Administration

The insurer with the greatest ACA market share, CareFirst (80% market share in 2016; Kaiser at 16%; and Evergreen at 4%), has raised rates for premiums year-over-year in Maryland, increasing the cost of having insurance for consumers who are not eligible for a tax credit (the

increase in premium should be offset by an increase in the tax credit if they continue to be enrolled in the benchmark plan). However, premiums vary by insurer and a consumer can avoid the increase by shopping around or purchasing a qualified health plan (QHP) with a narrower network.

**Exhibit 4.7** shows premiums for a CareFirst BlueChoice Silver Plan by age for residents of the Baltimore Metro Area. From 2014 to 2017, monthly premiums increased by 55% for individuals aged 21 and 40, or \$99 and \$126, respectively. For individuals aged 60, purchasing the same plan, monthly premiums increased by \$250 or 52% over the four-year period. The premium costs do not reflect any advanced premium tax credits for which a consumer may qualify.

**Exhibit 4.7**  
**Monthly BlueChoice Qualified Health Plan Premium for**  
**Baltimore Metro Area by Age (Silver)**  
**2014-2017 Plan Years**



Source: Maryland Insurance Administration, CareFirst (BlueChoice) Silver

## **Premium Increases in the Individual Market**

The large rate increase in 2017 for CareFirst in the individual market, as well as other carriers, is partially due to market factors that are systemic to health care as a whole, which include rising hospital and pharmaceutical costs.

Market factors unique to the individual market that are driving premiums up include ACA provisions such as a prohibition on preexisting condition exclusions and a standard benefit plan. Previously, those denied coverage due to a preexisting condition (who are often more expensive to insure) were provided insurance subsidized through the former MHIP. When the preexisting condition exclusion prohibition was enacted, insurance carriers took on the full cost of insuring these individuals (CareFirst being the main insurer). Small group reform in Maryland enacted similar provisions in 1993, and initial market disruptions occurred; however, the small group market evolved and is seeing more moderate premium increases. Individuals in the small group market also have been historically less transient than the individual market, with longer term coverage that may enable them to seek care right away and keep costs down in the long run.

The individual market also has the potential for adverse selection. Those previously uninsured individuals with greater health care needs are more likely to enroll and enroll sooner than those with lesser needs. This results in a sicker, more expensive risk pool than insurance carriers had previously experienced. The individual mandate penalty is aimed at incentivizing younger, healthier individuals to purchase insurance; however, the penalty may be much lower than the premiums an individual would have to pay. Additionally, there has been some difficulty attracting younger prospective customers. The ACA mandates that premiums for older individuals can be no more than three times the premiums for younger individuals, in effect causing younger individuals to subsidize the premiums for older individuals. This contributes to higher premiums for younger individuals, which may hinder them from purchasing insurance.

Some insurers may have set premiums low in the first few years relative to the market-wide risk profile. The ACA established three types of mechanisms to limit insurance risk: risk adjustment payments; risk corridor payments; and transitional reinsurance. Insurers have more information now than they did in previous years, including expected risk adjustment receipt and transfers. Risk adjustment payments, which redistribute funds from plans with lower risk enrollees to plans with higher risk enrollees, are meant to protect against adverse selections by spreading financial risk across the market. Insurers like Kaiser and Evergreen have had to pay large risk adjustment payments while CareFirst has received most of the risk adjustment payments.

While insurers are paying out and receiving large risk adjustment payments, the U.S. Congress has cut risk corridor payments. The risk corridor payments are meant to limit losses and gains beyond an allowable range based on actual claims. As a result, risk corridor payments to insurers for the 2014 benefit year were limited to \$362 million (or 12.6%) of the \$2.87 billion requested by insurers. The federal transitional reinsurance program, which provides payment to plans that enroll higher cost individuals and protects against premium increases, is set to sunset after 2016.

Additionally, the regulatory uncertainty faced by insurers increases their cost of doing business. The insurer has to deal with the new regulations, annual and mid-year changes to regulations, and new interpretations of existing regulations to comply with the ACA and operate in the individual market.

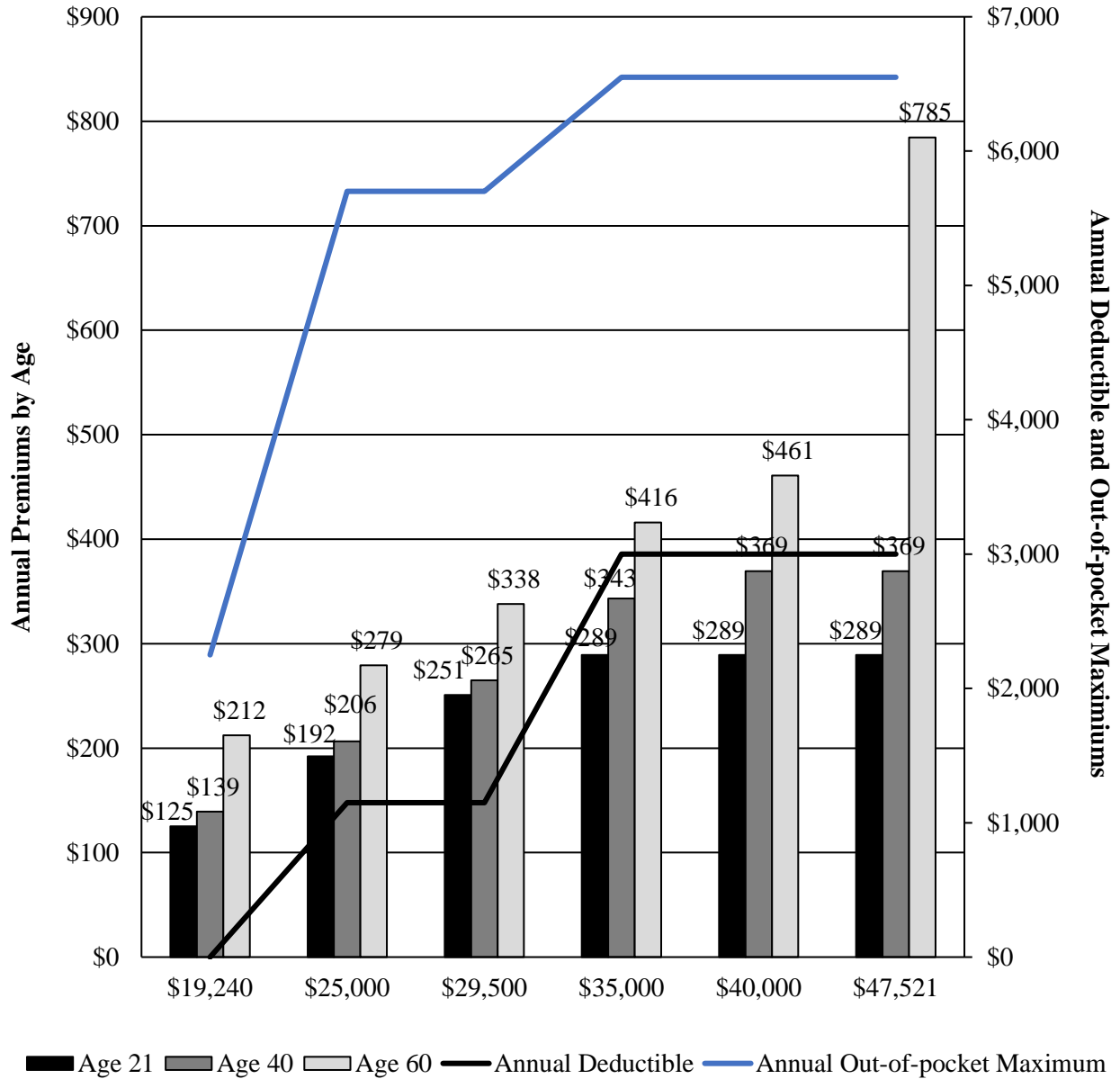
### **Advanced Premium Tax Credits and Cost-sharing Reductions**

Individuals who purchase an insurance plan through MHBE may be eligible for financial assistance and pay less than if they had bought the plan outside of MHBE. Through the ACA, consumers who purchase a QHP through MHBE may be eligible for an advanced premium tax credit (APTC), which can be used by individuals earning up to 400% FPG to help pay monthly health insurance premiums. An individual will qualify for the APTC in 2017 if their income is less than approximately \$47,520.

In addition to the APTC, an individual enrolled in a silver plan may qualify for cost-sharing reductions. The individual will qualify for the cost-sharing reduction subsidy if their income is less than 250% FPG, or \$23,750 in 2017. The cost-sharing reductions lower the amount individuals pay out-of-pocket for essential health benefits and may include lower copays or deductibles.

**Exhibit 4.8** shows the 2017 premiums by age and income for a Baltimore County resident. At an income of \$19,240, an individual enrolled in a QHP would qualify for both an APTC and cost-sharing reductions. They would pay no annual deductible and have a lower out-of-pocket maximum than higher income individuals. The annual deductible and out-of-pocket maximum are the same for all ages in each income group; however, the older an individual is, the more subsidized their premium is. At the highest income in Exhibit 4.5 (\$47,521), an individual would not be eligible for the APTC (\$1 over the threshold) and a 60 year old at this income would pay \$785 for a monthly premium. Comparing the \$785 premium with the \$212 premium for age 60 with an income of \$19,240, the individual receives a \$573 tax credit (a 72% reduction). Age 21 with an income of \$47,521 would pay the full premium of \$289 and would receive a subsidized premium of \$125 with an income of \$19,250, equating to a \$164 tax credit (a 56% reduction). Additionally, the premium age 21 would pay with a wage of \$35,000 (250% FPG) is the same as they would pay with a wage of \$47,521 (over 400% FPG), suggesting the subsidy phases out at a lower income for younger individuals.

**Exhibit 4.8**  
**Qualified Health Plan Premium for Baltimore County by Age (Silver)**  
**Calendar 2017 Plan Year**

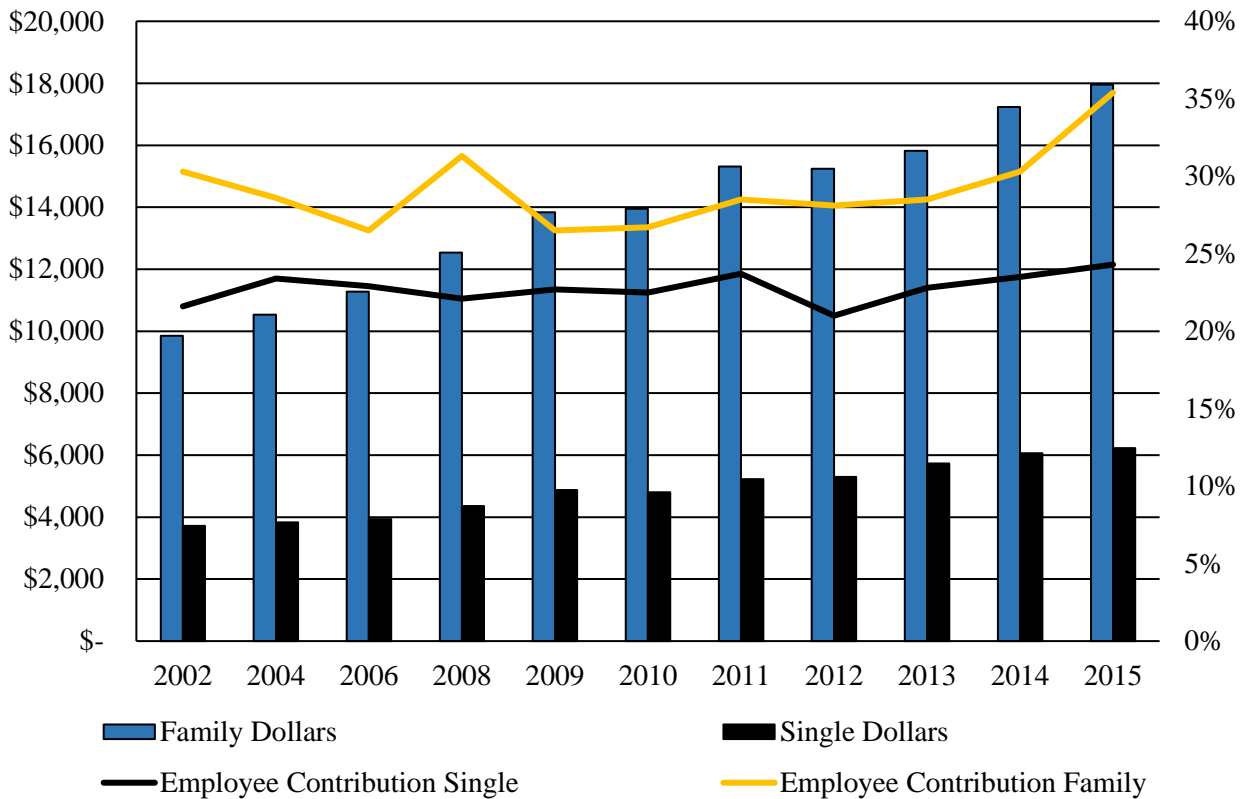


Source: Maryland Health Connection Estimates, *Most Enrolled Plan in 2016 BlueChoice HMO HSA Silver \$1500*

### Premiums for Employer-sponsored Insurance

In contrast to premiums in the individual market, premiums for employer-sponsored insurance grew only moderately in 2016. The annual survey of employer-sponsored insurance conducted by the Kaiser Family Foundation and the Health Research and Educational Trust found that, nationally, the average family premium rose 3% over the 2015 average premium, and the increase in the premium for single coverage was not statistically significant. Premiums for family coverage increased 20% from 2011 to 2016, compared with 31% from 2006 to 2011. The share of workers enrolled in high-deductible health plans with a savings option grew by eight percentage points from 2014 to 2016, helping to moderate the rise in premiums. **Exhibit 4.9** shows the cost of employer-sponsored insurance for single individuals and families between 2002 and 2015.

**Exhibit 4.9**  
**Total Annual Premium Cost of Employer-sponsored Insurance**  
**2002-2015**



Source: *Medical Expenditure Panel Survey – Insurance Component* (MEPS-IC Data), Agency for Healthcare Research and Quality; Center for Financing, Access and Cost Trends

Employers in Maryland, as well as across the United States, have mitigated the rising cost of health insurance by passing more of the cost to employees. In Maryland, from 2005 to 2015:

- the percent of private-sector employees enrolled in a health insurance plan that had a deductible rose from 51.6% to 83.0%, an increase of 60.9%;
- in health insurance plans subject to a deductible, the average deductible amount per employee increased from \$429 to \$1,128 (162.9%) for single coverage and from \$825 to \$2,115 (156.4%) for family coverage (still among the lowest average deductibles among the states); and
- although the percent of private-sector employees enrolled in a health plan that had a copayment, rather than a coinsurance requirement, for a physician visit remained high, there was a marked shift from a copayment to a coinsurance requirement, potentially subjecting employees to a much higher amount of cost sharing.

The Milliman Medical Index (MMI), which does not measure premiums but does measure health care costs for a typical American family of four covered under an employer-sponsored plan, found that the 4.7% increase in health care costs in 2016 was the lowest since the MMI began in 2001. The share of health care costs paid by the employee continued to grow over the 15-year period. Also, health care costs continued to rise faster than overall inflation and faster than median household income. Prescription drug costs, led by specialty drugs, were the fastest growing component of health care costs. The MMI found that health care premiums in individual plans sold through the health benefit exchanges exceeded the growth in the MMI in recent years largely because of:

- greater stability in the employer market, where people tend to be insured continuously than in the individual market;
- overly aggressive pricing of health insurance plans sold through the exchanges in the early years; and
- the expiration of provisions such as the federal reinsurance program.

## **Penalties Paid Under the Individual Mandate**

A principal feature of the ACA is the individual mandate. Most U.S. citizens and legal residents must have qualifying health coverage each month, qualify for an exemption, or pay a tax penalty (known as the health care individual responsibility payment) when they file their federal tax return. The purpose of the mandate is to incentivize all individuals to purchase health insurance coverage in order to guarantee a broad pool of insured individuals.

Internal Revenue Service data shows that in tax year 2014 (the most recent data available), 104,340 Maryland tax returns were subject to the health care individual responsibility payment. The value of these payments was \$23.6 million, an average of \$226 per return. In 2014, the penalty was the greater of \$95.00 per adult plus \$47.50 per child, up to a maximum of \$285, or 1% of family income in excess of the 2013 income tax filing thresholds. This penalty increased to the greater of \$695.00 per adult plus \$347.50 per child, up to a maximum of \$2,085.00 per family, or 2.5% of family income in excess of the 2015 income tax filing thresholds in 2016, and will increase according to inflation for tax year 2017.





## **Chapter 5. The Future of the Federal Patient Protection and Affordable Care Act**

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As discussed throughout this report, Maryland has taken significant steps to implement the federal Patient Protection and Affordable Care Act (ACA) since its enactment in 2010. Based on our preliminary analysis, since 2010 the percentage of uninsured Marylanders has fallen to 6.6%, with 291,000 individuals covered through the Medicaid expansion and more than 136,000 covered through the Maryland Health Benefit Exchange (MHBE). Given the results of the U.S. election, substantial revision or repeal of the ACA is anticipated and could have tremendous fiscal and policy implications for Maryland.

### **Efforts to Repeal the Federal Patient Protection and Affordable Care Act**

The ACA ushered in a set of reforms with an aim of expanding access to health coverage. Significant components of the ACA include (1) the individual mandate, a measure intended to spread risk among various types of individuals, regardless of health status, by requiring most Americans to obtain and maintain health coverage each month or pay a tax penalty; (2) the federal subsidies to individuals and small businesses to obtain health coverage; (3) the new insurance market reforms aimed to make coverage more accessible, thus prohibiting the denial of coverage on the basis of a preexisting health condition; (4) the establishment of exchanges, marketplaces through which individuals and small businesses can purchase insurance; and (5) the required coverage of certain health benefits in plans offered to individuals and small businesses.

For many years, critics of the ACA have sought to repeal it and called for alternatives to the health reform legislation, contending that the ACA has proven costly and detrimental to the health insurance market and economy. Common concerns are that the law has increased premiums and deductibles, resulted in narrow provider networks for plans offered on the exchanges, increased taxes to fund implementation, and imposed costs on employers to comply with the law. A recent and noteworthy critic of the ACA is President-elect Donald J. Trump, who has vowed to repeal at least some of the ACA reforms. A number of congressional proposals to replace the ACA have been offered, most recently by House Speaker Paul D. Ryan in June 2016. The Ryan Proposal would eliminate the individual mandate, replace the current income-based advanced premium tax credits with a new tax credit for individuals regardless of income, and expand the use of high-deductible “catastrophic” health plans paired with tax-free health savings accounts. President-elect Trump has indicated support for these changes but would like to preserve the ban on preexisting condition limitations and the provision that allows young adults to remain on their parents’ policies until age 26. A budget reconciliation bill including many of the changes supported by President-elect Trump passed the House and Senate in 2015, but was vetoed by President Barack H. Obama.

## **The Ryan Proposal**

The Ryan Proposal exemplifies what a replacement for the ACA might entail if critics of the legislation were to prevail in changing the federal health care law. President-elect Trump signaled support for a number of reforms included in the Ryan Proposal. The Ryan Proposal would eliminate the individual mandate and replace tax credits currently available under the ACA to help individuals afford their premiums with a new tax credit. Unlike the tax subsidies available under the ACA, the proposed tax credit would be available to individuals, regardless of income. The proposal would aim to expand the use of high-deductible catastrophic health plans paired with tax-free health savings accounts. Unlike the ACA, the proposal does not include a requirement that plans cover a minimum set of health benefits. The proposal retains the ACA's prohibition on denials of coverage for preexisting health conditions. However, this consumer protection only extends to individuals who maintain continuous coverage. For uninsured individuals, the proposal would establish a one-time open enrollment period in which premiums could not be based on an individual's health history. For individuals who seek to enroll after a lapse of coverage, insurers would be allowed to adjust premiums to reflect an individual's health history. Federally subsidized state-based high-risk pools would be established for individuals who find themselves priced out of coverage.

The Ryan Proposal would retain ACA reforms allowing dependents up to age 26 to stay on their parents' plan and ending the practice of insurers imposing lifetime limits on the coverage provided to individuals. The proposal also would allow consumers to purchase a health benefit plan offered by an insurer licensed in another state and envisions the expansion of "innovative purchasing platforms" like "private exchanges." Under the ACA, insurers may not charge older insureds more than three times what they charge younger insureds for the same health plan in the same state. Viewing the three-to-one ratio as resulting in artificially higher premiums for younger and healthier individuals, the Ryan Proposal would allow a five-to-one ratio to better align premiums with costs.

Regarding the expansion of Medicaid under the ACA, the Ryan Proposal would not repeal expansion outright for states that have already expanded Medicaid. It would, however, gradually eliminate the enhanced federal share of funding for coverage of the ACA expansion population. Currently, the expansion is fully funded by the federal government; its share gradually decreases to 90% in 2020. Beginning in 2019 under the Ryan Proposal, the enhanced federal funding for the expansion population would be phased down each year until it reaches the normal funding level provided to states. The Ryan Proposal also calls for the allocation of federal funds to states either as per capita allotments or as block grants. Beginning in 2019 under the per capita allotment option, a total federal Medicaid allotment would be available for each state based on its federal matching rate. The amount of the federal allotment would be the product of the State's per capita allotment for the four major beneficiary categories – aged, blind and disabled, children, and adults – and the number of enrollees in each of those four categories. The per capita allotment for each beneficiary category would be determined by each state's average medical assistance and nonbenefit expenditures per full-year equivalent enrollee during the base year (2016), adjusted for inflation. Under the block grant approach, state funding would be determined using a base year in

a manner that would assume states transition individuals currently enrolled in the ACA Medicaid expansion into other sources of coverage.

## **President-elect Trump's Position on Health Reform**

As noted above, President-elect Trump has vowed to repeal the ACA and has signaled support for a number of reforms included in the Ryan Proposal, such as eliminating the individual mandate, allowing the sale of health insurance across state lines, increasing the use of tax-free health savings accounts, and funding Medicaid through block grants to states. President-elect Trump also supports requiring price transparency from health care providers; removing barriers to entry into the market for pharmaceutical drugs for manufacturers that offer safe, reliable, and cheaper products; and allowing the importation of pharmaceutical drugs from other countries to provide more options to consumers.

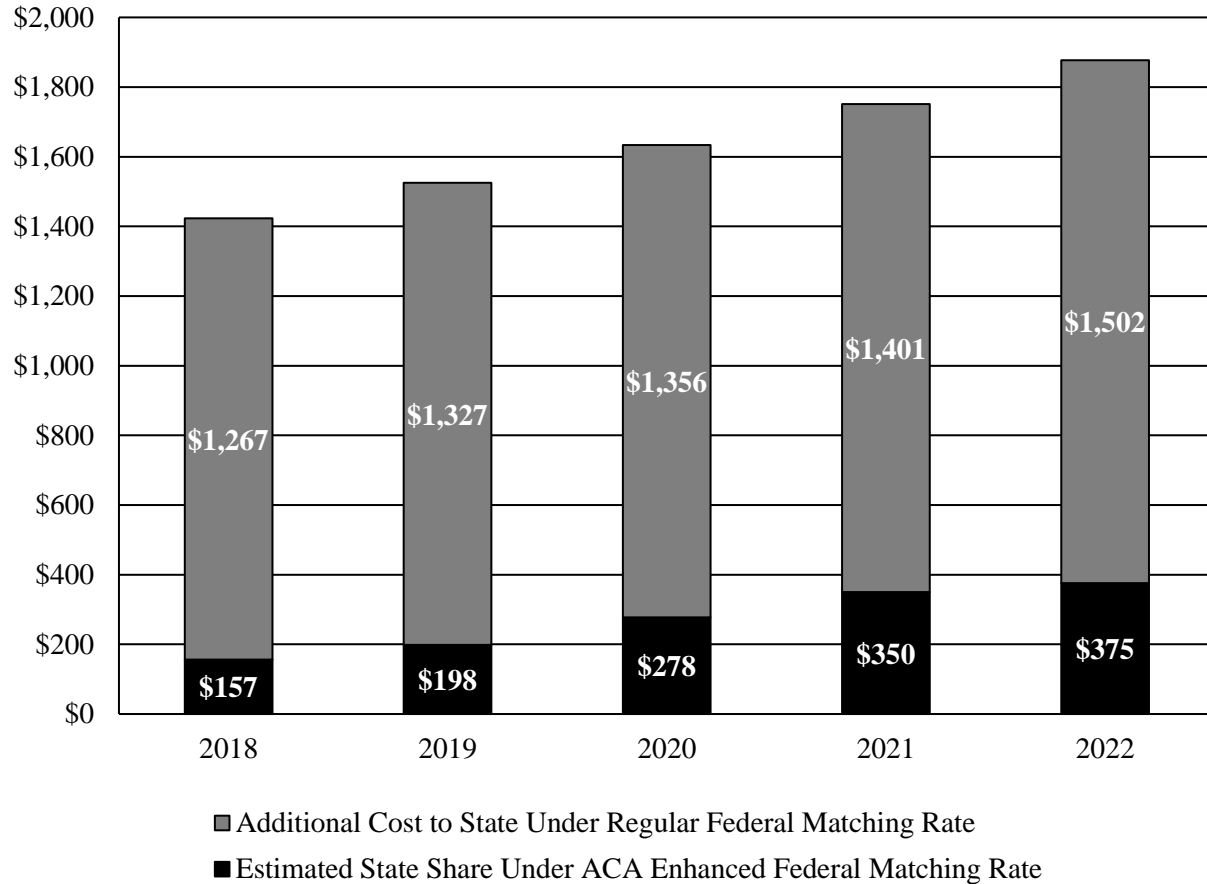
## **Consequences for the State from Repeal and Replacement**

Since the passage of the ACA, Maryland has moved to fully implement the health reforms ushered in by the law by enacting legislation establishing MHBE, expanding Medicaid eligibility, conforming State health insurance law to federal law, and requiring health insurance carriers to follow specific provisions of the ACA, in effect, allowing the Insurance Commissioner to enforce those provisions in the State. Legislation enacted to implement the ACA also closed enrollment in the Maryland Health Insurance Plan (MHIP) and provided for the transition of MHIP enrollees into MHBE.

While details remain uncertain, repeal or substantial amendment of the ACA and/or the adoption of alternative reforms could have a tremendous impact on Maryland and will likely require the General Assembly to consider significant financial and policy decisions, which are outlined below.

**Medicaid Expansion:** If the enhanced federal funding available for the Medicaid expansion is repealed, Maryland (along with 31 other states) must decide whether to maintain the expansion. If the State elects to preserve coverage, expenditures increase substantially. In fiscal 2018, the cost to serve the Medicaid expansion population is estimated to be \$2.8 billion, 94.5% of which is federally funded. As shown in **Exhibit 5.1**, in the absence of an enhanced federal matching rate, the net cost to Maryland (based on Maryland's traditional 50.0% matching rate minus the State liabilities currently assumed under the ACA) would be \$1.27 billion in fiscal 2018, rising to \$1.33 billion in fiscal 2019, and \$1.50 billion by fiscal 2022.

**Exhibit 5.1**  
**Additional Cost to Maryland to Cover the Medicaid Expansion**  
**Population at the Regular Federal Matching Rate**  
**Fiscal 2018-2022 Est.**  
**(\$ in Millions)**



ACA: Patient Protection and Affordable Care Act

Note: Additional cost reflects 50.0% (Maryland's regular Medicaid federal matching rate) of the total estimated cost to cover the Medicaid expansion population in each fiscal year minus the amount of State funds currently estimated to be provided under the enhanced federal matching rate available under the ACA. This rate is 94.5% in fiscal 2018, 93.5% in fiscal 2019, 91.5% in fiscal 2020, and 90.0% in fiscal 2021 and thereafter.

Source: Department of Legislative Services

Discontinuation of the Medicaid expansion could eliminate health coverage for as many as 286,000 enrollees.

**Loss of Enhanced Federal Matching Rate for Maryland Children's Health Program:** The ACA includes an enhanced matching rate for the Maryland Children's Health Program through September 2019, this rate is 88%. Loss of this enhanced matching rate would increase general fund spending by an estimated \$68.0 million in fiscal 2018, \$72.8 million in fiscal 2019, and \$19.5 million in fiscal 2020.

**Maryland Health Benefit Exchange:** Legislation enacted in 2011 and 2012 established MHBE with a primary function of certifying and making available qualified health plans (QHPs) to individuals and businesses and to serve as a gateway to an expanded Medicaid program under the ACA. A number of MHBE statutory functions, such as determining consumer eligibility for tax credits and facilitating enrollment in QHPs, are founded on the ACA and would likely need to be altered or discontinued if the ACA were to be repealed and replaced with the reforms of the Ryan Proposal. The State could elect to discontinue the operation of MHBE or continue the operation of MHBE as a marketplace with State funding and modified functions established by the State.

There is precedent for states establishing and operating exchanges without federal involvement. Before the ACA, Massachusetts operated a health insurance marketplace that offered subsidized coverage to individuals with income below a specified threshold and, for other individuals with incomes above the threshold, private health insurance plans that were subject to a standardized benefit design and other cost and quality standards. Utah also established an exchange, but with a more limited purpose of establishing a website that enables consumers to compare health plans.

In fiscal 2018, MHBE is estimated to be funded with a total of \$104.0 million (\$47.5 million in federal funds, \$56.3 million in special funds, and \$0.2 million in general funds). The special funds include \$35.0 million in premium tax revenues and \$21.3 million in former MHIP funds for the State Reinsurance Program (which is not planned to continue after fiscal 2018). State law mandates an annual appropriation of at least \$35.0 million to support MHBE.

**The All-payer Model Contract:** Repeal of the ACA could have a profound impact on the Maryland all-payer model contract that governs hospital rate setting. The contract is between the State and the Center for Medicare and Medicaid Innovation (CMMI), which itself was established by the ACA. If the ACA (including CMMI) is repealed, Maryland could eventually lose the model contract, putting in jeopardy \$2.3 billion in Medicare and Medicaid payments to Maryland hospitals per year. If the model contract continues, rising uncompensated care (UCC) costs could impede the State's ability to meet its obligation to limit annual growth in all-payer hospital per capita revenue and limit Medicare per beneficiary hospital cost growth. Under Maryland's all-payer system, the reasonable cost of hospital UCC is recognized in the payment rates of all hospitals. The Health Services Cost Review Commission has taken action to meet the growth

targets of the model contract, including approving a downward adjustment in hospital rates to reflect a reduction in UCC, due to the ongoing impact of Medicaid expansion.

***Mandated Benefits in Health Benefit Plans:*** The ACA requires health benefit plans offered to individuals and small employers to include a comprehensive set of essential health benefits (EHB) and delegates to states the authority to select a benchmark plan that includes EHBs. State law specifies that EHBs must be included in the State benchmark plan and, notwithstanding any other benefits mandated by State law, must be the benefits required in all non-grandfathered individual health benefit plans and health benefit plans offered to small employers.

If the ACA were to be repealed and replaced with the Ryan Proposal, the State likely would need to determine the coverage requirements for health benefit plans that no longer would be subject to the minimum coverage requirements under the ACA. For plans offered to individuals, there are a number of benefits mandated by State law that have continued to apply to plans grandfathered from ACA requirements. The State could elect to extend the State coverage requirements to all plans offered to individuals. In addition, certain benefits are mandated under the ACA that are not mandated under State law, such as pediatric dental and vision coverage. The State may need to decide whether to require plans to continue to cover these ACA-mandated benefits.

With respect to health benefit plans offered to small employers, the State would need to decide whether to reinstate State-established small group market reforms that have been replaced by the EHB coverage requirements of the ACA. Small group market reforms adopted by the State in 1993 required small group insurers to offer the Comprehensive Standard Health Benefit Plan (CSHBP), a minimum level of coverage, to all small employers. The Maryland Health Care Commission would annually update and modify the CSHBP to keep the average cost of coverage under control. The Ryan Proposal envisions a market in which insurers have more flexibility in designing their benefits and consumers are allowed to purchase plans across state lines. Such features of federal policy could have an impact on the State's ability to establish benefit standards for and control the cost of plans available to consumers in the State.

***High-risk Pool:*** For over a decade, Maryland operated MHIP, a high-risk pool offering subsidized coverage for medically uninsurable individuals. The ACA's prohibition on the denial of coverage for a preexisting health condition eliminated the need for MHIP and legislation repealed MHIP and the assessment on hospital rates used to operate and administer MHIP. A repeal of the ACA and adoption of the Ryan Proposal could revive a need for a high-risk pool in the State, like MHIP, as the proposal calls for the establishment of federally subsidized state-based high-risk pools to provide coverage to individuals who do not enroll in insurance coverage during a one-time open enrollment period and are then unable to obtain affordable coverage due to a preexisting health condition. MHIP was funded with an assessment on hospitals that was added to hospital rates. In fiscal 2014 (the last full year of the program), MHIP expenditures totaled \$137.3 million. Restoring MHIP with the same funding source would add costs to hospitals.

**Changes to State Insurance Law:** Through a series of legislative actions beginning in 2011, the State has adopted a number of changes to State insurance law to conform with and implement the ACA and corresponding federal regulations. A repeal of the ACA and adoption of the reforms under the Ryan Proposal may require the State to rollback and alter a number of these provisions that have been adopted. For example, State law requires health insurance carriers to follow specific provisions of the ACA, such as provisions relating to preexisting condition exclusions and policy rescissions, minimum loss ratio requirements, and annual limits for essential benefits. If federal legislation were to repeal or modify any of these provisions, changes to State law may be needed to harmonize State requirements on carriers.

In addition, State legislation repealed a number of provisions of insurance law obsolete under the ACA. For example, provisions of State law have been repealed that required group insurance policies to allow insured individuals whose coverage is terminated to obtain an individual policy (known as a conversion policy) from the insurer. These provisions were repealed because under the ACA an individual who loses coverage at any time during the year may enroll in a QHP offered through the individual exchange. Provisions of State law requiring health benefit plans to offer certain ACA-required open and special enrollment periods could be affected as well by a repeal and replacement of the ACA.

State legislation repealed provisions of insurance law that authorized the imposition of preexisting condition limitations under certain circumstances as such limitations are no longer allowed under the ACA. While the Ryan Proposal indicates that the prohibition on this underwriting practice would continue generally, it also states that a decision by an individual to forego coverage during a one-time open enrollment period would result in the “forfeiture of continuous coverage protections and lead to higher health insurance coverage costs for that individual for a period in the future.” It is unclear whether this proposal would merely allow an insurer to price a plan based on an individual’s health history or also again allow an insurer to impose preexisting condition limitations. If insurers are allowed to engage in this medical underwriting practice under certain circumstances, there may a need to reestablish standards in State law that govern the practice of medical underwriting by insurers.

**Changes to Medicare Prescription Drug Benefits:** The Medicare Modernization Act of 2003 established prescription drug coverage for Medicare (Part D). However, this coverage included a gap, known as the “donut hole,” which begins once a beneficiary reaches the initial coverage limit (\$3,700 in 2017) and ends when the beneficiary spends a higher catastrophic threshold (\$4,950 in 2017). Medicare beneficiaries were responsible for 100% of expenses while in the donut hole. Under the ACA, prescription drug copayments are phased down to 25% by 2020 and the donut hole is fully phased out by 2020. Should the ACA be repealed, Medicare beneficiaries would again be responsible for paying 100% of the costs of their prescription drugs while in the donut hole. According to the Commonwealth Fund, between 2010 and 2015, nationally eight million Medicare beneficiaries saved more than \$11.5 billion on prescription drugs under the phase-out of the ACA’s provisions that close the donut hole.



Under § 2-509.1 of the State Personnel and Pensions Article, the State must provide a prescription drug plan to retirees under the State Employee and Retiree Health and Welfare Benefits Program (State Plan). However, Chapter 397 of 2011 discontinued prescription drug benefits for Medicare-eligible retirees beginning in fiscal 2020. Exclusion of Medicare-eligible retirees from the prescription drug program significantly reduced the State's unfunded Other Postemployment Benefits (OPEB) liability. Therefore, if the donut hole is not fully phased out as provided under the ACA, Maryland may need to reconsider the 2011 decision and possibly reinstate prescription drug coverage for Medicare-eligible retirees, which would increase State Plan costs and the State's OPEB liability.

### **Proposed Fixes and the Need to Monitor Changes in Federal Health Policy**

Given the results of the U.S. election, substantial revision or repeal of the ACA is anticipated. The change in leadership in Washington underscores the importance of monitoring legislative and policy initiatives under consideration at the federal level, such as the Ryan Proposal, in light of the potentially significant impact that a change in federal health policy could have on the State.