SPOTLIGHT ON
MARYLAND

MHCC MARYLAND HEALTH CARE COMMISSION

Health Care Spending in Maryland Prior to Implementation of the Health Benefit Exchange

INTRODUCTION Federal health care reform under the Patient Protection and Affordable Care Act of 2010 (PPACA) makes a number of changes to the ways in which states regulate their private insurance markets. As of March 2013, 18 states, including Maryland, had received conditional approval from the U.S. Department of Health and Human Services to establish a state-based health insurance exchange, and another 7 states had been conditionally approved to operate a State Partnership Exchange.[1]

The Maryland Health Benefit Exchange—with its publicly facing marketplace to be known as the Maryland Health Connection—is scheduled to be open for enrollment by October 2013. Of an estimated 740,000 uninsured individuals in the state, 150,000 are expected to enroll in qualified health plans through the exchange.[2] It is also anticipated that over 20,000 individuals with current coverage through the state's high-risk pool will transition to coverage through the state's exchange.[3] Although the vast majority of small employers will continue to purchase through the small group market outside of the Exchange, about 1,000 small businesses are expected to enroll in plans through offerings to small employers[4]— referred to as the Small Business Health Options Program (SHOP), which is slated to open on March 1 of 2014.

The impact of a health insurance exchange for Maryland's private health insurance market will be felt primarily by those who are now uninsured, covered through small employer groups, or insured through individually-purchased products including high-risk pool policies. Health care reform will have the most significant effect on the individual market, in terms of carrier pricing practices and benefit requirements for products that will be sold in the exchange. While many of the changes mandated under the PPACA have existed in the small group market in Maryland for almost two decades, there will be some changes including the emergence of new products, availability of a slightly broader benefit package, and the opportunity for employees to select among similar plans offered by different carriers if the employer opts to participate in the SHOP portion of the Exchange. In the large group market (consisting of both fully insured and self-insured products), changes will be minimal. Those currently covered through large employers with fully insured plans are likely to maintain their coverage and be largely unaffected. Large self-insured plans, which constitute about two-thirds of the overall private health insurance market in Maryland, are not affected by the PPACA requirements governing the exchanges, since they are exempt from state regulation.[5] Exhibit A displays some of the features of the different markets that may affect spending and utilization.

The purpose of this Spotlight is to examine health care spending and utilization patterns for Maryland residents insured through the individual, small employer group, and high-risk pool markets. The analysis relies on 2011 data from Maryland's Medical Care Database (MCDB), which contains health care claims and encounter data submitted annually to the Maryland Health Care Commission (MHCC) by most private health insurance plans serving Maryland residents. This analysis updates an earlier MHCC publication that provided data on spending patterns for the year 2009 among those likely to purchase coverage through the state's health benefit exchange.

[1] *http://cciio.cms.gov/resources/factsheets/state-marketplaces.html*
[2] *http://marylandhbe.com/faq/*
[3] Maryland Health Care Reform Coordinating Council. Final Report and Recommendations. January 2011.
[4] Fakhraei, S. H. (2012). *Maryland health care reform simulation model: Detailed analysis and methodology.* Baltimore, MD: The Hilltop Institute, UMBC.
[5] ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B).

EXHIBIT A. Overview of Regulated Health Insurance Markets: Comparison of Current Features and Likely Impact of Exchange

	FEATURES			
MARKET	**Rating requirements/ eligibility**	**Benefits**	**Oversight**	**Likely Impact of Exchange**
Large employer, fully insured	Rated based on group experience, limited exclusions	Benefits packages vary by employer and carrier, but typically broad coverage	Federal/State	Minimal impact, most individuals expected to retain current coverage
Small employer	Modified community rating ▪ Allows for some premium variation based on individual factors ▪ Limits premium differences within specified rate bands ▪ Helps affordability by restricting impact of poor health status on costs	Employers must offer benefits that minimally meet the scope of services and the cost-sharing arrangements defined in the Comprehensive Standard Health Benefits Plan (CSHBP). Cost of the base CSHBP cannot exceed 10% of the Maryland average annual wage. Employers can add benefit riders to reduce copayments and deductibles. High deductible plans are capped at $2,700 (individual), $5,400 (family).	Maryland Insurance Administration (MIA). Expanded role in rate review and rate setting for MIA under the PPACA and 2012 Maryland legislation.	Limited impact as modified community rating and prohibitions on pre-existing conditions are already in place. New federal standards for "essential health benefits" are the health benefits currently included in the largest small group product with addition of broader mental health and rehabilitative services coverage. Employee choice model products will be available beginning in February 2014.
Individual	Medical underwriting allowed ▪ May charge enrollees higher premiums based on health status or age ▪ May place limitations on individual coverage or even deny altogether ▪ Lower premium rates for younger, healthier individuals	Tend to be less generous than in other markets—e.g., higher cost-sharing, narrower service coverage	Expanded role in rate review and rate setting for MIA under the PPACA and 2012 Maryland legislation.	Largest impact of regulated markets, with changes in carrier pricing practices and benefit requirements including restrictions on medical underwriting and elimination of exclusions for pre-existing conditions. Essential health benefits are same as for small group, plus other mandated benefits not applicable to small group market. "Grandfathered" plans representing about 50% of the current market will continue to operate outside of new rules.
MHIP (Maryland Health Insurance Plan)	Available to Maryland residents who meet at least one of the following eligibility requirements ▪ Are denied coverage due to existing health conditions ▪ Have 1 of approximately 70 qualifying health conditions ▪ Exhausted COBRA coverage	Higher premiums compared to other markets	Established by Maryland legislature and administered by CareFirst, under contract to MHIP	Program continues until 2020, enrollees will transitioned to the Exchange beginning in 2014.

The current analysis extends our understanding of existing differences in spending and use in the markets that may feed into the state-based insurance exchange. Spending and utilization in these markets is compared with the market for coverage through large, fully insured private employers (hereafter referred to as large employer plans). Although individuals insured through large employers will probably continue to maintain their current coverage, spending in that market serves as a point of reference for the markets that will feed into the exchange.

HOW DO SPENDING AND UTILIZATION VARY BY TYPE OF COVERAGE IN MARYLAND'S REGULATED HEALTH INSURANCE MARKETS? In 2011, there were approximately 550,000 persons insured through large private employers with fully insured plans and another 420,000 covered by small employers through a Comprehensive Standard Health Benefit Plan (CSHBP). Approximately 225,000 individuals purchased coverage through the individual market and almost 25,000 were covered through Maryland's high-risk pool. In order to be able to make comparisons across

TABLE 1. Spending and Use Among Maryland's Less-Than-65, Privately Insured, 2011: Markets Potentially Part of the Health Benefit Exchange

	Large Private Employers[a]	CSHBP	Individual	MHIP
Total number of full-year (FY) enrollees[b]	342,072	277,889	143,798	15,554
Percent of FY enrollees with a CDHP plan	11%	44%	26%	25%
SPENDING				
Mean spending, all services	$2,902	$3,354	$1,945	$9,591
Median spending, all services	$767	$895	$458	$3,084
PERCENT WITH USE				
Inpatient facility	4%	4%	3%	8%
Outpatient facility	22%	24%	17%	37%
Professional Services	83%	85%	77%	93%
Labs/Imaging	69%	69%	63%	84%
Prescription drugs[c]	66%	72%	34%	88%
RISK SCORE				
Median expenditure risk score[d]	0.24	0.24	0.19	1.15

NOTES: a. Fully insured
b. The analysis is limited to full-year enrollees, 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.
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.

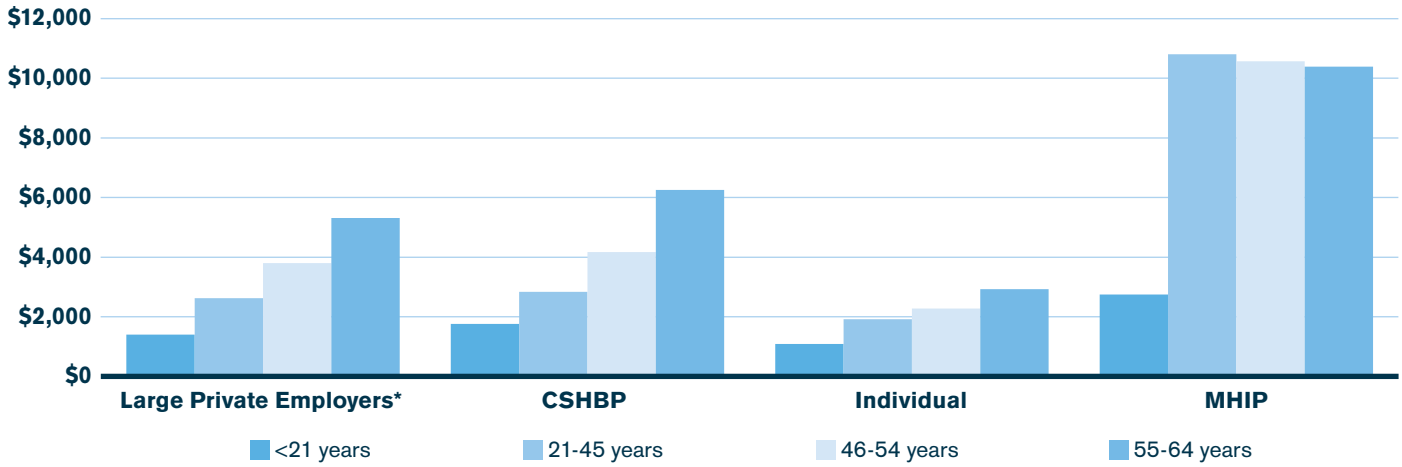
markets, the estimates presented in this Spotlight are limited to persons who were covered for the entire year by the same plan. This excludes approximately 440,000 persons for whom full-year records were not available because they lost or gained coverage, changed plans and could not be tracked across plans, or experienced a qualifying event such as birth or death.

Table 1 shows health care spending and utilization by type of coverage for those enrolled throughout 2011. Within each of these types of coverage, the proportion of enrollees with a consumer-directed health plan (CDHP) varied. Approximately 44 percent of those in the CSHBP market had one of these high-deductible plans compared to about one-quarter in the individual and MHIP markets and only 11 percent in the large, private employer market. High-deductible plans are often linked with health savings accounts (HSAs). In order to establish an HSA that qualifies for tax-preferred treatment of money saved for medical expenses, high-deductible plans must meet certain federal requirements—in 2011, deductibles had to be at least $1,200 for an individual and $2,400 for family coverage.[6] Under the current CSHBP, the deductible can be no greater than $2,700 for an individual policy and $5,400 for a group. These limits are significantly lower than the federal limits on HSA-eligible products of $5,950 for an individual policy and $11,900 for a family.

There were large variations in spending and utilization across the market segments. Spending was higher in the small-group and large employer markets compared to the individual market and highest for persons covered through the high-risk pool. Mean spending for MHIP high-risk plan enrollees was about three times higher than for enrollees covered by private employers, whether small or large, and almost five times higher than for enrollees with individually purchased policies. The low average spending in the individual market is due to both medical underwriting, which tends to exclude persons with serious health conditions, and less generous benefits, which may

[6] *http://www.treasury.gov/resource-center/faqs/Taxes/Pages/HSA-2011-indexed-amounts.aspx*

FIGURE 1. Per Capita Total Spending by Age and Coverage Type, 2011



NOTE: *fully insured

deter utilization. As is usual with health care spending, mean spending—which is affected by even small numbers of individuals with very high spending—was substantially higher than median spending across all markets.

Utilization by service type demonstrated similar patterns, with the percentage of enrollees obtaining health care services greatest in the high-risk pool and lowest in the individual market. Differences between the high-risk and individual markets in terms of the percentage of enrollees using a particular service were largest for inpatient care, prescription drugs, and outpatient facility care—where enrollees in the high-risk pool were more than twice as likely as those with individual policies to use services. This difference was even greater with respect to prescription drugs, where the percentage of enrollees with use was particularly low in the individual market. The proportion of enrollees with use was similar across all services in the large- and small-group markets. Similar to prior years, MHIP enrollees accounted for around 4 percent of users across the three markets (Individual, CSHBP, and MHIP) but a much larger proportion of spending—11 percent in 2011. The median expenditure risk score, which categorizes an individual's risk of having significant medical expenditures from the number and mix of diagnoses recorded on his or her insurance claims, is an indicator of the variation across markets in the health status of enrollees. As would be expected given utilization and spending measures, the risk score is highest for MHIP enrollees and lowest for persons insured through the individual market.

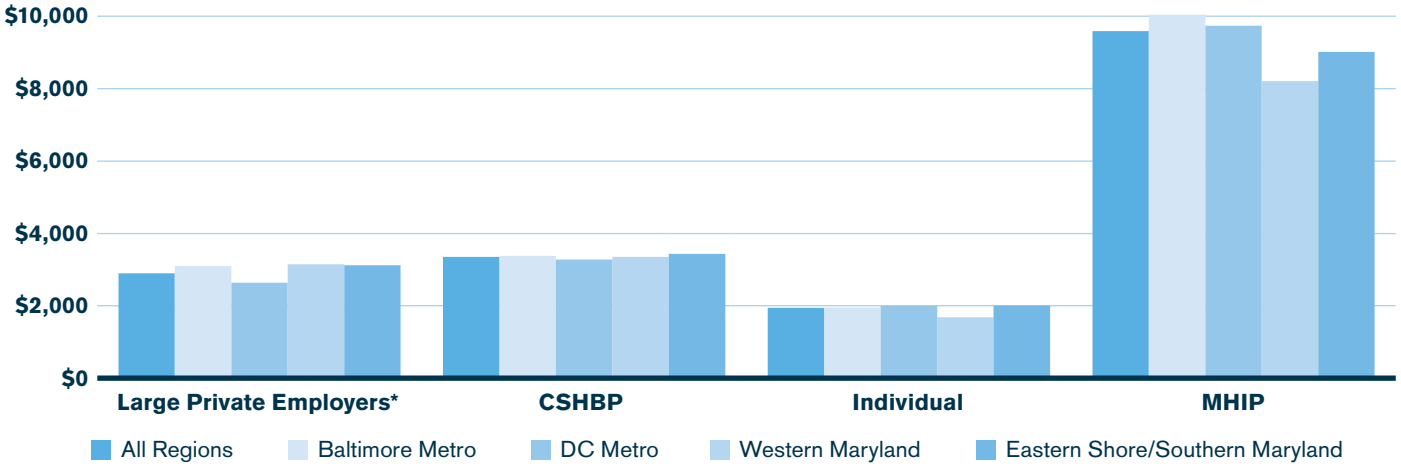
VARIATION IN SPENDING BY ENROLLEE CHARACTERISTICS Differences in health care spending and utilization within and across markets may reflect differences in the demographic characteristics of enrollees. The PPACA includes new federal rules that limit the extent to which insurers can vary rates by age. Currently, many insurers have age rating bands that are 5:1—which limits the amount an older individual will pay in premiums to no more than five times what a younger individual pays.[7] Starting January 1, 2014, health care reform limits a state exchange's age rating bands to 3:1, and requires use of a uniform age rating curve established by the state for the individual market, small-group market, or both markets specifying the relative distribution of rates across all age bands.[8] A federal standard default age curve would apply in certain cases. In this analysis, we have modified age bands derived from the federal standard default age curve.

Age is a big driver of health care use, with older individuals generally using more care. Age is a big driver of health care use, with older individuals generally using more care. This holds true across all the different coverage types, with the exception of the high-risk pool. About one-quarter of enrollees in the individual, small-group, and large employer markets were dependents less than 21 years of age, a group that tends to use relatively fewer health care services. In contrast, only about 12 percent of enrollees in the high-risk pool were less than 21 years

[7] *http://www.urban.org/uploadedpdf/412757-Why-the-ACAs-Limits-on-Age-Rating-Will-Not-Cause-Rate-Shock.pdf*

[8] *http://cciio.cms.gov/resources/files/market-reforms-guidance-2-25-2013.pdf*

FIGURE 2. Per Capita Total Spending By Region and Coverage Type, 2011



NOTE: *fully insured

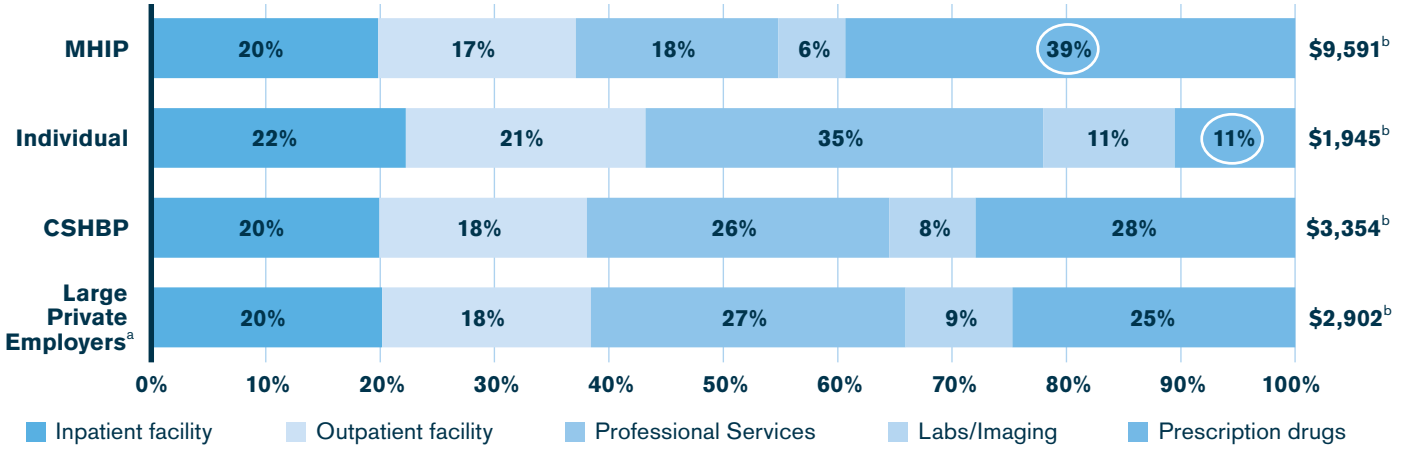
of age.[9] Persons in the 55-to-64 age group are generally more likely to use health care services; while less than 20 percent of enrollees from the individual, small-group, and large employer markets were in this group, this age cohort accounted for 41 percent of enrollees in MHIP.

In general, as shown in Figure 1, those under 21 years of age had the lowest per capita spending irrespective of market segment, while those in the 55-to-64 age category had the highest, again, with the exception of the high-risk pool. In that market, there was relatively little variation in spending for enrollees over 21 years of age, likely because the high-risk pool comprises individuals with serious health conditions where the impact of age is overwhelmed by health status. The effect of age on spending was also somewhat attenuated in the individual market, with smaller differences in spending by age group perhaps due to medical underwriting limiting enrollment by those with higher spending.

Spending and utilization can also vary by geography. Geographic variation derives from factors that influence the demand for services (such as regional differences in personal income or health status) as well as the supply of services (for example, variation in provider availability and

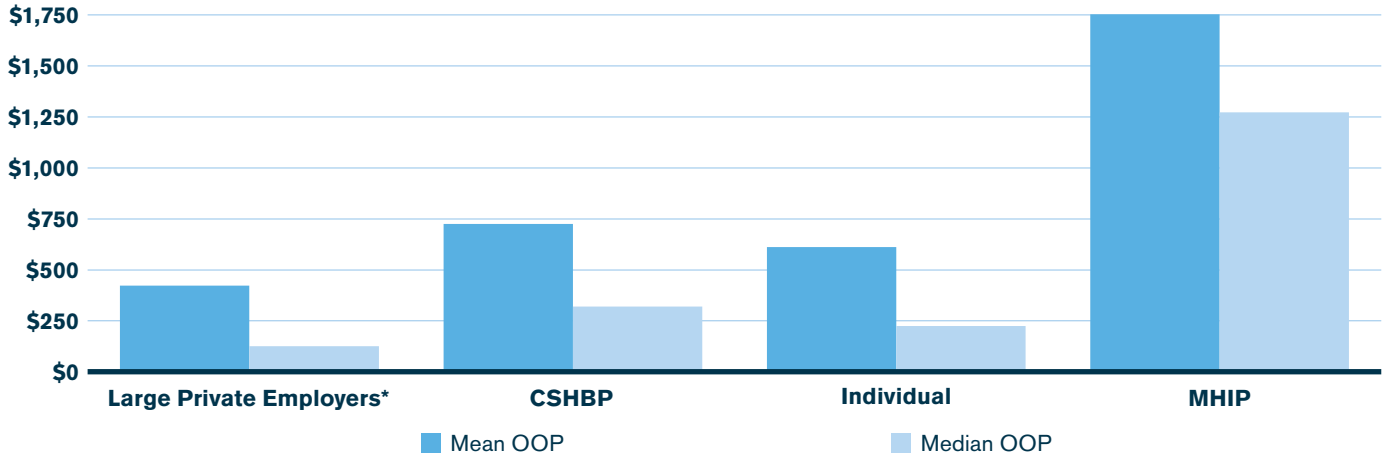
[9] Individuals that qualify for the state MHIP program may enroll the entire family. The federal high risk pool, Pre-Existing Condition Insurance Plan (PCIP), that is available through MHIP only permits the qualifying individual to enroll.

FIGURE 3. Distribution of Per Capita Total Spending by Coverage and Service Type, 2011



NOTES: a. fully insured
b. Mean Per Capita Spending

FIGURE 4. Mean and Median Out-of-Pocket (OOP) Spending by Coverage Type, 2011



NOTE: *fully insured

payer market share). As can be seen in Figure 2, there was relatively little regional variation in per capita spending within markets—differences from statewide spending were smallest in the small-group market and largest in the high-risk pool. In addition, the spending pattern varied by market, with no region having consistently higher or lower spending. Within the small and large employer markets, per capita spending was lowest in the D.C. Metro area while for the individual and MHIP markets Western Maryland had the lowest per capita spending.

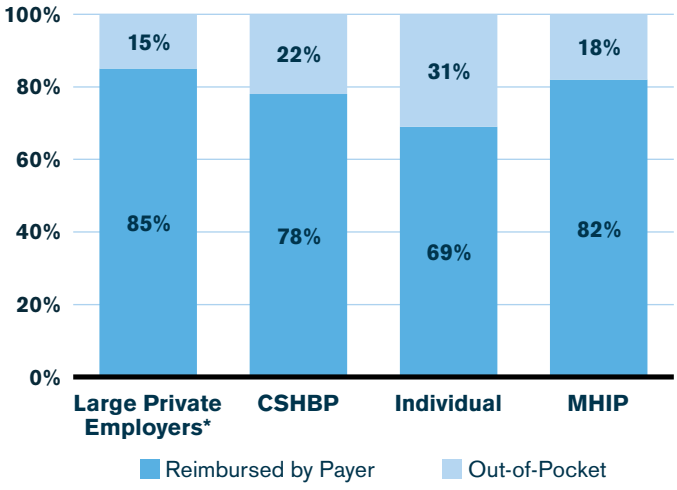
COMPONENTS OF SPENDING BY COVERAGE TYPE While the shares of per capita total spending allocated to inpatient and outpatient facility services were very similar across market segments, other service categories—including professional services, labs/imaging, and prescription drugs— showed greater variation across the markets (see Figure 3). Enrollees in the individual market had the highest share of spending allocated to professional services (35 percent), and the lowest share allocated to prescription drugs (11 percent). This latter is consistent with the relatively low percentage of enrollees in this market who used any prescription drugs (34 percent, as shown in Table 1).

In contrast, MHIP enrollees had the largest proportion of total spending for prescription drugs, consistent with their high use of expensive medications such as antivirals, protease inhibitors, atypical antipsychotics and antirheumatics. The top five most commonly used drug categories accounted for about 50 percent of the total MHIP drug spending for age groups 21-to-44 and 45-to-54 and 27 percent for the 55-to-64 age group.

Figure 4 shows mean and median out-of-pocket spending by coverage type, while Figure 5 shows the share of overall spending for each market that was paid for out-of-pocket. The former represents the average burden faced by individual enrollees in each market, while the latter, along with the share reimbursed by insurers, provides a picture of the generosity of reimbursement for each type of coverage across all enrollees.

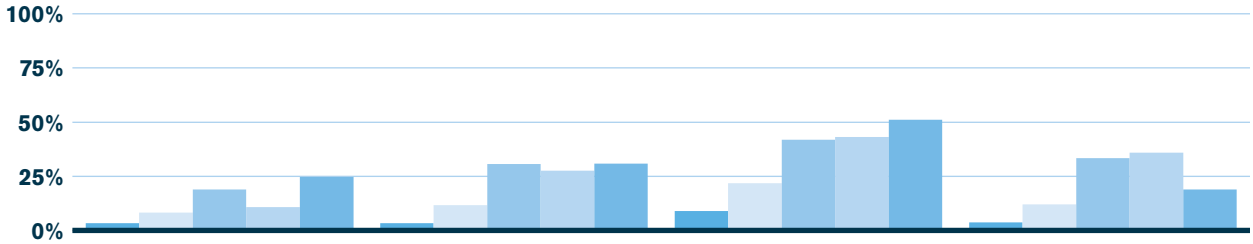
As seen in Figure 4, MHIP enrollees had the highest mean and median out-of-pocket spending, largely because their per capita spending was so much higher than that for other enrollees. However, the share of overall spending paid out-of-pocket by MHIP enrollees was the second lowest of the four coverage types, as shown in Figure 5. The lowest

FIGURE 5. Out-of-Pocket (OOP) and Reimbursed Shares of Total Spending by Coverage Type, 2011



NOTE: *fully insured

FIGURE 6. Variation in Overall Out-of-Pocket (OOP) Share of Total Spending by Type of Service and Coverage Type, 2011



	Large Private Employers*	CSHBP	Individual	MHIP
Inpatient facility	3%	3%	9%	4%
Outpatient facility	8%	12%	22%	12%
Professional services	19%	31%	42%	33%
Labs/Imaging	11%	28%	43%	36%
Prescription drugs	25%	31%	51%	19%

NOTE: *fully insured

mean and median out-of-pocket spending were in the large employer group market; that market also had the lowest share of spending paid out-of-pocket. This reflects both relatively low average spending and generous plan benefits. The out-of-pocket share of total spending was highest among those with coverage through the individual market due to the less generous benefit structure for plans in this market.

The proportion of spending borne by the individual varied considerably by type of service, both within and across markets (see Figure 6). Across all services, the highest OOP shares were in the individual market—for prescription drugs, half of total spending was paid out-of-pocket and for professional services and labs/imaging over 40 percent of spending was out-of-pocket. OOP shares were generally lowest in the large private employer market. The out-of-pocket share was generally highest for prescription drugs, regardless of coverage type, with the exception of MHIP where the OOP share was highest for labs/imaging.

IMPLICATIONS Features of Maryland's regulated insurance markets—consisting of small-group plans, plans offered by large fully insured private employers, individually purchased policies, and the high-risk pool—have potential implications for the implementation and functioning of the exchange. Once the exchange is operational, enrollees with current coverage through the individual marketw are expected to seek individual coverage through the exchange. Although MHIP will continue to operate until 2020, some MHIP enrollees may find the federal subsidies and/or policies offered through the Exchange to be very attractive. Significant subsidies as well as a coverage mandate should encourage currently uninsured persons to enter this new marketplace, as will some persons currently covered under employer plans—either in order to take advantage of the income-based subsidies or in the event that their employer discontinues providing health insurance.

Effective January 2014, insurance carriers that sell products within the exchange will be required to enroll all individuals seeking coverage in at least a basic benefit package, without application of underwriting rules.[10] While Maryland law does not currently specify the factors that an insurer may use to calculate an individual's premium for policies purchased in the individual market, the PPACA requires that premiums may only be calculated using modified or adjusted community rating—where the premium may only vary from one individual to another based on age, tobacco use, geography, and family size.

The introduction of modified community and expanded benefits defined under the Essential Health Benefit requirements of the PPACA may increase premiums for younger and healthier individuals currently in the individual market, since sicker and thereby costlier individuals from MHIP will not be included in the risk pool, and those with lower expected spending will no longer benefit from medical underwriting. Conversely, subsidies

[10]Maryland Health Care Reform Coordinating Council. Final Report and Recommendations. January 2011.

TABLE 2. Changes in Per Capita Spending Overall and by Coverage Type, 2010–2011

COVERAGE TYPE	2010	2011	Percent Change
All	$2,870	$3,020	5%
Large Private Employers*	$2,799	$2,902	4%
CSHBP	$3,206	$3,354	5%
Individual	$1,823	$1,945	7%
MHIP	$8,752	$9,591	10%

NOTE: *fully insured

may also encourage younger and healthier individuals to enter the market, thereby mitigating the adverse impacts of premium increases.

Between 2010 and 2011, across the markets that may contribute to the exchange, per capita spending increased the most for MHIP enrollees (10 percent), and those with individual policies (7 percent), while enrollees covered by small and large employer group saw relatively smaller increases of 5 percent and 4 percent, respectively (see Table 2). In light of the expected high expenditures for MHIP enrollees, and to mitigate the uncertainty among insurers that would result if MHIP were to close too quickly, the 2013 Health Progress Act included a provision to extend the phasing out of MHIP coverage through January 2020. Slowing the migration of MHIP enrollees to the Exchange will reduce uncertainty among carriers in setting premiums and could dilute some of the sharp premium increases forecast by the industry.[11]

With the large number of changes anticipated, it will be important for policymakers to monitor trends in spending as implementation of the Exchange moves forward. In this regard, planned changes to the MCDB will enhance its value as a tool in these monitoring activities. The integration of data from Medicare and Medicaid, as well as the adoption of a common identifier to track individuals across plans and over time, will support more robust measurement of enrollee spending across payers, markets, and service sectors, enhancing the ability of policymakers to fully support the marketplace and its many constituents.

[11] Society of Actuaries. Cost of the Future Newly Insured under the Affordable Care Act (ACA). March 2013. Available at *http://cdn-files.soa.org/web/research-cost-aca-report.pdf*

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