MILLIMAN REPORT

# Maryland Elimination of Labor and Delivery Cost Sharing Analysis

## Prepared for Maryland Health Care Commission

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# Introduction

The Chair of the Health and Government Operations Committee (HGO) of the Maryland House of Delegates requested the Maryland Health Care Commission (MHCC) assess the social, medical, and financial impact of requiring coverage for labor and delivery services (as required under § 15-1501 of the Insurance Article) without a deductible, coinsurance, copayment, or any other cost-sharing. At the request of MHCC, Millman, Inc ("Milliman") was asked to perform this analysis. The Insurance Article requires the following to be addressed in the analysis:

"social impacts, including:

- the extent to which the service is generally utilized by a significant portion of the population;
- the extent to which the insurance coverage is already generally available;
- if coverage is not generally available, the extent to which the lack of coverage results in individuals avoiding necessary health care treatments;
- if coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship;
- the level of public demand for the service;
- the level of public demand for insurance coverage of the service;
- the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts; and
- the extent to which the mandated health insurance service is covered by self-funded employer groups of employers in the State who employ at least 500 employees;

medical impacts, including:

- the extent to which the service is generally recognized by the medical community as being effective and efficacious in the treatment of patients;
- the extent to which the service is generally recognized by the medical community as demonstrated by a review of scientific and peer review literature; and
- the extent to which the service is generally available and utilized by treating physicians; and

financial impacts, including:

- the extent to which the coverage will increase or decrease the cost of the service;
- the extent to which the coverage will increase the appropriate use of the service;
- the extent to which the mandated service will be a substitute for a more expensive service;
- the extent to which the coverage will increase or decrease the administrative expenses of insurers and the premium and administrative expenses of policy holders;
- the impact of this coverage on the total cost of health care; and
- the impact of all mandated health insurance services on employers' ability to purchase health benefits policies meeting their employees' needs."

This report presupposes a mandate requiring the elimination of cost sharing for labor and delivery services goes into effect on January 1, 2025, which would apply to the commercial populations: individual, small group, fully insured large group, and State Health Plan. Health savings account (HSA) qualified high deductible health plans (HDHP) were excluded from the analysis because if a labor and delivery service cost sharing elimination mandate does not carve out HSA qualified plans, commercial fully insured enrollees will no longer be able to have an HSA.

# Highlights

### MEDICAL IMPACT

- The American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP) and others in the medical community have advised that hospitals and accredited birth centers are the safest places to give birth.
- No clinical practice guidelines from professional organizations of providers caring for pregnant people recommend unattended births.

### SOCIAL IMPACT

- The estimated birth rate for the non-Medicaid population is 8.8 births per 1,000 Maryland residents.
- The Patient Protection and Affordable Care Act requires non-grandfathered individual and small group plans to cover labor and delivery services as an essential health benefit. The state of Maryland has mandated that large group and grandfathered individual plans cover labor and delivery services.
- Eliminating cost sharing on labor and delivery would allow commercially insured families to allocate these savings toward other expenses, including child related expenses, such as diapers and childcare, which may reduce financial stress.

### FINANCIAL IMPACT

- The average estimated cost of labor and delivery in Maryland in 2025 is $21,750.
- Some health plans in Maryland do not have cost sharing on labor and delivery services. For enrollees using labor and delivery services with cost sharing on labor and delivery benefits, average out-of-pocket expense savings ranged from $230 for small group platinum metal tier enrollees to $3,900 for individual bronze metal tier enrollees.
- Due to the low response to the benefit coverage survey, the estimated financial impact on large group enrollees may not be reflective of the Maryland large group market. Many of the limited plan designs provided indicated that currently there is no cost sharing for labor and delivery services. The estimated impacts from a mandate to eliminate cost sharing may be understated to the extent that the plan designs received do not represent the actual market.
- A summary of the estimated financial impact is provided in Exhibit 1 below.

**EXHIBIT 1: SUMMARY OF FINANCIAL IMPACT OF REMOVING COST SHARING FROM LABOR AND DELIVERY SERVICES FOR NON-HSA QUALIFIED HEALTH PLANS (CALENDAR YEAR 2025)**

| | INDIVIDUAL | SMALL GROUP | FULLY INSURED LARGE GROUP | TOTAL FULLY INSURED COMMERCIAL | STATE HEALTH PLAN |
|---|---|---|---|---|---|
| **Deliveries for non-health savings account qualified health plans** | 2,010 | 790 | 2,710 | **5,510** | 1,850 |
| **Premium per member per month increase due to removing cost sharing for labor and delivery services** | $1.93 | $0.85 | $0.20 | **$0.92** | $0.81 |
| **Premium per member per year increase due to removing cost sharing for labor and delivery services** | $23.16 | $10.20 | $2.40 | **$11.04** | $9.72 |
| **Total premium increase due to removing cost sharing for labor and delivery services** | $5,274,000 | $908,000 | $747,000 | **$6,929,000** | $2,043,000 |

# Medical Evaluation

We consider labor and delivery services to be those services provided by healthcare providers during the labor and delivery period, defined as the beginning of uterine contractions resulting in cervical change (dilation or effacement) through delivery of the baby.[1] Labor and delivery services can be provided in a variety of birth settings, including hospitals, birth centers, and homes.[1] Clinicians typically apply multiple modalities to monitor labor and use the information they obtain from monitoring and cervical exams to determine the patient's stage of labor and monitor labor progression.[2]

The American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP) and others in the medical community have advised that hospitals and accredited birth centers are the safest places to give birth.[3,4] While each pregnant person has the right to make a medically informed decision about delivery, most deliveries occur in the hospital. In the United States, about 1% of births occur at home, and only approximately one-fourth of these births are unplanned or unattended.[5] For planned home births, the American College of Nurse Midwives recommends that midwives ensure that birthing people have ongoing monitoring during labor for indications of potential or emergent maternal and/or fetal/neonatal complications and that a minimum of two health care professionals who have current Neonatal Resuscitation Program training and cardiopulmonary resuscitation certification are present at birth.[6] ACOG guidelines state that planned home births should ensure availability of a certified nurse–midwife, certified midwife or midwife whose education and licensure meet International Confederation of Midwives' Global Standards for Midwifery Education, or physician practicing obstetrics within an integrated and regulated health system; ready access to consultation; and access to safe and timely transport to nearby hospitals.[5] The AAP and the American Heart Association have also published guidance recommending that each delivery should be attended by two individuals, at least one of whom has the appropriate training, skills, and equipment to perform a full resuscitation of the infant.[4]

Complications may arise during any of the stages of labor, including arrest of parturition, necessitating cesarean delivery, which may carry greater pregnant person or fetal risk; trauma of the delivery process to either the fetus or pregnant person; hemorrhage; cord avulsion; retained placenta; or incomplete removal of the placenta.[2] In summary, no clinical practice guidelines from professional organizations of providers caring for pregnant people recommend unattended births and, therefore, all birthing people would be expected to have labor and delivery services, regardless of the birth setting.

The services of a qualified healthcare team during labor and delivery, which may include a hospital and would always include one or more trained healthcare professionals, are critical to reducing pregnancy related complications. Many organizations have published guidance related to the development of the most effective and safe healthcare delivery teams.[4,7,8] This team may include physicians (e.g., obstetrician/gynecologists, family physicians, neonatologists, pediatricians), certified nurse midwives, certified midwives, registered nurses and other ancillary staff. ACOG and the Society for Maternal-Fetal Medicine have developed a facility level designation to standardize capabilities related to maternal care. Levels include basic care (level I), specialty care (level II), subspecialty care (level III), and regional perinatal health care centers (level IV).[7] Facilities capable of basic care (Level 1) are expected to have the capability and equipment to provide low-risk and appropriate moderate-risk maternal care and a readiness at all times to initiate procedures such as an emergency cesarean delivery.[7]

Nursing staffing standards published by the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), in collaboration with the AAP and ACOG, detail the appropriate nurse-to-patient ratio in each phase of care during the perinatal hospital stay.[8]

# Social Evaluation

## BIRTH RATE

Based on the 2020 Maryland Vital Statistics Annual Report, adjusted for the number of deliveries reimbursed using Medicaid coverage, we estimate the Maryland birth rate for the non-Medicaid population to be 8.8 births per 1,000 Maryland residents.

Exhibit 2 shows the estimated number of births in 2025 for enrollees in plans subject to the labor and delivery cost sharing elimination mandate by line of business. See Appendix B for more detail.

**EXHIBIT 2: BIRTHS BY LINE OF BUSINESS FOR NON-HSA QUALIFIED PLANS, 2025**

| Individual | Small Group | Fully Insured Large Group | State Health Plan |
|---|---|---|---|
| 2,010 | 790 | 2,710 | 1,850 |

## INSURANCE COVERAGE

The Patient Protection and Affordable Care Act requires non-grandfathered individual and small group plans to cover labor and delivery services as an essential health benefit. The state of Maryland has mandated that large group and grandfathered individual plans cover labor and delivery services.

Small group grandfathered plans may not cover labor and delivery services. For a plan to be grandfathered, it would need to remain substantially unchanged from the benefits provided prior to March 23, 2010.

We surveyed the Maryland Insurance Administration and fully insured large group insurance carriers in Maryland about labor and delivery services. For individual and small group plans, the Maryland Insurance Administration provided labor and delivery cost sharing benefit designs for the most popular plan by metal tier. For large group plans, carriers provided the labor and delivery cost sharing benefit designs for the most popular plan by deductible range.

For plans with the richest benefits, such as Platinum metal tier plans or $0 deductible plans, enrollees pay $0 out-of-pocket for labor and delivery services or a copayment per admission. For plans with leaner benefits, such as Bronze metal tier plans or plans with high deductibles, labor and delivery services are subject to higher deductibles and have coinsurances, up to 40% paid by the patient.

## PUBLIC DEMAND AND UTILIZATION

For those with low-risk pregnancies who are interested in an unmedicated birth, delivering at a free-standing birth center or at home are options. Most US births occur in a hospital (98.4% as of 2017).[9] According to a study published in 2021 using survey data from midwife practices, the average cost of a home birth is $4,650.[10] Insurance coverage for non-hospital birth varies state to state but is often not covered. We were unable to find evidence suggesting the financial burden from cost sharing is the reason for non-hospital births.

## POTENTIAL BENEFITS

Eliminating cost sharing means that commercially insured families may have, on average, an additional $1,120 to allocate toward other expenses.. Note that the savings for any individual will vary based on their labor and delivery benefits.

Families may choose to allocate these funds towards postpartum and childcare expenses. For example, birthing parents could have additional financial resources to seek treatment for related postpartum mental and physical health issues, such as postpartum depression or physical therapy. Note that as there is no requirement to use these funds

for medical services, families can use these additional funds could be used to purchase any consumer goods or services.

The US Department of Agriculture estimates that, on average, a child costs a two-parent family between $9,300 and $23,380 in the first year.[11] The American Academy of Pediatrics estimates that each family spends around $1,000 on diapers during a baby's first year of life.[12] Being able to afford diapers, often referred to as having a diaper need, is a widespread issue in the US and has been linked to stress and child health. A 2023 survey conducted by the National Diaper Bank Network found that 47% of respondents struggled to afford diapers, including 28% of which were classified as middle income and 6% as high income.[13] In this study, 70% of respondents with a diaper need also reported stress related to not being able to afford diapers and 25% of respondents with a diaper need reported having to miss work or school because their child did not have diapers for childcare[13] In a 2013 study on diaper need, 8% of respondents reported stretching diapers over time, a practice that has been linked to urinary tract infections (UTIs) and diaper rash.[14]

Another source of financial strain for families is childcare. In 2022, the average childcare costs in Maryland ranged across counties, but was consistently ranked one of the top household expenses for family. Annual childcare costs ranged from $13,520 in Garret County (19.9% of median income) to $35,713 in Montgomery County (26.7% of median income).[15]

### FINANCIAL BARRIERS

Legislation that removes cost sharing from labor and delivery services would have an impact on families experiencing financial hardship. For example, we estimate that labor and delivery out of pocket costs are on average $1,120 for fully insured commercial and state health plan enrollees. These costs are high relative to liquid assets available to families in the U.S. In 2019, the median liquid assets among non-elderly single-person households was $2,977 to $6,704 for multi-person households.[16] Financial hardship among peripartum and postpartum women has been shown to result in unmet health needs due to cost. For example, a study found that between 2013 and 2018, 24% of peripartum women had an unmet health need due to cost and 60% reported overall health care unaffordability. Within this population, women with private insurance had lower odds of having an unmet health need (0.67), and higher odds of health care unaffordability (1.88).[17]

In addition to the cost of care relative to savings, the cost of labor and delivery can impact medical debt. One study found that postpartum women had 48% higher-adjusted odds of having medical debt than those who were not postpartum, and this relationship held true even for those with private insurance.[18]

# Financial Evaluation

The financial evaluation projects the population, cost of benefits, premium and enrollee cost sharing for the 2025 calendar year under the following two annual scenarios:

1. Baseline – Enrollees pay deductible, coinsurance, copayment, or any other cost–sharing on labor and delivery services.
2. Post Mandate – Enrollee cost sharing is eliminated on labor and delivery services.

The difference between the baseline and post mandate values is the impact of the removing deductible, coinsurance, copayment, or any other cost–sharing from labor and delivery services.

### HEALTH SAVINGS ACCOUNT QUALIFIED HIGH DEDUCTIBLE HEALTH PLANS

Health savings account (HSA) qualified high deductible health plans (HDHP) were excluded from the analysis. HSAs can only be paired with HDHPs where the annual deductible applies to all services. Some services, such as preventive care and select insulin products, are exempt from this cost sharing requirement. Labor and delivery services are not included in the exemptions and are required to be subject to deductible for the plan to be paired with an HSA. If a cost sharing elimination mandate does not carve out HSA qualified plans, commercial fully insured enrollees will no longer be able to have an HSA.

HSA qualified plans make up a large proportion of employer-based health insurance, 34% of fully insured large group enrollees and 60% of small group enrollees in Maryland are enrolled in an HSA qualified HDHP. For individual members in Maryland, 9% are enrolled in an HSA qualified plan. No state health plans are HSA qualified.

### COST PER SERVICE AND ENROLLEE COST SHARING

Using 2022 data from the APCD across individual, small group, large group, and State Health Plan enrollees, we estimate the average commercial 2025 labor and delivery allowed cost to be $21,750 of which an average of $1,120 is paid by the enrollee out-of-pocket.

### SUBSTITUTIONS OF OTHER SERVICES

As discussed in the medical and social impact sections, there are a small number of home births that occur each year, but we were unable to find evidence suggesting financial burden from cost sharing is the reason for non-hospital births. To the extent that home births are motivated by financial burden, removing cost sharing from labor and delivery will encourage hospital and birthing center based labor and delivery as a substitute for those home births.

The financial impact on medical costs resulting from how enrollees spend the savings from labor and delivery cost sharing elimination is not considered in this analysis. It is possible that enrollees spend these savings in a way that offsets other medical expenses. For example, as mentioned in the social evaluation section, stretching diapers over time is linked to UTIs. If these savings are spent on additional diapers, leading to less diaper stretching, it may result in medical savings from fewer office visits for UTIs.

### ADMINISTRATION OF BENEFITS

Some maternity services, such as professional prenatal, labor and delivery, and postnatal services, are commonly bundled and reimbursed as a single payment from the insurance carrier to the professional rendering the services. To the extent these arrangements exist in the Maryland market, insurance carriers may need to separate labor and delivery services from these bundles and administer the benefits separately to comply with the mandate. Determining reimbursement methodologies for maternity benefits was considered outside of the scope of this analysis.

We project administration costs will increase in proportion to the insurer cost of removing cost sharing from labor and delivery as this is how premiums are typically developed.

We do not expect providing labor and delivery services without cost sharing to significantly impact individuals or employers' ability to purchase health benefits policies meeting their own or their employees' needs. Estimated average premium increases for commercially insured group enrollees ranges from $0.20 PMPM for fully insured large group enrollees to $0.85 PMPM for small group enrollees. The average individual premium impact is estimated to be $1.93 PMPM. Many of these enrollees have premium tax credits, limiting their exposure to premium increases.

## STATE BENEFIT DEFRAYAL EXCEEDING ESSENTIAL HEALTH BENEFIT

Labor and delivery services are part of the essential health benefits. Removing cost sharing for labor and delivery services does not exceed essential health benefits (EHBs) and does not require the state to defray costs of exceeding EHBs.

## PREMIUM IMPACT

The estimated premium impact of removing cost sharing from labor and delivery services is in Exhibit 3 below. Individual and small group premiums are estimated to increase $5,274,000 and $908,000 or $1.93 and $0.85 per member per month (PMPM) or $23.16 and $10.20 per member per year (PMPY), respectively. Fully insured large group premiums are estimated to increase $747,000 or $0.20 PMPM ($2.40 PMPY). The premium for the State Health Plan would increase $2,043,000 or $0.81 PMPM ($9.72 PMPY). These impacts apply only to non-HSA qualified plans.

**EXHIBIT 3: ESTIMATED PREMIUM IMPACT OF REMOVING COST SHARING FROM LABOR AND DELIVERY SERVICES, 2025**

| | INDIVIDUAL | SMALL GROUP | FULLY INSURED LARGE GROUP | TOTAL FULLY INSURED COMMERCIAL | STATE HEALTH PLAN |
|---|---|---|---|---|---|
| **Total Dollars** | $5,274,000 | $908,000 | $747,000 | **$6,929,000** | $2,043,000 |
| **PMPM (For non-HSA plans)** | $1.93 | $0.85 | $0.20 | **$0.92** | $0.81 |
| **PMPY (For non-HSA plans)** | $23.16 | $10.20 | $2.40 | **$11.04** | $9.72 |

## AVERAGE ENROLLEE OUT-OF-POCKET IMPACT

The estimated average enrollee out-of-pocket savings from removing cost sharing from labor and delivery services is in Exhibit 4 below. Individual and small group enrollee out-of-pocket costs are estimated to decrease $4,219,000 and $727,000 or $1.54 and $0.68 PMPM ($18.48 and $8.16 PMPY), respectively. Fully insured large group enrollee out-of-pocket costs are estimated to decrease $635,000 or $0.17 PMPM ($2.04 PMPY). The average out-of-pocket costs for the State Health Plan would decrease $1,736,000 or $0.69 PMPM ($8.28 PMPY).

**EXHIBIT 4: ESTIMATED AVERAGE ENROLLEE OUT-OF-POCKET SAVINGS FROM REMOVING COST SHARING FROM LABOR AND DELIVERY SERVICES, 2025**

| | INDIVIDUAL | SMALL GROUP | FULLY INSURED LARGE GROUP | TOTAL FULLY INSURED COMMERCIAL | STATE HEALTH PLAN |
|---|---|---|---|---|---|
| **Total Dollars** | $4,219,000 | $727,000 | $635,000 | **$5,581,000** | $1,736,000 |
| **PMPM (For non-HSA plans)** | $1.54 | $0.68 | $0.17 | **$0.74** | $0.69 |
| **PMPM (For non-HSA plans)** | $18.48 | $8.16 | $2.04 | **$8.88** | $8.28 |

## TOTAL COST OF CARE IMPACT

The estimated marginal impact on the total cost of care from removing cost sharing from labor and delivery services is in Exhibit 5 below. The total cost of care is calculated as the sum of the marginal impacts on premium and enrollee out-of-pocket expenses. Although a mandate to eliminate cost sharing on labor and delivery services could be considered a shift of expenses from the enrollee to the insurer, the new expense to the insurer is loaded for administrative fees which results in an increase in the total cost of care.

Individual and small group total cost of care impacts are estimated to be $1,055,000 and $181,000, or $0.39 and $0.17 PMPM ($4.68 and $2.04 PMPY), respectively. Fully insured large group total cost of care is estimated to increase $112,000 or $0.03 PMPM ($0.36 PMPY). The total cost of care for the State Health Plan is estimated to increase $307,000 or $0.12 PMPM ($1.44 PMPY). These impacts apply only to non-HSA qualified plans.

**EXHIBIT 5: ESTIMATED POST MANDATE TOTAL COST OF CARE FROM REMOVING COST SHARING FROM LABOR AND DELIVERY SERVICES, 2025**

| | INDIVIDUAL | SMALL GROUP | FULLY INSURED LARGE GROUP | TOTAL FULLY INSURED COMMERCIAL | STATE HEALTH PLAN |
|---|---|---|---|---|---|
| **Total Dollars** | $1,055,000 | $181,000 | $112,000 | **$1,348,000** | $307,000 |
| **PMPM (For non-HSA plans)** | $0.39 | $0.17 | $0.03 | **$0.18** | $0.12 |
| **PMPM (For non-HSA plans)** | $4.68 | $2.04 | $0.36 | **$2.16** | $1.44 |

See Appendix C for more detailed information on marginal and total premium, enrollee, and total cost of care impacts.

## USER OUT-OF-POCKET IMPACT

Due to the annual accumulation of deductibles and maximum out-of-pocket limits, the effects of removing cost sharing from labor and delivery services can vary greatly between users of labor and delivery services. Users with high utilization and cost unrelated to labor and delivery will see little to no annual out-of-pocket cost savings. This is because these users may meet the out-of-pocket maximum by utilizing other services. Instead of meeting their deductible and out-of-pocket maximum on labor and delivery, they may reach their out-of-pocket maximum on a later service. This results in a shifting of the payment to a later date in the year but no savings for the enrollee. Users whose only health care expense for the year is for their labor and delivery services will experience larger out-of-pocket savings. Savings will also vary by the richness of the labor and delivery benefit.

Exhibit 6 shows the average out-of-pocket expense savings for a user of labor and delivery services enrolled in the most popular individual and small group plans by metal tier. Silver cost share reduction plans with 87% and 94% actuarial value are estimated to have savings similar to individual platinum plans.

**EXHIBIT 6: ESTIMATED OUT-OF-POCKET IMPACT SAVINGS FOR USERS OF LABOR AND DELIVERY SERVICES BY METAL TIER, 2025**

| METAL TIER | INDIVIDUAL | SMALL GROUP |
|---|---|---|
| **Platinum** | $900 | $230 |
| **Gold** | $1,640 | $580 |
| **Silver** | $3,270 | $3,630 |
| **Bronze** | $3,920 | $3,460 |

Exhibit 7 shows the average out-of-pocket savings for users of labor and delivery services enrolled in the three State Plans, exclusion provider organization (EPO), preferred provider organization (PPO), and integrated health model (IHM), and enrolled in an average large group plan.

**EXHIBIT 7: ESTIMATED OUT-OF-POCKET IMPACT SAVINGS FOR USERS OF LABOR AND DELIVERY SERVICES FOR ENROLLEES WITH LARGE GROUP OR STATE HEALTH PLAN COVERAGE, 2025**

| PLAN TYPE | SAVINGS |
|---|---|
| **Fully Insured Large Group** | $230 |
| **State Health Plan EPO** | $0 |
| **State Health Plan PPO** | $1,140 |
| **State Health Plan IHM** | $0 |

# Methodology and Assumptions

As noted in the prior section, the financial evaluation projects the population, cost of benefits, premium and enrollee cost sharing for the 2025 calendar year under the following two scenarios:

1. Baseline – Enrollees pay deductible, coinsurance, copayment, or any other cost–sharing on labor and delivery services.
2. Post Mandate – Enrollee cost sharing is eliminated on labor and delivery services.

The difference between the baseline and post mandate values is the impact of the removing deductible, coinsurance, copayment, or any other cost–sharing from labor and delivery services.

### MARYLAND POPULATION

We used the Maryland population changes from the 2020 census to the 2030 census projection to trend 2021 and 2022 enrollment data from Maryland's All Payer Claims Database (APCD) to 2025. We adjusted our initial 2025 population estimate for Medicaid redetermination, which began in Maryland in April 2023. Based on Maryland Medicaid redetermination data through October 2023, we shifted 51,000 Medicaid enrollees out of Medicaid and into other populations for our 2025 estimate.

We shifted 40% of the 51,000 enrollees to uninsured, 10% to individual, 3.6% to small group, 7.4% to fully insured large group, 3.4% to the State Health Plan, and 35.6% to self-funded employer plans using transitional estimates from the Congressional Budget Office.[19]

### MARYLAND BIRTHRATE

The Maryland Vital Statistics Annual Report 2020 reported 68,546 live births in 2020 and March of Dimes estimates 39.4% of those births were covered by Maryland Medicaid. Using 2020 census data and 2020 Medicaid enrollment data from the APCD, we estimate the Maryland Medicaid birth rate to be 18.4 per 1,000 and the birth rate for non-Medicaid populations to be 8.8 per 1,000 using 2020 census data and 2020 Medicaid enrollment data from the APCD. In aggregate, we estimate Maryland's birth rate is 11.1 per 1,000.

### BENEFIT COVERAGE SURVEY

We surveyed insurance carriers in Maryland and the Maryland Insurance Administration about current enrollee cost sharing for labor and delivery services. For individual and small group plans, we requested benefit designs for their most popular (by enrollment) non-HSA plan designs by metal tier. For large group plans we requested the same information by five deductible ranges. The survey can be found in Appendix A. We downloaded the three plan designs for the State Health Plans from the health benefits section of the Maryland department of budget and management website.[20]

Maryland Insurance Administration provided the requested information for individual and small group plans. Only three of five carriers responded to the large group survey. Only one of the three carriers provided labor and delivery cost sharing details for each of the five deductible ranges. The other two carriers provided a total of three of their most popular plan designs by deductible range.

Due to the low response to the benefit coverage survey, the estimated financial impact on large group enrollees may not be reflective of the Maryland large group market. The carrier with full responses is approximately 20% of the full insured large group market but comprises over 70% of our survey enrollees. The enrollee weighted results for fully insured large group plans may have lower than expected out-of-pocket savings because the carrier with complete responses does not have labor and delivery cost sharing for any of their most popular plans.

### COST SHARE REDUCTION ADJUSTMENTS

Enrollees between 100% and 250% of the federal poverty level (FPL) qualify for cost sharing reductions (CSR) that lower the deductible, coinsurance, copayments, and maximum out-of-pockets for specific silver plans. These reductions raise the actuarial values (AV) of the silver plans from the standard 70% AV to 73% for enrollees between 201% and 250% of FPL, 87% AV for enrollees between 151% and 200% of FPL, and 94% AV for enrollees between 100% and 150% of FPL.[21]

We estimated 59% of silver plan enrollees to be in 87% or 94% AV CSR plans based on an October 2023 data report from Maryland Health Connection.[22] We assumed these enrollees have cost sharing similar to platinum plans, which have 90% AV.

### UTILIZATION, COST, AND ENROLLEE COST SHARING SAVINGS

MHCC used the APCD to summarize deliveries, claims, and membership for enrollees with labor and delivery claims in 2022, using Maryland's APCD and logic provided by Milliman.

Commercial fully insured and State Health Plan delivery admission and discharge dates were identified using ICD 10 procedures codes 10D00Z0,10D00Z1,10D00Z2,10D07Z3,10D07Z4,10D07Z5,10D07Z6,10D07Z7,10D07Z8, and 10E0XZZ. Using the admission and discharge dates from those claims, all claims in that time period were summarized and attributed to labor and delivery services for that user. After removing members with negative or zero-dollar deliveries, we identified 8,621 distinct users of labor and delivery services.

Each labor and delivery user's 2022 medical claims were split into separate service categories: delivery claims, preventive claims, office claims prior to delivery, all other medical claims prior to delivery, office claims post-delivery, and all other medical claims post-delivery. Office and preventive claims were identified using a flag populated in the ACPD data.

The services categorized as labor and delivery are limited to those with service dates during the delivery admission. Any professional services that are bundled and have a service date assigned that is different from the admission date would not be included in the delivery category.

For enrollees without a labor and delivery claim, their medical claims were summarized similarly into separate service categories: preventive claims, office claims, and all other medical claims.

Using Milliman's Health Cost Guidelines, office costs were trended from 2022 to 2025 using a 4.9% annualized trend. Delivery, preventive, and all other medical costs were trended forward from 2022 to 2025 using a 6.7% annualized trend.

We selected a set of plan designs to represent each of the commercial fully insured lines of business. For a given plan design, we applied the benefit design to the claim service categories of each enrollee with labor and delivery services. We calculated each user's plan liability and out-of-pocket expenses as if they were enrolled in the plan to develop a baseline estimate. Then we recalculated, assuming the out-of-pocket costs for labor and delivery were $0 with all other plan design cost sharing remaining the same to develop a post mandate estimate. We repeated these steps for every plan design received from the benefit design survey and for each enrollee with labor and delivery services.

Claims repricing according to different benefit designs can be a complex calculation. We made the following simplifying assumptions to account for incomplete information when repricing of the benefits:

- The maximum patient paid out-of-pocket for each plan was dampened by 2% to account for pharmacy claims not accounted for in our estimates. This is based on the percentage of pharmacy claims attributable to the total cost of care for enrollees using labor and delivery services and adjusted to account for differences in pharmacy cost sharing compared to other services.
- Some plan designs apply a copayment per day to labor and delivery services. Using an assumed value for the average cost of an inpatient day for labor and delivery services, we imputed the number of days each enrollee was in the hospital for a labor and delivery admission. We applied the copayment according to the

imputed number of days. We assumed one inpatient office visit per day of the hospital stay and applied the copayment to the imputed number of days.

- For plans that had a 0% enrollee coinsurance for labor and delivery services, we applied office copayments and deductible cost sharing to the non-labor and delivery services. These other services may be subject to the deductible and have an additional copayment which would cause enrollees to meet the out-of-pocket maximum sooner. We did not know the number of visits or copayments that would be applied in these instances due to limitations of the data summaries.
- Using an assumed value for the average cost for an office visit, we imputed the number of office visits for each enrollee, and we applied office visit copayments for each visit ranging from $10 to $38 based on the richness of the plan. The copayments were developed using a blend of primary care physician and specialist office visit copayments. Fully insured large group plans with $0 deductible were assigned $10 office visit copayments and small group silver plans were assigned $38 office visit copayments.
- For benefit designs with per admission facility and professional services copayments for labor and delivery services, the copayments were combined and applied per admission, after the deductible if labor and delivery services were subject to the deductible.
- For benefit designs with per diem facility and professional services copayments for labor and delivery services, the copayments were combined and applied per diem, after the deductible if labor and delivery services were subject to the deductible. Days were estimated for each user by dividing the cost of labor and delivery by the observed average daily cost of labor and delivery from the Milliman Consolidated Health Cost Guidelines™ Sources Database (CHSD).
- For benefit designs with facility coinsurance and a small professional services copayment for labor and delivery services, we applied only the facility coinsurance to the average percent of labor and delivery attributable to facility services by splitting labor and delivery using observed facility and professional proportions from the Milliman CHSD.
- Some benefit designs have patient cost sharing mainly in the form of copayments with 0% coinsurance paid by the enrollee. In those cases, we applied copayments of $10 to $38 dollars for office visits and applied no coinsurance to other medical services.

We calculated the average out-of-pocket savings for each plan design using these baseline and post mandate plan liability and out-of-pocket expenses estimates. Then we developed an average out-of-pocket savings for each line of business using metal tier or deductible level enrollment.

For per member per year calculations, we assumed members were enrolled for 12 months.

## PREMIUM AND RETENTION

We assumed a medical loss ratio of 80% for commercial fully insured individual and small group plans, and a medical loss ratio of 85% for fully insured large group and the State Health Plan.

We assumed no additional administrative costs due to this mandate beyond the typical proportional increase in retention costs when applied to medical cost increases.

## CONSIDERATIONS AND LIMITATIONS

- Due to the low response to the benefit coverage survey, the estimated financial impact on large group enrollees may not be reflective of the Maryland large group market. The carrier with full responses is approximately 20% of the full insured large group market but comprises over 70% of our survey enrollees. The resulting estimated out-of-pocket savings may be lower than what may be realized by an elimination of enrollee cost sharing on labor and delivery services because the carrier with complete responses does not have labor and delivery cost sharing for any of their most popular plans.
- The labor and delivery services we identified are limited to services billed during the delivery admission, if a labor and delivery service was prepaid and billed prior to the delivery admission, those costs would not be

included. Conversely, if non-labor and delivery services incurred prior to or after the delivery admission were billed during the admission, those costs would be included.

- Our methodology for identifying labor and delivery costs assumes each user has one delivery in a year.
- We are using the most popular plan designs by tier or deductible level as a proxy for the entire market. Plan designs, including labor and delivery benefits, deductibles and out of pocket maximums, may vary within metal levels and deductible ranges. Our estimates may not reflect the entire commercial market and may be high or low depending on how the other plan designs within metal tiers or deductible levels apply cost sharing to labor and delivery services.
- We are applying deductible, coinsurance, and out-of-pocket maximums to all medical services other than preventive or labor and delivery services. For services that are subject to copayments but not the deductible, this will over-estimate their accumulation to the deductible and out-of-pocket maximum and underestimate the impact of labor and delivery cost sharing elimination.
- We are applying a 2% reduction to the maximum out-of-pocket amount to account for pharmacy costs not otherwise modeled. This is a flat reduction that assumes pharmacy services occur in the beginning of the year. If pharmacy utilization happens more uniformly throughout the year, our methodology will overestimate the impact of labor and delivery cost sharing elimination.
- Births rates for the commercial and State Health Plan population developed from the APCD are not consistent with birth rates reported by the US Census for the state of Maryland. We rescaled the APCD data we received for consistency with birth rates using data from the Maryland Vital Statistics Report 2020 and the US Census.
- In per member per year calculations, we assume enrollees are enrolled for 12 months.

# Variability of Results

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made in this model. It is almost certain that actual experience will not conform exactly to the assumptions used in this model. Actual amounts will differ from projected amounts to the extent that the actual experience is better or worse than expected.

# Model and Data Reliance

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the impact of removing cost sharing for labor and delivery services. We have reviewed this model, including its inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman’s data and information reliance includes:

- Data from Maryland’s All Payer Claims Database, as summarized by MHCC
- Enrollment and plan data from the Maryland Insurance Administration
- Maryland vital statistics annual report 2020
- US Census data and projections
- All other sources mentioned inline and in references, including survey and studies.

The models, including all input, calculations, and output may not be appropriate for any other purpose.

We have performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our investigation.

## Qualifications to Perform Analysis

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications.  One of the developers of this model and author of this paper, Casey Hammer, is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses supported by this model.

## Distribution and Usage

We understand that MHCC intends to distribute this report to the Commissioners and it may be published on their website. We consent to this distribution as long as the work is distributed in its entirety. Milliman does not intend to benefit any third-party recipient of its work product and assumes no duty or liability to other parties who receive this work.

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# Appendix A: Coverage survey for labor and delivery services

## COVERAGE SURVEY FOR LABOR & DELIVERY SERVICES

Insurance Article §15–1501, Annotated Code of Maryland, requires the Maryland Health Care Commission (MHCC) to annually assess the medical, social, and financial impact of proposed mandated health insurance services that failed to pass during the preceding legislative session. Senate Bill 784 (SB 784) – Health Insurance – Labor and Delivery Services – Cost-Sharing Requirements, which did not pass, required health insurance carriers to provide coverage for labor and delivery services without certain cost-sharing requirements and generally relating to cost-sharing requirements for labor and delivery services.

For this survey MHCC is requesting information **only for the fully insured large group market**. MHCC is gathering similar information for the individual and small group markets from the Maryland Insurance Administration.

This survey is intended to inform this analysis. Please return this survey to Kenneth Yeates-Trotman via email at kenneth.yeates-trotman@maryland.gov by **Wednesday, November 1, 2023.**

1) What is the name of the insurance carrier?

| |
|---|
| |

2) For ***all plan designs (exclude all health savings account qualified plans – HSAs)*** for the Fully Insured Large Group Market, please provide the average premium.

| Deductible Amount | Average Premium (2022) |
|---|---|
| $0 | |
| $1 - $999 | |
| $1,000 - $1,999 | |
| $2,000 - $2,999 | |
| $3,000+ | |
| Average | |

3) For ***all plan designs*** for the Fully Insured Large Group Market, please provide the number of people enrolled.

| Deductible Amount | Number of people enrolled (2022) Non-HSA Qualified Plans | Number of people enrolled (2022) HSA Qualified Plans |
|---|---|---|
| **$0** | | |
| **$1 - $999** | | |
| **$1,000 - $1,999** | | |
| **$2,000 - $2,999** | | |
| **$3,000+** | | |
| **Average** | | |

*4)* For the ***most popular plan design (for 2023)*** for the Fully Insured Large Group Market, please provide the deductible. *Exclude all health savings account qualified plans – HSAs.*

| Deductible Amount | Deductible – Medical Only |
|---|---|
| **$0** | |
| **$1 - $999** | |
| **$1,000 - $1,999** | |
| **$2,000 - $2,999** | |
| **$3,000+** | |
| **Average** | |

**Please note that providing the summary plan descriptions for the most popular plans can be substituted this table.**

*5)* For the ***most popular plan design (for 2023)*** for the Fully Insured Large Group Market, please provide the maximum out of pocket. *Exclude all health savings account qualified plans – HSAs.*

| Deductible Amount | Maximum Out of Pocket – Medical Only |
|---|---|
| **$0** | |
| **$1 - $999** | |
| **$1,000 - $1,999** | |
| **$2,000 - $2,999** | |
| **$3,000+** | |
| **Average** | |

**Please note that providing the summary plan descriptions for the most popular plans can be substituted this table.**

6) For the ***most popular plan design (for 2023)*** for the Fully Insured Large Group Market, please provide the coinsurance. *Exclude all health savings account qualified plans – HSAs.*

| Deductible Amount | Coinsurance Medical Only |
|---|---|
| **$0** | |
| **$1 - $999** | |
| **$1,000 - $1,999** | |
| **$2,000 - $2,999** | |
| **$3,000+** | |
| **Average** | |

**Please note that providing the summary plan descriptions for the most popular plans can be substituted this table.**

7) For the ***most popular plan design (for 2023)*** for the Fully Insured Large Group Market, please indicate if **Labor and Delivery is subject to deductible.** *Exclude all health savings account qualified plans – HSAs.*

| Deductible Amount | Labor & Delivery- Subject to Deductible? (Medical Only) |
|---|---|
| **$0** | Yes/No? |
| **$1 - $999** | Yes/No? |
| **$1,000 - $1,999** | Yes/No? |
| **$2,000 - $2,999** | Yes/No? |
| **$3,000+** | Yes/No? |
| **Average** | Yes/No? |

**Please note that providing the summary plan descriptions for the most popular plans can be substituted this table.**

8) For the ***most popular plan design (2023)*** for the Fully Insured Large Group Market, please indicate if **Labor and Delivery is subject to coinsurance.** *Exclude all health savings account qualified plans – HSAs.*

| Deductible Amount | Labor & Delivery- Subject to Coinsurance? (Medical Only) |
|---|---|
| **$0** | Yes/No? |
| **$1 - $999** | Yes/No? |

| | |
|---|---|
| **$1,000 - $1,999** | Yes/No? |
| **$2,000 - $2,999** | Yes/No? |
| **$3,000+** | Yes/No? |
| **Average** | Yes/No? |

**Please note that providing the summary plan descriptions for the <u>most popular plans</u> can be substituted this table.**

9) For the ***<u>most popular plan design (for 2023)</u>*** for the Fully Insured Large Group Market, please provide the **Labor and Delivery copayment amount.** *Exclude all health savings account qualified plans – HSAs.*

| Deductible Amount | Labor & Delivery- Copayment (Medical Only) |
|---|---|
| **$0** | |
| **$1 - $999** | |
| **$1,000 - $1,999** | |
| **$2,000 - $2,999** | |
| **$3,000+** | |
| **Average** | |

**Please note that providing the summary plan descriptions for the <u>most popular plans</u> can be substituted this table.**

# Appendix B: Non-HSA qualified enrollees and deliveries

| | Individual | Small Group | Fully Insured Large Group | Total Fully Insured Commercial | State Health Plan | Total Commercial |
|---|---|---|---|---|---|---|
| **Total enrollees subject to state mandates** | 248,900 | 224,200 | 466,300 | 939,400 | 210,400 | 1,149,800 |
| **Total enrolled in non-HSA qualified plans subject to state mandates** | 227,700 | 89,500 | 307,900 | 625,100 | 210,400 | 835,500 |
| **Total deliveries** | 2,190 | 1,980 | 4,110 | 8,280 | 1,850 | 10,130 |
| **Total non-HSA qualified plan deliveries** | 2,010 | 790 | 2,710 | 5,510 | 1,850 | 7,360 |
| **% deliveries subject to mandate** | 92% | 40% | 66% | 67% | 100% | 73% |

# Appendix C: Annual Labor and Delivery Expenditures PMPM

| | Individual | Small Group | Fully Insured Large Group | Total Fully Insured Commercial | State Health Plan | Total Commercial |
|---|---|---|---|---|---|---|
| **Total enrollees subject to state mandates** | 248,900 | 224,200 | 466,300 | 939,400 | 210,400 | 1,149,800 |
| **Total enrolled in non-HSA qualified plans subject to state mandates** | 227,700 | 89,500 | 307,900 | 625,100 | 210,400 | 835,500 |
| **Total deliveries** | 2,190 | 1,980 | 4,110 | 8,280 | 1,850 | 10,130 |
| **Total non-HSA qualified plan deliveries** | 2,010 | 790 | 2,710 | 5,510 | 1,850 | 7,360 |
| **Baseline** | | | | | | |
| Premium attributable to labor and delivery for non-HSA qualified plans | $18.05 | $19.12 | $18.60 | $18.47 | $17.99 | $18.35 |
| Enrollee out of pocket expenses attributable to labor and delivery | $1.54 | $0.68 | $0.17 | $0.74 | $0.69 | $0.73 |
| **Total Cost of Care for non-HSA qualified plans** | **$19.59** | **$19.80** | **$18.77** | **$19.21** | **$18.68** | **$19.08** |
| **Post mandate** | | | | | | |
| Premium attributable to labor and delivery for non-HSA qualified plans | $19.98 | $19.96 | $18.80 | $19.39 | $18.80 | $19.24 |
| Enrollee out of pocket expenses attributable to labor and delivery | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| **Total Cost of Care for non-HSA qualified plans** | **$19.98** | **$19.96** | **$18.80** | **$19.39** | **$18.80** | **$19.24** |
| **Financial impact of mandate** | | | | | | |
| Change in premium | $1.93 | $0.85 | $0.20 | $0.92 | $0.81 | $0.89 |
| Change in enrollee out of pocket expenses | -$1.54 | -$0.68 | -$0.17 | -$0.74 | -$0.69 | -$0.73 |
| **Total Cost of Care impact for non-HSA qualified plans** | **$0.39** | **$0.17** | **$0.03** | **$0.18** | **$0.12** | **$0.16** |

# Appendix C: Annual Labor and Delivery Expenditures (Cont.)

| | Individual | Small Group | Fully Insured Large Group | Total Fully Insured Commercial | State Health Plan | Total Commercial |
|---|---|---|---|---|---|---|
| **Total enrollees subject to state mandates** | 248,900 | 224,200 | 466,300 | 939,400 | 210,400 | 1,149,800 |
| **Total enrolled in non-HSA qualified plans subject to state mandates** | 227,700 | 89,500 | 307,900 | 625,100 | 210,400 | 835,500 |
| **Total deliveries** | 2,190 | 1,980 | 4,110 | 8,280 | 1,850 | 10,130 |
| **Total non-HSA qualified plan deliveries** | 2,010 | 790 | 2,710 | 5,510 | 1,850 | 7,360 |
| **Baseline** | | | | | | |
| Premium attributable to labor and delivery for non-HSA qualified plans | $49,310,000 | $20,532,000 | $68,713,000 | $138,555,000 | $45,418,000 | $183,973,000 |
| Enrollee out of pocket expenses attributable to labor and delivery | $4,219,000 | $727,000 | $635,000 | $5,581,000 | $1,736,000 | $7,317,000 |
| **Total Cost of Care for non-HSA qualified plans** | **$53,529,000** | **$21,259,000** | **$69,348,000** | **$144,136,000** | **$47,154,000** | **$191,290,000** |
| **Post mandate** | | | | | | |
| Premium attributable to labor and delivery for non-HSA qualified plans | $54,584,000 | $21,440,000 | $69,460,000 | $145,484,000 | $47,461,000 | $192,945,000 |
| Enrollee out of pocket expenses attributable to labor and delivery | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Cost of Care for non-HSA qualified plans** | **$54,584,000** | **$21,440,000** | **$69,460,000** | **$145,484,000** | **$47,461,000** | **$192,945,000** |
| **Financial impact of mandate** | | | | | | |
| Change in premium | $5,274,000 | $908,000 | $747,000 | $6,929,000 | $2,043,000 | $8,972,000 |
| Change in enrollee out of pocket expenses | -$4,219,000 | -$727,000 | -$635,000 | -$5,581,000 | -$1,736,000 | -$7,317,000 |
| **Total Cost of Care impact for non-HSA qualified plans** | **$1,055,000** | **$181,000** | **$112,000** | **$1,348,000** | **$307,000** | **$1,655,000** |

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