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WHAT WILL OBAMACARE COST MARYLAND?

BY MARC KILMER

THE DEBATE OVER THE COST of the Patient Protection and Affordable Care Act (aka, "ObamaCare") has been obscured in Maryland by an overly-optimistic report put out by a council appointed by Governor Martin O'Malley. The real cost of this law to the taxpayers of Maryland is hard to estimate with any precision, but it will almost certainly be significant at both the state and federal level.

KEY POINTS:

- The governor's coordinating council assumed the state's high-risk pool will be fully funded by the federal government, contrary to the assumptions of other state governors as well as the Congressional Budget Office.
- The state's Medicaid burden under PPACA is likely to increase substantially, contrary to the rosy scenario of the governor's coordinating council.
- Around half of the "savings" found by the governor's coordinating council are not savings at all, but rather are increased tax revenue from insurance being sold in the state. This revenue estimate also rests on shaky assumptions.

The passage of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010 set in motion a fundamental change in the structure of health care regulation and financing in the United States. This legislation will affect health care providers, patients, taxpayers, insurance companies, and state and local governments in a variety of ways over the next decade.

The state of Maryland, like every other state, will be forced to change the way it regulates and finances health care. Governor Martin O'Malley established the Health Care Reform Coordinating Council (HCRCC) to examine how the legislation will affect the state. This council sent a final report to Governor O'Malley on January 7, 2011, concluded that the new health care law would impose $1.852 billion in new costs on the state, save the state $2.105 billion, and produce an additional $576 million in tax revenue.

News reports and press releases from politicians claimed that this report proved that the new health care law will save Maryland $829 million. However, these reports also assumed an estimated $576 million in new revenue from taxes on new insurance premiums was included as a "savings." Whether new tax revenue should be counted as "savings" is questionable. If it is not, then the real savings number is only $253 million.

Whether PPACA will actually save $253 million is questionable. While this report presents some ways PPACA will affect the state, a few important areas are overlooked. These omissions, in addition to questionable assumptions about how much the programs will cost, give the report an overly-optimistic view of what PPACA will cost Maryland taxpayers.

HIGH-RISK POOL COSTS

One of the areas the HCRCC overlooked was the cost of the high-risk pool. Under PPACA, states can establish and run a health insurance pool for high-risk individuals who cannot afford or otherwise obtain health insurance on their own. A state can establish and run its pools with federal funding or it can decline to operate such a pool and the federal government will administer and fund it.

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If a state decides to run this high-risk pool itself, it is obligated to fund it. The federal government will provide some possibly all of the funding for it, but this is not guaranteed. The deadline for states to decide whether to operate their own high-risk pools was April 30. Eighteen states, citing cost concerns, declined to operate theirs, leaving the job to the federal government.

Maryland was not one of 18 states. Legislators and the governor had already decided that the state would undertake the establishment and operation of the high-risk pool under PPACA. In April the General Assembly passed and the governor signed legislation that authorizes the board of directors of the Maryland Health Insurance Plan (MHIR) to administer a state high-risk pool as outlined by PPACA.

This legislation was passed without any idea of what it would cost. As the state Department of Legislative Services (DLS) stated in its fiscal and policy note on the bill,

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> the amount of federal funds that Maryland will receive is unknown at this time and will likely be clarified through regulations issued by the U.S. Secretary of Health and Human Services. Therefore, Legislative Services advises that the amount of federal funding that the State will receive along with the number of individuals who will be covered by the program is unknown.[1]

DLS did note that MHIP said there was no reason for alarm: "MHIP advises that it expects federal funding and premium revenues to cover the costs of program administration and claims costs."[2] If so, MHIP is making an assumption that is not widely shared.

The Congressional Budget Office, for instance, concluded:

> CBO estimated that the funding available for subsidies would not be sufficient to cover the costs of all applicants through 2013, so CBO assumed that HHS would use the authority given to it under the act to limit enrollment in the program. On that basis, CBO expects that the number of enrollees in the program will average about 200,000 over the 2011–2013 period. If, instead, more people are allowed to sign up initially, the available funds will probably be exhausted prior to 2013, but total spending for the program will still be capped at $5 billion.[3]

If the high-risk pools are operated under the mandates of PPACA, CBO found that they will cost far more than the $5 billion allocated by PPACA:

> If the program covered about 65 percent of enrollees' costs for health care, federal spending through 2013 would probably fall between $10 billion and $15 billion ~~or~~ $5 billion to $10 billion more than the cap specified in PPACA. Total enrollment in the federal high-risk pool program would be expected to grow from roughly 400,000 in 2011 to about 600,000 or 700,000 in 2013.[4]

The assumption that the new high-risk pool will not need any additional state funding is true only if the pool does not comply with PPACA's mandates. The state legislation implementing this pool says that the state may limit enrollment if federal funding runs out. However, once the state agrees to administer the pool, it is unclear if limiting enrollment is an option.

While the state may not be forced to supply funding for this high-risk pool, there is the distinct possibility it will. At some point during the pool's operation, it is almost certain that federal funding will not be sufficient to pay insurance benefits for enrollees in the pool. When federal funding runs out, if the state does not want to begin funding it with state money, it will be forced to cut back on benefits, charge higher premiums, or turn the administration of the pool over to the federal government.

These options may not be available to the state. In HHS's solicitation to states regarding high-risk pools, the only section dealing with what happens if federal funds run out is section A.5(6): "If the anticipated expenses of the high risk pool are projected to exceed the available HHS allotment of funds for the State, the Contractor shall make necessary adjustments to eliminate such deficit, in consultation with HHS."[5] HHS has the final say on what adjustments could be made. The solicitation has a section that outlines how HHS can terminate the contract with the state (or its contractor) but no section on how states can terminate the contract with HHS.[6]

What "necessary adjustments" could be undertaken is left unexplored. Will the state simply stop covering those in the high-risk pool? This could possibly happen, although the resulting uproar from the state stopping coverage of those with high-risk conditions would almost certainly result in some sort of state funding to reinstate coverage.

Since the nature of the high-risk pool's future funding is unknown, it would have been prudent for the state to determine what would the cost be and determine if the $85 million the federal government estimates Maryland will get would cover the pool's costs. Maryland's policymakers did not do this.

While Maryland is optimistic that this pool will not cost the state any money, other states are not so sanguine. For instance, John Oxendine, Georgia insurance commis-

sioner, wrote of his concerns about the high-risk pool in a letter to Secretary Sebelius:

> Ostensibly, the high-risk pool program will be funded by federal grants made available to the states. While many may see this as 'free money,' the taxpayers of Georgia and the other 49 states will ultimately bear the financial burden for this Washington-imposed program. Unfortunately, I have no confidence in any federal assertion that this so-called temporary program will not burden the taxpayers of Georgia. I am concerned that the high-risk pool program will ultimately become the financial responsibility of Georgians in the form of an unfunded mandate.[7]

Likewise, Idaho also rejected the opportunity to set up a high-risk pool because of cost concerns. According to a press release from Idaho Governor Butch Otter,

> Estimates prepared by the Idaho Department of Insurance indicate that the $24 million allocated for Idaho in the federal healthcare reform plan would provide only a month or two of coverage for the approximately 33,400 individuals who may qualify – even though it's a four-year program that will be implemented and administered by the Department of Health and Human Services.[8]

Cost may even be a factor if enrollment does not reach the levels anticipated. In late 2010, there were media reports that while enrollment in state high-risk pools was far lower than expected, the services being offered:

> An early feature of the new health-care law that allows people who are already sick to get insurance to cover their medical costs isn't attracting as many customers as expected.
>
> In the meantime, in at least a few states, claims for medical care covered by the "high-risk pools" are proving very costly, and it is an open question whether the $5 billion allotted by Congress to start up the plans will be sufficient.[9]

If this trend continues Maryland could end up with the situation where many of those who are eligible for the high-risk pools remain uninsured but those who do sign up impose large costs.

Only time will tell which scenario comes to pass: many enroll in high-risk pools and the costs are more than projected, few enroll in high-risk pools and the cost is more than projected, or significant numbers enroll in high-risk pools and the cost is lower than or meets projections. Given the short history of the program and the history of other health care programs, the first two options seem far more likely than the third. However, even if the third option comes to pass and states like Idaho and Georgia are wrong in their assertions that the high-risk pools will cost their states money, they lose nothing by their gamble. If Maryland is wrong, however, it will be a costly mistake for the state's taxpayers.

MEDICAID

The cost to state taxpayers from the high-risk pool and the state insurance exchange subsidies are likely, though not certain, to occur. The increased cost of an expanded Medicaid program, however, is a certainty. While the extent of how much the federally-mandated Medicaid expansion will cost is up for debate, no one disputes the fact that PPACA will result in more state dollars being spent on Medicaid.

The Health Care Reform Coordinating Council takes a very optimistic view on how much Medicaid will expand due to PPACA. Today, Medicaid covers 14.1 percent of Marylanders. The Commission estimates that this number will rise to 14.3 percent of Marylanders in 2017. [10]

The Heritage Foundation has estimated that the number of Marylanders eligible for Medicaid under PPACA will increase by 30.9 percent.[11] The idea that vastly expanding the state's Medicaid eligibility will only result in a slight increase in Medicaid enrollment seems highly unlikely. While it may not be the 31 percent increase expansion in Medicaid rolls, it will almost certainly be far higher than the 0.2 percent increase predicted by the Health Care Reform Coordinating Council.

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The HCRCC estimated that between 2014 and 2020, the newly-eligible enrollees in Maryland's Medicaid program would cost $126 million.[12] That differs from the estimate prepared by the Department of Legislative Services, which concluded that between 2014 and 2019 the total cost to the state from this expanded Medicaid program would be $221 million.[13] Since DLS's figures did not count cost in 2020, it is unclear what its estimate for the program's cost would be in those years. But since it estimated that the cost in 2019 would be $204 million, it is probably safe to add another $200 million or so onto DLS's estimate to get a comparable estimate for 2014 through 2020.

These numbers may be too low, however. Both the HCRCC and DLS assumed participation rates that may be

lower than actual participation rates. The HCRCC assumed that 90 percent of those living in families under 50 percent of FPL will obtain coverage and that 70 percent of those living between 50 percent and 133 percent of FPL will obtain coverage. The DLS estimate quoted above applies a take-up rate of 75 percent. Considering that the new health care law will mandate that everyone obtain health insurance (although penalties will not apply to those eligible for Medicaid) and that states must increase their outreach to Medicaid-eligible populations, it is probable that there will be a larger take-up rate than estimated. This would, of course, increase the cost to the state above the estimates provided above.

Likewise, the HCRCC also makes another assumption that leads to a lower cost estimate. As the study's explanation of its financial modeling tool, "we assumed that take-up is related to health status …such that the people enrolling due to the woodwork effect will be slightly less disabled/poor health status than the baseline Medicaid enrollment."[14] This may not be a safe assumption. For instance, when Indiana began providing coverage for previously-uninsured adults under its Healthy Indiana Program, an analysis by Milliman found that "the HIP population used more care than the typical commercial population in Indiana with the same age/gender characteristics."[15]

This is due to what is called an "anti-selection." As the Milliman analysis explains:

> Anti-selection in healthcare describes, in general terms, the results that occur from the financial behavior of the highest-risk, most expensive people in seeking healthcare coverage that is available to them. The people who create anti-selection for a healthcare plan include those with serious chronic conditions, individuals with immediate near-term medical treatment needs, and those with pent-up demand for services that have been deferred for financial or other reasons. Access to coverage is of great value to such individuals, compared to the perceived value of coverage for someone without known acute or chronic care needs, and they are more likely to enroll in a newly available program. This is especially true if they do not currently have realistic access to coverage or if they have to pay a premium for such coverage out of limited income. A consequence of anti-selection is higher cost levels than would be experienced by the population at large.[16]

In general, government health care programs tend to exceed estimated costs. Maryland's Medicaid program, for instance, has a long history of costing more than the state government estimates.[17] It would not be surprising if actual spending exceeds both the HCRCC and the DLS Medicaid estimates.

A further issue that will certainly raise the rates of Maryland Medicaid enrollment is the number of already-eligible Marylanders who sign up for Medicaid because of PPACA. Unlike the enrollees that are now eligible for Medicaid discussed above, these enrollees will only be covered by the federal government at the old Medicaid match rate.

Maryland Medicaid provides coverage for adults who are defined as "medically needy" and who are on certain government programs, such as Supplemental Security Income. The state also provides Medicaid to parents who are below 116 percent of the federal poverty level. The federal government reimburses 50 percent of the state's Medicaid costs for these individuals.

It is difficult to tell how many people are currently eligible for Medicaid but not enrolled. According to the Census Bureau, there are 68,000 uninsured adults in families of 3 or more people that are under 125 percent of the federal poverty level. Most of those uninsured adults are probably eligible for Medicaid but are not enrolled. Furthermore, there are 125,000 children in families making under 125 percent of the federal poverty level. They, too, are eligible for Medicaid but are not enrolled.

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The reasons for those who are eligible for Medicaid but not enrolled are numerous. PPACA requires that all legal residents of the United States have health insurance coverage and encourages states to increase outreach to residents who are eligible for Medicaid. Clearly many of those who are currently eligible for Medicaid but not enrolled will, over the next few years, enroll in the program.

These new enrollees will impose new costs on the system that do not seem to be anticipated by the HCRCC.

PREMIUM TAXES

As mentioned above, the vast majority of the "savings" the HCRCC estimates will result from the passage of PPACA is, in fact new revenue from the state tax on insurance policies. Between 2014 and 2020, the HCRCC estimates these new taxes will produce $576 million in new revenue.

The HCRCC report assumes that the insurance sold in the health insurance exchange will be subject to the state's 2 percent premium tax. It likely will, but is it wise public policy for this tax to be applied? This exchange was proposed to help lower insurance costs and the majority of people in the exchange will likely receive subsidies to purchase insurance. If the state does levy its insurance tax, the state will have a situation the federal government (and likely the state government) will be paying people subsidies to purchase insurance and then taxing the purchase of that insurance.

Taxing a product for which people are receiving subsidies to purchase seems counterproductive. If Maryland policymakers want to help lower the cost of health insurance sold in the state, eliminating the premium tax would be a good first step.

There is also an assumption that there will be large numbers of newly-insured Marylanders in the health insurance exchange. It is possible that the optimistic numbers put forth by the HCRCC will indeed materialize. It is just as likely, though, that many of these Marylanders expected to obtain insurance through the exchange will instead be enrolled in the state's Medicaid or Children's Health Insurance Program. If that is the case, then the revenue from the premium tax will be less than expected.

CONCLUSION

While the HCRCC has done significant work outlining how PPACA will affect Maryland, there are some omissions that lead it to underestimate, perhaps significantly, the fiscal impact this legislation will have on our state. Assuming that the state will bear no fiscal burden for the new high-risk insurance pool, underestimating the cost of Medicaid expansion, and being overly optimistic about the amount of premium taxes collected from newly-insured Marylanders are all serious flaws in the HCRCC report. No one should use such a flawed report to claim the state will see fiscal savings from PPACA.

MARC KILMER *is a senior fellow at the Maryland Public Policy Institute.*

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