MARYLAND
Department of Health and Mental Hygiene
Office of Health Care Financing

The Transformation of Insurance Coverage

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Preview

1. Brief History of Insurance
2. Insurance Coverage Patterns in the *Last* Ten (or so) Years
3. Insurance Coverage Patterns in the *Next* Seven Years

1. Brief History of Insurance

Brief history

- Employer-sponsored insurance (ESI) was not common before World War II – most health care was self-pay
- In World War II, the US imposed wage controls on employers to keep the wartime cost of goods and services down
- Employee benefits were not included in the wage controls – this was a loophole in the law
- Employers therefore began offering health insurance as a tool to recruit and retain talented employees, deducting these costs
- Unions also used health benefits as a key issue in collective bargaining agreements in the same period, largely because of wage controls
- This led to a rapid growth in ESI

The current effect on the federal budget of the deductibility by employers of contribution to employees health benefits: $150 billion per year

Medicare and Medicaid

- Both were enacted in 1965, well after ESI was the prevailing insurance paradigm in the US
- Both were enacted to *address gaps in coverage* because some people didn't have a connection to insurance through their employment
- Medicare was targeted at people who once had a connection to work but no longer did:
  - Retired
  - Below retirement age but became permanently disabled from work
  - The benefit package therefore was similar to ESI: an acute care and rehabilitative model
- Medicaid was targeted at the poor (non-workers), and disabled who didn't necessarily have a work history

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Medicaid

- Prior to the ACA, Medicaid generally was targeted at the "blameless" poor, especially children.
- Prior to the ACA, Medicaid covered:
  - *welfare households*, primarily to insure the children and the parent-caregiver who has home with the children and not working.
  - people with *disabilities*, many of whom never had a connection to the workforce.
  - many *pregnant women*, to provide prenatal care and improve birth outcomes.
- Medicaid also *wraps around Medicare for poor seniors* who can't afford Medicare's premiums and cost sharing

Before the ACA, absent an 1115 waiver, Medicaid law did not *permit* coverage of poor adults (unless they had a permanent disability or lived in a welfare households). Under the paradigm of Medicaid pre-ACA, these people were "supposed" to be working, and covered by their employers.

Failures in US Insurance Paradigm that the ACA is Intended to Address

- Assumption that virtually everyone who wasn't retired or determined to have a permanent disability *could obtain employment with affordable health insurance benefits at large firms*.
- Assumption that someone who could not work due to permanent disability would receive a prompt disability determination with no more than a short gap in coverage
  - Definition of disability itself is circularly tied to work in both SSI and SSDI (substantial gainful activity)
- Assumption that employment at large firms always includes ESI:
  - Employer offer
  - Employer contribution
  - No exclusion for part-time work
- Assumption that all workers who were offered insurance by their employers could afford the employee share of premiums.
- Assumption that people who are self-employed or at employers without an insurance could obtain insurance at reasonable rates in the private individual and small group markets.

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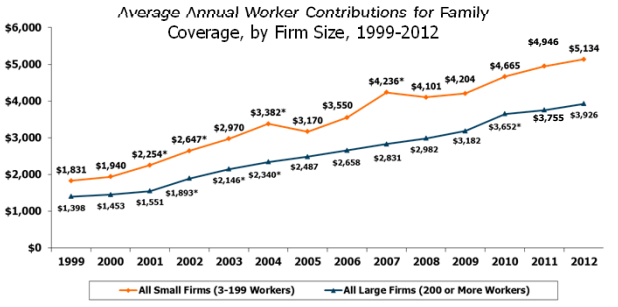
2. Insurance Coverage Patterns in the *Last* Ten Years

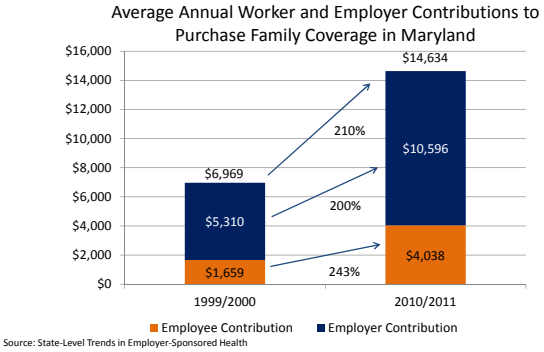
Nationally, worker contributions to purchase ESI have grown rapidly, especially at small firms.



* Estimate is statistically different from estimate for the previous year shown (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012.

In Maryland, in the past decade, overall family premiums in ESI more than doubled, and the worker's premium contribution grew at an even faster rate.



Source: State-Level Trends in Employer-Sponsored Health Insurance, A State-by-State Analysis. SHADAC. April 2013.

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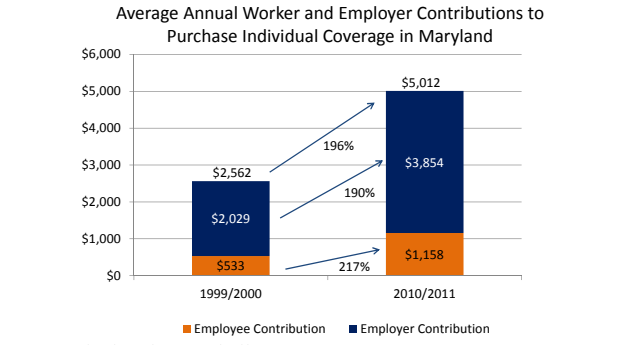
In Maryland, the same pattern existing for individual coverage through ESI, with worker contribution rates more than doubling in a decade.



Source: State-Level Trends in Employer-Sponsored Health Insurance, A State-by-State Analysis. SHADAC. April 2013.

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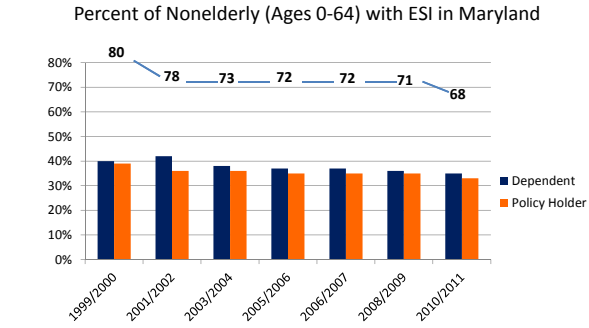
In Maryland, the percent of nonelderly (under age 65) covered through ESI fell from 80% to 68% in the last decade.



Source: State-Level Trends in Employer-Sponsored Health Insurance, A State-by-State Analysis. SHADAC. April 2013.

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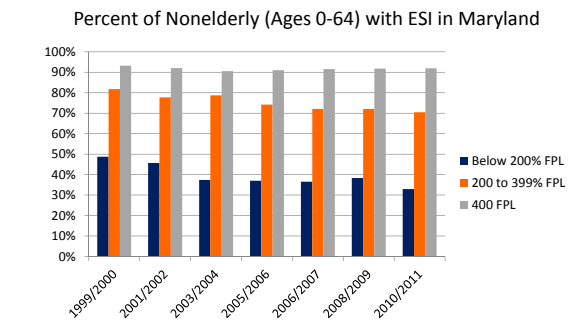
This fall in coverage through ESI was sharpest among the nonelderly (under 65) in lower income cohorts.



Source: State-Level Trends in Employer-Sponsored Health Insurance, A State-by-State Analysis. SHADAC. April 2013.

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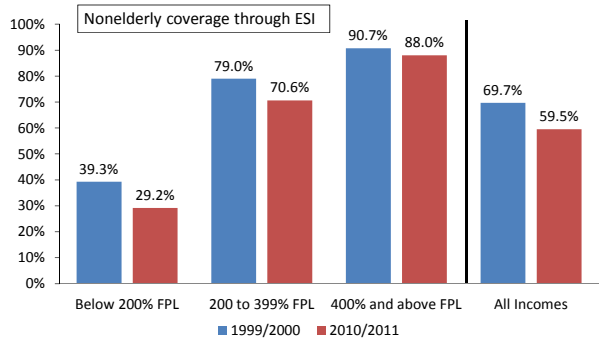
Nationally, the same pattern existed: a significant drop in ESI coverage among the nonelderly, especially among the lower income cohorts.



Source: State-Level Trends in Employer-Sponsored Health Insurance, A State-by-State Analysis. SHADAC. April 2013.

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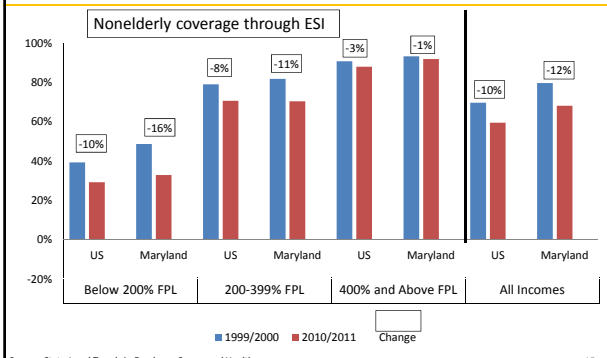
Compared to the nation, ESI coverage in Maryland among the nonelderly fell more sharply below 400% FPL, and less sharply at 400% FPL and above.



Source: State-Level Trends in Employer-Sponsored Health Insurance, A State-by-State Analysis. SHADAC. April 2013.

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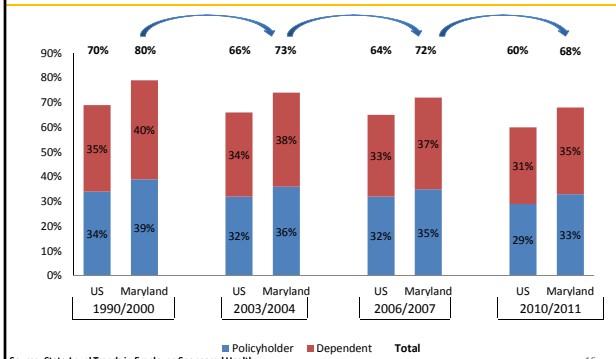
Overall among the nonelderly, ESI coverage in Maryland fell more than the national average, but the rate of ESI coverage remains above the national average.



Source: State-Level Trends in Employer-Sponsored Health Insurance, A State-by-State Analysis. SHADAC. April 2013.

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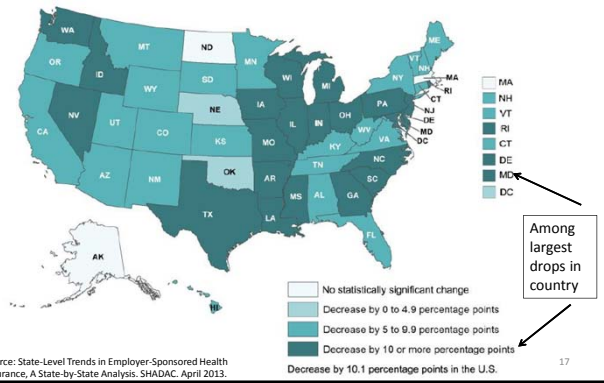
Change in Employer-Sponsored Insurance, 1999/2000 to 2010/2011 (population under age 65)



Source: State-Level Trends in Employer-Sponsored Health Insurance, A State-by-State Analysis. SHADAC. April 2013.

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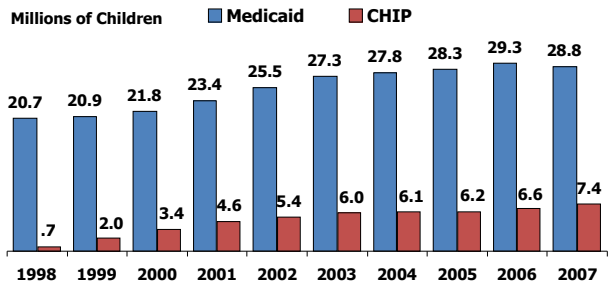
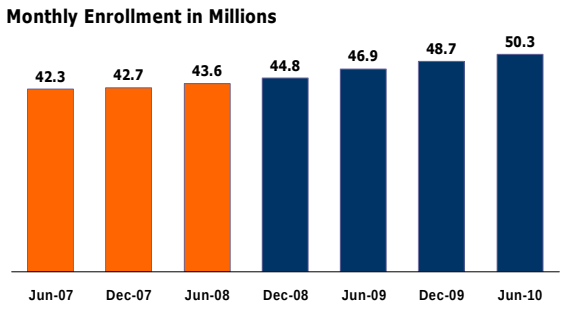
Over roughly the same time period, national enrollment among children in Medicaid and CHIP grew rapidly (1998-2007)



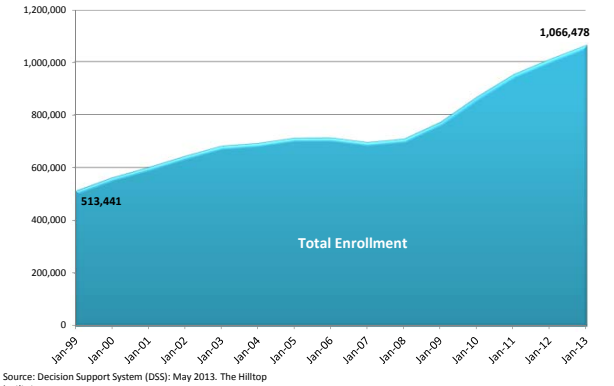
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of HCFA-2082, MSIS, and SEDS data, 2010.

National enrollment in Medicaid also grew rapidly in the Recession, adding more than 7 million to Medicaid between June 2007 and June 2010.



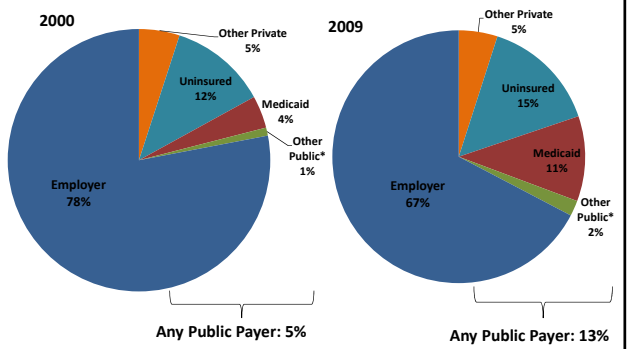
SOURCE: Analysis for KCMU by Health Management Associates, using compiled state Medicaid enrollment reports

The patterns held true in Maryland, where Maryland and CHIP enrollment more than doubled in the past decade.



Source: Decision Support System (DSS): May 2013. The Hilltop Institute.

Due to all these dynamics, the last decade saw a huge shift from ESI to Medicaid and CHIP among the nonelderly in Maryland



*Other Public includes Medicare and military-related coverage.

Source: Maryland Health Care Commission.

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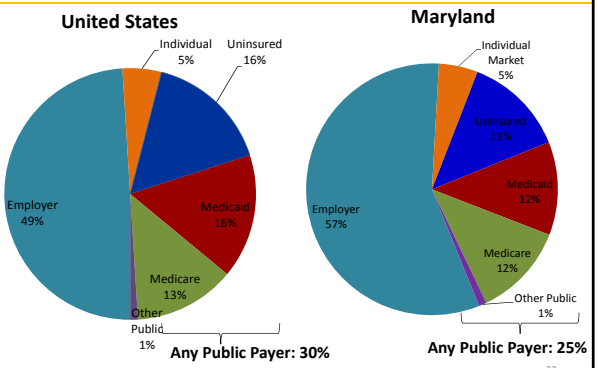
In spite of these shifts, in 2011 Maryland continued to have more people covered through private payers than public payers, compared to the national average (all ages).



Source: Kaiser Family Foundation, State Health Facts. http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3.

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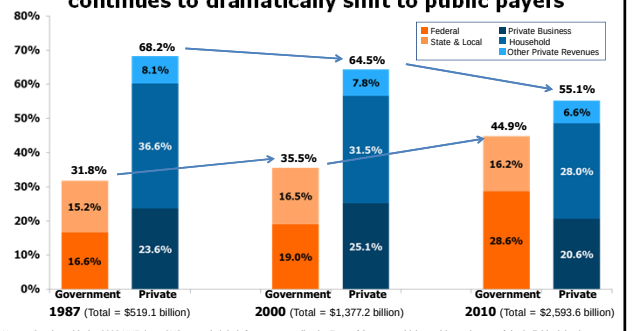
The percent distribution of National Health Expenditures *continues to dramatically shift to public payers*

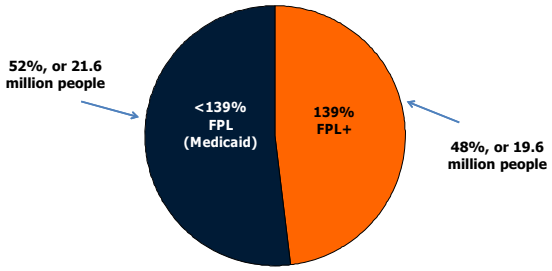


Notes: Starting with the 2009 NHE data, CMS expanded their focus on spending by Type of Sponsor, which provides estimates of the individual, business, or tax source that is behind each Source of Funds category and is responsible for financing or sponsoring the payments. "Federal" and "State & Local" includes government contributions to private health insurance premiums and to the Medicare Hospital Insurance Trust Fund through payroll taxes, Medicaid program expenditures including buy-in premiums for Medicare, and other state & local government programs. "Private Business" includes employer contributions to private health insurance, the Medicare Hospital Insurance Trust Fund through payroll taxes, workers' compensation insurance, temporary disability insurance, worksite health care. "Household" includes contributions to health insurance premiums for private health insurance, Medicare Part A or Part B, out-of-pocket costs. "Other Private Revenues" includes philanthropy, structure & equipment, non-patient revenues.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group at https://www.cms.gov/NationalHealthExpendData/ (see Historical; NHE Web tables, Table 5).

3. Insurance Coverage Patterns in the *Next* Seven Years

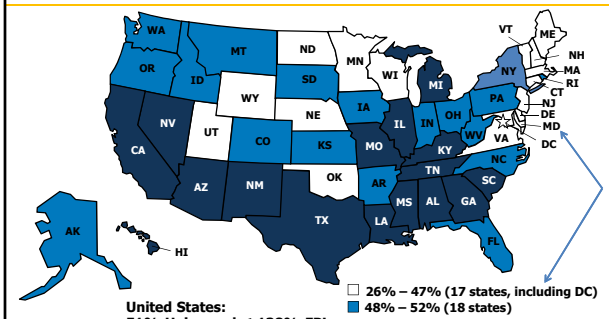
When the ACA passed in 2010, the uninsured almost equally split above and below the new Medicaid eligibility threshold of 138% FPL



Total Uninsured Adults Under Age 65 = 41.2 Million

Adults includes all individuals aged 19-64. The federal poverty level for a family of three in 2010 was $18,210. Percentages may not sum to 100 due to rounding.
SOURCE: KCMU/Urban Institute analysis of March 2011 Current Population Survey, Annual Social and Economic Supplement.

When the ACA passed, the projected percent of nonelderly uninsured at or below 138% FPL varied by state, with a lower than average rate in Maryland



SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements).

Between now and 2020, Medicaid will grow with the expansion, Medicare will grow as boomers age into Medicare, and the Exchange enrollment will grow

Population Insurance Coverage Status	2014	2015	2016	2017	2018	2019	2020
Medicaid	**1,088,032**	**1,128,677**	**1,156,494**	**1,185,380**	**1,207,779**	**1,227,410**	**1,243,952**
Medicare	**832,755**	**859,944**	**892,748**	**925,551**	**958,355**	**991,158**	**1,023,962**
Other Public	188,188	187,247	186,311	185,379	184,453	183,530	182,613
Commercial Insurance	3,247,574	3,279,889	3,282,342	3,282,888	3,285,083	3,284,280	3,284,853
Maryland Exchange	**147,233**	**169,836**	**184,323**	**208,145**	**234,721**	**257,870**	**283,743**
Uninsured	599,003	514,388	488,539	472,749	439,614	415,441	390,352
Total Population	**5,924,320**	**5,962,013**	**6,012,841**	**6,063,669**	**6,114,498**	**6,165,326**	**6,216,155**

Source: Maryland Health Care Reform Simulation Model: July 2012. The Hilltop Institute.

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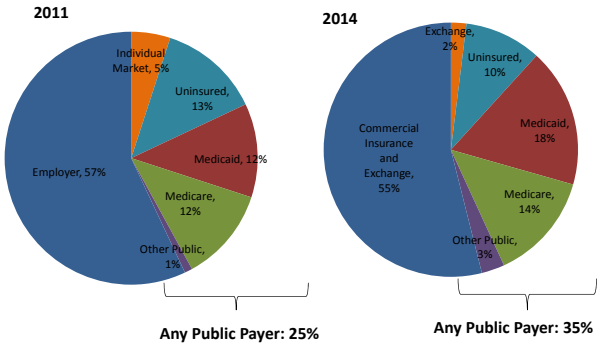
Across all ages in Maryland, the shift toward public payers will continue in the first year of health reform.



Source: Maryland Health Care Reform Simulation Model: July 2012. The Hilltop Institute.

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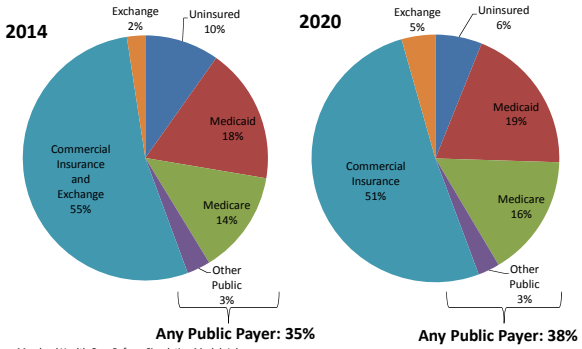
By 2020, across all ages, only 51% of the state's population will be covered by ESI, with 38% covered by public payers -- 43% including individuals covered through the public MHBE.



Source: Maryland Health Care Reform Simulation Model: July 2012. The Hilltop Institute.

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Major Takeaways

1. Medicaid's rapid growth has been driven by many factors: policy expansions; the recession; and the huge erosion in ESI.
2. Among at-risk payers, Medicaid is the largest payer in the state (measured both in terms of dollars and people covered), and this will become even more prominent after the Medicaid expansion occurs.
3. The payer mix has been shifting from private payers to public payers, which will continue after the ACA implementation occurs and as more boomers enter Medicare.
4. Every dimension of health insurance is dependent on federal fiscal policy: spending in Medicaid, Medicare, and APTCs; exempting employer contributions from taxation in ESI.

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