SPOTLIGHT ON
MARYLAND

MARYLAND HEALTH CARE COMMISSION

HEALTH CARE SPENDING IN MARYLAND'S INDIVIDUAL AND SMALL GROUP MARKETS

INTRODUCTION AND PURPOSE The 2010 Patient Protection and Affordable Care Act (ACA) requires states to establish a health insurance exchange (HIE) by January 2014, or participate in the federal exchange. The primary purpose of the HIEs is to assist individuals and small employers in purchasing health insurance through the creation of an insurance marketplace. The ACA allows for creation of two types of exchanges—one for individuals and another for small employers. States are afforded flexibility in designing certain aspects of the exchanges, including whether to merge the two types of exchanges into one. Federal subsidies are available to individuals with incomes between 138 percent and 400 percent of the federal poverty level (FPL), though purchase of insurance through the exchanges is not limited to individuals meeting these income criteria. The Congressional Budget Office estimates that, by 2019, about 24 million people will have purchased coverage via state insurance exchanges.[1]

As of July 2011, 13 state legislatures had passed laws setting up exchanges and more than a third of the states had begun to plan for exchanges.[2] Maryland is in the forefront of the 13 states: In April 2011, Maryland passed legislation that provides a framework for establishing the state's Health Benefit Exchange, including creation of a nine-member Governing Board. The legislation sets out a number of issues for the Exchange's Board to study and report on—perhaps the main one being whether the individual and small group markets should be merged. Other issues involve the financing of the Exchange, whether a parallel market outside of the exchange will be allowed, and the role of insurance brokers.

The purpose of this Spotlight is to provide information from Maryland's Medical Care Database (MCDB) that may be useful to policymakers in implementing Maryland's Health Benefit Exchange. The MCDB contains health care claims and encounter data submitted annually to the Maryland Health Care Commission by most private health insurance plans serving Maryland residents. Data from the MCDB can be used to examine patterns of health care use and spending by type of coverage among Maryland's privately insured residents. Data on spending patterns among different demographic subgroups may contribute to a more informed understanding of how different exchange configurations will affect purchasing decisions and premium levels.

THE MARKET FOR HEALTH INSURANCE IN MARYLAND Approximately 7 percent[3] of Maryland residents are insured through small employers, defined as those with 2 to 50 employees, and another 4 percent[4] purchase coverage in the individual market. Under Maryland law, health plans sold to small employers must meet benefit and cost-sharing requirements of the Comprehensive Standard Health Benefit Plan (CSHBP). These plans also face other requirements related to premium levels, accessibility, and renewability. Some of these requirements—such as guaranteed issue and renewal—may increase premiums for very healthy persons, relative to the individual market, making them less attractive to such individuals. Policies sold in the individual market, in contrast, are subject to medical underwriting, meaning that a consumer's health status directly influences the premium he or she pays. While this makes premiums relatively attractive for healthier persons, it may make these policies very costly for persons with serious health conditions. CareFirst Blue Cross Blue Shield dominates both markets, covering more than 75 percent of those in the small employer market and more than 80 percent of those in the individual market.[5] As a consequence, CareFirst is pooling the risks of most individuals insured in the individual market and, similarly, pooling the risks of most people covered by small employer policies.

[1] Congressional Budget Office, "H.R. 3590, Patient Protection and Affordable Care Act," November 18, 2009. Available at *http://www.cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf*.

[2] Kaiser Family Foundation, "Establishing Health Insurance Exchanges: An Update on State Efforts," July 2011, Available at *http://www.kff.org/healthreform/8213.cfm.*

[3] MHCC analysis of Comprehensive Standard Health Benefit Plan enrollment data.

[4] Somerville, M., John, J., & Skopac, J. (2011, August). *Health Benefit Plan Contracting: A Background Paper*. Baltimore, MD: The Hilltop Institute, UMBC.

[5] Ibid.

The Maryland Health Insurance Plan (MHIP) is the state's high-risk health insurance program. State residents are eligible if they have been denied private health insurance in the individual market in the past six months or if they suffer from 1 of approximately 70 conditions that automatically qualify a person for the program. These conditions include chronic illness such as diabetes or an acute condition like cancer. Maryland residents may also qualify if they have lost their employer-sponsored group insurance and have exhausted the continuation benefits (COBRA). The program is administered by CareFirst under contract to MHIP, but the benefits and premiums are defined by the MHIP Board. The program is subsidized by a 1 percent assessment on hospitals; slightly more than 60 percent of the program's funding comes from the assessment via the state's all-payer system.[6] Beneficiaries cover the remaining 40 percent of program costs through premium payments. People with incomes below 300 percent of the federal poverty level (FPL) receive premium subsidies. Approximately 20,000 individuals are currently covered through MHIP.[7] Qualifying individuals may enroll their entire family, if they qualify for the program.

Because of the differences in the individual, small group, and high-risk markets—in terms of requirements facing insurers and subsequent premiums—the demographics, health status, and spending of the insured vary markedly across the markets. If the markets are combined for the Health Benefit Exchange, the premiums facing different market segments may change substantially. Moreover, the policies sold within these markets tend to have different cost-sharing requirements; the cost-sharing required of policyholders within the individual market is higher than that required of people in the CSHBP.

THE AFFORDABLE CARE ACT AND HEALTH INSURANCE EXCHANGES The ACA spells out a number of requirements for the products sold within health insurance exchanges.

- Premiums are allowed to vary based on age (by a 3 to 1 ratio) and geographic area within the state, tobacco use (by a 1.5 to 1 ratio), and the number of family members covered. Presumably, Maryland could continue to allow premiums to vary by the four geographic areas it has now: Baltimore metro region, DC metro region, Eastern Shore/ Southern Maryland, and Western Maryland.
- Premium subsidies are available for people with incomes between 138 percent FPL and 400 percent FPL (for 2011, 138% FPL is approximately $15,000 for an individual and $30,000 for a family of four[8]).
- The ACA sets maximum out-of-pocket spending limits for people with incomes below 400 percent FPL. Insurers are free to vary patient cost-sharing (deductibles, copayments, and coinsurance) as long as it meets certain requirements in terms of the value to consumers.[9] These requirements correspond to the different plan offerings—bronze, silver, gold, and platinum plans. As plans increase in value (moving from bronze to platinum), they cover an increasing share of the enrollees' medical expenses (going from 60 percent to 90 percent).

This report provides information on the differences that currently exist in the markets that may feed into the Health Benefit Exchange. These differences may help policymakers to better understand the likely health spending among those purchasing through the Exchange. One critical factor that will have an impact on premiums is the composition of those who are currently uninsured and will come to the Exchange to purchase coverage. While it is not possible to precisely predict the composition of this group, we provide some basic background on Maryland's uninsured population that may be suggestive of the likely impact on premiums in the Exchange.

CURRENT SPENDING IN THE INDIVIDUAL AND SMALL GROUP MARKETS AND HIGH-RISK POOL On all indicators, utilization of health care services and spending are higher for persons covered through the small group market as compared with those who purchased coverage in the individual market. Not surprisingly, spending is highest for persons covered through the high-risk pool. Overall spending for all services differed substantially across markets, with mean spending among high-risk pool enrollees almost two and one-half times that of persons covered in the small group market, and almost four times that of those covered under individually purchased policies. Across service types, the percentage of users obtaining health care services was also greatest in the high-risk pool and lowest in the individual market. Across the three markets, MHIP enrollees account for slightly less than 4 percent of users and about 10 percent of health care spending.

[6] Popper, Richard. MHIP Maryland Health Insurance Plan, *Implementation of Federal High-Risk Pool under Patient Protection and Affordable Care Act,* Presentation to Maryland Health Care Reform Coordinating Council, May 6, 2010. Available at *http://dhmh.maryland.gov/healthreform/pdf/priormeetings/May2010/High_Risk_Pool_Slideshow.pdf.*

[7] Ibid.

[8] *http://liheap.ncat.org/profiles/povertytables/FY2011/popstate.htm*

[9] The ACA uses the term "actuarial" value to establish the required level of benefits for each plan tier. As an example, this means that, for a standard population, a plan with an actuarial value of 70 percent (referred to as a "silver" plan in the ACA) will pay 70 percent of their health care expenses, while the enrollees themselves will pay 30 percent through some combination of deductibles, copays, and coinsurance. For more information, see "What the Actuarial Values in the Affordable Care Act Mean," available at *www.kff.org/healthreform/upload/8177.pdf.*

TABLE 1. Variation in Spending and Use Among Maryland's Less-Than-65, Privately Insured, 2009: Markets Potentially Part of the Health Benefit Exchange

	COVERAGE TYPE		
	CSHBP	Individual	MHIP
Total number of full-year users[a]	163,758	100,515	10,324
Mean spending, all services	$3,888	$2,574	$9,498
Median spending, all services	$1,278	$708	$3,716
Percentage paid out-of-pocket	20%	31%	20%
Percentage with use[b]			
Inpatient hospital	5.8%	4.3%	10.7%
Outpatient hospital	29.2%	24.5%	41.3%
Prescription drugs[c]	79.4%	31.1%	90.3%
Median expenditure risk score[d]	0.83	0.58	1.86

NOTES: [a] The analysis is limited to full-year users, i.e., individuals enrolled in the same insurance plan for the entire year, to provide a more accurate picture of annual spending and to be able to make comparisons across markets.
[b] Because coverage type is defined by professional service use, all users across the three coverage types have professional service use. According to the Medical Expenditure Panel Survey, 41 percent of privately insured individuals less than 65 years old used physician services in 2008.
[c] The percentage of persons using prescription drugs in the individual market may be artificially low because these policies may not cover prescription drug use.
[d] The expenditure risk score is based on the Chronic Illness and Disability Payment System (CDPS). The CDPS, developed by researchers at the University of California, San Diego, categorizes an individual's risk of having significant medical expenditures from the number and mix of diagnoses recorded on his or her insurance claims.

However, in examining the current spending of persons insured through the individual and small group markets, it is important to consider how individuals in each of these markets differ and how features of the coverage itself vary in ways that likely affect health care spending. The age and income distribution in each of the markets differ considerably. Age tends to be highly associated with health care use, with individuals using more care as they grow older. Almost one-quarter of users in the individual and small group markets are children less than 18 years of age, a group that tends to use relatively few health care services. In contrast, just 10 percent of users in the high-risk pool are children. People in the 60- to 64-year-old age group are highly likely to use health care services; while fewer than 10 percent of users with coverage through the individual or small group markets are 60 to 64 years of age, this age cohort accounts for almost one-quarter of those enrolled in MHIP. These differences in the age distribution of people covered in the markets partially explain the differences in median and average health care spending and use in the current markets shown in Table 1.

Individual-level and family income data are not collected by insurers. The median income in the ZIP code where the user resides is used in this Spotlight as a rough approximation of household income.[10] The distribution of where the users in each of the three markets live is fairly uniform—slightly more than 40 percent of users from each of the markets live in the Baltimore metro area, 30 percent in the DC metro area, and the remaining split roughly evenly between Western Maryland and the Eastern Shore/Southern Maryland. There is a slightly higher representation of those in the individual market in the Baltimore metro area, and the high-risk pool has a slightly larger proportion of those in the lower-income group. In general, the relationship between income and use of health care services is not straightforward. People living in low-income ZIP codes tend to be in somewhat worse health (suggesting greater spending), but they also have fewer resources available to purchase services (which may lead to lower spending). Within each market, persons living in the lower-income ZIP codes are more likely to use both inpatient and outpatient hospital services. Risk scores are somewhat higher among users in lower-income ZIP codes, indicating

[10] Median household income, 2009 American Community Survey 1-Year Estimates, U.S. Census Bureau, *http://factfinder.census.gov/servlet/ThematicMapFramesetServlet?-geo_id=04000US44&-tm_name=ACS_2009_1YR_G00_M00721&-ds_name=ACS_2009_1YR_G00_.*

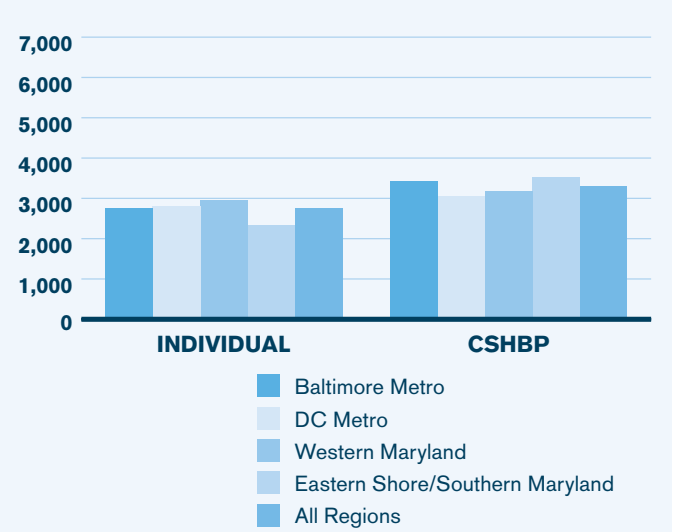
more health conditions and helping to explain the higher use of both inpatient and outpatient hospital services.[11] Median spending is higher within low-income areas for MHIP (high-risk pool) enrollees only; however, mean spending is higher for this group across all three markets, suggesting that there may be a subset within the low-income group with particularly high spending.

Spending by people in the MHIP, not surprisingly, is heavily influenced by greater disease burden. The expenditure risk score indicates substantially greater evidence of health conditions that are associated with higher spending. The typical (median) risk score for those in MHIP is more than twice that of those in the small group market, and more than three times that of individual purchasers.

While higher spending levels in the high-risk pool are certainly related to greater disease burden, differences in spending patterns between the individual and small group market are likely due at least in part to differences in the cost-sharing required of people in each market. Those in the individual market were responsible, on average, for almost one-third of spending compared with a one-fifth share in the other markets (see Table 1). This larger financial liability likely reduced use of services among persons covered in the individual market. In particular, the proportion of persons using prescription drugs in the individual market may be low because most individually purchased policies limit pharmacy expenditures through high copayments or deductibles. The limit on pharmacy benefits could both discourage use of prescription drugs as well as result in underreporting, since there may be no claims record for a covered service below the deductible.[12] Thus, we expect that spending for individuals currently in the individual market would rise if cost-sharing requirements in the Exchange were to be lower than those currently faced.

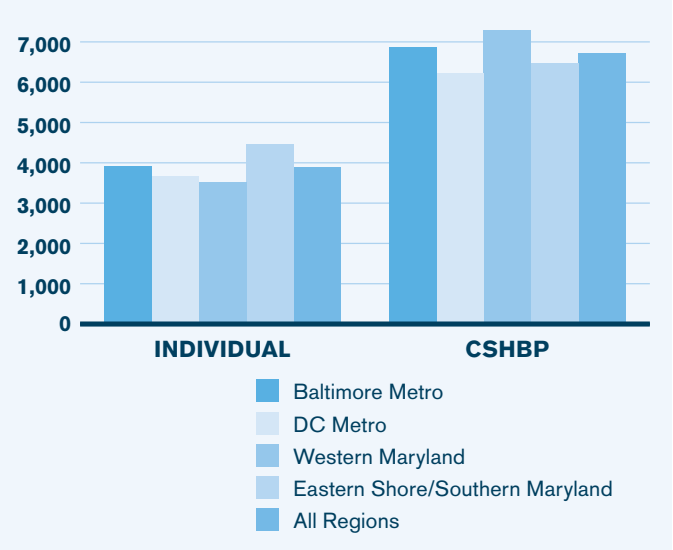
In order to illustrate some of the variation in spending, the charts below show health care use and spending for a small number of prototype individuals currently insured in one of the markets that might feed into the Exchange.

Average spending for a 25- to 34-year-old with a household income between $60K and $90K is higher in the small group market than in the individual market, following the overall pattern across markets. Regional variation is greater in the individual than small employer market but relatively limited overall. Spending also differs markedly for males and females (not shown), but premiums cannot be rated by gender.



NOTE: Comparisons for MHIP enrollees are not shown due to small cell sizes—i.e., too few persons to support reliable estimates when disaggregated by region, age, and so on.

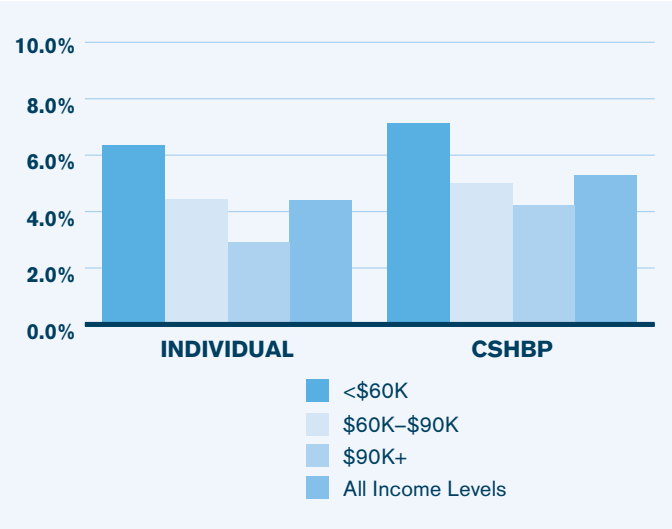
For a 55- to 64-year-old with a household income between $60K and $90K, average health care spending is higher than for a 25- to 34-year-old (not surprisingly), but the pattern of spending is the same across regions within Maryland and across the two insurance markets.



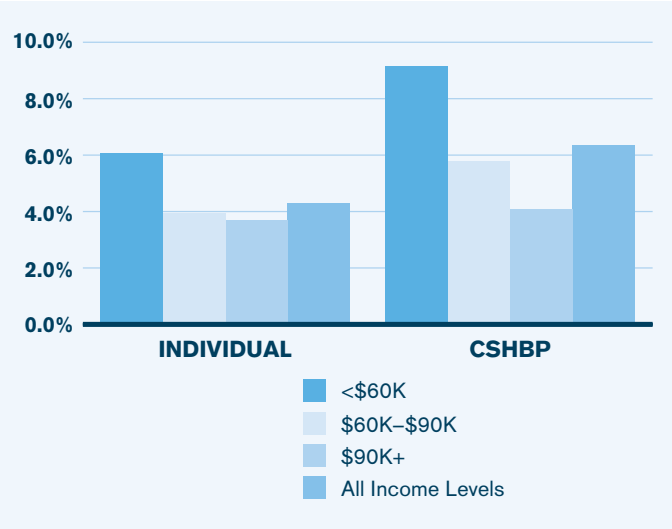
[11] The expenditure risk score is based on the Chronic Illness and Disability Payment System (CDPS). The CDPS, developed by researchers at the University of California, San Diego, categorizes an individual's risk of having significant medical expenditures from the number and mix of diagnoses recorded on his or her insurance claims.

[12] A review of 89 plans offered by Aetna, CareFirst, Coventry, Kaiser Permanente, and United HealthCare via eHealthInsurance.com for the Baltimore and DC Metro markets showed that only 3 plans offered no drug benefit. Accessed October 11, 2011 *http://www.ehealthinsurance.com/ehi/ifp/all-plans.*

For an 18- to 24-year-old living in the Baltimore metro area, the likelihood of using inpatient hospital services decreases as income rises. This pattern holds across geographic areas. While the likelihood of using inpatient hospital services is relatively small, at each household income level, it is slightly higher for those insured in the small group market compared with the individual market.



Though overall use of inpatient services is higher for people enrolled in the CSHBP than in the individual market, the pattern of use in each market by household income is similar for a 45- to 54-year-old living in the Baltimore metro area.



THE IMPACT OF NEW ENTRANTS TO THE EXCHANGE

In addition to the likely spending of those currently insured through the three markets discussed above, premiums for policies offered by the Exchange will be influenced by new entrants who will come primarily from the pool of those currently uninsured. In 2010, there were 730,000 uninsured persons under age 65 in Maryland.[13] Approximately one out of five of the uninsured had incomes below the federal poverty level, and most of these individuals are expected to be covered by Medicaid rather than the Exchange. Another substantial group—those with incomes up to 200 percent of poverty—could also be covered by an alternative outside the Exchange. The ACA gives states the option to create a Basic Health Plan (BHP), a Medicaid-like insurance plan targeted at adults with incomes between 138 percent and 200 percent of poverty and certain legal immigrants with incomes at or below 138 percent of poverty. If a state creates a BHP, people with incomes below 200 percent of poverty cannot obtain coverage through the state's Exchange because federal funding for the subsidies for such people will be used to finance the BHP. The BHP would be state-run but federally financed; it could be offered through Medicaid managed care organizations or be fee-for-service with case management. BHP enrollees are required to receive the same essential benefits and the same or lower premiums and cost-sharing that they would receive from an Exchange plan. Benefits under the BHP would likely be more similar to those currently offered through the small group market than benefits obtained in the individual market. If Maryland were to create a BHP, it would reduce the pool of people obtaining insurance through the Exchange, but it also would reduce the administrative burden of churning[14] enrollments due to fluctuating incomes among the people with incomes below 200 percent of poverty. It is not clear how a BHP would affect the premiums of other policies sold in the Exchange. The fact that people living in low-income ZIP codes have higher risk scores for health expenditures suggests that the risk pool for the other policies purchased in the Exchange will be reduced by a BHP for lower-income people. But data are needed about the health status of all people with incomes between 138 percent and 400 percent of poverty—not just those who used health care services—to know the impact of creating a BHP for people with incomes between 138 percent and 200 percent of poverty on the other premiums in the Exchange.

The largest group of currently uninsured adults can be represented by a male, 25 to 34 years of age, with a household income of $60K–$75K, and living in either the Baltimore or DC metro areas. Average spending for a person with these characteristics in the individual market was approximately

[13] 2011 Current Population Survey Annual Social and Economic Supplement. See also Maryland Health Care Commission, *Health Insurance Coverage in Maryland through 2009,* January 2011, Available at *http://mhcc.maryland.gov/health_insurance/index.html.*

[14] The frequent transition from public to private insurance coverage and vice versa.

$2,500 (Baltimore metro) and just under $2,000 (DC metro), while in the small employer market, this same person had spending of $2,600 and slightly over $2,000, respectively. Spending for people with these characteristics in the Baltimore metro area was higher than the overall average spending in each of these markets, while spending in the DC metro area was somewhat lower, suggesting that post implementation of the ACA, there could be more geographic variation in spending than exists today. Current spending for insured females with similar income is as much as two times higher, depending on the region and market; much of this spending may be pregnancy-related so that, while women currently constitute one-half of the uninsured, these uninsured women may be substantially different in their health needs than those insured women for whom we have spending data.

Thirteen percent of the uninsured are children 18 years of age or younger; this group is overrepresented among the lowest income groups and is likely to be disproportionately eligible for Maryland Medicaid.[15] In addition to these younger uninsured, a little more than one-quarter of those currently uninsured in Maryland are between the ages of 45 and 64. Average spending for people in this age group in the individual market was approximately $3,400 (Baltimore metro) and $3,600 (DC metro), while in the small employer market, this same person had spending of about $6,200 and $5,200, respectively.

IMPLICATIONS This Spotlight provides data on current spending levels for Maryland residents insured through the individual, small employer group, and high-risk pool markets. This information is important in understanding spending patterns for those likely to purchase coverage through Maryland's Health Benefit Exchange. Unfortunately, however, gaps in information remain.

The first major gap in information is an understanding of who among the currently uninsured is likely to enter the Exchange in search of coverage, and the second gap involves what their level of spending is likely to be. Such people are not included in the MCDB. The composition of the population who will be purchasing coverage in the Exchange is affected by Medicaid eligibility, as well as ability to pay for coverage and whether Maryland chooses to create a Basic Health Plan. While some information on the demographic characteristics of Maryland's uninsured population are known, there is limited information on their health status and no information on what their spending would be once they have health insurance coverage. From survey data, we know that the nonelderly uninsured in Maryland are slightly more likely to report being in fair or poor health status than those with insurance coverage (10 percent versus 7 percent). For persons 45 to 64 years of age, the differential is similar with 17 percent of the uninsured reporting fair or poor health status compared with 13 percent of the insured.

Second, it is difficult to predict how spending for those who are currently uninsured will be similar to or different from the spending data presented here for those who are currently insured. Spending will be influenced by individual characteristics—including age, income, gender, and health status—as well as the structure of benefits and cost-sharing. Those who are currently uninsured may also have greater demand for services that could cause spending to be higher than anticipated in the first year or two of the Exchange.

Finally, there are decisions about the structure of the Exchange that remain. Requirements for risk adjustment and reinsurance—how premiums are adjusted for health status differences and how much of the risk insurers have to bear—will affect which health plans offer coverage through the Exchange and what their initial premiums will be.

All of the cost estimates based on current enrollees in the individual market, the CSHBP, and the MHIP could be inundated by the proposed rules issued by the U.S. Department of Health and Human Services on July 12, 2011, relating to reinsurance and risk adjustments. The final rules will have a significant impact on the premiums for policies sold within the exchanges and the finances of the health plans themselves.[16] These rules could counteract any adverse financial effects due to adverse selection (less healthy people choosing certain plans) by currently uninsured people when they choose options within the Exchange. Nonetheless, the cost estimates in this report should assist Maryland policymakers as they review the proposed rules relating to reinsurance and risk adjustment to see how such rules might affect Maryland's health plans.

[15] Maryland Medicaid includes the Maryland Children's Health Insurance Program (MCHIP).

[16] See Tim Jost's blog on the *Health Affairs* Web site at *http://healthaffairs.org/blog/2011/07/13/implementing-health-reform-health-insurance-exchanges-part-3/.*

MHCC is an independent, regulatory commision
administratively located within the
Maryland Department of Health and Mental Hygiene.
Marilyn Moon, Ph.D., Chair
Ben Steffen, Acting Executive Director

MARYLAND HEALTH CARE COMMISSION
4160 Patterson Avenue, Baltimore, Maryland 21215
Telephone: 410-764-3570
Fax: 410-358-1236
mhcc.maryland.gov