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MANAGING HEALTH REFORM

MARYLAND: ROUND 1

State-Level Field Network Study
of the Implementation of the
Affordable Care Act

August 2014

Rockefeller Institute of Government
State University of New York

The Brookings Institution

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MANAGING HEALTH REFORM

MARYLAND: ROUND 1

State-Level Field Network Study of the Implementation of the Affordable Care Act

Part 1 – Setting the State Context

1.1. Decisions to Date

Why MD opted in: Maryland was an early and enthusiastic supporter and adopter of the Affordable Care Act (ACA) and Medicaid expansion. Known as a progressive health reform state, and led by an entrepreneurial and politically savvy and experienced health reform expert with strong executive and legislative support, Maryland wasted no time in announcing its intentions.

On the day following the federal announcement of the ACA's passage in 2010, Governor Martin O'Malley established the Maryland Health Care Reform Coordinating Council (HCRCC), a bipartisan legislative and executive branch body charged with conducting a transparent and public process inclusive of a multitude of stakeholders. The HCRCC, cochaired by Lieutenant Governor Anthony Brown and Secretary of Health and Mental Hygiene Dr. Joshua Sharfstein, was created to advise the government on efficient and effective implementation of federal health care reform. The HCRCC made policy recommendations and offered implementation strategies to keep Maryland among the leading states in expanding quality, affordable health care while reducing waste and controlling costs.¹

Federal Planning Grant: Four federal grants have been awarded to Maryland.

In August 2012, the state received a \$123 million federal Level Two Establishment Grant to continue the development and

implementation of the state-based health benefit exchange (HBE) that will become operational by October 2013 under the ACA. Funds will be used by the state to support the continued development of policies, administration, and operations, as well as consumer outreach, assistance, and education. A substantial portion of the grant funding will support the information technology (IT) system being developed in collaboration with the Maryland Health Benefit Exchange, Department of Health and Mental Hygiene (HMH), and Department of Human Resources (DHR) (Medicaid). Its aim is to ensure that all federal and state functions are operational, including eligibility determinations and enrollment, as well as the transfers of information necessary between individuals, employers and plan issuers, and state and federal agencies.

The August 2012 grant is the fourth federal grant Maryland has received to date to support the implementation of a state-based exchange through the ACA, bringing the total to \$157 million. Prior to this award, Maryland has received \$34.4 million in grants for research, planning, IT development, and implementation, including a planning grant for \$1 million for initial research and planning; a \$6.2 million Early Innovator Grant to design and implement an IT model for the state that could also serve as a model for other states; and a \$27.7 million Level One Establishment Grant for policy development, planning, technology and operational infrastructure, and the IT platform.²

The state expects to enroll approximately 150,000 individuals in 2014.³ Anticipated cost savings are unclear and sometimes conflicting. But according to the Urban Institute, "An analysis conducted by the Hilltop Institute ... (July 2010) estimates that the state will save \$829 million through fiscal year (FY) 2020 as a result of federal health reform. Expected savings through FY 2020 include, among others, over \$1 billion from elimination of the state's high-risk pool (under the assumption that enrollees will transfer to either the Medicaid program or to exchange-based coverage); \$423 million in reductions from state-only programs and grants (e.g., public health programs, mental health administration, and alcohol and drug abuse administration); and \$232 million in prescription drug rebates for managed care organizations. Another important assumption in the state's financial model is the expected reduction in state costs associated with the PAC [Primary Adult Care] program [Medicaid for childless adults]."⁴ PAC enrollees are to be transferred to the exchange via Medicaid expansion in January 2014.

Time frame. Key decisions were all reached well before the Supreme Court decision and the 2012 election.

1. 2010. The day following enactment of the 2010 law, O'Malley created the state's Health Care Reform Coordinating Council to oversee implementation of the ACA in Maryland.⁵

2. On April 12, 2011, the Maryland legislature enacted the Health Benefit Exchange Act of 2011, establishing its exchange as an independent unit of state government, referred to in the legislation as a “public corporation.” The act included provisions for additional Medicaid expansion under the law.⁶

1.2. Goal Alignment

Maryland is a prototypical affirming state. The state’s goals were very much aligned with – indeed may have driven some of – the ACA’s goals.

Clearly, Maryland had been preparing for many months for the launch of the law. O’Malley was rumored to have presidential aspirations and he was grooming Brown to run in the 2014 gubernatorial election. They were both seen as eager to make their mark as leaders in health care reform. Sharfstein, the health secretary, is a pediatrician with deep public policy interests. He served as principal deputy commissioner of the U.S. Food and Drug Administration (2009-11) and as commissioner of health for Baltimore City from 2005-09. Other relevant experience includes service on the U.S. House of Representative’s minority staff and health policy advisor to the Government Reform Committee (2001-05). He was featured as *Governing Magazine’s* 2008 Public Official of the Year.⁷

The state’s level of preparation is consistent with Maryland’s progressive health reform history. Maryland’s long history with all payer rate-setting, anchored by its Health Services Cost Review Commission (HSCRC), means that it was well positioned to move forward to make the most out of the ACA. Maryland’s HSCRC has set rates for all payers in the state – beginning with hospitals in 1977, and gradually expanding to all commercial, Medicaid, Medicare, and indigent care payers – and therefore has acquired substantial experience in the areas of health care costs, quality, and risk. As noted on its website, “The Health Services Cost Review Commission’s (HSCRC’s) enabling statute was enacted in 1971. After a three-year phase-in period, the Commission began setting hospital rates in July 1974. At that time, its authority extended only to the rates hospitals charged to the non-governmental purchasers of care. In 1977, however, Maryland was the first of five states granted a waiver by the federal government exempting the State from national Medicare and Medicaid reimbursement principles. Since that time, all payers pay Maryland hospitals on the basis of the rates established by the HSCRC.”⁸

Many of the ACA’s provisions were already operational in Maryland. In addition to setting payer rates, the state had already adopted small group insurance market reforms. Maryland has, under a Section 1115 Medicaid waiver, provided limited-benefit coverage to low-income individuals without children (Primary Adult Care). PAC enrollees will be transitioned to the exchange via Medicaid expansion in January 2014. More than 75 percent of

the state's Medicaid enrollees are served in managed care programs, and in 2012 Maryland ranked ninth highest in the U.S. in state HMO penetration rates.⁹ Maryland has traditionally been among the most generous states with regard to Medicaid eligibility levels.¹⁰

In addition, since the early 1990s, Maryland's small-group insurance market had been regulated through community rating rules allowing risk adjustments for geography and age. The state also set minimum standards for service coverage and patient cost-sharing limits.¹¹ And the state operates a state-funded high-risk pool, which serves more than 20,000 individuals, characterized as "one of the largest and most successful of its kind in the country," which includes provisions for coverage of preexisting conditions.¹²

Legislative support was strong for the executive push on implementing the ACA. In 2011, SB 183/HB 170 formally adopted the ACA's early implementation insurance market reforms as state law and authorized the state's insurance commissioner to enforce the ACA's insurance reforms. This support was never in doubt in this heavily Democratic state. The part-time bicameral Maryland legislature — its Senate and House of Delegates — has been strongly Democratic for over a decade.

On April 12, 2011, Maryland adopted SB 182 and HB 166, the Maryland Health Benefit Exchange Act (MHBE) of 2011, establishing a state health insurance exchange as an independent unit of state government — a "public corporation." The law authorized executive implementation of the ACA. It also required stakeholder participation and stipulated that MHBE policy decisions needed sign off by the governor and state legislature. A clear focus of the law was health care governance in the state. The MHBE Board of Trustees, appointed by the governor with the approval of the legislature, was to include representatives of employers and consumers as well as state agency heads representing health, insurance, and others. The law also required extensive stakeholder participation.

The statute requires the MHBE to maintain at least two standing committees. Several advisory committees have been or are focusing on specific aspects of the ACA's implementation:

1. Implementation Advisory Committee (established September 2012);
2. Navigator Advisory Committee (established in 2012);
3. Continuity of Care Advisory Committee (established in 2012 to deal with Medicaid "churn" issues);
4. Plan Management Advisory Committee (established in 2012);
5. Web-Based Entities (WBE) Advisory Committee;

6. Standing Advisory Committee**
7. Finance and Sustainability;
8. Navigators and Enrollment;
9. Operating Model and Insurance rules; and
10. Small Business Health Options Program (SHOP).

** Some of these committees have been more active than others, with the standing advisory committee serving as a more permanent committee.

In addition to the governor, lieutenant governor, and Sharfstein, the additional key actors include:

- Rebecca Pearce, executive director, Maryland Health Benefits Exchange, appointed in September 2011. Formerly director of benefits administration at Kaiser Permanente. Helped develop Kaiser Permanente's national preventative benefit package as required by the ACA.¹³
- Carolyn Quattrocki, executive director, Governor's Office of Health Care Reform. Former special assistant to then-Attorney General J. Joseph Curran Jr. and former deputy legislative officer under O'Malley. She was chosen by the governor to lead the state's health reform efforts.¹⁴
- Jonathan Kromm, deputy director, Governor's Office of Health Care Reform. Former experience in the Centers for Medicare & Medicaid (CMS) in Baltimore.
- Therese Goldsmith, commissioner, Maryland Insurance Administration (MIA). By virtue of her position, she serves on the board of the Maryland Health Benefit Exchange. The MIA licenses and regulates all Maryland insurance companies. She is experienced in health care law.¹⁵

In addition, several key leaders in advocacy organizations have served on committees advising the exchange board.

Part 2 — Implementation Tasks

2.1. Exchange Priorities

The exchange is operating as a public corporation, quasi-governmental organization. (On April 12, 2011, Maryland enacted the Health Benefit Exchange Act of 2011, establishing the state's exchange — Maryland Health Connection (MHC) — as an independent unit of state government, referred to in the legislation as a "public corporation.")

Maryland is NOT participating in a regional exchange.

Maryland has not established subsidiary exchanges in sub-state areas/regions. However, it does have regional "connectors," or navigators.

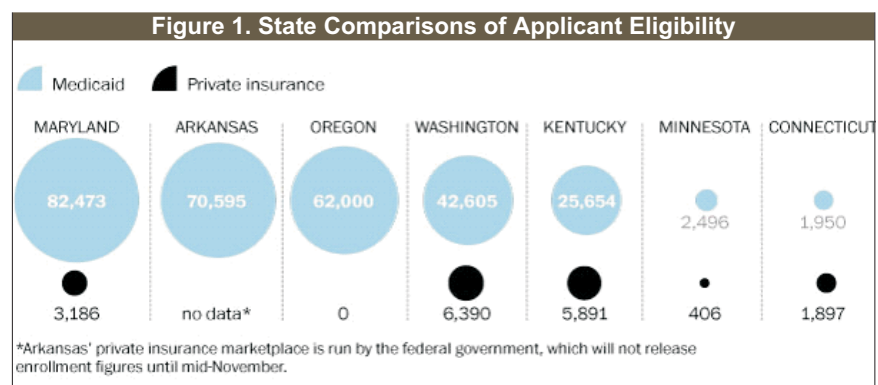
Federally Facilitated Exchange: No.

Exchange priority and status: The state's priorities include a fully integrated, state-operated exchange website able to interface

with state information systems for Medicaid, SCHIP, etc. As of October 1, the website was, at least publicly, described as ready for the October 1 ACA launch date.

However, mirroring the experience of the federal exchange and those in several other states, Maryland’s exchange website essentially failed. During the first 10 days after launch, the exchange had enrolled just more than 1,120 people – compared with more than 9,000 in Kentucky, which has fewer uninsured.¹⁶

As of November 11, 2013, the HBE’s website had had more than 350,000 unique visitors and more than 44,000 calls to call centers. As of October 31, 2013, more than 46,000 Maryland households had created accounts with verified identity, more than 31,000 had learned whether or not they are eligible for financial assistance, and more than 4,500 had chosen to enroll through a Maryland Health Connection navigator.¹⁷ Clearly, this enrollment level was lower than anticipated. As in other states, most exchange applicants qualified for Medicaid, as seen in Figure 1 below.¹⁸



In its monthly exchange report for November, the state said that: “In response to our concerns about the site’s performance, our prime contractor, Noridian Healthcare Solutions, is making a number of changes, including increasing the resources devoted to the project. These new resources will provide additional information technology and project management support; additional expertise in electronic data interface with insurance carriers; and enhanced user testing capacity. The Maryland Health Benefit Exchange is currently working with Noridian to identify additional measures that may be necessary for the project’s success.”¹⁹

Program articulation, outreach, navigational assistance: high and performing reasonably well. For example:

- **Accessibility for Spanish language users:** Marylanders can download from the site a range of materials in Spanish, including videos and written overviews of Maryland Health Connection, fact sheets on income eligibility, Medicaid health insurance, fraud protection, assistance for small business, and answers to frequently asked questions. The Spanish version of the application for health coverage and

financial assistance is also available. Bilingual staff can provide consumer assistance in Spanish through call center and connector entities. The state is working to make the Maryland Health Connection website in Spanish as well.

- Accessibility for persons with disabilities: Consumer information materials will soon be available in braille and large print. More information about when the website will be compatible for blind consumers' software will be provided soon. Consumers seeking services for the deaf or hard of hearing may call a phone number for assistance.
- Navigational assistance, which includes extensive outreach designed through a wide-ranging stakeholder-informed design, is up and running successfully and trying to deal with the exchange web problems. More detail on the navigator program can be found in Section 2.5 (Navigational Assistance) below.

2.2. Leadership – Who Governs?

Maryland's health system governance is dominated by well-trained experts who are highly regarded in their professions (see 1.2 Goal Alignment above). Maryland's population is among the most educated in the nation, and the state's proximity to Washington, D.C., and other eastern seaboard population centers has facilitated the construction of a strong health exchange board and staff.

Maryland's exchange board consists of nine members, including the executive director of Maryland's Health Care Commission; the secretary of health and mental hygiene (Sharfstein); the commissioner of insurance (Goldsmith); and six members, all appointed by the governor with the Senate's consent. Three members represent exchange users (employers and individuals) and three have health care expertise. Strict conflict of interest provisions restrict the governor's appointments.

The exchange board members reflect the state's commitment to involving leading policy experts with political acumen. Aside from the three state employees above, Maryland's exchange board members are:

- Darrell Gaskin (vice chair), associate professor, Johns Hopkins Bloomberg School of Public Health and deputy director of the Hopkins Center for Health Disparities Solutions. He is a nationally recognized scholar on hospital safety net issues.
- Kenneth Apfel, University of Maryland, School of Public Policy. He is former commissioner of U.S. Social Security Administration, with experience at U.S. Office of Management and Budget and at U.S. Health and Human Services department (HHS).
- Georges Benjamin, MD, executive director, American Public Health Association. He is an internist and former secre-

tary of the Maryland Department of Health and Mental Hygiene and deputy secretary for Public Health Services.

- Jennifer Goldberg, assistant director of advocacy for Health Care and Elder Law , Maryland Legal Aid Bureau.
- Enrique Martinez-Vidal, vice president, AcademyHealth and Robert Wood Johnson Foundation. He is the former deputy director for performance and benefits at the Maryland Health Care Commission, with responsibility for small group insurance market reforms and legislative matters.
- Thomas Saquella, former president, Maryland Retailers Association. His experience includes service as chief of staff to the state's secretary of the Department of Economic and Community Development.

2.3. Staffing

Staffing in the state agencies and the exchange appears to be robust, although there is some concern about the absence of expertise from the “consumer side” in key leadership in the exchanges’ administration.²⁰ More specifically, while Rebecca Pearce brings experience from the private health care and insurance industries, there is less expertise in the higher levels of the exchange staff in the areas of Medicaid and low-income user behaviors. Navigational and outreach work is conducted through contracts with a range of community-based groups that represent six regions identified by the exchange. The navigators subcontract extensively to provide enrollment and outreach coverage throughout localities in the state. Maryland is a small state, and geographic proximity to the capitol and state office clusters facilitates administration.

2.4. Outreach and Consumer Education

Maryland has committed significant state and federal resources to outreach and consumer education. The navigator system, described below, is responsible for outreach and consumer education as well as assistance with enrollments through the exchange.

The state has an aggressive marketing and outreach plan underway, allocating \$2.5 million for this purpose. Efforts include advertising through social media, as well as commercials, music, radio, print, and out-of-home advertising that emphasize the potential for consumers to gain health coverage, peace of mind, and free or low-cost health coverage if they qualify.²¹

Maryland has made use of the Baltimore Ravens, subway cars and buses, nearly 200 CVS pharmacies, and 100 Giant supermarkets to get the word out to potential exchange enrollees. Nearly all exchange materials are available in Spanish. Advertising targets the state’s diverse populations and geographic regions.

A 2013 faith-based summit included meetings between religious leaders and state officials, as well as navigators, to learn more about the ACA in order to share information with their congregations.²²

2.5. Navigational Assistance

Maryland has six navigational regions, each with a “connector” organization that contracts with the state. The connectors are responsible for consumer assistance with exchange enrollment and plan selection, but also for community outreach related to the ACA.

The six connectors are:

1. Central region (Baltimore City, Baltimore County, and Anne Arundel County): Health Care Access Maryland (HCAM). HCAM was created in 1997 by the Baltimore City Health Department as a nonprofit entity to facilitate the Medicaid transition to managed care. With a mission of outreach and support to applicants for Medicaid and related health coverage, as well as wrap-around support services for this population, HCAM began as a small organization with forty employees and a \$3 million budget. That budget has grown to \$23 million, which includes a \$7.9 million grant from the Maryland Health Benefit Exchange to help establish navigation systems and facilitate outreach to, and enrollment of, uninsured residents. Now staffed with 200, HCAM serves more than 125,000 clients each year.

HCAM played a key role in advising the state on the design and establishment of the connector (navigation) system and on effective community outreach. This was particularly helpful because of the concentration of commercial expertise in the exchange leadership; HCAM helped to fill the gaps on consumer needs and attitudes.

HCAM retains a close relationship with the Baltimore City Health Department. Sharfstein, its former commissioner and now state health secretary, is the key actor in the state’s ACA implementation and has served in the past on HCAM’s board of directors.

As the central region connector, HCAM works with seventeen partners to deliver services. These partners – subcontractors funded through a grant from the Maryland Health Benefit Exchange – include hospitals, health departments, clinics, nonprofit service and advocacy groups, faith-based groups, and others.

HCAM has traditionally served outreach and eligibility determination/enrollment support for Medicaid and SCHIP populations. Its mission is to make “Maryland healthier by connecting residents to insurance and

care, educating the community about healthier living and advocating for a more equitable health care system.”²³

2. Capital region (Montgomery and Prince George’s counties): Montgomery County Department of Health and Human Services.
3. Lower Eastern Shore region: Worcester County Health Department.
4. Southern region: Calvert Health Solutions, a community health group focused on providing primary/preventive care to uninsured residents of Calvert County.
5. Upper Eastern Shore region: Seedco, Inc. The Maryland branch of this national nonprofit serves the Baltimore area, facilitating access to public programs and services offered by community-based organizations.
6. Western region: Health Howard, Inc., a community-based organization that focuses on the facilitation of access to health care for uninsured and low-income populations in rural western Maryland.

Fifty subcontractors provide further support for navigation and outreach.

Maryland has allocated substantial resources to navigation and outreach and it is using some of those resources for training requirements that are comparatively rigorous (forty hours of training and an exam). The state used a \$24 million federal grant to fund the connectors. As of September 27, 2013, 164 navigators, 170 assisters, and 1,236 caseworkers have been trained. As of October 3rd, 1,827 producers have been trained. More training sessions are scheduled.²⁴

The Kaiser Foundation has given high marks to navigation planning in Maryland, noting that the state has far more funding per uninsured, far more navigators/assisters, and higher training requirements compared with Oregon and Nevada. While Maryland spent \$24 million, Nevada and Oregon allocated \$2.5 million and \$3.16 million, respectively.²⁵

As noted above, all navigational organizations are responsible for extensive outreach and consumer education. The six Maryland “connectors” are public or nonprofits, ranging from county departments of social services and/or public health to community-based nonprofits focused on health care access. These six connectors further subcontract with a wide range of additional community-based organizations ranging from hospitals to homeless shelters for assistance in the navigation process.

2.6. Interagency and Intergovernmental Relations

2.6(a) Interagency Relations. As noted in an Urban Institute report on the ACA’s implementation in Maryland, the tremendous reorganization needed in most states and the consequent

coordination needs are very challenging. It also mentioned “historic tensions” between two of the key agencies – health/mental hygiene (health) and human resources (welfare and Medicaid). In the case of Maryland, O’Malley’s immediately established the Health Care Reform Coordinating Council, a bipartisan legislative and executive branch body cochaired by Brown and Sharfstein, to facilitate implementation and coordination among the key agencies involved:

- Department of Health and Mental Hygiene, responsible for the state’s public health and health care systems.
- Department of Human Resources, responsible for Medicaid.
- Maryland Insurance Administration, which licenses and regulates the state’s insurance companies.
- Health Services Cost Review Commission, established by the state to oversee its all-payer rate system, which is responsible for setting ACA exchange plan rates.
- Governor’s Office of Health Care Reform

2.6(b) Intergovernmental Relations. Maryland has worked closely with HHS/CMS over the years, negotiating special exemptions from Medicaid and Medicare regulations as part of its all-payer rate system. Negotiations are currently underway with CMS, as part of the state’s new hospital cost growth caps, to cap per capita Maryland Medicare hospital costs to 0.5 percent less than national annual growth. While other states have attempted to negotiate waivers similar to Maryland’s, they have not been successful.

Federal awards of generous planning grants also imply that the professionals leading Maryland’s reform implementation have forged good working relationships with HHS and CMS.

As noted earlier, Jonathan Kromm, deputy director of the Governor’s Office for Health Care Reform, has work experience in CMS’s Baltimore headquarters.

2.6(c) Federal Coordination. Unclear.

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs). At a September meeting of the Maryland Health Benefit Exchange board of directors, the board learned that there would be forty-five medical plans for consumers to choose from, thirty-six of which included embedded pediatric dental benefits, and stand-alone dental plan options. Choices include a variety of product types – preferred provider organization (PPO), point-of-service organization (POS), health maintenance organization (HMO), and exclusive provider organizations (EPO).

The four insurance companies participating are:

- Kaiser Permanente – serves Anne Arundel County, Baltimore County, Baltimore City County, Calvert County,

Carroll County, Charles County, Frederick County, Harford County, Howard County, Montgomery County, Prince George's County;

- UnitedHealthcare – statewide;
- CareFirst (BCBS) – statewide. Owns approximately 70 percent of the individual insurance market in Maryland.
- Evergreen Health Co-Op – statewide with special coverage in Anne Arundel County, Baltimore County, Baltimore City, Howard County, Prince George's County. It was created in response to the ACA.

All Savers is the planned provider for small businesses through UnitedHealthcare

Aetna and Coventry also applied, but withdrew from consideration in August 2013.

Early indications were that Maryland's exchange premium rates would be among the lowest of those publishing their rates by mid-summer 2013.²⁶

2.7(b) Clearinghouse or Active Purchaser Exchange. According to the Kaiser Family Foundation, "In the first two years of operation, Maryland Health Connection will act as a clearinghouse with any qualified health plan (QHP) in the state eligible to participate. Beginning in 2016, Maryland Health Connection will have the authority to employ an alternative contracting option or active purchaser strategy, such as competitive bidding or negotiations with carriers."²⁷

2.7(c) Program Articulation. The intent of the Maryland exchange is to connect applicants to all of these programs. It is certainly an ambitious plan, and early website failures suggest that this objective may not be met. However, extensive investments in the state's navigation system, which is community-based and staffed with well-trained navigators and assisters, should facilitate enrollments for those who have encountered difficulties enrolling. Early enrollment glitches are in fact being addressed by the navigator "connectors," though their ultimate success in dealing with the software glitches remains to be seen.

And, as noted earlier, the exchange website is designed to interface with Medicaid and other data systems in the state and serve as a "one stop shop"; this feature should facilitate eligibility adjustments.

2.7(d) States That Did Not Expand Medicaid. N/A

2.7(e) Changes in Insurance Markets. As noted earlier, group and small insurance rate reforms have an established history in Maryland. Thus, the private exchange plans, along with all other providers, are reimbursed at the same rate.

2.8. Data Systems and Reporting

Maryland has made extensive use of its comparatively generous Medicaid program and the resulting data to establish geographic and demographic targeting under the ACA. The state has

made extensive use of existing data to tailor its approach to the ACA and will have the capability to perform well in terms of monitoring exchange activity. Very generous federal facilitation grants have buttressed the state's efforts to build an ambitious exchange that will interface with most/all related state public programs to track eligibility and changes in eligibility and participation.

Part 3 – Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

Maryland's small business health options program (SHOP) will commence in April 2014. Implementation will be guided by one of four dedicated health benefit exchange's committees chartered with addressing specific issues.

Part 4 – Summary Analysis

4.1 Policy Implications

There is clear alignment among most groups and institutions on the state's adoption and implementation of the ACA. Because of its all-payer rate system, competition between private plans and exchange plans is muted. Some conservative elements in the Democratic-heavy legislature oppose rate-setting and the state's generous Medicaid expansions as well as its affirmation of the ACA. But with strong Democratic majorities in both houses, together with Democrats in the governor's and lieutenant governor's offices and professionals with policy and political expertise, the state's progressive reformers are clear winners. The state's inclusive and generous eligibility decisions will afford coverage to a broad portion of the state's uninsured populations. Advocates for these groups also win.

In the case of Maryland, the "stars were aligned" to formulate an aggressive and expansive approach to the law. Minority opposition simply could not mount effective challenges to these forces.

4.2. Possible Management Changes and Their Policy Consequences

Maryland has had one of the most effective ACA implementation plans in the country. Although not without management challenges, the state is comparatively well-prepared, well-staffed, well-resourced, and enjoys a relatively unified and reform-supportive political environment. Nonetheless, as in other states and in the federal exchange, early indications are that management and policy related to the exchange website will have much to do to come up with the "fix" necessary to push the system forward as planned. Political fallout is certainly possible and likely if the repairs are not quickly forthcoming.

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