

ACA Implementation—Monitoring and Tracking

Maryland

Site Visit Report

February 2012

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Robert Wood Johnson Foundation



With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers and policy-makers learn from the process as it unfolds. This report is one of 10 state case study analyses. The quantitative component of the project will produce analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit <http://www.rwjf.org/coverage>.

BACKGROUND

Governor Martin O'Malley and his administration were very supportive of national health care reform throughout the debate and continuing through the passage of the Affordable Care Act (ACA) and beyond. The day following enactment of the law, O'Malley created the state's Health Care Reform Coordinating Council (HCRCC) to oversee implementation of the federal law in Maryland.¹ The high-level advisory group is led by Lieutenant Governor Anthony Brown and is comprised of cabinet secretaries, chairs of the state's health commissions, and members of the state legislature. The group had an aggressive meeting schedule from the start, with eight meetings between May and December 2010 alone. This ambitious meeting schedule right out of the box and the expectation of commitment, coordination, and cooperation at the highest levels of the administration were credited by multiple key informants interviewed for this study with setting the tone for the state's efforts and allowing them to move forward efficiently in meeting important milestones, such as enactment of state laws for implementing the federal reforms, obtaining stakeholder input, and contracting with consultants to inform exchange design decisions.

On April 12, 2011, Maryland enacted SB 182 and HB 166, the Health Benefit Exchange Act of 2011, establishing a state health insurance exchange (HIX) as an independent unit of state government, referred to in the legislation

as a "public corporation." The legislation delineated the requirements and standards for members of the exchange governing board, as well as the board's duties and those of the executive director of the exchange. The focus of the legislation is the exchange's governance structure, but it also commissioned six studies on particular policy issues, to inform the exchange design decisionmaking process. Explicit decisions on a broad array of policy choices facing the state were not included in the initial legislation, allowing the process to move forward without becoming bogged down and potentially derailed by controversies during the first year. The law provides the exchange with the ability to implement the federal law (including qualifying and contracting with health plans, providing consumer information, etc.) and lays out a structured approach for stakeholder engagement. The law also makes clear that many major policy decisions that will characterize the nature of the exchange must be made with the approval of not just the governor and the exchange board, but also the state legislature.

In addition to legislation establishing the exchange, Maryland has also enacted legislation (SB 183/HB 170) adopting the ACA's early implementation insurance market reforms as state law. The legislation authorizes the state's insurance commissioner to enforce the insurance reforms currently in effect under the ACA, including

benefit expansions, medical loss ratios, disclosure of information and external review.

The legislation requires the board of the exchange to create and consult with advisory committees. The advisory committees are comprised of a broad array of stakeholders, including insurance carriers, producers (brokers and agents), third-party administrators, health care providers, employers, public employee union members, consumers, consumer advocates, public health researchers and other academics with relevant knowledge and expertise, and any other stakeholders identified as important. Each advisory committee holds regular public meetings and provides notes of the proceedings on the state's website. Since our visit to the state, a bill has also been introduced in the legislature that includes recommendations by the exchange board on particular policy design issues.²

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Unlike the situation in many states, the political environment in Maryland is quite unified, with a Democratic governor and Democratic majorities in both chambers of the state legislature. As such, there was no doubt that the state would take steps to actively implement the ACA, and no strong organized opposition to moving forward. Many of the major design issues that could engender some degree of controversy were put off pending the results of the studies, so significant policy debates are still likely to occur now that the next piece of exchange legislation is being considered. Two areas where some policy disagreements surfaced early on, however, were related to the governance structure of the

exchange and the conflict-of-interest protections related to the exchange board's composition.

Some stakeholders originally advocated for the exchange to be a nonprofit, as opposed to a quasi-governmental entity. However, extensive conversations about the transparency and accountability protections that go along with a quasi-governmental entity but which would not necessarily constrain the operations of a nonprofit led to an agreement for the former. The name of the entity type was changed, however, to a public corporation.

The governor and lieutenant governor were strongly committed to rules that would eliminate the possibility that members of the exchange board or their employers would have a financial stake in the outcome of the board's policy decisions and recommendations. This meant that board members were prohibited from having an affiliation with a carrier, an insurance producer, a third-party administrator, a managed care organization, a trade association representing these entities, or any other entities in a position to contract directly with the exchange. This approach met with resistance from the stakeholders excluded from board representation, as they felt that the expertise of their membership would be valuable to the decisionmaking process. The administration developed the advisory committee system described above as a mechanism to ensure sufficient input to the policy process by knowledgeable stakeholders. As a result, universally, all stakeholders described the exchange development process as being extremely inclusive, and all felt their issues and views were getting an appropriate hearing.

According to Urban Institute estimates based upon the Health Insurance Policy Simulation Model, in 2011 67 percent of those Marylanders below age 65 had employer-sponsored health insurance, 5 percent had nongroup coverage, 11 percent had Medicaid or CHIP, 2.5 percent had other public coverage, and 14.5 percent were uninsured. If the ACA were fully implemented today, the uninsured would fall from 734,000 to 421,000.³

INSURANCE EXCHANGE: PLANNING AND IMPLEMENTATION

The state of Maryland is one of the first states to legislatively establish an exchange and the first to name an executive director for the exchange. Maryland has applied for and received the range of federal funds available to support development and implementation

of exchanges, including a planning grant,⁴ a level one establishment grant,⁵ and an early innovator grant.⁶

Maryland appears to have taken enthusiastically to the challenge of implementing the ACA, and was happy to

have some flexibility to shape it in a way consistent with the state's priorities, values and history. The state has had experience developing programs and rules intended to expand insurance coverage and increase affordability for purchasers of medical care. This includes the development of a successful high-risk insurance pool, the establishment of the Maryland Health Care Commission, reforms of the private small group insurance market (including a standardized benefit package in this market), expansions of Medicaid and CHIP coverage, and maintenance of a long-standing all-payer system for hospital care. The state's history of commitment to and expertise in health issues led policy-makers to view the ACA implementation process as one that would entail significant challenges, but as a process that the state would embrace. While the state was predisposed to health care reform prior to the passage of the ACA, fiscal stresses would not have allowed Maryland to move forward without the federal funds provided through the law.

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Overall, the exchange development process in Maryland appears to be an aggressive one—there was a strong interest by the administration to demonstrate an ardent commitment to reform and the ACA, yet the nature of the early activities was limited largely to structural decisions. This somewhat tempered approach is allowing policy-makers the time to carefully analyze and assess the most challenging policy design choices that must be made. As one informant put it, the state is ahead of the others, but it feels like it is merely a week ahead, since the difficult decisions are yet to be made. One example cited by advocates was an early decision not to push forcefully for selective contracting in the exchange, as it became evident that doing so early on could impede passage of establishment legislation.

The exchange establishment legislation clearly delineates the goals of the exchange:

1. Reduce the number of uninsured in the state;
2. Facilitate the purchase and sale of qualified health plans in the individual market by providing a transparent marketplace;

3. Assist qualified employers in facilitating the enrollment of their employees in qualified health plans in the small group market and in accessing small business tax credits;
4. Assist individuals in accessing public programs, premium tax credits, and cost-sharing reductions; and
5. Supplement the individual and small group insurance market outside of the exchange.

There is widespread enthusiasm in the state for creating an exchange that operates smoothly as a “one-stop shop” for Medicaid, small group, and nongroup coverage, and ensures that obtaining coverage is not burdensome for consumers. Identifying and implementing that vision in a relatively short period of time, however, is seen as a substantial challenge. A number of informants agreed that at least the initial emphasis on exchange operations has to be on efficient enrollment of qualified individuals. Without sufficient enrollment, risk issues could become an insurmountable problem, plans could be reluctant to participate, and public perceptions of the quality of exchange coverage could be compromised. However, the addition of goal 5, which explicitly identifies the exchange as being a supplement, not a replacement for existing individual and small group markets in the state, is notable. This later addition to the original list of purposes included in earlier versions of the bills reflects the concerns of some producers (i.e., agents and brokers) that the state not allow the exchange to become the exclusive source of private insurance coverage for individual and small employer purchasers. Its addition also reflects the political strength of the producers in the state, their intense involvement in the health reform planning process, and the sensitivity of policy-makers to their concerns.

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As noted above, four advisory committees were established for the exchange, chiefly as a mechanism for stakeholders to have sufficient opportunities to provide input into the policy decision process surrounding reform. These advisory committees, identified by the topic areas they cover, are:

- Finance and sustainability;
- Navigators and enrollment;
- Operating model and insurance rules; and
- Small business health options program (SHOP).

One exchange board member serves as a liaison to each advisory committee.

The exchange legislation requires the exchange, in consultation with the advisory committees, to study an array of policy issues in six areas:

1. *Operating rules* (the feasibility and desirability of selective contracting, competitive bidding or other negotiation processes, and multistate or regional contracting);
2. *Market rules and risk selection* (the rules under which health benefit plans should be offered inside and outside the exchange, with the goal of mitigating adverse selection);
3. *Financing the exchange* (how the exchange can be self-sustaining by 2015 in compliance with the ACA);
4. *SHOP* (design and function of the SHOP exchange beyond the requirements of the ACA, including whether the individual and small group market should be merged, and the definition of small employer prior to 2016);
5. *Navigator program* (design and operation of the exchange's navigator program and any other appropriate consumer assistance mechanisms); and
6. *Public relations and advertising* (how the exchange should conduct its public relations and advertising campaign).

The exchange thereby entered into contracts with six independent consultants to provide factual information on these issues and develop policy options but not recommendations. The advisory committees took this information into account when reporting to the exchange board, and the board took the six studies and the advisory committee reports into account when advising the governor and the state legislature on the various policy options.

Stakeholder and consumer advocate participation is very high on all of the advisory committees. In general, the broad spectrum of interests report attending every advisory group meeting held. While uncertain of the policy design decisions to come, they universally consider the process that has been set up by the state to be an

inclusive one, and all felt that their issues and concerns were being heard.

While no decisions will be made pending the completion of the legislative debate and process, there appears to be significant interest in the possibility of using the three existing third-party administrators (TPAs), broker entities that are integral parts of the state's small group market, as contractors to provide the structure of the SHOP exchange. These TPAs combined account for virtually the entire small group market in the state and have an already established system of enrollment, disenrollment, billing, and other administrative functions. As such, there is a perception that adapting their administrative infrastructure to fulfill the SHOP exchange's needs could create substantial efficiencies for the state while increasing SHOP participation by small employers who are already familiar with the entities. This orientation is reflected in the recommendations of the exchange board: "The exchange should analyze options for partnering with existing resources in the state in developing the SHOP exchange. This analysis and a plan for the partnership should be established before the end of the second quarter of 2012 in order to allow enough time for implementation."⁷

However, policy decisions related to the role of brokers and, particularly, whether they will have a role in the navigator program⁸ are likely to be among the most controversial decisions made. There is a strong perception among the advocacy community that the brokers will not play an effective outreach and education role for high-need and low-income communities, and that those serving such communities today will be necessary in order to ensure that these vulnerable groups are enrolled in coverage effectively. The exchange board has recommended separate navigator programs for the individual and small group markets, integrating the programs with Medicaid outreach and enrollment efforts in order to increase continuity for those changing sources of coverage.⁹ The recommendations are to allow producers to sell qualified health plans in the exchanges, but their compensation would come from the carriers themselves, not the exchange navigator program. A separate navigator program would be developed in each market, and these state-certified navigators would be compensated by the exchanges. The board also recommends that the Maryland Insurance Administration (MIA) develop an enforcement model for navigator misconduct.

None of the informants anticipated that the state would supplement the federal exchange-based tax credits for low-income people with additional funds to increase

affordability, at least in the near term, due to the state's current difficult fiscal situation. However, there is a particularly recognized concern that the federal end-of-year tax reconciliation of these credits could leave some modest income purchasers whose incomes rise during the year with unexpectedly high tax liabilities. The concern is that individuals would be dissuaded from enrolling in subsidized coverage for fear of an uncertain end-of-year cost. Policy-makers did acknowledge that there were alternative approaches to realizing the same goal of making coverage more affordable for families, including creating a Basic Health Program ((BHP), for families with incomes up to 200 percent of the federal poverty level (FPL)).

While serious discussions related to particular design issues were delayed until the studies were released in mid-November (after our site visit interviews)¹⁰ and the board made its recommendations in late December, at least some anticipated that the state will take an active role in correcting flaws in the insurance markets, particularly in the realm of transparency and data. The Health Care Commission has, since its inception, collected and analyzed data and engaged in a considerable amount of information sharing, assessed the appropriateness of mandated benefits, been involved in the certificate of need process, developed and modified standardized benefits in the small group market, and focused on quality of care issues. Providing consumers with accurate information on available plans is expected to be a high priority, and the experience of the commission sets a related precedent (perhaps strongest in the small group market) that could expand more comprehensively to the individual market under the ACA.

The commission is also expected to play a critical role in the assessment of any state-mandated benefits that do not fall within the pending federal guidelines for essential health benefits. While government informants were anticipating controversy over how to address continued coverage of the state's mandates, it is possible they could sidestep some of that controversy because of recent guidance issued by U.S. Department of Health and Human Services (HHS). On December 16, 2011, HHS released a bulletin on essential health benefits¹¹ suggesting that, instead of one national standard for EHB, states may choose among four benchmark options: (1) the largest small employer plan in the state, (2) any of the three largest state employee health benefit plans, (3) any of the largest three national Federal Employee Health Benefits Program options, or (4) the largest commercial health maintenance organization operating in the state. If

Maryland officials choose a benchmark plan that already includes existing state benefit mandates, the mandates will be included as part of the minimum EHB and the state will not need to account for or pay for them as additional benefits for at least two years.¹² The exchange board has recommended that the state have the EHB decision made no later than September 30, 2012.¹³

Each advisory committee report reflects the varied views of that committees' membership and their views of the consultant reports. As a result, there are few areas of agreement, and the reports largely summarize the various reactions to the consultant analyses. The consultant reports provide information on options and their advantages and disadvantages, but consultants were specifically asked not to make policy recommendations. The advisory committee reports do reflect a few areas of greater member agreement, however. The exchange board made final policy recommendations to the governor and the legislature for their approval in the following areas where at least a majority of committee members seemed to be in agreement:

- Delaying a potential merging of the small group and nongroup markets;
- Maintaining the definition of small employer at two to 50 employees until 2016;
- Providing the exchange board and executive director with the flexibility to include criteria beyond those delineated in the ACA for certifying qualified health plans; and
- The complexity and consequent undesirability of collaborating with other states to jointly certify qualified health plans, but the flexibility to assess requests from other states.

Additional exchange board recommendations include:

- Requiring small group and non-group carriers of minimum sizes to offer products in the exchanges, as well as requiring carriers offering a catastrophic plan outside the exchange to also participate in the exchange. Both strategies are intended to mitigate adverse selection in the exchanges;
- Allocating the state's assessments that currently fund its high-risk pool to the exchange starting in 2014 in order to mitigate the effect on premiums of enrolling current high-risk pool enrollees in the mainstream exchange pool;
- Offering the federally required level of employee choice in the SHOP exchange to start, thus allowing

a small employer to offer its workers only one issuer in the exchange, while reevaluating the employee choice options in 2016;

- Using a broad-based assessment to finance the exchange, combined with some transaction fees tied to exchange enrollment; and
- Using federal grant funds to develop and implement a broad marketing and outreach campaign for the exchange.

Coordination across multiple state agencies has been one of the challenges faced so far in the exchange planning and development process. The Department of Health and Mental Hygiene (DHMH), responsible for administering the Medicaid program (among others), has been a very active player, with Secretary Joshua Sharfstein taking a prominent leadership role. The Department of Human Resources (DHR), which administers a number of social

services programs, is also responsible for Medicaid enrollment and eligibility determination, a critical task for both the soon-to-be expanded Medicaid program and the exchanges under the ACA. In addition, as mentioned above, the Health Care Commission plays a number of roles in the current state health care system and is intended to coordinate with, but does not report to, DHMH. The MIA has an important role to play in the exchange as well. Each agency has somewhat different priorities, and not surprisingly, had somewhat different visions for how the planning and development of the exchange would proceed. Such coordinating tensions seem to be common to most states actively engaged in the reform process, and creating a highly interactive process among agencies previously operating in a siloed fashion can be difficult. However, Maryland appears to have moved past these challenges in large part,

Key Provisions of Maryland's Health Insurance Exchange Law (SB182/HB166)

- Establishes Maryland Health Benefit Exchange as a public corporation (an independent unit of state government).
- Provides for exemptions to certain state personnel rules for exchange staff.
- Establishes board of trustees and rules of its terms and composition: Secretary of Health and Mental Hygiene, Commissioner of the Insurance Administration, executive director of the Health Care Commission, three members representing interests of employers and individual consumers of exchange products (appointed by governor with advice and consent of Senate).
- Sets strong conflict-of-interest provisions in composition of board that prohibit affiliation of trustees with carriers, third-party administrators, managed care organizations, or those contracting directly with exchange.
- Requires board to perform all necessary duties to comply with the state exchange law and the ACA, including:
 - Making qualified health plans available to qualified individuals and employers; developing procedures for certifying, recertifying, and decertifying health plans as qualified; creating website and toll-free hotline; presenting standardized information on plans; facilitating enrollment in public programs as well as exchange-based subsidies and coverage; developing an electronic cost calculator for consumers; providing appropriate consumer assistance; and establishing a navigator program.
 - Creating and consulting with advisory committees and appointing representatives of an array of stakeholder groups, consumers and experts to them.
 - Studying and making recommendations regarding an array of design issues (e.g., selective contracting, multistate contracting, strategies for mitigating adverse selection, mandated benefits, the navigator program, design and function of SHOP exchange).
- Establishes the Maryland Health Benefit Exchange Fund to provide funding for the operation and administration of the exchange.

and many credit the establishment of the high-level coordinating council for that progress.

There was also a sense, expressed over multiple informants of different types and responsibilities, that delays in federal regulatory and other guidance were impediments to the state's progress in the exchange development process. One often repeated concern was the lack of information on the essential health benefits that will be required in small group and nongroup plans beginning in 2014. While a bulletin was issued on this

topic since our interviews, an array of issues related to essential health benefits remain undecided. The state's exchange establishment legislation requires many of the exchange design decisions to be made with legislative approval, and state officials are highly attuned to the fact that the state's legislature is part-time. Without the necessary information on which to base such policy decisions, the legislature may go out of session, and then the state would be unable to have the approval necessary to construct the exchange infrastructure in time to meet federal deadlines.

HEALTH INSURANCE EXCHANGE: ENROLLMENT AND SUBSIDY DETERMINATIONS

With just over two years to go before implementation of the ACA's required health insurance exchange and Medicaid expansion, much work remains to be done to establish Maryland's process for eligibility and subsidy determination. However, policy-makers fully embrace the philosophy embedded in the ACA that this system should ultimately be "seamless" and capable of working "behind the scenes" to process applications and assure that consumers are placed in the correct program for which they are eligible. Furthermore, Maryland has the advantage of building this system upon a strong public program foundation—the state has a long and positive track record for adopting policies and strategies to simplify and streamline enrollment (and retention) in both Medicaid and the Maryland Children's Health Program (MCHP). For example, Maryland is one of just eight states that have adopted Express Lane Eligibility,¹⁴ using (in Maryland's case) information from state income tax records to make initial Medicaid eligibility determinations for children. The state has also developed simplified joint applications for Medicaid and MCHP, eliminated requirements for a face-to-face interview with social services staff (by permitting applications to be submitted by mail), and dropped assets tests from eligibility procedures, among other strategies.

Maryland Leading the Way with IT Development

To support its building of a system for HIX eligibility and subsidy determination, Maryland has invested an enormous amount of time and energy in information technology (IT) development. Widely considered (along with the State of Oregon) as a national leader in IT, in 2011 Maryland received a \$6.2 million early innovator

grant from the U.S. Department of Health and Human Services. Monies were used to hire a chief innovations officer—an individual with private-sector IT experience in both Silicon Valley and Europe—and to establish an interagency team, possessing strong management and subject matter expertise, to design a vision for the IT system and develop a solicitation for a vendor to support that system.

Described by one high-ranking state official as, "without question, the single most stressful piece of health reform," IT planning is showing good progress in Maryland. Initially, the state's early innovator grant envisioned building the HIX system off the Healthy Maryland electronic application architecture. This pilot program, operating in a handful of counties, uses a web-based application to gather applicant information and determine eligibility for multiple state health programs. Critically, however, it also then falls back on Maryland's 30-year-old legacy computer systems (called CARES) to actually determine eligibility. The state's new IT team, bolstered by input from DHMH and DHR officials, quickly concluded that this approach would not succeed, that the old system would not be adequate to the task and would not be able to "perform the new tricks" required of the exchange. Therefore, with the support of the Center for Consumer Information and Insurance Oversight (CCIO), Maryland modified its innovator work plan and designed a new front-end system to determine eligibility for both HIX subsidies *and* the Medicaid populations whose eligibility will be determined using modified adjusted gross income (MAGI) beginning in 2014. "Legacy" populations, such as the elderly and disabled, will continue to be processed through Maryland's traditional eligibility systems for the

time being. The principles underpinning the new system are that it be:

- Modular (i.e., designed to allow other programs and populations to be added to the system over time);
- User focused (i.e., designed based on how administrators, eligibility staff, navigators and, most importantly, consumers will use the system); and
- Interoperable (i.e., capable of communicating in real time with other data systems to access and exchange information).

Most importantly, Maryland officials want to avoid purchasing a custom-built system that would require the state to rely on a vendor, in perpetuity, for future coding and programming needs. Indeed, they are confident that various IT vendors will have been anticipating such needs among the states and that they will be able to procure an off-the-shelf product meeting their requirements.

A request for proposals (RFP) to solicit a vendor to support the Maryland Health Benefit Exchange was released in October 2011.¹⁵ The RFP specifically calls for proposals to develop and support a single IT infrastructure to evaluate eligibility for exchange plans, Medicaid/MAGI, MCHP, and advance premium tax credits and cost-sharing reductions. Given the aggressive implementation timeframe required by the ACA, these health coverage-related components constitute the core of the Phase I solicitation. However, the RFP also asks for capabilities statements for an eventual further expansion to integrate eligibility determinations for non-MAGI Medicaid populations (Phase II), as well as other human services programs—such as the Supplemental Nutritional Assistance Program (SNAP) and Temporary Assistance to Needy Families (TANF)—(Phase III) into the HIX. Maryland officials were (at the time of this writing) hoping to make an award in early 2012 and plan to secure federal matching dollars (at an enhanced 90/10 rate¹⁶) to support purchase and maintenance of the new IT system.

Anticipating Implementation Challenges

Though the vast majority of policy-makers' attention, thus far, has been paid to the design and solicitation of the exchange IT system, many officials were also anticipating the challenges that might ensue when it comes time to implement this system at the local level. Maryland operates a state-administered eligibility system through its network of local Department of Social Services (DSS) offices, essentially arms of the state DHR. Local DSS offices process applications for Medicaid and MCHP, as well as for social service programs like SNAP and

TANF. There is already some anxiety and confusion being expressed by local DSS officials and caseworkers about how the implementation of federal health reform may affect their roles, responsibilities and, to the extent the new system is fully automated, jobs. For now, the HCRCC has expressed its vision that local offices will be partners. But it also acknowledges that local DSS roles will change over time, as the state introduces new methods for applying to Medicaid, MCHP, and social services programs. Change management—a structured process for helping staff transition from current roles and functions to future roles and functions—will be a challenge for Maryland, according to key informants interviewed for this study. But it was also identified as a critical step to successful implementation of the ACA coverage expansions. A related challenge will be coordination between DHMH and DHR. Though there are historic tensions between the two agencies, Maryland officials noted the importance of interagency collaboration moving forward, as well as positive early signs of collaboration surrounding the recent development of the IT vendor solicitation.

Maximizing Enrollment in Medicaid and Exchange Plans

The legislation establishing Maryland's HIX did not include specifics regarding key policy and implementation strategies. Rather, the six study groups mentioned above were authorized to assess alternatives and their implications. Two of those studies, released in mid-November 2011, have direct relevance to the question of how Maryland might maximize enrollment in subsidized coverage through both the exchange and Medicaid. The first, conducted by Weber-Shandwick (the same firm that worked with Massachusetts on its public relations campaign for the MassHealth reform initiative), analyzes public relations and advertising strategies intended to raise public awareness and provide consumers with information about newly available coverage. The study includes an environmental scan and market analysis to identify and prioritize audiences for the state's advertising and public relations campaign, and describes three potential levels for the campaign—Basic, Plus, and Full-Scale—distinguished by cost (option costs range from \$2.45 million to \$6.3 million in year one) and intensity of effort. The advisory committee charged with making recommendations on this study has, in turn, provided a report outlining advantages and disadvantages of each level and suggesting overall design considerations for the campaign, which include (among others) quantifying how additional media efforts result in increased enrollment,

beginning to address myths about the ACA and education of key stakeholders now (as opposed to just before the exchange is launched), and designing a campaign that supplements rather than replaces the health insurance market currently served by brokers.

The second study relevant to maximizing exchange enrollment, conducted by Manatt Health Solutions, assesses approaches to designing and implementing the exchange's navigator program, intended to help employers and consumers in applying for coverage through the exchange. This study describes two options for designing a navigator program for the individual exchange market and two options for a navigator program in the SHOP—the options are distinct in the contracting/employment relationship that the exchange would have with navigators and in the role that brokers would play in each. For instance, in one option brokers could choose to become certified navigators to sell exchange-based health insurance products, while also continuing to sell coverage outside of the exchange; in another option, brokers could sell policies through the exchange but not as navigators—the exchange would directly employ a limited number of navigators to serve employers who opt not to use a broker and fill in gaps in the broker distribution channel. The advisory committee considered the advantages and disadvantages of each option (and developed a third option for the SHOP navigator program) and, while they did not expressly recommend one option above others, suggested guiding

principles for the program. These include the need for a transparent, coordinated effort on recruitment, training, and management of the navigator program and consideration of the cross-system compatibility of the SHOP and individual options.¹⁷ The recently introduced legislation takes the second approach—separating the roles of brokers and navigators, with the brokers being compensated by insurance carriers and the navigators paid by the exchange.

A number of informants interviewed for this case study expressed concern that the state's focus on consumer outreach and communications was lagging. Advocates, in particular, believe that the state, at this point, lacked a cohesive communications strategy for health reform implementation. Indeed, they pointed to what they saw as a fairly poor track record for past state efforts to conduct outreach and advertising campaigns for public program expansions. Still, these groups acknowledged that Maryland had done a commendable job of inviting consumer advocates "to the table" for discussions of reform implementation. And they were cognizant of the impending release of studies and the Governor's Office's intention of launching a communications strategy group in the near future, and thus were hopeful that attention to this critical area would soon crystalize. In the meantime, advocates were working to get the word out through such means as newsletters, meetings with community groups, and other forms of outreach to consumers.

INSURANCE REFORMS

Maryland has enacted legislation that provides the MIA with authority to enforce the insurance regulations delineated in the ACA that went into effect on September 23, 2010.

Maryland has enacted legislation (SB 183/HB 170) that provides the MIA with authority to enforce the insurance regulations delineated in the ACA that went into effect on September 23, 2010.

The legislation is highly consistent with the ACA's regulatory standards, and informants relayed that no controversies were associated with its passage. The state has yet to pass legislation that would make state insurance law conform to the ACA's more expansive

insurance reforms to be implemented in 2014, but they planned to do so and did not expect it to be controversial legislation either.

The MIA made significant efforts to facilitate compliance with the ACA's early consumer protections in insurance markets. For example, the staff developed template language for amendment riders that carriers could rely on when bringing policy forms into compliance with these protections.¹⁸ In addition, they issued guidance on complicated questions surrounding the implication of the grandfathering rules. While carriers changing policies in a way that went beyond the minimum requirements of Maryland and federal law would have to modify the template language somewhat, the intent was to assist carriers in drafting amendments to their filings that were necessary to comply with portions of the ACA.

Highlights of Insurance Reforms in Maryland's Legislation

- Requirement to allow children up to age 26 to stay on a parent's policy;
- Prohibition of lifetime dollar coverage limits;
- Phased-in elimination of annual dollar limits;
- Guaranteed issue and elimination of preexisting condition exclusions for children under 19;
- Prohibition on rescissions;
- Access to choice of primary care and OB/Gyn providers;
- Access to out-of-network emergency care;
- Requirement for insurers to establish internal and external appeals processes.

Issues with Early Market Reforms

There was an initial backlash by carriers, however, against the new rules requiring guaranteed issue for children and prohibiting preexisting condition exclusions for them. The state's insurance carriers decided to stop selling child-only policies in the nongroup insurance market. Through negotiations with the MIA, CareFirst, the state's largest insurance carrier, agreed to continue to provide child-only policies on the condition that the state could identify at least one additional carrier that would also do so. The MIA was able to secure such an agreement with Kaiser Permanente, and so the child-only policies, a very small fraction of any carrier's business, continue to be provided in the state with no obvious adverse selection consequences.

The Maryland Insurance Administration made significant efforts to facilitate compliance with the ACA's early consumer protections in insurance markets.

The MIA also drafted materials directed to consumers to explain grandfathered status for insurance plans; grandfathered plans (those in place at the time of the law's enactment and not changed substantially since) are exempt from a number of consumer protections introduced by the ACA. Still, this issue remains a challenging one, particularly for issuers in the small group market. Since the federal law includes significant changes in worker versus employer premium cost-sharing as a modification that could end grandfathered status of a plan, and because carriers generally have been unaware of how workers and employers split premium costs, it creates a new system issue that needs to be

addressed. Calculations necessary for determining grandfathered status are complex, with comparisons required between current or contemplated coverage and the coverage in place at the ACA's passage, and small employers may ignore worksheets sent to them by the carriers as a result. Without an information flow from small groups to carriers—and most small employers use brokers and are not used to interacting with the carriers directly—it is difficult for the carriers to obtain the information necessary in order to identify whether a policy is grandfathered or not. The need for such identification will become substantially more important once the more expansive 2014 insurance market reforms are in place. Another area of carrier concern is accurately tracking employer group size in order to ensure compliance with new rules. Again, this concern is one related to the complications of information flow from small employers to the carriers.

Medical Loss Ratio Requirements and Premium Rate Review

Maryland had medical loss ratio (MLR) requirements in place prior to the ACA. MLR refers to the share of a health insurance premium the insurer spends on health care services and improving the quality of care, as opposed to administrative costs. While the state's standards in the small group market were determined by the state to be generally in compliance with the standards required in the ACA (taking into account certain definitional differences in the rules), the state's standard in the individual insurance market was not. As a result, under the new rules, some carriers will be required to change their practices or pay significant rebates to consumers at the end of the year. It is acknowledged at both the state and federal levels, that the MLR standard applies within carrier and within state. Certain plans, high deductible plans specifically, will not meet the MLR standard, but in aggregate, a carrier's

plans must do so in order to avoid having to make refunds to consumers at the end of the year.

In the past, Maryland's MLR review was intrinsically entwined with its premium rate review process. If a carrier met the MLR standards and the state's actuaries agreed that the carrier was using appropriate trend factors, it was generally presumed that the filed premium was appropriate. However, the ACA does not appear to explicitly relate premium rate approval to an expectation that the MLR standard will be met. If the MLR is not met, carriers will be required to refund the difference to consumers under the ACA, but there is not a directly stated intent in the law that state departments of insurance attempt to ensure carriers' filed rates will hit the MLR mark prior to rate approval. This potential discrepancy in approach has yet to be resolved. The new MLR provisions under the ACA appear to have an ancillary benefit of providing the state with additional and valuable information about carriers and products they market in each state. Under the ACA, issuers must supply to CCIO specific information (outside of their normal state reporting for form and rate review purposes) regarding their MLR calculations.¹⁹ These reports collect data in a way that specifically allows the regulators to differentiate carriers' business (i.e., between major medical and life insurance) allowing for more accurate review of revenues and expenses.

There is an active effort underway to develop a consumer-operated and oriented plan (CO-OP) under the auspices of the ACA. Its mission is to make insurance more affordable for working class families.

In addition, for the first time, the data being collected have allowed regulators in Maryland to better understand the size of their association market, which has fallen outside the traditional rate review processes. Monitoring this segment of the market, which may not necessarily be subject to the same insurance rules as traditional carriers, will allow a better understanding of market loopholes for avoiding the small group and nongroup reforms that will be implemented in 2014. Historically, there have been a number of legislative efforts in Maryland that attempted to regulate association plans and stop-loss coverage in the same manner as traditional health insurance, but they were not successful. From the state's perspective, federal

action to ensure a level playing field for these types of coverage would be desirable.

Additional federal resources have allowed the MIA to hire additional personnel for premium rate review, which will allow that process to become more comprehensive and efficient.

Potential for Increased Competition in Maryland Insurance Markets

The state's insurance market is highly concentrated, with CareFirst the dominant carrier by far, having about 70 percent of the small group and individual insurance market enrollment. As a result, many were skeptical that the new HIX and insurance reform rules both inside and outside the exchange could increase competition in the markets. While the federal multistate plans could introduce a new carrier or carriers, informants thought it unlikely that the new plans would be able to negotiate with physicians for lower rates than those already obtained by CareFirst.

There is, however, an active effort underway to develop a consumer-operated and oriented plan (CO-OP) under the auspices of the ACA. The effort is called the Evergreen Project and is being led by the developer of the Healthy Howard initiative, a program in Howard County for the uninsured that provides affordable access to a limited network of providers. A group of interested parties, including investors, insurance officials, attorneys, and public health experts, are involved. A feasibility study financed by local foundations is currently underway. The focus of the effort is different from those in other states, in that the intent is to create a new health system.

The mission of the CO-OP is to make insurance more affordable for working class families. The initial plan is to phase the CO-OP in over a period of five years, starting in a single region of Baltimore and then expanding north and south until the plan is statewide. There are three pillars to the plan: medical homes, payment reform and evidence-based care protocols.

At the core of the system are "teamlets" made up of a primary care doctor, a family nurse practitioner, a care coordinator, a health coach, a mental health/substance abuse social worker, and an office staff person hired from the neighborhood. The teamlets will set up in storefronts in moderate-income neighborhoods. Primary care physicians will be salaried employees, as will be "high-volume" specialists working in regional specialist centers. The CO-OP will contract on a fee-for-service

basis with Super Specialists (those focusing on low-volume conditions). Telemedicine for communication with the specialists is expected to be an important part of the practice structures. Hiring sufficient numbers of salaried physicians is likely to be a challenge, as is financing if the federal support for CO-OPs is further reduced.²⁰

State-Administered High-Risk Pools

Since 2003, Maryland has operated its own state-funded high-risk pool, with most recent enrollment measuring over 20,000 people. Maryland's high-risk pool, the Maryland Health Insurance Plan (MHIP) is one of the largest and most successful of its kind in the country. Unlike most other state plans, MHIP allows any enrollee to avoid the six-month preexisting condition exclusion period by paying an extra premium (a "buy-down" program) and MHIP provides reduced premiums for low-income enrollees (MHIP Plus). The same agency that administers MHIP also administers the new federally financed Preexisting Condition Insurance Plan (PCIP) in

the state, with the new program known as MHIP Federal. Enrollment in MHIP Federal stands at about 550 people. The state requested and received approval from the U.S. Department of Health and Human Services to extend its reduced-premium program for low-income beneficiaries in MHIP to MHIP Federal, doing so entirely at state cost.

Informants varied in their assumptions why enrollment in MHIP federal is so low. Most felt that having a long-standing, well-run high risk pool in the state meant that the vast majority of people who would avail themselves of high-risk pool coverage had already done so. A number of others also felt that the federal requirement that PCIP enrollees be uninsured for at least six months prior to participation was another important factor, since this rule significantly limits the number of eligibles, and others felt that a more comprehensive outreach effort might increase enrollment significantly. At the time of our interviews, MHIP staff was awaiting approval for an additional comprehensive outreach effort.

PROVIDER AND INSURANCE MARKET

Once other issues are resolved, much of the success of health reform will depend on the responses of provider and insurance markets; these will affect coverage, premiums, subsidy costs and access to care. Provider and insurance industry issues in Maryland are very much influenced by the state's all-payer rate-setting system. In a waiver granted to the state that went into effect on July 1, 1977, the state has set hospital rates for all payers (e.g., commercial payers, Medicare and Medicaid). The system has resulted in some success in controlling health care cost growth, though, as discussed below, it has been limited by high rates of admissions and successful legislative lobbying by the hospital industry. While the rate-setting system has prevented the impact, seen elsewhere, of provider consolidation causing upward pressure on hospital payment rates, the problem has been utilization. However, between actions of the rate-setting commission and CareFirst, the state's largest insurer, steps are being taken to address this. Rate-setting also provides for the sharing of the costs of uncompensated care across hospitals.

There are four large hospital systems in the state: University of Maryland, MedStar, Johns Hopkins and Dimensions. The University of Maryland and Johns Hopkins are academic medical centers; MedStar is affiliated with the Washington Hospital Center, the major

Provider and insurance industry issues in Maryland are very much influenced by the state's all-payer rate-setting system for hospitals.

teaching center in Washington, D.C. Each of these hospitals owns or is affiliated with several other hospitals within the state as well as in Washington. The Dimensions system operates two hospitals in Prince George's County, primarily serving low-income populations. The three larger systems have considerable market power, but this has not resulted in higher rates because of the rate-setting process. The nature of competition in the state is over market share and the hospitals aggressively attempt to increase their patient volume.

The rate-setting commission seems to have been quite successful in controlling hospital costs per equivalent inpatient discharge, but less successful in controlling costs per capita. For example, costs per equivalent inpatient discharge fell from 25 percent above the national average in 1976 to slightly below the U.S. average in 2009. However, admissions have grown considerably and have offset some of the system's success in controlling rates per admission. Volume has fallen in the last few

years because of the recession and because of the rate-setting commission's efforts to address the problem (discussed below). The major hospital systems have also been able to lobby effectively for higher and stable rates. There is little additional consolidation expected among hospitals, although it is expected that the few remaining small hospitals in the state could be purchased or go out of business. The rate-setting system in Maryland provides the structure of demand-side market power, not always fully exploited, that should permit the state to control costs. This is key to the success of reform, because it will limit the growth in subsidy costs.

The rate-setting commission has led the way in initiating important delivery system reforms (along with CareFirst, discussed below). The major hospital systems have been cooperative, perhaps because the initiatives sought by the rate-setting commission are less threatening than policies explored by the federal government. Hospitals are generally supportive of payment and delivery system reform. Johns Hopkins, University of Maryland, and Mercy Medical Center have been the leaders in helping the rate-setting commission promote quality and payment-reform initiatives. One of the major initiatives of the rate-setting commission has been a bundled payment initiative, implemented effective July 1, 2011. A single payment per admission will include any readmissions over the next 30 days. The initiative applies to all payers and all causes (not simply preventable readmissions). It applies to 30 (of 46) hospitals that account for 70 percent of the market. A global payment system is also in place in 10 other smaller hospitals in eastern and southern Maryland.

The Center for Medicare and Medicaid Innovation is enacting an initiative that would allow physicians to gain from reducing hospital use. This strategy is also thought to offer promise. There is skepticism about the likelihood of accountable care organizations being adopted widely in the state, as it would require coordination across providers for which there is likely to be resistance. There is, however, clear interest in gain-sharing proposals (e.g., structuring incentives so the physicians can gain from reducing hospital utilization).

The safety net hospital system in the state consists of an inner-city hospital, Bon Secours in Baltimore, and the Dimensions' hospitals in Prince George's County. The University of Maryland and Johns Hopkins systems also provide a considerable amount of care to the uninsured and Medicaid populations, though this is not their primary focus. As part of the rate-setting system, hospitals all share in the cost of uncompensated care and there are

no disincentives to provide such care. With the coverage expansion, there will be less uncompensated care, which will mean lower rates for all payers. This includes commercial insurers but also Medicare and Medicaid. Safety net hospitals should benefit from health reform because they now have to subsidize the costs of hospital-based physicians who serve the uninsured; with reform, these costs for the newly insured will be paid for.

While hospitals have generally prospered in Maryland despite the regulatory environment, the same is not true of physicians. The substantial power of commercial insurers, primarily BlueCross and UnitedHealthcare, has kept fees down to a relatively low level. Medicare is not thought to be a particularly generous payer, and Medicaid is far worse. Physicians express concerns about the sustainable growth rate policy in Medicare as well as high malpractice premiums. The low payment rates and other problems faced by physicians in the state have made them increasingly willing to entertain hospital employment or contracting. There seems to be an agreement that hospitals can probably bargain more effectively on behalf of doctors, given that physicians are typically in small practices. There is concern over whether physicians would be as productive (e.g., see as many patients, perform as many procedures) as hospital employees, as they are as independent entrepreneurs. There is also some concern on the part of physicians that subsequent contracts with hospitals would not be as attractive as the initial arrangements.

There is some possibility that the dominance of the hospital systems has had negative implications for physicians and other providers in the state (e.g., because hospitals rates are controlled by the Health Care Commission, insurers have been more aggressive with respect to physician payment levels). The real issue is that physicians are typically in small practices with little negotiating power; the volume of physician services is high, however, and thus physician incomes are not considered low.

The prevailing view seems to be that physician capacity in the state is ample—but this is far truer for specialist care than for primary care. It is expected that the future will bring more consolidation of physicians into larger practice groups, but also that many more physicians will become hospital employees. The lack of primary care capacity is a concern, and this is exacerbated by low Medicaid fees which seem unlikely to change. Hospitals may fill this void to some degree by employing or contracting with primary care, doctors and combining them with nurses and

physician assistants, which would give hospitals access to their patients when they need inpatient care. There are also a large number of federally qualified health centers, which are also expected to have enough capacity to help deal with the primary care shortage.

The principal insurer in the commercial market in the state is CareFirst, with about 70 percent of the individual and small group market.²¹ United, Coventry, Aetna, and a few other smaller plans make up the rest of the market. CareFirst believes it has greatly increased market share in recent years because its premiums are lower due to its being nonprofit and therefore under less pressure to increase premiums. CareFirst fully expects to compete in exchanges but is unlikely to compete in Medicaid or in a BHP, if there is one. They cite lower Medicaid rates and a population that they do not have experience serving. CareFirst is actually hopeful that there will be a BHP so that the population with incomes between 138 and 200 percent of the federal poverty level, one they expect to be difficult for them to serve, will not be in the HIX.

The major plans in Medicaid are Johns Hopkins Priority Partner Program, Kaiser, Amerigroup, United, MedStar, and MD Physician Care. Federally qualified health centers generally participate in all of the Medicaid managed care networks. It is expected that Medicaid plans will participate in the BHP if Maryland develops one. Some of the Medicaid plans, such as Johns Hopkins, may compete in the exchange, but commercial insurance is a substantially different model than Medicaid. It is likely that a Medicaid plan could pay providers more than their current Medicaid rates and make it attractive for their networks to expand. These plans could be successful competitors, but they lack pricing expertise (in Medicaid they are price takers), experience in marketing to broad populations and dealing with commercial benefit packages (including extensive cost sharing), and they would have to build up reserves.

CareFirst has adopted a major initiative known as the Primary Care Advanced Medical Home Initiative. It is a voluntary program for providing care to patients with chronic conditions. Participating providers get a 12 percent increase in fees if they sign up. In addition, they get a \$200 payment for developing a care plan with the patient and \$100 each year when they provide a follow-up assessment. If the primary care providers, who are grouped into panels by CareFirst, reduce spending (including specialist care and hospitalizations) for their chronically ill patients relative to prior levels, they have the potential to earn 30 percent of the savings they create. CareFirst reports that 3,000 providers have signed up for the medical home program. The initiative is thought to have considerable potential to reduce unnecessary utilization. The incentives for physicians to gain through the system are substantial. Physicians do not perceive themselves to be well paid in Maryland, and this initiative gives the primary care doctors the potential to increase their revenues by 60 to 70 percent if they are successful. The physician panels are small, between five and 15 doctors in each, which is thought to be small enough for there to be interaction among physicians, in order for incentives to be effective and for a “tragedy of the commons” to be avoided. If the panel saves money from reducing specialty and hospitalization services, all physicians in the panel will gain. The panels are not at risk if they do not save; they will still get the increased payments, they just do not receive the shared savings and they risk being terminated from the program. There is a great deal of enthusiasm among primary care physicians for this initiative. Hospitals, however, have concerns. Since some hospitals have primary care capacity, they are anxious to join in the program as well. However, BlueCross has concerns about bringing the hospitals in due to conflicting incentives.

MEDICAID POLICY

Description of the State’s Medicaid Program and MCHP

Maryland’s Medicaid and MCHP programs are among the most generous in the country. The state’s commitment to coverage for low-income families is evident in the way it has expanded Medicaid and MCHP over time, and in the various policies it has adopted to simplify and streamline enrollment in these programs (described in greater detail

in the section *Health Insurance Exchange: Enrollment and Subsidy Determinations* of this report). Children from families with incomes up to 300 percent of the FPL are eligible for Medicaid or MCHP (table 1). Pregnant women with incomes up to 250 percent of the FPL and parents and other caretakers with incomes up to 116 percent of the FPL are also eligible for full Medicaid benefits. Adults without dependent children who have incomes up to 116 percent of the FPL are eligible for Primary Adult

Care (PAC), a limited-benefit coverage program implemented in 2006 under the state’s Medicaid 1115 Demonstration Waiver.²²

Table 1. Maryland’s Medicaid and CHIP Eligibility Levels, as a Percentage of the Federal Poverty Level, November 2011

	Medicaid Eligibility Limit	CHIP Eligibility Limit
Children under 1	185%	300%
Children ages 1-5	133%	300%
Children ages 6-19	100%	300%
Pregnant women	250%	N/A
Parents/Caretakers	116%	N/A
Adults without Dependent Children	116% (limited benefit package)	N/A

Source: Kaiser Family Foundation, Income Eligibility Limits for Children, Low-Income Adults, and Pregnant Women as a Percent of the Federal Poverty Level (FPL), Available at <http://statehealthfacts.org/comparecat.jsp?cat=4&rgn=6&rgn=1>.

The state’s most recent expansion of public coverage occurred in 2007, when it increased Medicaid eligibility levels for adults significantly.²³ The expansion to parents and caretakers, which raised eligibility from 40 percent of the FPL to the current level of 116 percent of the FPL, took effect in 2008. The same legislation authorized the expansion of full Medicaid coverage to other adults (i.e., those without dependent children) who were previously ineligible for full Medicaid benefits but could enroll in the limited-benefit PAC. The state planned to effectively transition enrollees from PAC to full Medicaid over time, but the anticipated phase-in of this expansion component has not occurred because of state budget constraints.

The state’s Medicaid expenditures are matched by the federal government at a rate of 50 percent,²⁴ and financing sources for the state’s share include a tobacco tax and industry taxes such as a managed care organization (MCO) premium tax, a tax on intermediate care facilities for people with intellectual disabilities, a nursing facility tax, and a hospital tax.²⁵ The hospital tax was recently adopted during the 2010 legislative session, as the state was facing a \$1.2 billion structural budget deficit. The FY 2012 assessment on gross patient revenues (actually, an assessment on regulated hospital charges) was structured to generate \$260 million in revenue (approximately \$203 million coming from an increased assessment on hospital rates and \$57 million coming directly from hospitals’ operating budgets) to support Medicaid general operations.²⁶ The state has an

all-payer hospital rate-setting system (described in more detail in the section *Provider and Insurance Market*), and rates were updated in the magnitude of the assessment, resulting in an approximate 1.9 percent additional increase in hospital rates for Medicare, Medicaid, and commercial payers. This tax allowed Maryland to avoid cuts to Medicaid benefits, though the state has reduced Medicaid reimbursement rates to physicians—which were already very low—over the past two years in response to budget pressure.

State Estimates of ACA Impacts on Enrollment and Costs

According to Urban Institute estimates, an additional 212,000 Maryland residents would have Medicaid coverage in 2011 if the ACA coverage expansions were fully implemented that year.²⁷ An analysis conducted by the Hilltop Institute as part of the HCRCC’s Interim Report (July 2010) estimates that the state will save \$829 million through fiscal year (FY) 2020 as a result of federal health reform. Expected savings through FY 2020 include, among others, over \$1 billion from elimination of the state’s high-risk pool (under the assumption that enrollees will transfer to either the Medicaid program or to exchange-based coverage),²⁸ \$423 million in reductions from state-only programs and grants (e.g., public health programs, mental health administration, and alcohol and drug abuse administration), and \$232 million in prescription drug rebates for managed care organizations.

Because adults in the Primary Adult Care (PAC) program do not have coverage for a comprehensive benchmark benefit package (including no coverage of hospital services), they will be considered part of the Medicaid expansion population beginning in 2014.

Another important assumption in the state’s financial model is the expected reduction in state costs associated with the PAC program. Because adults in this program do not have coverage for a comprehensive benchmark benefit package (including no coverage of hospital services), they will be considered part of the Medicaid expansion population beginning in 2014 and the state will receive enhanced federal funding (100 percent in 2014–16, decreasing to 90 percent in 2020 and beyond) for their coverage. This will generate savings for the state,

as the current PAC costs are matched at the standard 50 percent federal matching level.

Medicaid and CHIP Eligibility and Enrollment Policy Decisions

Given state budget constraints, Maryland officials reported that they are unlikely to opt to transition any populations (e.g., PAC or other limited-benefit plan enrollees) into full Medicaid coverage before 2014. No decisions have been made with regard to transferring existing Medicaid enrollees with incomes above 133 percent of the FPL (i.e., pregnant women and children, in Maryland) into the exchange when it is fully functioning.

Maryland plans to upgrade its Medicaid eligibility system with major investments in information technology (discussed above in the section *Health Insurance Exchange: Enrollment and Subsidy Determinations*). The state will procure a new eligibility and enrollment system for the exchange and Medicaid; the Medicaid component will initially determine eligibility only for populations using MAGI and will be expanded over time to include “legacy” Medicaid populations (e.g., aged, blind, and disabled enrollees) in later phases.

When the state expanded Medicaid coverage for adults in 2008, a privately funded \$300,000 outreach and marketing campaign was the primary means for reaching and enrolling new eligibles.

As mentioned in earlier report sections, outreach and enrollment assistance related to the ACA Medicaid expansion will be part of a larger state effort for outreach and public education on the ACA coverage expansions, including the creation of a navigator program. Though Maryland has not yet developed a formal plan for this effort, two of the studies authorized by the health insurance exchange legislation address this area (study findings were discussed above, in the section *Health Insurance Exchange: Enrollment and Subsidy Determinations*). When the state expanded Medicaid coverage for adults in 2008, a privately funded \$300,000 outreach and marketing campaign was the primary means for reaching and enrolling new eligibles. The campaign included media ads featuring the governor and NFL players, and helped increase enrollment by more than 75,000 people, far exceeding goals.²⁹ Consumer advocates in Maryland were a key partner in that effort

and expect to play a similar role with regard to ACA coverage expansions.

Traditional safety net providers may need to overcome a “learning curve” with regard to participating in Medicaid.

Medicaid Provider Issues

Maryland has not made a decision about whether it will increase Medicaid fee-for-service and managed care payments beyond the federally funded increase in 2013 and 2014 for evaluation and management services provided by primary care physicians (PCPs). This will depend on economic conditions and the state’s budget situation. Notably, the Maryland Medicaid program had established a plan prior to ACA passage to gradually increase PCP rates in Medicaid until they were equal with Medicare rates, using the Rate Stabilization Fund (an annual 2 percent premium tax imposed on health maintenance organizations and managed care organizations). Budget constraints prevented the state from achieving its goal of parity with Medicare—in 2008, Medicaid PCP rates in Maryland were 82 percent of Medicare rates³⁰—but informants thought that, given Maryland’s commitment to increasing Medicaid reimbursement before the ACA, there was potential the state would make improvements in this area that reach further than the temporary federal increases.

Traditional safety net providers may need to overcome a “learning curve” with regard to participating in Medicaid. With the exception of federally qualified health centers, these providers may need to learn how to contract with and seek reimbursement from the program if they want to continue serving previously uninsured patients who gain coverage through the ACA Medicaid expansion. Maryland has an advantage in this regard—when the state’s PAC program started in 2005, many community-based safety net providers had to begin billing Medicaid for the services they provided. This was a big transition for the providers, who had up to that point relied primarily on grant funds. Experience with the PAC may have given Maryland a head start, but state officials still noted the need to support providers (primarily in the safety net system) to ensure that they have the capacity to work with the Medicaid program. The state recently passed legislation authorizing technical assistance for safety net providers as the ACA is implemented.

Medicaid Managed Care

More than three-quarters of Maryland's Medicaid beneficiaries are enrolled in the state's Medicaid managed care program, HealthChoice.³¹ Seven MCOs participate in the program, including two plans that also participate in commercial health insurance markets (the remaining five plans serve public coverage programs only).³²

The program uses a noncompetitive contracting approach and a sophisticated rate-setting method that adjusts for health status. The state is contemplating a shift to competitive bidding for HealthChoice. Site visit informants suggested there is political will in the state for establishing a more selective contracting process that considers quality outcomes and strengthens MCO accountability standards. But others felt that competitive bidding could disadvantage the few MCOs that operate in every area of the state and effectively "take all comers."

Maryland officials expressed concern that current Medicaid MCOs will not have sufficient capacity to serve Medicaid expansion enrollees. At the same time, DHMH is concerned about its ability to contract with additional MCOs that may want to participate in the plan in anticipation of the 2014 influx of enrollees—at least one health plan has already expressed interest in joining the Medicaid managed care market. No decisions have been made regarding whether Medicaid MCOs will be required to participate in Maryland's health insurance exchange (and serve higher-income exchange enrollees), or conversely, whether plans wishing to participate in the exchange will be required to participate in the state's Medicaid managed care program. Though state leaders have emphasized the ACA's requirement that Medicaid, MCHP, and exchange coverage be seamless, it is not clear whether requiring plan participation will be a part of the strategy to achieve this goal. Site visit informants reported that MCOs in the state, including those that participate

in Medicaid or the commercial market, are apprehensive about being forced to participate in either market.

Basic Health Program Option

Maryland has not decided whether to create a BHP. They have established that they do not have sufficient information at this point. The state is seriously considering the option and is conducting a study that will help inform the decision (this study is separate from the six commissioned by the exchange and is being done internally at DHMH), which will be made by the DHMH (in consultation with exchange officials). This will be a data-driven decision based on estimates of projected premiums and enrollment. Consumer advocates expressed support for the option as an approach to ensure seamlessness of coverage and greater affordability for low-income residents. Several site visit informants also noted that some Medicaid MCOs support the BHP option, presumably because it offers these plans a way to increase their enrollment without becoming part of the exchange-based commercial market. While no strong opposition to the BHP was revealed, one informant suggested that commercially licensed MCOs may not support the BHP out of fairness, since the BHP could allow some insurers without commercial licenses to increase their market share without fully participating (and getting licensed) in the commercial market.

Virtually all informants expressed one major concern about the BHP: that the option would adversely affect the exchange by reducing the size of its enrollment and could draw healthier risks out of the exchange risk pool. State officials also noted concerns about the viability of a BHP that was structured to mirror the Medicaid program, particularly with regard to provider capacity and reimbursement. They questioned the soundness of BHP models that base provider reimbursement on the Medicaid fee-for-service schedule.

CONCLUSIONS

At this early point in the implementation process, it is possible to identify a number of factors that have helped Maryland officials in their initial, successful launch of health care reform. Important lessons, shared by informants interviewed for this study, include the following:

- ***Unequivocal gubernatorial leadership and support set the tone for rapid and effective implementation.*** As described in this report,

Governor Martin O'Malley established the state's Health Care Reform Coordinating Council the day after President Obama signed the Affordable Care Act into law, and stated his goal that Maryland would lead all states in implementing health reform. With Lieutenant Governor Anthony Brown at the helm, the council and its participants worked aggressively to gather stakeholder input, analyze policy options, pursue federal grant funding, and

ultimately develop legislation to enact federal reforms. The governor's imperative that Maryland would succeed was critical in spurring state health, human services, and insurance officials to work together efficiently and at an unprecedented level of coordination.

- ***Involving a broad range of stakeholders in the reform process, from the beginning, was critical in garnering buy-in and support.*** Starting with the HCRCC (which is composed of cabinet secretaries, leadership from health care commissions, and state legislators—both Democrat and Republican), continuing through a series of public town hall meetings, and by forming a large number of policy workgroups that engaged consumer advocates, physician, hospital, and safety net providers, health insurers and managed care organizations, and representatives of the business community, Maryland officials invited advice and input from a broad range of health system stakeholders throughout the reform planning process. This garnered critical support for the effort, according to informants, who were unanimous in their belief that they had been “at the table” and that their concerns and priorities had been heard.
- ***Tackling health exchange legislation incrementally was a smart move.*** Whether done intentionally or not, Maryland officials were wise in limiting the scope of the state's initial exchange legislation to issues related to governance, establishing it as a public corporation. Fairly early in the process, these officials realized that the many complex policy decisions to be made about the operations of the exchange were too numerous to be adequately addressed during the first planning year. Furthermore, they were concerned that prolonged debates over these potentially controversial issues could derail the planning process. Therefore, state officials created six policy workgroups, each of which commissioned studies to analyze options related to the exchange, and asked them to make recommendations to state officials by December 2011 so that subsequent legislation during the 2012 session could be developed to further specify the exchange goals and operations. This two-stage approach succeeded in diffusing tension between policy-makers and vested interests and allowed a more methodical, careful, and inclusive analytical process

to be completed. They also moved quickly to pass legislation that allowed the state to effectively implement and enforce the early consumer protections in private insurance markets included in the ACA.

- ***Maryland is taking advantage of the reform opportunity to transform its IT systems.*** State officials are tackling, head on, the challenge of transforming their eligibility determination systems so that they can deliver the seamless, real-time, and data-driven process called for in the ACA. After quickly abandoning the notion that they could rely on out-of-date legacy systems for much of this function, leadership has hired a team with strong, current IT expertise that has surveyed the landscape and identified the need for a new system that is modular, user focused, and interoperable. A RFP has been released soliciting a vendor to build the IT system that will support eligibility determination for the exchange and Medicaid MAGI populations, and that can be expanded in the future to include other Medicaid and human services program populations. This process—while intense, time consuming, and stressful—holds promise to result in a system that will vastly improve Maryland's capacity to facilitate consumer enrollment into health coverage.
- ***Maryland's progressive Medicaid program provides a strong foundation upon which to build broader health system reforms.*** Maryland has long operated expansive Medicaid and CHIP programs and, as described in this report, took steps in recent years to extend public program coverage to new groups of parents and childless adults in advance of the ACA. On the enrollment front, the programs have adopted numerous policies over the years to simplify and streamline enrollment and retention of eligible populations. And with regard to service delivery, state officials have recognized the importance of raising reimbursement rates for primary care (though budget constraints have stymied planned raises) and a dynamic Medicaid managed care system currently serves over three-quarters of Medicaid beneficiaries. Combined, these characteristics provide a strong public program base upon which further Medicaid expansions (required by the ACA) can be layered, and with which new structures—like the HIX—can be integrated.

- ***Maryland’s long-standing Health Services Cost Review Commission (HSCRC) has given the state valuable experience controlling costs, promoting quality, spreading risk, and innovating with service delivery and payment models.***

Since 1977, Maryland’s HSCRC has set hospital rates for all payers—including commercial insurers, Medicare, and Medicaid—and done so in a way that accounts for uncompensated care and shares those costs across all hospitals. The commission has succeeded in controlling per admission costs and has used its leverage to establish various delivery and payment system reforms, including a bundled payment initiative that creates incentives to provide high-quality care while reducing preventable readmissions. This experience should give Maryland

policy-makers a leg up in implementing the ACA as they consider, design, and roll out innovative service delivery initiatives to promote quality while controlling costs.

With two years to go before the Affordable Care Act is fully implemented, the State of Maryland appears well poised to fulfill Governor O’Malley’s goal of being a health care reform leader among states. While much work remains, a combination of strong leadership, inclusive planning, and deliberate but aggressive action by committed state officials and system stakeholders has permitted Maryland to make strides in designing its reformed health care system.

About the Authors and Acknowledgements

Linda J. Blumberg and Ian Hill are senior fellows, Brigette Courtot is a research associate, and John Holahan is director of the Urban Institute’s Health Policy Center. The authors thank the many Maryland government officials and health care stakeholders for their time and insights. This report would not have been possible without them. In particular, we are grateful for the contributions of staff from the governor’s Office of Health Reform, the Department of Health and Mental Hygiene, the Health Care Commission, the Health Services Cost Review Commission, and CareFirst. Finally, a thank you is extended to Kevin Lucia, Sabrina Corlette, and Shanna Rifkin for their comments and input to the study and the report.

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The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit www.urban.org.

NOTES

1 http://articles.baltimoresun.com/2010-03-25/health/bal-md-reform25mar25_1_medicaid-rolls-health-care-reforms.

2 Maryland Health Benefit Exchange Act of 2012 (SB 238), text available at: <http://mlis.state.md.us/2012rs/bills/sb/sb0238f.pdf>.

3 An analysis conducted by the Hilltop Institute as part of the HCRCC's interim report estimates that the ACA coverage expansions will reduce Maryland's uninsured rate by half, from 14 percent in 2010 to 6.7 percent in 2017. The analysis estimates that an additional 358,710 residents will have coverage in 2020, including 137,839 newly eligible Medicaid enrollees, 34,401 Medicaid enrollees who are already eligible for the program, and 186,470 exchange enrollees. Roughly 400,000 residents will remain uninsured. See Maryland Health Care Reform Coordinating Council, *Interim Report to the Governor* (July 26, 2010). Available at <http://www.msa.md.gov/megafile/msa/speccol/sc5300/sc5339/000113/013000/013025/unrestricted/20100902e-001.pdf>.

4 Information on the planning grants made by the U.S. Department of Health and Human Services can be found at http://ccio.cms.gov/resources/files/grant_award_faq.html.

5 A fact sheet on the establishment grants available through the U.S. Department of Health and Human Services can be found at <http://www.healthcare.gov/news/factsheets/2011/01/exchestann.html>.

6 Details of the Early Innovator Grant program and grantees are available at <http://www.healthcare.gov/news/factsheets/2011/02/exchanges02162011a.html>.

7 Maryland Health Benefit Exchange, *Recommendations for a Successful Maryland Health Benefit Exchange: A Report to the Governor and Maryland General Assembly* (2011). Available at http://dhmh.maryland.gov/healthreform/exchange/pdf/HB0166_MHBE-Report_of_2of2_12-23-11_OGA_1204.pdf.

8 Each state exchange is required to develop a navigator program to provide information to individuals and small employers about the availability of qualified health plans within the exchange and to facilitate enrollment in those health plans. The role of the navigators will include outreach and education efforts as well. The Hilltop Institute produced a background paper on navigators for the board. It can be found at <http://www.hilltopinstitute.org/publications/Navigators-BackgroundPaper-August2011.pdf>.

9 Maryland Health Benefit Exchange, *Recommendations for a Successful Maryland Health Benefit Exchange*.

10 As of February 2012, many of the study reports, as well as the accompanying advisory committee reports were available on the State Reform website sponsored by the National Academy for State Health Policy: <http://www.statereform.org/>.

11 Center for Consumer Information and Insurance Oversight. 2011. *Essential Health Benefits Bulletin*. Available at: http://ccio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

12 The HHS bulletin suggests that a different approach could be taken after the first two years of full implementation of the ACA.

13 Maryland Health Benefit Exchange, *Recommendations for a Successful Maryland Health Benefit Exchange*.

14 Express Lane Eligibility is a state option, created under the Child Health Insurance Program Reauthorization Act, that permits state Medicaid and children's health insurance programs to use another agency's eligibility findings to qualify children for health coverage, despite the programs' different methods of assessing income or otherwise determining eligibility.

15 The RFP is available at http://www.statereform.org/system/files/support_maryland_health_benefit_exchange_to_implement_the_affordable_care_act_10-21-2011.pdf.

16 States are eligible for an enhanced federal matching rate of 90 percent for design and development of new Medicaid eligibility systems and a 75 percent matching rate for maintenance and operations. States must meet certain conditions, including seamless coordination with the exchanges, in order to qualify. The 90 percent matching rate is available for eligibility systems until December 31, 2015, and the 75 percent match is available beyond that date, assuming the conditions continue to be met. More information can be found at <http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf>.

17 Ibid.

18 For example, 2010 bulletins and templates for dependent coverage for children up to age 26, grandfathered plans, external review, and so on, can be seen at <http://www.mdinsurance.state.md.us/sa/news-center/life--health-bulletins-current-2006.html>.

19 While this information must be provided to CCIIO in the future, the first year's information was collected by the National Association of Insurance Commissioners as a request of carriers.

20 See a full discussion of issues and challenges facing CO-OPs under the ACA in Bradford Gray, "Consumer Operated and Oriented Plans (CO-OPs): An Interim Assessment of Their Prospects" (Washington, DC: The Urban Institute, 2011). Available at <http://www.urban.org/url.cfm?ID=412388>.

21 Kaiser Family Foundation, "How Competitive Are State Insurance Markets?" Focus on Health Reform brief (Menlo Park, CA: Kaiser Family Foundation, 2011). Available at <http://www.kff.org/healthreform/upload/8242.pdf>.

22 The current PAC program's limited health care benefit package includes primary care physician services, pharmacy services, over-the-counter medications with a doctor's order, family planning and gynecological services, mental health services delivered by a PCP, community-based substance abuse services, and outpatient emergency room services.

23 The Medicaid expansion was part of the Working Families and Small Business Coverage Act of 2007 and was financed with revenue generated from a tobacco tax increase (\$1 per pack) and reductions in the uncompensated care component of the state's all-payer hospital rates.

24 <http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4>.

25 Ibid.

26 "477th Meeting of the Health Services Cost Review Commission," April 15, 2011, http://www.hsrc.state.md.us/documents/CommissionMeeting/2011/04-15-11/HSCRC_Post-MeetDocs04-15-11.pdf.

27 The HCRCC contracted with the Hilltop Institute to develop estimates of Medicaid enrollment increases related to the ACA. That analysis estimates that in 2020, an additional 137,839 newly eligible Medicaid enrollees and 34,401 Medicaid enrollees already eligible for the program will be enrolled. See Maryland Health Care Reform Coordinating Council, *Interim Report to the Governor*.

28 The Hilltop Institute analysis assumes that the 1 percent assessment on hospital revenues now used to help fund the Maryland Health Insurance Program (MHIP) will become savings to the state when MHIP no longer exists—these savings totaled \$1,055 million through FY 2020. However, the HIX board has recently recommended that the MHIP assessment be used, at least in the near term, to help mitigate the effect on premiums of mainstreaming this high cost population into the private nongroup market.

29 Health Care for All (Maryland Citizens' Health Initiative), "Comments to the Governor's Coordinating Council on Health Care Reform, Education and Outreach Workgroup" (October 5, 2010). Available at http://healthcareforall.com/wp-content/uploads/2010/11/Education-and-Outreach-Workgroup_FINAL.pdf.

30 Stephen Zuckerman, Aimee Williams, and Karen Stockley, "Medicaid Physician Fees Grew by More Than 15 Percent from 2003 to 2008, Narrowing Gap with Medicare Physician Payment Rates," *Health Affairs*, April 2009; <http://www.kff.org/medicaid/kcmu042809oth.cfm>.

31 HealthChoice enrolls TANF-related and ABD-related beneficiaries on a mandatory basis throughout the state. Medicaid enrollees who are dually eligible for Medicare and those who are institutionalized are excluded from managed care.

32 Participating HealthChoice MCOs include Amerigroup Community Care, Jai Medical Systems, Maryland Physicians Care, MedStar Family Choice, Priority Partners, Diamond Plan, and UnitedHealthcare. The latter two plans also offer commercial health insurance. Notably, CareFirst—the state's largest insurance carrier—does not participate in the Medicaid managed care market, though it did at one time.