Impact of State vs. Federal Control of Maryland’s Health Insurance Exchange

Glenn Nordehn, DO
Health Policy Fellowship 2012
Summary

• ACA set in place Insurance Exchanges
• States that elect to participate
  – Have a choice of benefit benchmarks
  – Have financial advantages
  – Maintain state control
• States electing to not implement an exchange
  – No choice of benefit benchmarks
  – Financial advantages are potentially lost
  – State control declines
Basic premise

• I looked at the example of Maryland’s choice to set up an exchange.

• Finding: By passing the *Maryland Health Benefit Exchange Act*
  – Maryland maintained state rights and
  – lowered the cost of the exchange
History and Background

• Exchanges
  – Must include federally-defined coverage areas
  – States select one plan from a menu of ten options as their benchmark
  – Insurance companies on the exchange will all offer the same coverage areas as the benchmark
  – Subsidies for those between 133% and 400% FPL
  – Eligible if income > 133% FPL and no other affordable option
    • Affordable option = no coverage that costs > 9.5% of income
Benchmarks

States can select one benchmark from a choice of ten options:

• Largest HMO, 3 largest private plans; 3 largest gov’t. employee plans; 3 largest small company plans

Benchmark plan must include:

• All mandated coverage areas
• Incorporated in this are two areas of coverage
  – Benefits the plan covers *not* mandated by the state’s laws
  – Benefits the plan covers that *are* mandated by the state’s laws
• Plus any essential health benefits (as defined by feds)
State areas of mandated coverage

• All states mandate various benefits
  – Dependent upon plan type
    • HMOs are **mandated** by MD state law to cover in-vitro fertilization in Maryland
    • Small group plans are **not mandated** to cover in-vitro fertilization in Maryland

(In-vitro fertilization is not considered an essential health benefit by the Federal Government)
Cost Implications

• There are areas of coverage (such as IVF for MD) that are:
  – Not Essential Health Benefits
  – Are mandated for certain types of insurance in the menu states may select for their benchmark
  – Are not mandated by state law for other types of insurance states may select for their benchmark

• States must pay for non-EHB required by state mandates
Consequence

• If a state starts an exchange:
  – The state can minimize the number of non-essential health benefit in their benchmark by selecting the benchmark with the *fewest* non-essential health benefit mandates
Two Roads

• States can elect to start an exchange
  – the state has ten choices for the benchmark
• States can elect to not start an exchange
  • The federal government will start an exchange
  • The default benchmark will always be the state’s **small group plan** with the most people on the plan.
Unintended consequences

• Starting an exchange and selecting the plan with the least number of state mandated coverage areas considered non-EHB costs MD ~$ 10 million.

• Not starting an exchange and having to use the small group plan as a benchmark costs MD ~ $80

• Difference = ~$70 million

Unintended consequences

• Starting an exchange and selecting the plan maintains state control

• Not starting an exchange and having to use the small group plan gives up state control and has financial consequences
Stakeholders – if the Maryland Act is not passed

• Maryland taxpayers: not starting an exchange costs ~$70million
• Maryland citizens who value state rights as the benchmark decision is lost to the feds
• Small businesses: oppose due to cost unknowns
• American Hospital Association: mixed statements of support
• AOA: supports. AOA states ACA will improve the health of the nation
Conclusion

- Two paths: Start an exchange; do not start an exchange
- Starting an exchange saves Maryland funds
- Starting an exchange maintains state rights