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MARYLAND'S PATH FORWARD UNDER THE AFFORDABLE CARE ACT

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INTRODUCTION

Maryland could face a big “October Surprise” this fall when more than 150,000 residents who buy health insurance on the state’s exchange learn their premiums will increase as much as 50 percent. Inability on behalf of Congress to repeal the Affordable Care Act (ACA) combined with the long, slow erosion of Maryland’s health exchange is forcing state policymakers to find ways to protect residents from a painful sticker shock.

At the federal level, the Trump administration has taken a variety of actions toward the ACA that gives Maryland and other states the opportunity to innovate in how they regulate health insurance and health care, as well as how they administer Medicaid. Regulators and legislators should take advantage of this federal leeway by allowing consumers greater freedom to purchase insurance that meets their needs and budgets, reforming Medicaid to contain costs and prioritize the neediest recipients and giving more opportunities for health care professionals and facilities to serve consumers in Maryland.

MAKE INSURANCE AFFORDABLE, NOT MANDATORY

One of the key parts of the ACA was the mandate that individuals must purchase health insurance or pay a tax penalty. This individual mandate was one of the more unpopular aspects of the ACA, but the Supreme Court held it to be a legal use of federal taxing power in a 2012 case. In 2017, however, the federal tax legislation set the penalty for failing to comply with this mandate at \$0. This makes the individual mandate, while still technically in place, meaningless.

The end of the individual mandate at the federal level has prompted a bill in Maryland that would re-impose the requirement at the state level. This bill, SB 1011, would impose a fine on uninsured Marylanders of 2.5% of an individual's gross income, or \$695 (plus \$347.50 per child), whichever is greater. The state would then earmark this money so the taxpayer could use it as a down payment on health insurance.¹ Under this legislation, the state would assist the uninsured taxpayer with navigating insurance plans, finding federal tax credits, and picking plans that meets certain qualifications. The state would also determine if an uninsured taxpayer qualified for Medicaid and, if so, enroll him or her in the program.

The activities of the new state bureaucracy to enforce and administer this law would be paid for by a new Maryland Insurance Stabilization Fund. This fund would consist of money paid by uninsured taxpayers who choose to pay a penalty rather than work with the state to obtain insurance. It is unclear if this funding would actually be sufficient to do the work envisioned by the bill's drafters or whether such a fund would require an infusion of taxpayer dollars to sustain it.

While there are arguments that the government must compel individuals to purchase health insurance in order to make the insurance market work, the experience of the federal individual mandate shows that this type of coercive measure has significant drawbacks. Because of the mandate's persistent unpopularity, the Obama administration took many steps that undermined whatever effectiveness such a mandate might have had in requiring younger, healthier individuals to purchase insurance in order to subsidize the premiums of sicker, older insurance customers. The penalty for refusing to purchase insurance was never high enough to give many people a strong enough economic incentive to buy a product that they considered too expensive and did not meet their needs. The Obama administration also provided a raft of exceptions to this mandate. If someone was low-income, a member of federally recognized Indian tribe, a member of a religious sect that objected to health insurance, or suffered a financial hardship, that person could obtain an exemption from the mandate.²

There are certainly justifiable reasons for every one of the exemptions granted by the Obama administration.

However, that speaks to the inherent problems with the mandate itself. A requirement that individuals must purchase a specific product to meet a certain public policy goal is a broad tool that is not fine-tuned to meet the variety of circumstances that individuals find themselves in. If Maryland adopts the same policy at the state level, it will suffer from similar drawbacks. There will need to be a number of exceptions to the mandate, each of which make it less effective from a policy standpoint.

Instead of imposing a state mandate that Marylanders must be covered by health insurance, a better alternative

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would be to allow the sale of a wider diversity in insurance products, thereby increasing the likelihood that people will find a product they like and can afford. Currently, state law mandates a variety of services and procedures that must be covered by insurance sold in state-regulated markets. These mandates all sound like reasonable procedures or products to cover, but their cumulative effect is to make insurance more expensive in the state. For many people, they do not want (or have any hope of needing) many of the mandated services.

The ACA also mandates that certain services must be covered by insurance. The ACA's legislative language is broad in many respects, however. Under the Obama administration, regulations clarified what types of services must be covered by insurance to comply with the ACA. Maryland's federal lawmakers should request that the U.S. Department of Health and Human Services loosen its requirements to allow more freedom for Maryland consumers to buy health insurance.

At some level, the vast majority of people recognize the need for health insurance – but not everyone wants the same types of coverage. Maryland legislators and regulators should allow products to be sold that can meet the diverse needs of the state's population. Providing freedom for consumers to choose products that suit them – at a more reasonable price than today's insurance – is a superior way to help Marylanders obtain insurance coverage rather than using a state mandate to force them to buy a product that they otherwise would not purchase.

REMOVE RESTRICTIONS ON ASSOCIATION HEALTH PLANS

One way to expand affordable insurance in Maryland would be to allow the expansion of Association Health

Plans (AHPs). AHPs offer another way for Marylanders to obtain affordable health care coverage. Since many times these plans are offered by associations bringing together people in the same occupations, the plans are also more likely to be tailored to meet any particular needs that individuals in this occupation share.

Prior to the enactment of the ACA, legislators considered but did not pass bills that would ease the creation of AHPs in Maryland. The fiscal note to one of these bills explained why they were so rare:

Association Health Plans (AHPs) have existed for decades, both nationwide and in Maryland. However, while the Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulations for most corporate and union health plans, it does not preempt AHPs, a significant difference that has led to the relative extinction of AHPs. An AHP with members in more than one state would be subject to state insurance laws in each respective state, making these types of health benefit plans difficult to administer in a cost-effective manner. Consequently, as state regulations and mandates across the nation have proliferated in the last decade, AHPs have become increasingly difficult to operate. In 1990, there were more than 1,000 AHPs in the U.S. Currently, there are fewer than 200.³

As this fiscal note points out, state regulations made it virtually impossible for associations to offer health plans across state lines. This severely limits those plans and the ability of associations to recruit enough enrollees to make them viable.

In early January, the U.S. Department of Labor released a proposed regulation that would allow more AHPs to be covered by federal law rather than state law—making it easier to operate, especially interstate—and to enroll more individuals in AHPs.⁴ Among other things, associations would have an easier time showing that enrollees have a “commonality of interest,” benefits could be provided to a “working owner” who is ineligible to receive subsidized coverage from another employer, and prohibits coverage discrimination within groups of similarly situated individuals (but not discrimination across those groups).⁵

Even if this new federal policy goes into effect, most potential AHPs would likely still be subject to state laws. Maryland should look at the various rules and mandates placed upon AHPs operating in the state. Regulators should review the restrictions that the state places on AHPs with the goal of making it easier for associations to offer health care coverage in the state. In line with the recommendations above for legislators to remove mandates on the overall health insurance marketplace, they should also remove restrictions that hamper AHPs from filing the health coverage needs that exist in this state.

In an ideal situation, the state would modify its rules so that there is minimal conflict with the new federal rules. That would make it easier for AHPs to operate in Maryland by eliminating any difference between those who are governed by federal rules and those who must comply with state rules. A uniform standard for AHPs would ensure a wider variety of choice for Marylanders.

If regulators and legislators take steps to encourage, rather than hamper, associations from offering health coverage, the state will be poised to take better advantage of the Trump administration’s final AHP regulation. The easing of federal rules along with the removal of state restrictions could lead to a much more vibrant market in Maryland for AHPs. This would be another health coverage product that Marylanders would be able to access in order to meet their diverse health care needs.

REFORM MEDICAID

Medicaid is the joint federal–state program that provides health care coverage for lower-income individuals. States have some leeway to operate this program, but they must do so under federal rules. In certain circumstances, states can apply for waivers from these rules to try innovations in Medicaid delivery. Officials in states around the nation have had new ideas on how to change the Medicaid program to improve health care services, but the ultimate decision on whether these ideas can be tried is with the U.S. Department of Health and Human Services. Under the Obama Administration, this type of approval was rare.

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The Trump administration, however, has signaled it is more willing to grant such waivers. Maryland should take advantage of this willingness to give states more control over the Medicaid program to make some key changes to how Medicaid operates.

A key part of the ACA’s attempt to lower the uninsured rate was an expansion of Medicaid. The ACA required that states increase Medicaid eligibility to childless adults with incomes up to 133% of the federal poverty level (FPL). The federal government would pay a higher matching rate for these newly eligible enrollees. In 2012, however, the Supreme Court held that this provision was unconstitutional. Instead, states could choose to expand or not.

There was an incentive for states to grow their Medicaid program, however. Under the ACA, the federal government paid the full cost of newly eligible enrollees for the

first six years. This is in contrast to the traditional federal match rate for Medicaid enrollees, which in Maryland is 50 percent. This 100 percent match rate for the newly eligible enrollees declines slightly each year until 2020, when it becomes 90 percent.

Even though the federal government is paying an enhanced matching rate for these higher-income, able-bodied adults with no children, there is still a fiscal impact to the state. In the budget analysis for the Maryland Department of Health this year, the Department of Legislative Services (DLS) notes that Medicaid is a large reason the state has a structural deficit (the gap between projected revenue and mandatory spending):

the main driver of expenditure growth is entitlements, which are slated to grow by \$1.3 billion in general funds between fiscal 2019 and 2023, 36.0% of the total expenditure growth in that period; of the entitlement growth, almost all of it is in Medicaid (98.4%).⁶

DLS then goes on to say, “the pressure Medicaid will impose on the General Fund is likely to be even greater in fiscal 2020 and 2021 as the enhanced federal match for the Affordable Care Act (ACA) expansion population and Maryland Children’s Health Program is reduced.”⁷ The pressure that the ACA expansion population is putting (and will continue to

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put) on the budget is seen by its enrollment growth. Since 2015, the Medicaid expansion population has increased 5.9%, which nearly doubles the 3.2% rate of growth for traditional Medicaid enrollees over the same time period.⁸

Enrollment Freeze

One of the ways that Maryland could deal with the looming fiscal problems that expanded Medicaid will cause is to impose an enrollment freeze on the population of recipients who became eligible as a result of the ACA. This enrollment freeze would not deprive anyone currently on Medicaid of coverage. Instead, it would prevent anyone new from enrolling in the program. That would gradually reduce the number of enrollees in this new population.

Pre-ACA, Maryland had a low threshold for Medicaid enrollment for childless, able-bodied adults with no children. If state policymakers think that the old threshold is too low, and still want to allow some higher-income indi-

viduals into Medicaid but not set the limit at the ACA level of 133% of FPL, they could impose an enrollment freeze for only some of the population. They could, for instance, freeze enrollment for anyone whose income is above 100% of the FPL. This would alleviate some of the fiscal pressure of the program while also targeting it to better serve lower-income individuals.

Require Work from Childless, Able-Bodied Adults on Medicaid

One of the Medicaid innovations that the Trump administration has favored is allowing states to require some Medicaid recipients to work or seek work in order to receive benefits. This idea has been pursued by Arizona, Kansas, Kentucky, Indiana, Maine, New Hampshire, Ohio, and Wisconsin. Maryland should do something similar. The state could seek a waiver from the Trump administration to require Medicaid recipients who are eligible under the ACA—childless, able-bodied adults—to work or seek work.

According to the Foundation for Government Accountability (FGA), only 16 percent of able-bodied, working age Medicaid recipients work full-time.⁹ This requirement would provide a further incentive for beneficiaries to find work and move into private insurance. Keep in mind that this population of Medicaid recipients excludes those who are taking care of children or who have a disability that may preclude finding a job. The requirement could be set at a minimum of 20 hours of work, training, or volunteering. It could also include reasonable exemptions for those who may be unable to find work.

A similar requirement is in place for childless adults who receive food stamp benefits. Nic Horton and Jonathan Ingram of the FGA point out the beneficial outcomes that work requirements have produced when enforced in other government programs:

Work requirements have proven to be a highly effective way to not only reduce caseloads but increase incomes. After Kansas implemented work requirements for able-bodied, childless adults on food stamps, caseloads dropped by 75 percent and the average amount of time spent on welfare was cut in half. Individuals who left welfare went back to work in more than 600 different industries and saw their incomes skyrocket, more than doubling on average. Even better, this increased income more than offset their lost welfare benefits. When Maine implemented the same change, it saw similarly impressive results: incomes of former enrollees more than doubled and caseloads declined by 90 percent.¹⁰

The goal of the Medicaid program should not be for able-bodied adults to remain permanently as Medicaid recipients. State policymakers should pursue programs

that transition Medicaid recipients into private insurance. Employer-sponsored insurance is a better alternative than Medicaid. A work requirement coupled with an enrollment freeze for some in the ACA expansion Medicaid population could go a long way toward slowing the growth of the Medicaid program and providing better health care options for Marylanders.

Insurance is no good for someone who does not have access to health care professionals or health care facilities.

Focus on reducing waiting lists

Maryland has nearly 46,000 residents who are on waiting lists to receive Medicaid services under the federal home and community-based services waiver.¹¹ These individuals are elderly, have disabilities, or are children who are eligible under Medicaid for home and community-based care but the state does not have enough resources to provide those services. Instead, the state has been focusing on expanding Medicaid to able-bodied adults who do not have children. Moving the individuals in the ACA expansion population to work and freezing their enrollment in Medicaid would free up resources that could then be applied to reducing the waiting list for services to the elderly and people with disabilities.

ALLOW MORE HEALTH CARE PERSONNEL AND FACILITIES TO SERVE MARYLANDERS

A significant portion of the debate and discussion over the ACA is about accessible and affordable health insurance. Health insurance is not health care, however. Insurance is no good for someone who does not have access to health care professionals or health care facilities. While it is necessary to reform Maryland's laws and rules in response to the changing federal policies regarding the ACA, it is also a good idea to take some steps that will ensure Marylanders have expanded access to health care, not merely health insurance.

Expand telemedicine

More and more services are being provided online. There is significant potential for the delivery of health care remotely, using computers or smartphones. Unfortunately, state law hinders innovation in this field. The biggest obstacle is the rule that a doctor, regardless of his or her physical location, must hold a Maryland license in order to treat someone located in the state. This reduces patient choice by limiting Marylanders from being able to access services from health care professionals outside the state.

Limits on telemedicine also harm efforts to improve health care quality. Researcher Shirley Svorny points out the many areas where telemedicine has already proven to help patients receive better care:

The list of areas where telemedicine can improve outcomes is long and is expanding rapidly. It includes emergency stroke intervention, military applications (where it can eliminate risky patient evacuations), diabetic monitoring and care, replacing on-call physicians, delivering care to Parkinson's patients, mental health services, and many other situations. Broader use of telemedicine is likely to improve outcomes for patients with rare diseases by allowing physicians who specialize in those diseases to treat a cohort of similar patients across the country or around the world.

The potential for telemedicine to reduce the cost of health care by monitoring individuals living with common chronic diseases is substantial, as chronic disease is expensive to treat and poor compliance with physician recommendations is the norm. Studies of the impact of the use of telemedicine to treat chronic conditions find lower mortality, reduced hospital admissions, lower costs, and increased patient satisfaction.¹²

Maryland legislators and regulators should embrace the potential that telemedicine can provide to patients throughout the state.

Allow more health care professionals to serve Marylanders

Not every health care problem needs to be addressed by a doctor and not every dental problem needs to be addressed by a dentist. There are a variety of trained health care professionals, such as nurse practitioners, physician assistants, and dental hygienists, who have the training and knowledge necessary to treat some types of health and dental concerns. These health professionals can offer this treatment at lower cost than doctors. They can also expand the reach of health care services to areas that are generally underserved, such as rural communities.

State law restricts what types of services these health care professionals can offer. These laws drive up the price of health care and deprive some Marylanders access to services. There has been bipartisan support for bills in previous legislative sessions that expand the scope of practice for these health care workers. Legislators should continue these efforts.

They should also look at creating a new category of health care professional: dental therapists. These are dental professionals who focus on preventative and restorative care. Dental therapists operate in over 50 countries and a handful of U.S. states. Where they operate in the United

States, they have a proven track record of reaching underserved populations, especially those on public health insurance programs.¹³ Maryland legislators should look at the experience in these states and then create a regulatory framework so dental therapists can operate in the state.

End restrictions on building health care facilities

If someone wants to build a new health care facility in Maryland, he or she must go through a complex state process to do so. If state bureaucrats do not think that there is a need for such a facility, it does not get built. This top-down control over the provision of health care services is allowed under Maryland's certificate of need (CON) law. This law protects incumbent health care providers at the expense of patients and consumers who would benefit from wider access to facilities. It should be repealed.

The evidence is clear that CON laws do not improve the health care marketplace. They were championed in the 1970s as a way to ensure that the supply of health care does not lead to a surge in wasteful health care spending. The experience since these laws were enacted shows that, in fact, health care consumers suffer because of them.¹⁴ Numerous states have repealed their CON laws in response to these findings, but Maryland still has the law in place. Marylanders seeking health care services would benefit significantly if legislators finally repealed this outdated law.

CONCLUSION

The health care system in Maryland (and across the United States) has numerous problems. Even with the Affordable Care Act's goal of expanding access to affordable health insurance, such coverage is still elusive for many Marylanders.

The policies outlined above—allowing consumers to have more options for health insurance, reforming Medicaid, and expanding the availability of health care professionals and facilities—will address some of the

problems in this system. However, this is not a comprehensive proposal to deal with all the issues that plague health care in Maryland. Instead, these are proposals to deal with the changing nature of the ACA.

The Trump administration's approach to implementing this law is far different than the approach taken by President Obama. Maryland has an opportunity to respond to this administration's actions in ways that will provide better choices for the state's health care consumers. Instead of working to stymie the new federal health care approach, regulators and policymakers should embrace the opportunity to innovate and meet consumer needs.

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14. "Improving Health Care: A Dose of Competition," Department of Justice and the Federal Trade Commission, July 2004. <https://www.justice.gov/sites/default/files/atr/legacy/2006/04/27/204694.pdf>

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