Mid-Atlantic Association of Community Health Centers

Maryland Economic Environmental Assessment:

Assessing the Impact of the Economy on Employment, Health Insurance, the Affordable Care Act

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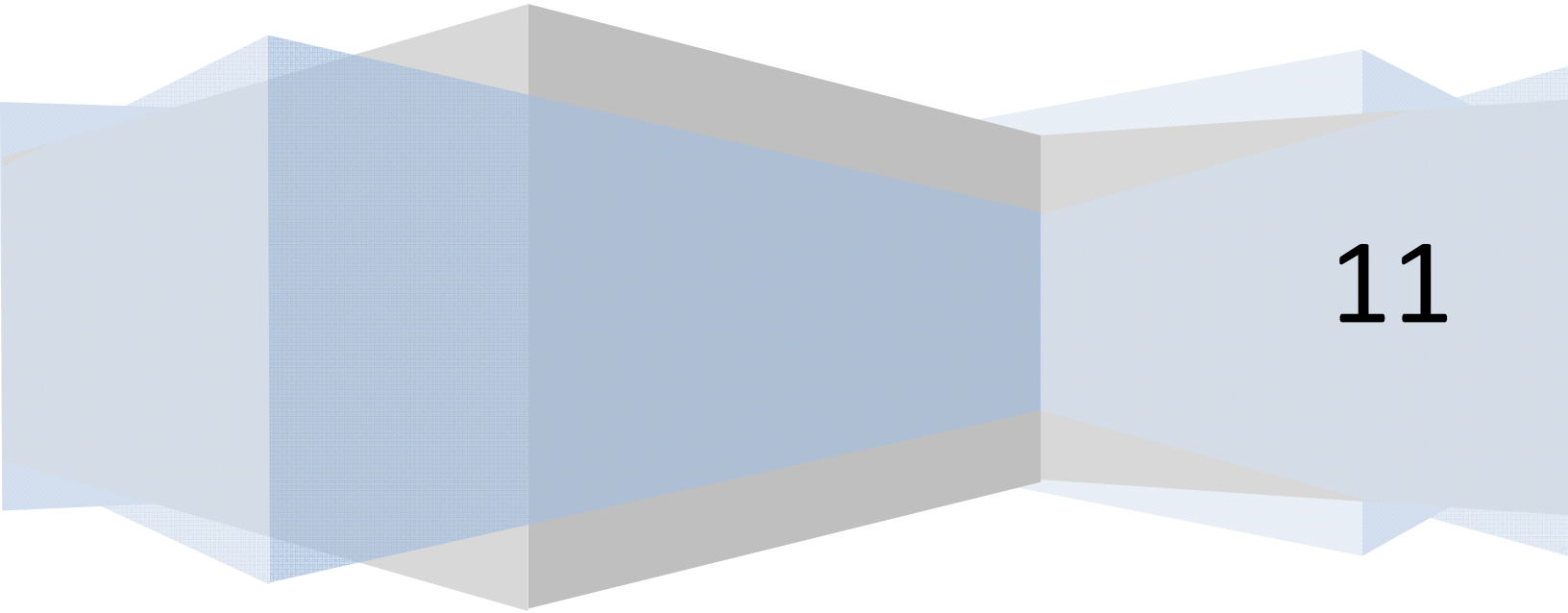

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Purpose of Report

Maryland's economy, like the nation's, has been severely impacted by the late 2000s recession. An assessment of the economic trends in Maryland reveals a myriad of implications for community health centers, the Affordable Care Act, and the structure of health insurance markets. This report will examine the relationship that the overall economy holds with employment, health insurance markets, Medicaid, and the implementation of the Affordable Care Act. The report will also demonstrate how all of these forces have implications for CHC strategic planning, governance, and site location. The purpose of this report is to examine all of these relationships and offer CHCs the most complete information to make strategic planning decisions.

The report is divided into four primary sections:

- An overview of the regional employment situation
- An assessment of Medicaid trends throughout the state's regions
- An examination of employment and the health insurance markets over the last decade
- Estimates of the impact of the Affordable Care Act

Executive Summary

Since 2007, the state's, and the nation's, economy has undergone rapid changes. Between 2007 and 2011, all but three counties in the state had declines in their labor forces. Unemployment rates at least doubled in 16 of the 24 counties, and all but one county (Baltimore City) saw increases by at least 90 percent. Moreover, every county in the state has fewer people employed in 2011 than in 2007. This report will examine how these economic forces, along with policy changes and other economic shifts, have impacted the demand for safety-net health care services and the focus for community health center strategic planning.

While no area of the state has remained untouched by the recession, each county and region has experienced the downturn differently. As mentioned above, nearly all counties experienced an over 90 percent increase in their unemployment rates. The counties that have had the most drastic changes in employment are those that experienced rapid development in the mid-part of the last decade. These counties include Frederick County, Washington County, and counties on the Eastern Shore that featured housing development booms. Most of these more drastically affected counties were on the suburban fringe of development. These declines have had wide-ranging implications on the levels and locations of economic development. Economic development has greatly contracted throughout the state, but especially in the aforementioned outer-ring suburbs and rural areas that had seen strong growth throughout the previous decade.

The recent expansion of unemployment has produced shifts in insurance markets. The most striking trend of the decade shows a large percentage of residents moving from private to public insurance.

Maryland has seen a strong decline in the percentage of residents who receive their insurance through their (or their spouses') employer. The trend in falling rates of employee-sponsored insurance began in the early part of the decade, leveled out, and then continued during the recession where it fell to its lowest level in the decade.

Additionally, beginning in 2008, Medicaid enrollment began to swell dramatically. Initially this growth was due to Maryland policy changes, but as job losses were incurred in the following years, the growth of Medicaid continued unabated. Since 2007, Medicaid enrollment has increased by 49 percent in the state. The fastest growing areas in the state were generally suburban counties and counties that had previously low to moderate levels of Medicaid enrollment. This finds that the suburbanization of poverty in Maryland, as demonstrated in MACHC's previous demographic assessment, has been furthered by the recession.

The recent economic changes also have large implications for the implementation of the Affordable Care Act (ACA). Because of high levels of Medicaid enrollment due to unemployment and state policy changes, the net growth in Medicaid patients from the ACA will be lower than it would be otherwise. However, the ACA will result in an estimated 200,000 residents with incomes under 200 percent of the poverty level by 2017 becoming insured, many of whom will be a part of the new exchanges.

The uncertain economic outlook and the ACA produce many implications for community health centers seeking to strategically plan for future growth. Demand for CHC-style services has increased greatly over the past decade as fewer people have employer-based insurance, but the net growth of the uninsured receiving insurance (especially Medicaid) will likely be smaller as a result of this Medicaid growth. To continue strong patient growth, CHCs should capture low-income, non Medicaid eligible patients (with incomes between 133-200 percent of the poverty level), who will be on the exchanges by 2014.

Due to the interrelated processes of the economy, employment, public policy, and health insurance, it is vital that CHCs follow trends in these areas. As this report will discuss, the state's employment trends have a large impact on the distribution of health insurance, which in turn has major implications for the implementation of the Affordable Care Act. In an uncertain time that features a middling economic recovery and a pending reorganization of health insurance via the ACA, it is crucial that health centers take these trends into account during strategic planning processes.

Methodology

This report uses employment data, Medicaid data, census insurance data, interviews with stakeholders, and quantitative analysis of prior research on the Affordable Care Act implementation to reveal trends that have implications for CHCs. The purpose of examining these data is to examine the relationship between the economy and health insurance markets that affect CHCs. As can be seen in the report, the recession's effects on employment have reverberating impacts on health insurance markets and the potential outcomes of implementing the Affordable Care Act.

In examining the impacts of the Affordable Care Act, we built upon work completed by the Maryland Healthcare Reform Coordinating Council to create estimates of the number of uninsured residents who will become insured by 2017 by state and county by poverty level. To do this, we used the Maryland Healthcare Reform Coordinating Councils estimates of percentage uninsured who will become insured by 2017. We then calculated, using Census data, an estimate of the percentage of residents in each county who are below and above 200 percent of poverty. Then, using a survey conducted by the Maryland Healthcare Commission that estimated the breakdown of Maryland's uninsured by income level, we estimated the total number of the state's uninsured that will attain insurance by poverty level. I then multiplied these numbers by the already calculated percentage of residents in each county below and above 200 percent of the poverty level to attain the resulting estimates.

1. Regional Employment Trends

1.1 Overall Trends and Implications

This section is divided up by analysis of the state's five regions. Each section details the employment trends over the last five years for the region.

When analyzing the employment trends since 2007, a few strong trends emerged that are impactful on CHCs. During this period, every region in the state was deeply marred by unemployment and weak growth, and within the regions there is much variation between counties. The first major trend emerging as a result of the depth of the recession is that unlike previous downturns, suburban unemployment rates have been growing as fast as or faster than their urban counterparts.[1] This trend is clearly seen in the central region, as every county showed faster growth in unemployment than Baltimore City. Although Baltimore City's unemployment rate remains the region's highest, other counties in the region are converging on Baltimore City's levels with faster declines in employment during the recession.

A second major trend seen in Maryland is that counties on the edges of suburbanization (exurban areas) who benefited from growth in housing and construction in the middle part of the decade have seen larger declines relative to their inner-ring suburban counterparts. These counties include Washington, Frederick, and Carroll. Many counties in the Eastern Region showed immense growth in unemployment brought on by similar forces: a decline in home construction and tourism. The declines in housing and building development in these areas led to deeper recessions for many businesses and workers.

The wide geographic distribution of unemployment has created many implications for CHCs, including attracting new Medicaid patients and estimating future patient growth. Since employment trends have a strong impact on the need for safety net services, it is important for CHCs to stay abreast of these developments in their local and regional areas. With the employment market recovering slowly, many of the currently unemployed residents may remain so for some time, potentially without private insurance options. Employment trends should also be followed for potential site expansion opportunities. If certain areas of the state continue to stagnate with regards to employment while the overall economy improves, these areas could provide opportunities for CHC growth to meet the newfound safety-net need.

As a result of this uncertainty, the changes in employment make it difficult for CHCs to gauge the long term need versus the short term, temporary need caused by the recession. Following the trends in unemployment in upcoming months and years will allow CHCs to gain a greater grasp of these issues.

[1] Kneebone and Garr, *The Landscape of Recession: Unemployment and Safety Net Services Across Urban and Suburban America,* The Brookings Institute, 2009.

1.2 Central Region

Figure 1.1: 2007 Central Region Employment Statistics

2007	Labor Force	Employment	Unemployment	Unemployment Rate
Howard County	161,405	157,231	4,174	2.6%
Carroll County	95,296	92,441	2,855	3%
Anne Arundel	283,765	275,058	8,707	3.1%
Harford County	133,533	128,977	4,556	3.4%
Baltimore County	433,012	417,364	15,648	3.6%
Baltimore City	279,149	263,391	15,758	5.6%
Total	1,386,160	1,334,462	51,698	3.7%

Source: Bureau of Labor Statistics

The period between 2007 and 2011 saw great increases in the unemployment of every Central Region county. Carroll County, which had the largest relative decline in labor force participation, had the biggest increase in the region of 130 percent from 3 to 6.9 percent (see Figures 1.2 and 1.3). As mentioned in the overview, many counties on the fringe of urban development (exurbs) that benefited from growth in the housing boom have seen the steepest relative declines. Harford County, a county with exurban areas, also saw a large increase in the period resulting in a 7.7 percent unemployment rate, the region's third highest (see figure 1.2).

Figure 1.2: 2011 Central Region Employment Statistics

2011	Labor Force	Employment	Unemployment	Unemployment Rate
Howard County	157,955	149,834	8,121	5.1%
Anne Arundel	277,539	258,979	18,559	6.7%
Carroll County	92,325	85,965	6,360	6.9%
Harford County	130,580	120,581	9,999	7.7%
Baltimore County	420,330	386,540	33,790	8%
Baltimore City	272,376	243,671	28,705	10.5%
Total	1,351,105	1,245,570	105,534	7.81%

Source: Bureau of Labor Statistics

Baltimore County also featured a dramatic rise, with its unemployment rates growing from 3.6 to 8 percent between 2007 and 2011. Baltimore City's unemployment rates remain the region's highest, having risen from 5.6 to 10.5 percent in the period. While every county suffered large employment losses during the recession, it appears that the urban and inner-ring suburban areas (Baltimore City and Baltimore County) were impacted the most. Similarly, the two exurban counties that feature a mix of rural and suburban geographies, Carroll and Harford, endured great gains in unemployment. The remaining two suburban counties, Anne Arundel and Howard, had relatively smaller increases in unemployment, rising to 6.7 and 5.1 percent, respectively.

Figure 1.3: Changes between 2007 and 2011 in Central Region Employment Statistics

2007-2011	Labor Force	Employment	Unemployment	Unemployment Rate
Carroll County	-3.11%	-7.0%	122.76%	130%
Howard County	-2.13%	-4.7%	94.56%	96.15%
Anne Arundel	-2.19%	-5.84%	113.15%	115.72%
Harford County	-2.21%	-6.5%	119.46%	126.4%
Baltimore County	-2.92%	-7.38%	115.93%	122.2%
Baltimore City	-2.42%	-7.48%	82.161%	87.5%
Average	-2.5%	-6.48%	108.0%	113.01%

Source: Bureau of Labor Statistics

1.3 Capital Region

Figure 1.4: Changes between 2007 and 2011 in Capital Region Employment Statistics

2007	Labor Force	Employment	Unemployment	Unemployment Rate
Montgomery	516790	502904	13886	2.7%
Prince George's	451740	435146	16594	3.7%
Frederick	125402	121717	3685	2.9%
Total	1093932	1059767	34165	3.12%

Source: Bureau of Labor Statistics

The Capital Region's economy fared better than the Central Region's during this period, while still suffering steep declines. Unemployment rates increased dramatically in all three counties during the five year period. Of the three counties, Frederick County has suffered the worst, continuing the trend of exurban areas struggling greatly during the recession. Frederick County's unemployment rate grew the most in the region, from 2.9 to 6.6 percent during the period and also saw the steepest labor force declines (see Figures 1.5 and 1.6). Frederick County's unemployment rate, once on par with Montgomery County's, has nearly converged with Prince George's rate.

Figure 1.5: Changes between 2007 and 2011 in Capital Region Employment Statistics

2011	Labor Force	Employment	Unemployment	Unemployment Rate
Montgomery	512,874	486,083	26791	5
Prince George's	444,751	413,072	31680	7.1
Frederick	122,403	114,350	8053	6.6
Total	1080028	1013505	66524	6.16

Source: Bureau of Labor Statistics

Prince George's County saw its unemployment rate rise from 3.7 to 7.1 percent between 2007 and 2011, while Montgomery County maintained the lowest unemployment rate in the region, rising from 2.7 to 5 percent. Both of these counties performed relatively better than other counties in the state, and their proximity to the federal government's employment centers has benefitted them.

Figure 1.6: Changes between 2007 and 2011 in Capital Region Employment Statistics

Changes 2007-2011	Labor Force	Employment	Unemployment	Unemployment Rate
Montgomery	-0.75%	-3.34%	92.93%	92.59%
Prince George's	-1.54%	-5.07%	90.91%	91.89%
Frederick	-2.39%	-6.05%	118.53%	127.58%
Average	-1.56%	-4.82%	100.79%	104.02%

Source: Bureau of Labor Statistics

1.4 Eastern Region

Figure 1.7: Changes between 2007 and 2011 in Eastern Region Employment Statistics

2007	Labor Force	Employment	Unemployment	Unemployment Rate
Dorchester	16,905	15,906	999	5.9%
Somerset	11,329	10,711	618	5.5%
Caroline	16,429	15,733	696	4.2%
Queen Anne's	26,398	25,561	837	3.2%
Wicomico	52,872	50,769	2,103	4%
Kent	11,281	10,876	405	3.6%
Talbot	19,127	18,470	657	3.4%
Cecil	51,235	49,224	2,011	3.9%
Worcester	27,884	26,219	1,665	6%
Total	233,460	223,469	9,991	4.28%

Source: Bureau of Labor Statistics

The Eastern Region has struggled through the recession more than any other of Maryland's regions. These employment data, coupled with the Medicaid data later in the report, demonstrate that the Eastern Region's need for safety-net services has grown considerably during the recession.

Figure 1.8: Changes between 2007 and 2011 in Eastern Region Employment Statistics

2011	Labor Force	Employment	Unemployment	Unemployment Rate
Dorchester	16,434	14,525	1,909	11.6%
Somerset	10,906	9,685	1,221	11.2%
Caroline	16,249	14,660	1,589	9.8%
Queen Anne's	26,317	24,352	1,965	7.5%
Wicomico	51,167	46,307	4,860	9.5%
Kent	10,527	9,579	948	9%
Talbot	18,204	16,643	1,564	8.6%
Cecil	49,782	44,583	5,199	10.4%
Worcester	24,870	20,425	4,445	17.9%
Total	224,456	200,759	23,700	10.56%

Source: Bureau of Labor Statistics

With already high unemployment in 2007, the Eastern Region saw unemployment rates at least double in all but one county (Figure 1.9). As an example of the recession's impact on the region, presently unemployment rates in the region range from 7.5 percent in Queen Anne's County to 17.9 percent in Worcester County. These two counties began 2007 with roughly the same sized labor forces, but Queen Anne's County's unemployment rate grew by 133 percent, compared to the 198 percent increase in Worcester County's. Both of these growth rates are quite stark, and it underscores the dramatic growth in need in Worcester County.

Figure 1.9: Changes between 2007 and 2011 in Eastern Region Employment Statistics

Changes 2007-2011	Labor Force	Employment	Unemployment	Unemployment Rate
Dorchester	-2.78%	-8.68%	91.09%	96.61%
Somerset	-3.73%	-9.57%	97.57%	103.63%
Caroline	-1.09%	-6.82%	128.3%	133.33%
Queen Anne's	-0.30%	-4.72%	134.76%	134.37%
Wicomico	-3.22%	-8.78%	131.09%	137.5%
Kent	-6.68%	-11.92%	134.07%	150%
Talbot	-4.82%	-9.891%	138.05%	152.94%
Cecil	-2.83%	-9.42%	158.52%	166.66%
Worcester	-10.8%	-22%	166.96%	198.33%

Source: Bureau of Labor Statistics

Four of the state's counties featured growth in unemployment rates over 150 percent: Kent (150 percent), Talbot (153 percent), Cecil (167 percent) and Worcester (198 percent). Concurrently, five of the nine counties in the region have unemployment rates over ten percent, while three more have rates over eight percent. As health insurance is tied to unemployment, the Eastern Region's sharp growth in unemployment produces concerns for being able to meet the need for these often rural counties.

1.5 Western Region

Figure 1.10: Changes between 2007 and 2011 in Western Region Employment Statistics

2011	Labor Force	Employment	Unemployment	Unemployment Rate
Allegany	35,418	33,573	1,845	5.2%
Garrett	16,909	16,153	756	4.5%
Washington	69,011	65,943	3,068	4.4%
Total	121,338	115,669	5,669	4.67%

Source: Bureau of Labor Statistics

The Western region, especially the less populated counties of Allegany and Garrett, performed relatively well during this period. However, Washington County saw an extraordinary increase in its unemployment rates, having grown from 4.4 to 10.6 percent in 5 years (See Figures 1.10-1.12). Washington County, like Frederick County and other exurban counties, suffered as the building boom of the mid-2000s subsided and the recession took over. Based on these data, it appears that the need for services has increased dramatically in the county.

Figure 1.11: Changes between 2007 and 2011 in Western Region Employment Statistics

2007	Labor Force	Employment	Unemployment	Unemployment Rate
Allegany	36,233	32,675	3,558	9.8%
Garrett	16,912	15,403	1,509	8.9%
Washington	67,453	60,283	7,170	10.6%
Total	120,598	108,361	12,237	10.14%

Source: Bureau of Labor Statistics

Allegany County, despite seeing an 88 percent increase in the unemployment rate, had a 2.3 percent increase in its labor force. Allegany County also showed the smallest relative decline in employment at 2.67 percent. Allegany County's unemployment rate still increased to 9.8 percent, and these data together may demonstrate that fewer of the county's residents have stopped looking for employment than in other counties. While unemployment is still very high, the above analysis shows that Allegany County has come through the recession better than most counties relative to labor force and employment changes.

Figure 1.12: Changes between 2007 and 2011 in Western Region Employment Statistics

Changes 2007-2011	Labor Force	Employment	Unemployment	Unemployment Rate
Allegany	2.3%	-2.67%	92.84%	88.46%
Garrett	0.01%	-4.64%	99.6%	97.77778
Washington	-2.25%	-8.58%	133.7%	140.90%
Average	0.02%	-5.3%	108.71%	109.04%

Source: Bureau of Labor Statistics

Garrett County performed similarly, seeing smaller relative declines in labor force activity than most counties and roughly a doubling of its unemployment rate in the period. Their separation from Washington County's growth may have shielded them from greater collapse, as their level of development did not reach the heights of Washington County's.

1.6 Southern Region

Figure 1.13: Changes between 2007 and 2011 in Southern Region Employment Statistics

2007	Labor Force	Employment	Unemployment	Unemployment Rate
Calvert	48,273	48,273	46,886	2.9%
Charles	76,970	76,970	74,690	3%
St. Mary's	51,512	51,512	49,957	3%
Total	176,755	171,533	5,222	2.95%

Source: Bureau of Labor Statistics

All three of the Southern Region's counties saw similar employment changes throughout the recessionary years. Calvert and Charles Counties both saw their unemployment rates double over the period, while St. Mary's grew by 103 percent (see Figure 1.15). Additionally, all three counties have very similar unemployment rates, all within 5.8 and 6.1 percent (see Figure 1.14). With regards to employment, the Southern Region has weathered the recession better than any other in the state. While the unemployment rates have still doubled, they are still lower than in most of the state.

Figure 1.14: Changes between 2007 and 2011 in Southern Region Employment Statistics

2011	Labor Force	Employment	Unemployment	Unemployment Rate
Calvert	47,446	44,695	2,751	5.8%
Charles	75,881	71,303	4,578	6%
St. Mary's	52,890	49,674	3,216	6.1%
Total	176,217	165,672	10,545	5.98%

Source: Bureau of Labor Statistics

Figure 1.15: Changes between 2007 and 2011 in Southern Region Employment Statistics

Changes 2007-2011	Labor Force	Employment	Unemployment	Unemployment Rate
Calvert	-1.71%	-4.67%	98.34%	100%
Charles	-1.41%	-4.53%	100.78%	100%
St. Mary's	2.67%	-0.56%	106.81%	103.33%
Average	-0.15%	-3.25%	101.98%	101.11%

Source: Bureau of Labor Statistics

2. Regional Medicaid Trends

2.1 Summary and Implications

Just as unemployment increases were widespread across the state, Medicaid enrollment increased dramatically in every region. This section of the report will detail the changes in Medicaid enrollment and eligibility by the state's regions and the implications that these changes bear on CHCs. Medicaid enrollment will be examined by county and by local access area in those areas for which this data was available.[2]

Overall Trends

Statewide, Maryland saw an increase of 238,646 Medicaid enrollees between 2007 and 2011, while eligibility increased by 245,543 patients over the same period. These are increases of 49 percent and 35 percent, respectively. This growth was brought on by two distinct forces: policy changes in 2007 that increased Medicaid eligibility to parents in families who are under 116 percent of the poverty level, as well as increasing unemployment caused by the recession. The Maryland Healthcare Coordinating Council estimates that 65,000 additional residents received Medicaid as a result of the 2007 policy changes,[3] which signals that the bulk of the new enrollees have been added as a result of the recession.

Of the state's regopms, the Eastern and Central Regions showed the fastest growth in Medicaid enrollment between 2007 and 2011, with six out of the seven fastest growing counties being in these regions. While the Central Region added many more enrollees than the Eastern Region (107,000 and 25,000, respectively), both contained counties that showed great growth in the need for safety-net healthcare services. Anne Arundel County, in the Central Region, in particular showed the most dramatic emerging need in the state, by adding over 18,000 new enrollees for a change of 70 percent in just five years.

An additional trend emerging is that inner-ring suburbs bordering either Baltimore or Washington generally added the greatest number of patients. Baltimore, Anne Arundel, Prince George's, and Montgomery Counties added 53 percent of the new Medicaid enrollees over the five year period. While these counties are all population centers so the percentage of total growth isn't shocking, it underscores the opportunities for CHCs to capture an emerging suburban Medicaid market. While these inner-ring suburbs accounted for much of the growth, the Eastern Region's Medicaid expansion, coupled with their massive unemployment growth, also shows extensive need for health services.

Certain counties in the state, specifically Anne Arundel and Montgomery County, have shown interesting results when their unemployment rates are taken into account. Both of these counties had some of the lower unemployment rates in the state (although still much higher than they featured in 2007), but also had two of the highest increases in Medicaid enrollment. This shows that the need for

[2] Local access area data is available for areas within Baltimore County, Baltimore City, Anne Arundel County, Harford County, Prince George's County, and Montgomery County.
[3] Maryland Healthcare Coordinating Council, Initial Report, 2010

safety-net services is being masked by the area's general prosperity; the growth in Medicaid shows that these counties have a large growing need for services.

Challenges and Opportunities

A nearly 50 percent statewide increase in Medicaid enrollment poses many challenges and opportunities for health centers. The opportunities are clear: with nearly 240,000 new patients throughout the state, CHCs can reach many more of their targeted patients. While many of these patients are clustered in the densest service center of Baltimore City (which added 33,000 new Medicaid patients), many of the new Medicaid patients are in Baltimore County, Anne Arundel, and Montgomery Counties (36,000, 32,000 and 18,000 new patients, respectively) where relatively fewer CHC services are available. This growth in the suburban counties offers many opportunities for CHC expansion.

However, while many of new Medicaid patients are clustered surrounding population centers, others have been equally dispersed across the state. This creates issues for CHCs attempting to attract new Medicaid-eligible populations. Especially in lower density exurban or rural communities that experienced large job losses over the last five years, reaching new patients over large geographies is a challenge.

Another prominent challenge for CHCs involves determining if the growth in their service areas will be permanent and if these patients will remain on Medicaid for years to come. It is possible, as the Maryland Healthcare Coordinating Council predicts, that the majority of the new enrollees will attain employer-sponsored insurance over the next five years as the economy recovers.[4] For this reason, it is important for CHCs to follow the trends in Medicaid enrollment in their counties and regions to ensure effective strategic planning.

2.2 Central Region

Figure 2.1: Medicaid Enrollment, 2007, 2011

County	2007	2011	Nominal Change	Percentage Change
Anne Arundel	25,944	44,269	18,325	70.63%
Howard	10,940	18,206	7,266	66.41%
Baltimore County	55,253	91,743	36,490	66.04%
Carroll	6,817	11,110	4,293	62.97%
Harford	14,415	21,559	7,144	49.55%
Baltimore City	134,837	168,476	33,639	24.94%
Total	248,206	355,363	107,157	43.17%

Source: Maryland eHealth Statistics

As unemployment grew during the recession, the need for government provided health insurance increased dramatically in the region. This increase is widespread across the region. Baltimore County

[4] Maryland Healthcare Reform Coordinating Council, Final Report

added the largest number of Medicaid recipients, 36,490, in the region between 2007 and 2011, an increase of 66 percent (see Figure 2.1). Baltimore City had the second largest nominal increase in Medicaid recipients, as 33,639 more residents receive Medicaid in 2011 over 2007. Due to the already very large size of Baltimore's Medicaid population, this percentage increase was the lowest in the region at roughly 25 percent.

Figure 2.2: Medicaid Eligibility 2007, 2001

COUNTY	2007	2011	Nominal Change	Percentage Change
Anne Arundel	38,918	57,730	18,812	48.33753
Carroll	10,587	15,070	4,483	42.34438
Howard	17,078	24,297	7,219	42.27076
Baltimore County	85,206	120,635	35,429	41.58041
Harford	21,150	28,020	6,870	32.48227
Baltimore City	188,782	228,157	39,375	20.85739
Total	361,721	473,909	112,188	59.42728

Source: Maryland eHealth Statistics

Anne Arundel County had the third largest nominal growth in Medicaid patients, 18,812, and the highest growth rate in the region at over 70 percent. This illustrates Anne Arundel County's growing need for health services, especially in the Northern area of the County, where 11,000 newly Medicaid eligible residents were added. This change was an increase of 49 percent between 2007 and 2011, and the highest increase of any local access area (see Figure 2.3). The southern area of Anne Arundel County also had a very high growth rate, but added a fewer number of eligible residents at 6,348. While some of this growth is due to Medicaid expansion, Anne Arundel County should be monitored by CHCs to see if its Medicaid rates remain high as the economy recovers.

Figure 2.3: Medicaid Eligibility by Central Region Local Access Area, 2007-2011[5]

	2007	2011	Nominal Change	Percentage Change
Anne Arundel North	22,897	34,175	11,278	49.25%
Baltimore County Northwest	27,819	37,902	10,083	36.24%
Baltimore City West	45,907	54,448	8,541	18.6%
Baltimore County East	21,513	29,940	8,427	39.17%
Baltimore City Southeast	22,982	31,356	8,374	36.43%
Baltimore City East	34,679	41,875	7,196	20.75%
Baltimore County Southwest	21,792	28,892	7,100	32.58%
Baltimore City Northeast	25,841	32,899	7,058	27.31%
Anne Arundel South	13,595	19,943	6,348	46.69%
Baltimore City South	18,693	24,370	5,677	30.36%

[5] Data by local access area is only available for higher populated counties, so Carroll County and Howard County are not included in this list

Baltimore County North	14,007	19,365	5,358	38.25%
Baltimore City Northwest	25,992	31,261	5,269	20.27%
Harford West	13,978	18,529	4,551	32.55%
Baltimore City North Central	16,627	19,270	2,643	15.89%
Harford East	7,255	9,588	2,333	32.15%

Source: Maryland eHealth Statistics

As mentioned above, at the local access area, Anne Arundel County had the most striking increase in Medicaid eligibility. Both Baltimore County and City showed large increases as well by local access area, with the exceptions of Northern Baltimore County, and South, North, and Northwest Baltimore City which showed more moderate growth in eligibility. Harford County also showed more moderate growth in Medicaid eligibility than most of Baltimore City, Baltimore County, and Anne Arundel County.

The large growth of Medicaid eligibility in Baltimore County and Anne Arundel County show, again, the growth of need in suburban counties where fewer services are available as compared to the inner cities.

2.3 Capital Region

Figure 2.4: Medicaid Enrollment, 2007, 2011

County	2007	2011	Nominal Change	Percent Change
Frederick	11,743	19,514	7,771	66.18%
Montgomery	53,605	85,901	32,296	60.25%
Prince George's	75,309	115,452	40,143	53.30%
Total	140,657	220,867	80,210	57.03%

Source: Maryland eHealth Statistics

Figure 2.4 shows that Medicaid enrollment rose drastically throughout the region between 2007 and 2011. Nominally, Prince George's County showed the largest increasing by adding 40,143 enrollees, an increase of 53.3 percent. Montgomery County also showed a very large increase in enrollment, adding 32,296 patients for an increase of over 60 percent. Frederick County, being the least populated in the region, only added 7,771 patients, but this number accounted for an increase of 66 percent. Frederick County's need grew considerably during the recession, as job losses have led to greater numbers who require public assistance.

Figure 2.5: Medicaid Eligibility, 2007,2011

County	2007	2011	Nominal Change	Percent Change
Frederick	17,399	25,442	8,043	46.23%
Montgomery	78,811	113,736	34,925	44.31%
Prince George's	102,074	141,382	39,308	38.51%
Total	198,284	280,560	82,276	41.49%

Source: Maryland eHealth Statistics

As Figure 2.5 shows, Capital Region Medicaid eligibility from 2007 to 2011 rose similarly to its enrollment, suggesting that most of the newly eligible patients are likely enrolling.

Figure 2.6: Medicaid Eligibility by Local Access Area[6]

	2007	2011	Nominal Change	Percent Change
Prince George's NW	51,900	71,585	19,685	37.93%
Mont. - Silver Spring Area	37,256	54,519	17,263	46.34%
Montgomery N	26,985	39,223	12,238	45.35%
Prince George's SW	24,280	33,905	9,625	39.64%
Prince George's NE	14,126	21,003	6,877	48.68%
Mont. Mid-County	15,927	21,010	5,083	31.91%
Prince George's SE	10,332	14,195	3,863	37.39%
Total	182813	257451	74,638	40.83%

Source: Maryland eHealth Statistics

At the local access area level, all of the available areas showed large relative increases. The Northwestern area of Prince George's County showed the largest nominal increase in Medicaid eligibility by adding 19,685 enrollees. Two areas in Montgomery County- the Silver Spring area and the northern part of the county (bordering Frederick County) showed very large increases 17,263 and 12,236 respectively. This again highlights the growing need in Montgomery County, and demonstrates that despite having the state's lowest unemployment rate, the need in this county is growing rapidly.

2.4 Eastern Region

Figure 2.7: Medicaid Enrollment in Eastern Region Counties, 2007,2011

County	**2007**	**2011**	**Nominal Change**	**Percentage Change**
Queen Anne's	3,020	5,207	2,187	72.42%
Worcester	4,147	6,905	2,758	66.51%
Cecil	9,010	14,820	5,810	64.48%
Kent	1,807	2,754	947	52.41%
Talbot	2,793	4,236	1,443	51.66%
Wicomico	12,206	18,277	6,071	49.74%
Caroline	4,667	6,861	2,194	47%
Somerset	3,368	4,782	1,414	41.98%
Dorchester	4,971	7,053	2,082	41.88%
Total	45,989	70,895	24,906	54.16%

Source: Maryland eHealth Statistics

[6] Data is only available at the local access are for some jurisdictions

As a result of the collapsing labor market in the Eastern Region, Medicaid enrollment has increased precipitously over the last five years for most of the region's counties. Every county had at least a 41 percent increase in enrollment between 2007 and 2011 (Figure 2.7). Even the more affluent county of Queen Anne's saw its Medicaid population increase by 72 percent in the period. Worcester County, which as noted above, had a nearly 200 percent increase in its unemployment rate and added over 2,700 new residents to Medicaid for a growth rate of 66 percent.

Figure 2.8: Medicaid Eligibility in Eastern Region Counties, 2007,2011

COUNTY	2007	2011	Nominal Change	Percentage Change
Queen Anne's	4,202	6,627	2,425	57.71%
Worcester	6,347	9,237	2,890	45.53%
Cecil	12,873	18,707	5,834	45.32%
Wicomico	17,282	23,481	6,199	35.87%
Talbot	4,211	5,721	1,510	35.86%
Kent	2,749	3,701	952	34.63%
Caroline	6,541	8,776	2,235	34.17%
Somerset	4,797	6,353	1,556	32.44%
Dorchester	7,233	9,432	2,199	30.4%
Total	66,235	92,035	25,800	38.95%

Source: Maryland eHealth Statistics

The sharp growth in enrollment and eligibility for Worcester and Cecil Counties coincides with dramatic rises in unemployment demonstrated earlier in the report. The growth in each county's enrollment poses challenges for CHCs trying to reach the region's disparate population.

2.5 Western Region

Medicaid Trends

Figure 2.9: Medicaid Enrollment in Western Region Counties, 2007,2011

County	**2007**	**2011**	**Nominal Change**	**Percentage Change**
Washington	13,773	21,579	7,806	56.68%
Allegany	8,093	11,956	3,863	47.73%
Garrett	3,910	5,358	1,448	37.03%
Total	25,776	38,893	13,117	50.89%

Source: Maryland eHealth Statistics

As with the unemployment figures, Washington County saw the biggest increase in Medicaid enrollment and eligibility in the region, adding nearly 8,000 enrollees for an increase of over 56 percent in five years. Allegany County, despite seeing less drastic declines in employment relative to the region, still

had nearly a 48 percent increase in Medicaid enrollment. Garrett County performed better than the other two counties, adding over 1,400 residents to Medicaid for a percentage increase of 37.

Figure 2.10: Medicaid Eligibility in Western Region Counties, 2007,2011

County	**2007**	**2011**	**Nominal Change**	**Percentage Change**
Washington	20,467	28,758	8,291	40.51%
Allegany	13,262	16,568	3,306	24.93%
Garrett	5,892	7,159	1,267	21.50%
Total	39,621	52,485	12,864	32.47%

Source: Maryland eHealth Statistics

2.6 Southern Region

Figure 2.11: Medicaid Enrollment in Southern Region Counties, 2007,2011

County	2007	2011	Nominal Change	Percentage Change
Calvert	5,192	8,511	3,319	63.92%
St. Mary's	7,527	12,020	4,493	59.69%
Charles	9,207	14,565	5,358	58.19%
Total	21,926	35,096	13,170	60.06%

Source: Maryland eHealth Statistics

As seen in the employment analysis, all three of the Southern Region's counties featured similar growth in Medicaid enrollment and eligibility. All three counties added Medicaid enrollees at rates between 58 and 64 percent. With relative size of each county taken into account, no county appears to have been harmed more than the others with regards to Medicaid growth. However, an average growth in Medicaid enrollment of 60 percent over five years is extremely high and demonstrates growth in need for service providers in these counties.

Figure 2.12: Medicaid Eligibility in Southern Region Counties, 2007,2011

County	2007	2011	Nominal Change	Percentage Change
Calvert	7,499	10,879	3,380	45.07%
Charles	13,437	18,750	5,313	39.54%
St. Mary's	11,091	15,092	4,001	36.07%
Total	32,027	44,721	12,694	39.63%

Source: Maryland eHealth Statistics

3. Employment and Health Insurance Markets

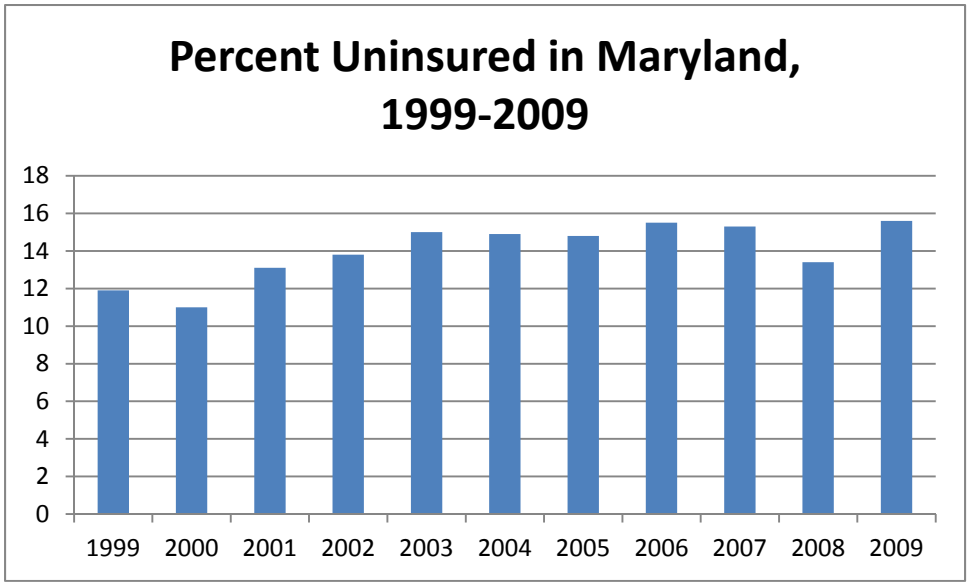
3.1 Summary and Implications

Since 1999, a reorganization in the ways Maryland residents receive health insurance has occurred. At the beginning of the last decade, a strong majority of residents under the age of 65 received their insurance through employers. Due to a variety of factors, a significant percentage of residents are no longer receiving this traditional means of insurance and are either receiving public insurance or becoming uninsured. This trend away from employee-sponsored healthcare has strengthened during the recession, and Medicaid enrollment has soared as a consequence. Concurrently, the percentage of residents who are uninsured has remained relatively stable throughout last seven years, implying that many of the newly uninsured received public insurance. This reorganization of employment and health insurance markets, with widespread implications for health care delivery and CHC operations, will be discussed in this section.

This reorganization of insurance markets has led to many environmental changes for CHCs. The adjustments over the last decade have furthered the need for safety-net healthcare services statewide, as prior research has demonstrated that those who lost employer-sponsored health insurance during the decade were likely to be low-income. The growth that these changes have caused in public insurance, especially in Medicaid, has been a boon for CHCs and will likely continue as the ACA is implemented. However, it will be important to monitor the changes in private/public insurance as the economy recovers. The Maryland Health Reform Coordinating Council expects that the percentage of residents with private insurance will increase as the recession cedes over the next five years. Thus, CHCs should incorporate these factors into strategic planning in coming years to gauge the permanence of growth in public insurance and the decline in employer-sponsored healthcare.

3.2 Examination of Employment and Health Insurance

Figure 3.1: Percentage of Maryland Residents without Health Insurance, 1999-2009

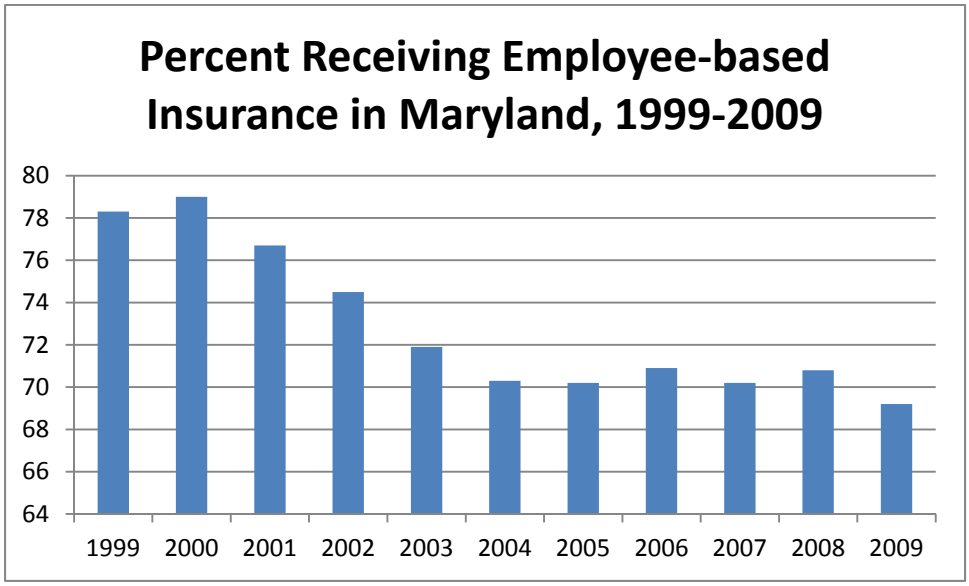


Source: U.S. Census, Health Insurance Coverage Statistics, 2010

In 1999, 11.9 percent of Maryland's residents were uninsured. By 2009, that number had risen to 15.6 percent, a rise of 31 percent.[7] Maryland's level of uninsured, while having risen between 2008 and 2009, has maintained at 15 percent between 2003 and 2009 with some variation. This change over the ten year period demonstrates a large increase in the need for safety net services. However, while the percentage of uninsured has increased, this change has not been as large as some of the other insurance market changes over the same period. Between 1999 and 2009, Maryland saw both very large decreases in the percentage that have employment-based health insurance and increases in the percentage that have Medicaid. As can be seen in figures 3.2 and 3.4, the impacts of the late-2000s recession have reverberated strongly in insurance markets.

[7] U.S. Census Current Populations Survey, 2010

Figure 3.2: Percentage of Maryland Residents with Employee-Based Health Insurance, 1999-2009



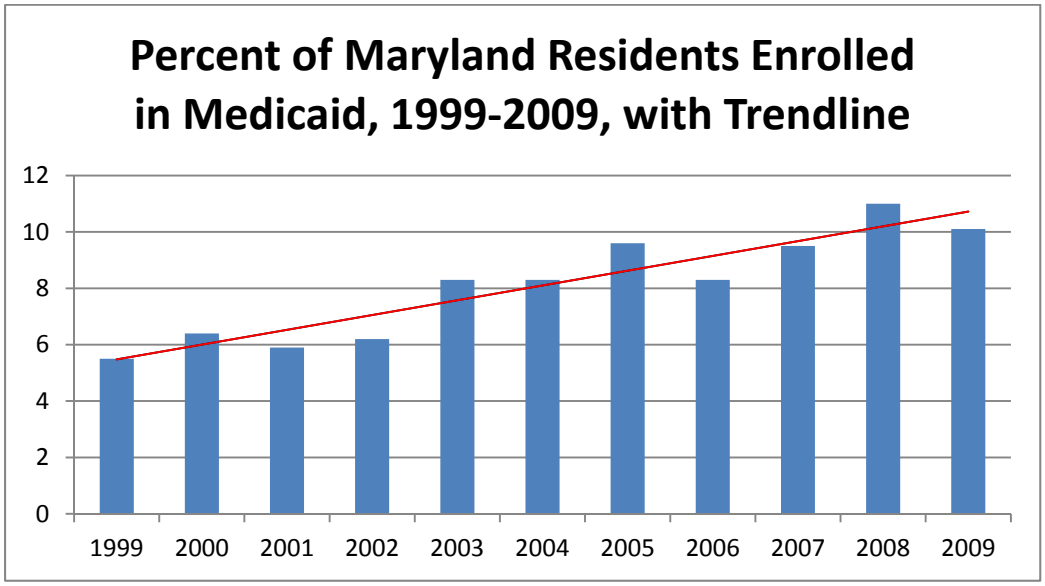
Source: U.S. Census, Health Insurance Coverage Statistics, 2010

Between 1999 and 2009, a nearly ten percentage point decline in the percentage of the under-65 population that has employment based insurance (from 78.3 to 69.2 percent) has corresponded with a rise in the percentage of under-65 residents who have public insurance (from 9.9 to 15 percent). The decline of employment-based health care began in the first years of the decade before and during the early-2000s recession. The decline had leveled out until 2009 where it dropped to its lowest level in the period due to the late 2000s recession.

The Kaiser Commission on Medicaid and the Uninsured examined this drop between 2001 and 2005 at the national level. Their study determined that 48 percent of the decline in employment-based insurance was due to employers no longer providing insurance, 27 percent due to employees not electing to receive benefits, 14 percent due to employees being ineligible for insurance, and 11 percent due to the loss of a spouse's insurance.[8] The report also concluded that the decreases in employee sponsored health insurance were greatest amongst low-income workers.[9] In summary, it was determined that most of the decline in employee-sponsored insurance in the first half of the decade was due to employers no longer offering health insurance to employees. An additional 14 percent of the change was due to insurance companies not accepting certain employees. Although the Maryland data only goes until 2009, it is assumed that much of the decline in employee-sponsored insurance between 2008 and 2009 was due to job losses and that these declines continued with greater unemployment. The job losses, in large part, contributed to a 1.6 percentage point drop in the percentage with employer-sponsored insurance between 2008 and 2009.

[8] The Kaiser Commission on Medicaid and the Uninsured, 2007
[9] The Kaiser Commission on Medicaid and the Uninsured, 2007

Figure3.3: Percentage of Maryland Residents Receiving Medicaid, 1999-2009



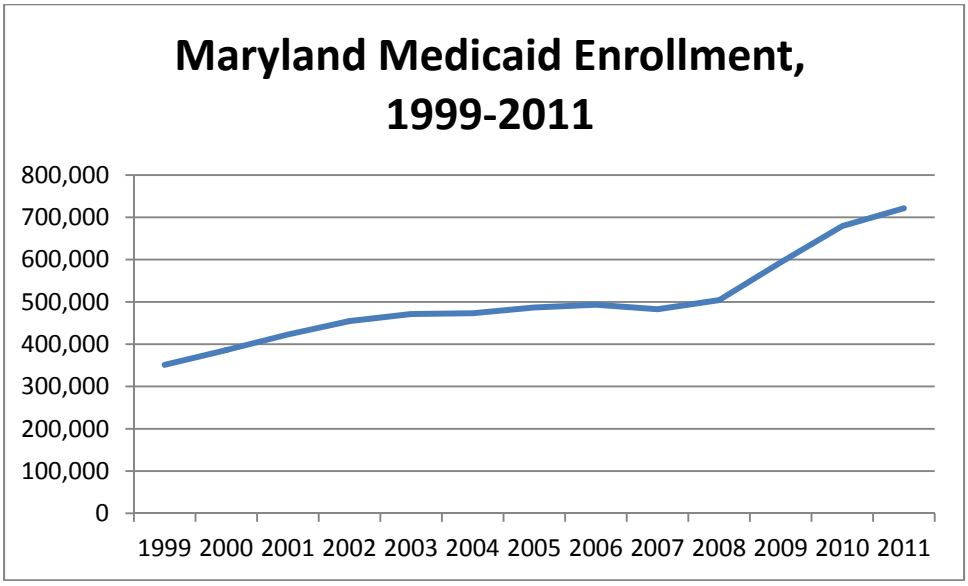
Source: U.S. Census, Health Insurance Coverage Statistics, 2010

With this large decline in employee-sponsored insurance has come an increase the percentage of residents who receive public insurance. The rise in public insurance for the population under age 65 is mostly comprised of Medicaid recipients, who increased from 5.5 to 10.1 percent of the population by 2009. The percentage of residents who have Medicaid has been rising steadily throughout the decade, but did not show a large change from the recession up to 2009 (see Figure 3.3). However, as viewed in Figure 3.4, Medicaid enrollment spiked considerably between 2009 and 2011. We can assume that with this growth in Medicaid enrollment, the percentage of residents who are enrolled in Medicaid has also grown since 2009.

In 2007, Maryland expanded Medicaid eligibility and enrolled an estimated 65,000 new residents in the program.[10] Between 2007 and 2009, Medicaid enrollment grew by nearly 111,000, with a large percentage representing growth from the expansion.[11] In 2009-2011, during the recession, Medicaid enrollment grew even further, adding over 127,000 new residents.[12] This rapid growth over 4 years is shown in Figure 3.4 below.

[10] Maryland Healthcare Reform Coordinating Council, Interim Report
[11] Maryland eHealth Statistics
[12] Maryland eHealth Statistics

Figure 3.4: Number of Maryland Residents Enrolled in Medicaid, 1999-2011



Source: Maryland E-Health Statistics

4. Estimated Effects of the ACA

4.1 Summary and Implications

Due to a variety of uncertain elements, it is difficult to estimate the effects of the ACA on the uninsured with the desired level of accuracy. However, in this section we have estimated, with the best available information, the impact that ACA implementation will have on CHC strategic planning. As a result of the complexity of the implementation, there are many scenarios that health centers should consider while planning for future growth.

Impact on the Uninsured
Based on estimates developed by the Maryland Health Reform Coordinating Council, the ACA's implementation will result in roughly half of Maryland's uninsured population gaining insurance by 2017. These newly insured will be covered by either Medicaid, Medicare (if aging past 65), private insurance through the exchanges, or employee-sponsored insurance if they attain employment. We estimate that the state will gain nearly 200,000 newly insured patients by 2017 that have incomes that are below 200 percent of the poverty level. Many of these uninsured under 200 percent of poverty may already be health center patients. Additionally, we estimate that over 253,000 uninsured residents with incomes over 200 percent of the poverty line will attain insurance.

Medicaid
The Medicaid patient population will grow as a result of the ACA. The total amount of growth from present day levels that will occur will be determined by the employment picture and the number of current Medicaid enrollees who attain private insurance by 2017. As a result of Medicaid's recent growth of nearly 50 percent in 5 years, the ACA will likely result in a lower net growth in Medicaid by 2017 than it would otherwise. This is due to the assumption that many of the new Medicaid enrollees will return to the workforce and attain employer-sponsored health care. If many current Medicaid patients do not attain employer-sponsored insurance by 2017, the growth in Medicaid will be higher than expected.

Implications
The uncertainty regarding the implementation of the ACA poses many challenges and opportunities for CHCs. While we can estimate the number of uninsured who will be covered in 2017, it is difficult to gauge with complete accuracy the outcomes of the new policy. With high unemployment inflating Medicaid, uncertainty about consumer behavior, and the exact nature of the exchanges yet to be determined, there are many unanswered questions about the ACA's outcomes.

As they are tied to the ACAs outcomes, CHCs must be vigilant about monitoring employment, Medicaid, and policy trends in the state, their regions, and local areas. With the number of Medicaid patients in an area being dependent on levels of unemployment, it is critical that CHCs measure these factors leading up to and beyond the implementation of the ACA in 2014. If Medicaid levels are dropping and employment is increasing in the CHC's area, it would indicate that the economy is recovering as estimated. However, if the opposite is occurring, it may indicate that Medicaid enrollment might be larger than estimated in your area. Regardless of the final number, CHCs will see increases in Medicaid enrollment in their communities by 2017. The above trends are examples what indicators will be important to follow in upcoming years.

The state will see a large number of newly insured patients who have incomes below 200 percent of the federal poverty line. These patients will hopefully now be able to pay for health services at CHCs and

allow CHCs to increase their revenue streams. With these newly insured, CHCs must work to ensure that currently uninsured patients who obtain insurance through the health exchanges continue to seek care at their centers.

4.2 ACA Implementation Analysis

The upcoming implementation of the Patient Protection and Affordable Care Act (ACA) will further alter insurance markets. With the recent changes in health insurance composition and the uncertainty of ACA policy implementation, making predictions about the effects of the ACA have proven difficult. However based on prior research, we can make rough estimates on the short to medium term outcomes of the policy. According to the Maryland Health Care Coordinating Council's estimates, the changes in insurance brought on by the PPACA will lower the percentage of non-elderly uninsured by over 50 percent, from roughly 14 percent to 6.7 percent by 2017.[13] These 7.3 percent of newly insured nonelderly residents will gain coverage through four possible avenues: the new health exchanges, Medicaid, employee-sponsored healthcare for those who have found new employment, or Medicare for those aging beyond age 64.

Due to the aforementioned increases in the level of Medicaid eligibility and the recession, Medicaid enrollment increased by roughly 50 percent over four years, with overall eligibility increasing by 35 percent.[14] Because of Maryland's recently expanded eligibility policies, families who earn less than 116 percent of the federal poverty level are already eligible for Medicaid. Thus, the ACA expansion of Medicaid eligibility to all residents who earn less than 133 percent of the federal poverty level will bring fewer residents into the system than in many other states. Moreover, the effects of the ACA will appear to be smaller over time as many who are currently on Medicaid will be phased back onto employee-sponsored insurance over the next 5-10 years.[15]

The Maryland Health Care Coordinating Council estimates a net increase in Medicaid patients of 68,800 by 2017. This 68,800 is in addition to those who have been added throughout the last five years and includes a 6.9 percent population growth rate.[16] The actual number of new Medicaid entrants via the ACA is higher, but this number is obscured by the high volume of Medicaid recipients that are expected to regain health insurance through employers as the economy recovers. The Maryland Health Care Coordinating Council also estimates that approximately 179,800 residents will join the healthcare exchanges created by the ACA, while 205,000 residents will age into Medicare.[17]

[13] Maryland Health Care Coordinating Council, Final Report, 2010
[14] Maryland eHealth Statistics
[15] Maryland Health Care Coordinating Council, Final Report, 2010
[16] Maryland Health Care Coordinating Council, Final Report, 2010

[17] Maryland Health Care Coordinating Council, Final Report, 2010

The actual number of unemployed Medicaid patients who will return to private health insurance will depend on a number of factors, including location and economic growth. If the economy recovers as expected, many of the recent Medicaid additions will return to private insurance over the next five to seven years; if the economy stagnates and does not endure a sustained recovery, enrollment could remain inflated for years to come. Additionally, geographic areas that were disproportionately harmed by the economy might see slower growth and a smaller drop in Medicaid enrollees than other areas.

4.3 Limitations of Income-Level Assessments

In the following sections, we will present estimates of the number of residents who will receive coverage through the ACA by their income brackets. As a result of the difficulty of predicting a policy when one of its main features, the healthcare exchanges, hasn't been developed yet, there are many limitations to projecting the outcomes of the ACA. First off, we do not know the exact plans for the health exchanges, so it is unclear how they will impact enrollment. Additionally, we do not know how consumers will behave when confronted with the new choices presented in the ACA. Consumers may behave differently than expected depending on income level, educational background, or any number of factors. Also, the uncertainty around the economic recovery poses large problems for projection. The employment picture has a large effect on the number of patients who will be enrolled in Medicaid and also on the number of residents who are under 200 percent of the poverty level. With that being said, the following estimates are made with the best possible information available and can provide a snapshot of what may happen by 2017 as a result of ACA implementation.

4.4 Assumptions for Income-Level Estimates

In making the following estimates regarding the ACA's impact on uninsurance by poverty level, we have to make a number of assumptions:

- The Maryland Healthcare Coordinating Council's estimates of roughly 52 percent of uninsured residents will receive health insurance through the ACA by 2017 are accurate.
- Population growth will be 6.9 percent by 2017, as estimated by the Maryland Healthcare Coordinating Council, and the uninsured population will grow at the same rate.
- The breakdown of the uninsured population by income level is considered to be the same as identified by the Maryland Healthcare Commission in 2007 (see Figure 4.1).
- For the county projections, it is assumed that the 2009 U.S. Census estimates of county income breakdown are accurate and will remain constant.

4.5 Estimates for ACA Impact on the Uninsured by Income Level

Figure 4.1: Uninsured Distribution by Age and Poverty Level, 2005-2006

Age	**Poverty Level**			
	0-200%	200-400%	400%+	All
0-18	9%	5%	3%	17%
19-34	16%	16%	8%	41%
35-64	19%	14%	10%	42%
All	44%	35%	21%	100%

Source: Maryland Healthcare Commission, 2007

As shown in Figure 4.1, 44 percent of the state's uninsured residents have incomes below 200 percent of the federal poverty line, while 66 percent have incomes over 200 percent of the poverty line. Using these data along with the Maryland Health Care Coordinating Council's projections, we can estimate the number of residents who will attain insurance by income group. As Figure 4.2 demonstrates, an estimated nearly 452,200 Maryland residents will be newly insured by 2017. Nearly 200,000 of these are estimated to have incomes under 200 percent of the poverty level, while about 253,232 are estimated to have incomes over 200 percent of the federal poverty level.

Figure 4.2: Newly Insured Residents, Current Estimates[18]

Estimated Uninsured 2011	812,000
Newly insured by 2017	452,200
Newly insured under 200%	198,968
Newly insured over 200%	253,232

*Estimates derived using analysis from the Maryland Healthcare Reform Coordinating Council and the Maryland Healthcare Commission

As described above, these newly insured patients will be divided into four methods of insurance procurement: the health exchanges, Medicaid, Medicare, or private insurance. The residents whose incomes are under 200 percent of poverty are more likely to enter the exchanges or attain Medicaid coverage, although some will attain private, employee-sponsored insurance as the economy recovers. Those residents who have incomes over 200 percent of poverty will most likely either attain insurance through the exchanges or privately through employers. A large portion of these uninsured, covering all income brackets, will also age into Medicare as the baby boomers old age.

Using the current income distribution throughout Maryland's counties, we can make rough estimates as to the number of residents who will receive insurance by 2017. These results are detailed by region below:

[18] 2017 projections include an estimated population growth of 6.9 percent from current levels

Figure 4.3: Estimated Newly Insured Central Region Residents by Poverty Level, 2017[19]

	0-200%	>200%
Anne Arundel	13,420	24,875
Baltimore County	29,994	34,488
Harford	7,025	11,350
Howard	4,936	14,135
Baltimore City	44,920	20,183
Carroll	4,853	8,014
Total	105,148	113,044

Figure 4.4: Estimated Newly Insured Capital Region Residents by Poverty Level, 2017

	0-200%	>200%
Frederick	5,828	10,866
Montgomery	21,368	47,094
Prince George's	24,554	39,385
Total	51,749	97,346

Figure 4.5: Estimated Newly Insured Eastern Region Residents by Poverty Level, 2017

	0-200%	>200%
Caroline	1,508	1,335
Cecil	3,584	4,417
Dorchester	1,843	1,144
Kent	1,119	741
Queen Anne's	1,264	2,242
Somerset	1,693	869
Talbot	1,433	1,557
Wicomico	4,593	3,667
Worcester	2,338	1,973
Total	19,375	17,944

[19] Methodology for projections: Using the Maryland Healthcare Reform Coordinating Councils estimates of percentage uninsured who will become insured by 2017, I calculated, using Census data, an estimate for the percentage of residents in each county who are below and above 200 percent of poverty. Using a survey in Maryland conducted by the Maryland Healthcare Commission that estimated the breakdown of Maryland's uninsured by income level, I estimated the total number of the state's uninsured that will attain insurance by poverty level. I then multiplied these numbers by the already calculated percentage of residents below and above 200 percent of the poverty level to attain my result.

Figure 4.6: Estimated Newly Insured Western Region Residents by poverty level, 2017

	0-200%	>200%
Allegany	5,302	2,215
Washington	7,098	5,708
Garrett	1,775	1,053
Total	14,175	8,975

Figure 4.7: Estimated Newly Insured Southern Region Residents by Poverty Level, 2017

	0-200%	>200%
Charles	3,339	6,911
St. Mary's	3,052	4,682
Calvert	2,129	4,329
Total	8,520	15,923

Limitations of Report

This report, although completed with the best available data, contains many limitations. With regards to trends in private insurance and uninsurance, data is only available up to 2009. It would be ideal to have 2011 data to fully measure the impacts of the recession on these variables. As mentioned above, many limitations exist with regards to estimating the effects of the ACA. Much of the analysis we conducted was based on the Maryland Healthcare Coordinating Council's estimates and prior research conducted by the Maryland Healthcare Commission. As noted in the assumptions section before the ACA analysis, in order to produce any estimates at all, many assumptions about the next five years have to be made. These uncertainties engender limitations for the report, as a number of factors, including future economic shocks, policy changes, or consumer behavior could change the course of the ACA's implementation at any given time. For these reasons, this report should be used a guide to help frame CHC's strategic planning processes with the understanding that many uncertainties in the marketplace still exist.

Conclusions

The macro economy has had immense effects on employment in Maryland in recent years. In turn, Maryland's healthcare landscape has undergone major shifts as well. For CHCs, these changes, coupled with the upcoming implementation of the Affordable Care Act, require adjustments in strategic planning. The major findings of this report are as follows:

- Unemployment from the recession has led to changes in health insurance as more residents attain public insurance
- All counties were heavily impacted by the recession, but those in rural and exurban areas have experienced the largest shocks to employment
- Throughout the past decade, a lower of percentage of residents have received employer-sponsored health insurance, and the recession furthered this trend
- Participation in public insurance has grown during the decade, and Medicaid has grown significantly during the recession
- While Medicaid increases were widespread across the state, over 50 percent of the new Medicaid enrollees are in the suburban counties of Montgomery, Prince George's, Anne Arundel, and Baltimore
- Some counties' relatively low unemployment rates, specifically Montgomery, Anne Arundel, and Queen Anne's are masking the safety-net need, as determined by the large growth of Medicaid enrollment in these counties
- Effects of the ACA on Medicaid are largely dependent on unemployment trends over the next five years
- If the economy recovers as expected, many current Medicaid patients will attain employer-sponsored insurance and the net effect on Medicaid will be relatively small due to recent growth in Medicaid
- New entrants to insurance markets by 2017 will receive insurance either through Medicaid, the healthcare exchanges, employer-sponsored care, or Medicare for those who age into the program
- An estimated 200,000 uninsured residents under 200 percent of poverty are estimated to receive insurance by 2017 via the ACA, with an estimated 250,000 over 200 percent of the poverty line becoming insured

These changes carry immense implications for Community Health Centers. These major implications are as follows:

- As unemployment directly affects public insurance markets, it is important for CHCs to monitor employment trends in their areas to gauge the need for services
- Inner-ring suburban counties offer CHCs opportunities for further expansion as a result of extensive Medicaid growth
- The widespread growth of Medicaid, especially in suburban and exurban regions will require CHCs to reach patients over a wider geographic area

- Opportunities for expansion exist in areas where the need has grown dramatically and Medicaid and unemployment do not subside in upcoming years
- To strategically plan for Medicaid's growth from the ACA, CHCs should monitor unemployment and Medicaid enrollment to gauge the number of patients returning to employer-sponsored care
- If the economy recovers and Medicaid patients leave the program in a CHC's service area, the CHC should expect only modest net growth in Medicaid patients via the ACA
- With nearly 200,000 residents under 200 percent of poverty expected to attain insurance by 2017, CHCs should actively work to attract and retain patients who join the health exchanges

Resources

Unemployment Data for Maryland Communities:
http://www.dllr.state.md.us/lmi/laus/

U.S. Census Data: http://factfinder.census.gov

Maryland Medicaid Data: http://chpdm-ehealth.org/