MHCC MARYLAND HEALTH CARE COMMISSION

Report on Health Policy Options

Including:

- Uninsurance Among Young Adults
(in response to HB 1057)

- Personal Responsibility
(in response to HB 572)

- Health Insurance Exchange
(in response to the Chairmen's letter)

January 1, 2008

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Report on Health Policy Options

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INTRODUCTION

The Maryland Health Care Commission is pleased to submit its *Report on Health Policy Options* to the Governor and General Assembly. This report is a confluence of several streams of activity.

This report represents a summary of the Commission's work on broad health policy issues extending over the past two years. At the outset, Commissioners asked that Commission staff analyze a series of policy issues involved in relatively comprehensive reform proposals such as the Massachusetts plan to determine whether a similar plan might be appropriate for consideration in Maryland.

During the last regular session of the General Assembly, Commission staff presented its analysis of a comprehensive reform proposal encompassing market reform, a health insurance exchange, personal responsibility, and low income premium subsidies. That proposal, designed to identify an upper bound of cost, proved to be both highly effective and unaffordable. The second year of analysis examined a series of modifications that would target subsidies more effectively, reducing the cost substantially while still achieving near universal coverage.

Also during the last regular session of the General Assembly, two bills were enacted requiring the Commission to analyze specific health policy options aimed at expanding coverage. HB 572 requires the Commission to submit a report on personal responsibility proposals, addressing a specific set of questions. HB 1057 requires the Commission to submit a report on the high prevalence of uninsurance among young adults and to examine options to insure more young adults.

In addition, the Chairs of the Senate Finance and House Health and Government Operations Committees sent a letter to the Commission asking for an analysis of the feasibility and desirability of establishing a health insurance exchange, with answers to a specific series of questions about exchanges.

Because these three policy options are interrelated and part of a larger set of issues relating to escalating health care costs, variable health care quality, and problems with access to health care, the Commission requested and the Chairs granted permission to write a single report encompassing all these issues and options.

Finally, the General Assembly and the Governor took a major step toward covering the uninsured in Maryland by enacting Senate Bill 6 during the 2007 Special Session. This act expands Medicaid coverage first to parents in families up to 116 percent of the federal poverty level and then to childless adults at the same income levels. It also provides substantial premium subsidies for employers and employees in small businesses not currently offering health insurance, provided they meet specific size and income requirements. We hope that this report will contribute to discussions about the logical next steps in expanding coverage while improving quality and controlling the rise in health care costs.

CHALLENGES

Maryland is blessed with a wealth of medical resources, including superbly trained professionals, excellent hospitals, outstanding academic medical centers, a model trauma response system, the world's premier medical research organization, and a unique approach to controlling the costs of hospital care. At the same time, Maryland faces the same problems that afflict other states: rapidly rising health care costs, uneven health care quality, and limited access to health care for the uninsured. These are not new problems -- and they will not be solved with short-term solutions. To this end, The Maryland Health Care Commission has conducted an aggressive program of health policy analysis to define the issues confronting our health care delivery system and to identify the strengths and weaknesses, the costs and savings, and the effects on access of a range of reform proposals.

Cost and Quality Concerns

The cost of our health care system is substantial – one-sixth of the economy and a larger percentage and amount per person than anywhere else in the world. The Centers for Medicare and Medicaid Services (CMS) estimates the total health expenditures for the U.S. to be $2.16 trillion in 2006, and projects these expenditures to rise to over $4 trillion in 2015.[1] Public and private health care expenditures in Maryland totaled $30.2 billion in 2005, up by about $2.1 billion, or seven percent from 2004.[2] Medicare (21%) and Medicaid (18%) accounted for 39 percent of total health care spending in 2005, compared to 40 percent paid by private insurance arrangements.

Insurance premiums are also rising rapidly. According to the ninth annual Henry J. Kaiser Family Foundation/HRET Survey of Employer-sponsored Health Benefits, the average premium for family coverage in the U.S. rose 6.1 percent in 2007, which is lower than the 7.7 percent increase for 2006 but still much higher than the overall rate of inflation (2.6%) or the increase in workers' earnings (3.7%).[3] While premiums continue to rise, this is the fourth consecutive year in which premium increases were less than they were in the previous year. Overall, health insurance premiums have risen 78 percent since 2001.[4] The average cost of premiums for single coverage in 2007 is $373 per month or $4,479 per year. This figure includes both the worker and employer contribution. The average cost of premiums for family coverage is $1,009 per month or $12,106 per year.[5]

Part of the high cost reflects our superb acute care system, including highly-skilled and well-compensated professionals and early access to new technology. Health care expenditures are

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[1] Borger, C. et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs*, *Web Exclusive*, March/April 2006.
[2] Maryland Health Care Commission, *State Health Care Expenditures: Experience from 2005*. Feb. 2007.
[3] Claxton, G. et al. "Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, While Offer Rates and Enrollment Remain Stable." *Health Affairs*. September/October 2007. 26(5): 1407-1416.
[4] Ibid.
[5] Ibid.

also high because of the lack of the usual incentives to pay attention to value and cost. Both the patient and the doctor – the people most involved in deciding on care – have been insulated from the true cost of health care by our third party payer system, by insurance designs, and by tax policies that encourage inefficient spending.

In spite of high expenditures, there are major problems with health care quality. A significant amount of clinical care delivered appears to be of relatively low value. Patients receive the diagnostic studies or treatments that are recommended by professional guidelines only half of the time. Medical errors are too common. The Institute of Medicine estimates that 48,000 - 96,000 Americans die each year in hospitals due to medical errors.[6] Low quality care and medical errors not only produce bad outcomes but also increase health care costs.

Many analysts believe that strategies to address health care costs and health care quality need to be more closely linked – and that efforts to broaden access to health care must be accompanied by aggressive efforts to focus expenditures on the procedures, the treatments, and the providers that produce greater value for the money spent.

While there are no magic bullets to slow the growth of health care expenditures and to improve the quality of the care delivered, promising strategies include:

- incentives to patients to promote preventive care and to encourage healthier lifestyles, effective weight management, and smoking cessation;
- realignment of both patient and provider incentives to encourage higher quality and better outcomes, choices based on value, and better management of chronic diseases;
- the use of health information technology and electronic health records to improve quality and prevent errors; and
- better evidence of effectiveness and cost-effectiveness, enabling innovations in benefit design, including tiered services and tiered provider networks based on value.

These points were particularly well explicated in two recent editorials in the New York Times[7] and in a recent report by the Commonwealth Fund analyzing the impact of 15 policy options to address health care costs, including:

- widespread adoption of health information technology and health information exchange to improve quality and facilitate appropriate care,
- development of a public-private center to assess which treatments work best for which patients, deterring the use of high cost/low value alternatives and interventions with a weak evidence base,
- reform of physician payment systems to emphasize payments for episodes of illness and chronic disease management rather than payment for individual services, and
- limiting Medicare payments in areas of the country with practice patterns that result in higher costs without apparent improvements in outcomes.

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[6] Institute of Medicine. *To Err is Human: Building a Safer Health System*. Nov. 1999. http://www.nap.edu/books/0309068371/html/

[7] "The High Cost of Health Care," *New York Times*, November 25, 2007 and "Slowing the Rise in Health Care Costs," *New York Times*, December 20, 2007.

The Commission agrees that health information technology and health information exchange are vital to the success of many cost and quality initiatives and has been actively involved with stakeholders in developing viable strategies in Maryland.

The Commission also agrees that better assessment of the value - the cost-effectiveness - of interventions is essential to targeting our health care spending more effectively. Centers for technology assessment already exist and are used by health plans in establishing coverage policy. The fundamental impediment to value based decisions about coverage is public resistance to limitations on access to "promising" options, whether recommended by their physician, their internet resource, or the most recent direct-to-consumer advertising. The challenge will be two-fold:

- develop the knowledge base and the professional consensus to link assessments of value or cost-effectiveness to incentives, and
- develop public support for the concept that our shared finances – the premiums we pay for private coverage or taxes we pay to support public programs – should preferentially be used for high value, proven health care.

Using this strategy, high cost treatments with limited benefit would either not be covered or would receive less support from these shared resources. Ideally, rather than using the hard "no" of non-coverage that evoked the backlash against managed care, the strategy would use a soft "yes, but your cost sharing will be much higher." While this approach allows higher income individuals better access to low value or unproven care, it may make it easier both to afford insurance and to expand coverage to the currently uninsured. The uninsured currently face a major access barrier to both high and low value care; this strategy coupled with coverage expansions could improve their access to high value care while disincentivizing low value or unproven care for all. Coverage of experimental treatments of high cost and unproven benefit could be limited to those participating in randomized controlled clinical trials, receiving the possibility of experimental treatment in exchange for helping researchers determine the true value of the treatment.

Developing the knowledge base and the consensus will not be easy. Health information technology will be essential to this effort in two ways: health information exchanges will be essential to gather real-world data about what works for whom, at what cost, and with what complications, and electronic health records with decision support will be essential to delivering information and incentives to the time and place of care.

Finally, reform of provider reimbursement will pose a substantial challenge, but relatively low reimbursement rates in Maryland coupled with some evidence of higher rates of utilization of some services suggest an opportunity for health plans to address both concerns through changing their reimbursement strategies, preferably in close collaboration with both public payers and providers. The Task Force on Health Care Access and Reimbursement will provide one avenue to examine reimbursement approaches. Ongoing efforts by private and public payers both in Maryland and nationally to develop meaningful pay for performance / pay for value programs offer another.

Access and the Uninsured

Approximately 780,000 Marylanders (14.2% of the total population) did not have health insurance from 2004-2005, according to the Current Population Survey (CPS). These estimates probably correspond best to individuals who are uninsured for more than four months during the year. The number of Maryland residents who are uninsured for the entire year is lower – between 450,000 and 650,000. The number who are uninsured at any time during the year is higher – from 1 to 1.1 million individuals. Despite the variation in the number of uninsured, there are notable trends. From 2000 to 2005, employment-based coverage declined from 77 percent of Marylanders to 69 percent. Conversely, the Medicaid rate rose during this time period from 6 percent to 9 percent.

In order to target our efforts effectively it is essential to understand several key facts about the uninsured in Maryland.[8] Contrary to the expectations of many, most of Maryland's uninsured are working adults. In fact, over 83 percent of the uninsured are in a family with one or more worker. Since small firms are less likely than larger firms to offer coverage, it is not surprising that over 42 percent of the working uninsured are employed by firms with fewer than 25 workers. Even though nearly all large firms offer health coverage, over 14 percent of the working uninsured are employed at firms with more than 500 workers. Almost 9 percent of the working uninsured are government employees.

There are substantial numbers of uninsured at every income level. The largest proportion (47%) consists of individuals who have a household income of less than 200 percent of the federal poverty level, roughly $20,000 for an individual and $40,000 for a family of four. A surprising proportion (16%) is in families with incomes of above 400% FPL. Certain populations with historically high uninsured rates continue to be less likely to have health care coverage. For example, young adults ages 19 to 29 are less likely to have health insurance than children or older adults. Over 28 percent of Marylanders in this age group were uninsured at any given point in 2005. The most common reason for being uninsured is the high cost of coverage. Even those who have access to coverage and can afford to pay for it may still decline to purchase health insurance because they perceive it to have low value for the price charged.

Medicaid is a crucial part of the state's safety net for low-income families. In Maryland, coverage for low income adults and children varies greatly. The State offers very generous coverage for children through Medicaid and the Maryland Children's Health Program (MCHP). Conversely, prior to the enactment of the Working Families and Small Business Health Coverage Act (Senate Bill 6 of the 2007 Special Session), Maryland had one of the lowest Medicaid eligibility rates for parents among all states at just 39 percent of the federal poverty level. Barring disability, single adults without dependent children would not qualify for Medicaid. As a result, many low-income working parents, who make up a significant portion of Marylanders without health insurance, were ineligible to receive full Medicaid benefits. Enactment of Senate Bill 6 was a crucial step in expanding coverage to Maryland's uninsured.

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[8] All uninsured figures are based on the Maryland Health Care Commission report, *Health Insurance Coverage in Maryland Through 2005*. Jan. 2007.

While the implementation of MCHP has proven successful in enrolling additional children, an estimated 140,000 children were uninsured from 2004-2005, of whom a substantial number were likely eligible for Medicaid or MCHP but are not enrolled. Maryland also operates a Primary Adult Care (PAC) Program which provides limited coverage to childless adults and parents not eligible for full Medicaid coverage. Even with the access provided through the PAC program, many adults lack comprehensive coverage. Senate Bill 6 helps address these major gaps in access to affordable health insurance. An extensive body of research shows that covering low-income parents increases enrollment by eligible children in health insurance programs, thereby reducing the number of children who are uninsured. Parental coverage also increases the likelihood that they will seek health care services for their children.

There is a well-documented connection between insurance coverage and access to care and health. The Institute of Medicine recently concluded that "the relationship between health insurance and access is well established."[9] The IOM concluded that as a result of un- and underinsurance, families are less likely to receive preventative and screening services; receive fewer and less timely services; have increased morbidity and are in poorer health. The growing number of uninsured reduces access to many health care services, contributes to poor health and increases the cost of health care.

Based on figures presented in a 2003 report of the Johns Hopkins Bloomberg School of Public Health and Maryland Department of Health and Mental Hygiene, MHCC estimates that the FY 2007 indirect cost of non-insurance, which is largely due to poorer health, financial insecurity, and decreased productivity of uninsured individuals, is between $1.4 and $2.9 billion.[10,11] Direct costs can be calculated with greater certainty. Maryland State government will spend $439 million, mostly through public health programs, but also through $34 million in increased hospital rates. The Federal government will spend $239 million in increased hospital rates and $195 million in public health and federally-qualified health center expenditures. Local governments will spend approximately $14 million while private insurance companies will pay $165 million in increased hospital rates, amounts passed on to employers and individuals in higher premiums. Private physicians are estimated to contribute approximately $295 million in uncompensated care of the uninsured. Out of pocket expenditures by the uninsured themselves amount to $445 million, bringing the direct cost to care for the uninsured to roughly $1.8 billion annually. The Health Services Cost Review Commission (HSCRC) estimates that approximately $350 of the estimated average annual family premium of $13,000 is attributable to hospital uncompensated care in Maryland. While this figure only reflects the hospital component of uncompensated care, other components include uncompensated care paid by Maryland families either through cost shifting by other providers, which results in higher premiums, or through an increase in state or federal taxes to pay for an increase in expenditures of public programs.

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[9] Institute of Medicine. *Care without Coverage: Too Little Too Late*. 2002. http://www.iom.edu/File.aspx?ID=4160

[10] Johns Hopkins Bloomberg School of Public Health and Maryland Department of Health and Mental Hygiene: *Maryland HRSA State Planning Grant: The Costs of Not Having Health Insurance in the State of Maryland.* Dec. 2003. http://statecoverage.net/statereports/md26.pdf

[11] Note: these figures were presented for FY03 and inflated to FY07 estimates.

QUALITY, OUTCOMES & VALUE INITIATIVES

The United States spends far more on health care than any other country in the world, both on a per capita basis and as a percentage of GDP. In spite of this, one in seven Americans is uninsured, measures of population health such as infant mortality give great cause for concern, recommended care is often not delivered, medical errors are too frequent, and outcomes are largely unrelated to costs. Our acute care system is superb in many ways, but our care for chronic diseases is fragmented and leaves much to be desired. These simple observations suggest fundamental problems in our care delivery system: poor communication and integration, faulty priorities, and misaligned incentives. They also suggest that we have a problem with low value health care.

Many initiatives exist that address aspects of this cost and quality problem. Public reporting of cost and quality measures can be an essential stimulus to improvement. The Commission's Consumer Guides to hospitals, nursing homes, and health plans, together with other public and private sector organizations, provide consumers with quality and, to a lesser extent, cost information to help guide their choice of providers. The Maryland Patient Safety Center has undertaken a series of ambitious quality improvement projects involving both process reengineering and objective measurement of results. Multiple stakeholders are working to implement electronic health records and health information exchange to improve quality, reduce costs, and provide the potential for better care coordination and a virtually integrated care system. But there is a need for a broader perspective.

Recently, Governor O'Malley signed an Executive Order establishing the Maryland Health Quality and Cost Council to coordinate best practices of the private and public sector to improve health care in our State.[12] The Maryland Health Quality and Cost Council, which will be chaired by Lieutenant Governor Brown, shall do the following:

- coordinate and facilitate collaboration on health care quality improvement and cost containment initiatives;
- make recommendations on health care quality and cost containment initiatives and priorities to various policy makers, governmental entities, professional boards, the Maryland Patient Safety Center, industry groups, consumers, and other stakeholders;
- develop a chronic care management plan to improve the quality and cost-effectiveness of care for individuals with, or at risk for, chronic disease;
- facilitate the integration of health information technology in health care systems; and,
- examine and make recommendations regarding other issues relating generally to the Council's mission to improve health care quality and reduce costs in the State.

This Council will provide a forum for stakeholders to take a hard look at cost and quality problems, to assess a wide range of proposed quality improvement and cost-control

[12] Office of Governor Martin O'Malley. Executive Order 01.01.2007.24. "Maryland Health Quality and Cost Council." http://www.governor.maryland.gov/executiveorders/01.01.07.24eo.pdf

initiatives, and to propose the most promising strategies. The sections below outline several of these possible strategies.

Promote Higher Value in Health Care Expenditures

Consumer Incentives. Adjusting how our society thinks about health care by reconnecting patients with cost and value is viewed by many as a means to help address the rising cost of health care. Contrary to initial perceptions, this is not intended to shift costs to the patient. It does mean that we need to design benefits to encourage choices based on value. Smart incentives, such as tiered pharmacy and hospital plans based on relative value and quality can help guide decisions. Decision-support tools can help both patients and doctors make complex medical decisions using the best available evidence, taking cost and quality into account.

Another important option, consumer-directed health care, particularly the use of individually-owned, tax-advantaged, portable Health Savings Accounts linked to low-cost, high-deductible health plans – may be a vehicle to change how individuals think about routine health care expenditures, helping make them more value-conscious. Some automatic funding of the HSA each year through a combination of employer and employee dollars may help address the concern that some individuals, particularly lower income, may be deterred from seeking needed care, in addition to being deterred from seeking unneeded care.

Provider Incentives. Consideration should also be given to current payment systems that tend to discourage quality improvement efforts and in some cases reward errors. For example, a physician practice that invests in a diabetes management program that reduces the need for office visits will lose money under fee-for-service plans, just as hospitals that reduce complications that lead to readmissions will lose revenue. Rewarding clinically effective care through financial incentives could help to improve care. These incentives addressing both quality and cost may be structured either as "pay for performance" reimbursement strategies or as "gain sharing" programs.

High Performance Plan Designs. High performance plan design is another option to promote high value in health care. Such designs ideally have at least three key components. First, the network providers are selected based on their ability to produce quality outcomes at lower prices per episode of care, or per year. Second, the covered services and cost sharing arrangements emphasize high value, evidenced based care. Finally, individuals with substantial health care costs are enrolled in disease management or case management programs.

MHCC contracted with our actuarial consultant, Mercer to analyze the development of a high performance plan design in the small group market. While such designs have been discussed for quite some time, their introduction into the market is relatively recent. To date, those participating in the market have focused primarily on identifying high performance provider networks on the basis of cost sharing and were marketed mainly to the large group market.

Savings from high performance networks range from 5 to7 percent, based on anecdotal reports from carriers.[13] It is estimated that the use of a narrow network product with only high performance providers and no benefits for non-network services could produce a higher savings but at the cost of reducing consumer choice. A more recent analysis by Mercer indicates that high performance networks could generate estimated savings of between 3 and 8 percent.[14]

It is important to note that the introduction of such plan designs in the small group market may pose additional challenges. Insurance companies need to find that delicate balance between identifying the efficient providers while still providing a network that is acceptable in the marketplace. There will also be a need for cost sharing as an incentive to use the more efficient providers.

Mercer also looked at the cost impact of minimizing mandated benefits with the exception of those related to wellness or preventive services. The mandates that are politically difficult to narrow, minimize or eliminate and mandates that reflect wellness and/or preventive services represent the vast majority of the full cost of mandates for the Comprehensive Standard Health Benefit Plan. There are insufficient savings to be realized by the remaining mandates to materially impact premiums.[15] Using differential cost sharing to encourage the use of proven, high value services may prove to be a more effective cost containment strategy in the long run than trying to eliminate entire classes of services.

Using high performance networks for behavioral health services may generate another 1 to 2 percent in savings as would mandating that insures have robust disease management programs. In the aggregate depending on the structure, Mercer concluded that high performance networks and minimizing mandated benefits could generate savings in the 8 to10 percent range without significant aggressive measures.[16]

Health Information Technology Initiatives

The use of information technology (IT) in health care lags well behind most industries – yet it is one of the few tools that can improve health care quality, prevent medical errors, assure the delivery of preventive care, and decrease the use of unproven and low value care. Health IT can deliver information about the patient, the choices, and the costs directly to the point of care, influencing decisions as they are made.

Effective health IT has two fundamental components:

- **Electronic health records.** Providers must have secure electronic medical record systems, including computerized order entry, error prevention, reminders about

[13] Memo to Commission Staff from Mercer. Nov. 6, 2007.
[14] Maryland Health Care Commission. *Options Available to Reform the Comprehensive Standard Health Benefit Plan, as required under HB 579 (2007).* Jan. 2008.
[15] Memo to Commission Staff from Mercer. Nov. 6, 2007.
[16] Ibid.

needed care, and decision support. The most far-reaching, most controversial, most challenging, and least well implemented feature is decision support, which uses information in the record and professionally developed guidelines or decision trees to recommend the most effective or cost-effective options for evaluation or treatment.

- **Health information exchange.** There must be a secure way to exchange standardized information among providers, assuring both the identity and the proper authorization of each user and protecting privacy. Patient access is also essential to promote active involvement in managing our own health and health care.

These two components allow the proper information to be delivered to the time and place of care – information about the patient and information about the best evaluation and treatment options. Beyond the obvious role of health IT in assuring that records of illnesses, treatments, allergies, lab and radiology studies, and current medications accompany the patient, health IT may provide for information to move in the opposite direction. Effective health information exchange should also provide a way to gather information inexpensively about what works for whom, to conduct post-marketing surveillance of drugs and devices to identify unexpected complications, to perform disease surveillance for public health purposes, and to assess risk-adjusted outcomes associated with treatments and providers. Finally, well-designed health IT systems may provide real time cost and outcomes information about different treatments at the time treatment decisions are made, enabling a newer, kinder type of incentive to choose high value options. Increasingly, plan designs are including consumer-directed features, with cost-sharing features that require decisions based on cost as well as expected outcomes. For these plans to work effectively, information about the relative cost and outcomes must be available at the time and place of choice – usually the doctor's office.

With regard to electronic health records, some sources of health information are already primarily in electronic format, including laboratory data, radiological studies, and prescription data. Hospitals are moving forward at varying speeds to integrate the multiple legacy electronic record systems and to develop more comprehensive electronic health records to document inpatient and ambulatory care. Decision support tends to be absent or limited to specific functions such as prescribing. The greatest challenge lies both in long term care facilities and in physicians' offices, which generally rely on paper records. In the long-term care industry, few facilities have invested in electronic medical records, generally those that are part of a large long-term care provider system. While large group practices of physicians can reap efficiencies from electronic health records that may offset the cost of acquisition and maintenance and in the process produce higher quality or better coordinated care, for most practices the current business case for health IT is weak. While direct subsidies for health IT adoption have been proposed, most policy analysts prefer to incentivize the adoption of health IT through a reformed payment system, with enhanced payments for superior quality, care coordination, and efficiency. Well-designed pay-for-value programs establish criteria for enhanced payments that are most readily achieved and documented through the use of health IT.

Effective electronic medical records also require connectivity to gather relevant data from other providers. Meaningful coordination of health care in our diverse and relatively uncoordinated care system will require the safe, secure, and appropriately authorized transfer

of health information both among providers and between patient and provider through a health information exchange. Multiple regional efforts are underway across the nation to establish health information exchanges, but many have failed and few have found a successful business model. The harsh economic reality is that effective health information exchange will improve quality and reduce costs, but providers generally do not benefit financially from health information exchange. The benefit flows to payers, to purchasers, and ultimately to patients – but there is no effective model of how to use the promise of savings to fund the development and operation of a health information exchange. Here Maryland has a substantial initial advantage, being able to spur development through funding from the all-payer rate system. The challenge will be to institute a longer term strategy to support health information exchange and to realize the promised savings.

The Commission has joined with other major groups to tackle these health IT challenges in several specific ways:

- The General Assembly established and the Governor appointed the Task Force on the Electronic Health Record, which completed its report in December 2007.
- The Commission has conducted a study of privacy and security issues, engaging stakeholder groups in identifying issues and evaluating solutions. Its first report was published in the Fall of 2007.
- The Commission, in collaboration with the Maryland Health Services Cost Review Commission, has released a Request for Applications for funding three parallel nine-month projects to develop different models for a statewide, citizen-centric health information exchange. Following the planning projects, an RFA for an implementation project, funded through rate adjustments totaling up to $10 million, is planned.

Through this strategy, Maryland will be able to take advantage of lessons learned from early positive and negative experiences elsewhere, thus maximizing the likelihood of successful implementation.

Specific Small Group Market Options

Over the last two decades, the General Assembly has been actively engaged in policy development for the small group market, now comprised of businesses with 2 to 50 employees. There are many reasons for that active interest. As previously noted, a large percentage of Maryland's uninsured are employed in small businesses. As the cost of health care has continued to escalate, both the number of participating employers and the number of individuals with insurance coverage in this market have declined. Prices for health insurance in the small group market continue to rise faster than inflation and somewhat faster than other markets, posing a challenge to small businesses and their employees.

In 1993, in the face of a number of major concerns in the small group market, including concerns about marked increases in premiums for small groups with one or more individuals in poor health, the General Assembly enacted a major reform of the small group market, eliminating health factors as a rating feature, applying modified community rating to all small

groups, and establishing the Comprehensive Standard Health Benefit Plan to standardize the basic plan designs and allow price comparisons across plans, while allowing plans to also offer riders to improve (but not diminish) the benefits of the base CSHBP. The reform act and subsequent amendments have established both a floor and a ceiling to the value of the plans offered in the small group market.

Having reached a peak in 1998-1999, participation has progressively declined since that time. The market concentration has steadily increased due to mergers and departures from the Maryland market, with the top two carriers, CareFirst and United Health Care, now accounting for 86 percent of the covered lives. Finally, the basic CSHBP plan designs have become increasingly unattractive, in part because deductibles and co-payments have steadily been increased in order to keep the "average" cost of a CSHBP policy below the premium cap. Almost no CSHBP plans are sold without riders, yet the relatively prescriptive benefit design may pose a barrier to the introduction of novel programs with incentives to emphasize high value care and high performance networks. A comprehensive analysis of policy options for the small group market, required by legislation passed in the last session, was submitted to the General Assembly on January 1, 2008.[17]

Small Business Health Benefit Premium Subsidy Program. Senate Bill 6, the "Working Families and Small Business Health Coverage Act" enacted during the 2007 Special Session of the General Assembly, established a Small Employer Health Benefit Plan Premium Subsidy Program. Under this program, a small business that has 2 to 9 full-time employees, has not offered health insurance to its employees during the preceding 12 months, and meets wage and salary requirements established by the Commission, is eligible to receive a subsidy of up to 50 percent of the premium. To receive the premium subsidy, the employer must establish a Section 125 premium conversion plan and must elect a "wellness benefit" offered as a rider to the basic CSHBP benefit design. The subsidy goes both to the employer and to the employee.

The General Assembly gave the Commission broad discretion in designing the specifics of the subsidy, and that planning is underway, in consultation with the Department of Health and Mental Hygiene, the Maryland Insurance Administration, the Comptroller, the Department of Budget and Management, health plans, brokers, third party administrators, small businesses, actuaries, and health economists. In addition to designing a subsidy that helps uninsured small businesses offer health insurance by making it more affordable, we aim to create a subsidy program that is easy to administer, that seamlessly integrates employee payroll deductions with employer contributions and state subsidies, that maintain established business relationships, processes, and incentives, and that assures effective auditing of the subsidy.

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[17] Maryland Health Care Commission. *Options Available to Reform the Comprehensive Standard Health Benefit Plan, as required under HB 579 (2007)*. Jan. 2008.

BROADER HEALTH REFORM INITIATIVES: A LOOK AT MASSACHUSETTS

In an effort to address the problem of the rising number of uninsured, several states have looked at comprehensive health care reforms, aimed at reaching near universal coverage. This goal would be accomplished through broad system reforms that include quality initiatives, cost containment efforts, and strategies to control the underlying cost of health care. In 2006, Massachusetts passed a much-anticipated and heavily observed universal health care law that combines both private and public sector reforms. Many state policymakers, including those in Maryland, are looking closely at variations in this law to see if its model would work for them.

Fundamental Features of Massachusetts Health Care Reform

In an effort to insure every resident of the state, Massachusetts enacted a groundbreaking law to offer affordable private insurance, premium subsidies, and expansions of the existing SCHIP program. The plan required individuals, businesses, and the government to take steps to ensure every resident is covered. Several forces contributed to this bipartisan initiative, but two of the most important were the potential loss of $385 million in federal funds if coverage were not expanded, and skyrocketing premiums and adverse risk selection in the Massachusetts individual market due to the use of community rating principles.

<u>The Individual Mandate.</u> The plan included an individual mandate that required all residents to have health insurance by July 1, 2007.[18, 19] The mandate only applies if "affordable" coverage is available in the market, requiring the definition of what is an "affordable" plan for someone at more than 300% FPL who would not be eligible for the state-subsidized plan. Individuals who can afford coverage and do not obtain it risk the loss of their personal exemption for 2007 income taxes. In subsequent tax years, the penalty will include a fine up to half the premium cost of minimum coverage.

<u>Employer Responsibilities.</u> Employers with more than 10 employees must offer a certain level of insurance coverage to their employees or pay an assessment. Employers must also offer its employees Section 125 cafeteria plans which permit workers to purchase health care with pre-tax dollars.[20] Non-offering employers whose employees use a determined level of free care in the state's hospitals may also be assessed under the "Free Rider" provision in the law.

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[18] Commonwealth of Massachusetts. Commonwealth Connector. Massachusetts Healthcare Reform: Summary of the Legislation. http://www.mass.gov/legis/summary.pdf

[19] Due to the fact that the requirement is enforced through tax returns, Massachusetts residents effectively have until December 31, 2007, to enroll in coverage before facing a penalty.

[20] Commonwealth of Massachusetts. Commonwealth Connector. Massachusetts Healthcare Reform: Summary of the Legislation. http://www.mass.gov/legis/summary.pdf

The Commonwealth Connector. The state plan created the Commonwealth Health Insurance Connector, which will offer small businesses and individuals the opportunity to buy affordable health insurance. In addition, the state has created the Commonwealth Care Health Insurance Program, which offers sliding-scale subsidies for individuals with incomes up to 300 percent of poverty to buy health insurance.[21] The benefits package for Commonwealth Care had to meet state specifications and is being offered initially through the State's four Medicaid managed care plans. Massachusetts also increased the eligibility levels for the SCHIP program from 200 to 300 percent of poverty.[22]

Merger of the Individual and Small Group Markets. Structurally, the reform legislation partially merged the failing individual market with the comparatively stable small group market. Because the legislation included an individual mandate, the potential for adverse risk selection into the merged pool was markedly reduced, allowing the merged market to adopt modified community rating with a 2:1 rating ratio reflecting age (but not health status). Each employee has a policy that combines features of an individual policy (such as portability and premium contributions that reflect age) with features of employer sponsored insurance (including being subject to the provisions of HIPAA and COBRA). The employee has a choice of plans (like either the individual market or a large group plan). Unlike most employer plans, however, employee contributions will vary somewhat by age, since their underlying premiums vary by age. The employer will contribute a percentage of premium and the employee the remaining percentage.

Interestingly, the small group market also continues in parallel to the new merged structure. Small employers have a choice – they can either continue to purchase a single group plan, paying modified community rates for the group, or they can identify the Connector as their health plan administrator, allowing each employee a choice among the health plans offered by the Connector. However, subsidies are only available through the Connector in conjunction with specific health plans.

Funding the Massachusetts Plan. The Massachusetts plan relies on funding from the existing uncompensated care pool, Medicaid funds, general state revenues, and employer contributions.[23] The impetus for this reform effort was the $385 million in federal Medicaid funds that would have been lost if a plan had not been created.[24] The state did not predict that other state funds will be needed after the first three years of the program.[25]

Lessons Learned

Massachusetts recently celebrated the first anniversary of its history-making healthcare reform law. Selected aspects of the law and its implementation can be considered early

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[21] Ibid.
[22] Blue Cross Blue Shield of Massachusetts Foundation. Massachusetts Health Care Reform Bill Summary. http://www.bcbsmafoundation.org/foundationroot/en_US/documents/MassHCReformLawSummary.pdf
[23] Commonwealth of Massachusetts. Commonwealth Connector. Massachusetts Healthcare Reform: Summary of the Legislation. http://www.mass.gov/legis/summary.pdf
[24] Ibid.
[25] Kaiser Commission on Medicaid and the Uninsured. *Massachusetts Health Care Reform Plan* (2006). http://www.kff.org/uninsured/7494.cfm

successes (Medicaid expansion and fully subsidized insurance enrollment for certain adult populations), while the success of other components remains to be seen. Nevertheless, other states are looking to Massachusetts for specific measures to replicate as well as waiting to see what works.

Support of Mandates. Surveys have shown that many of Massachusetts' uninsured had higher levels of income (most over 200% FPL and a fair number over 500% FPL). This was part of the argument for inclusion of an individual mandate. The individual mandate applies only when affordable, comprehensive health care coverage is available, leaving some discretion for circumstances where an individual cannot afford insurance or if insurance costs increase over time. In a recent June 2007 poll released by the Kaiser Foundation, acceptance of the individual mandate has risen to 57 percent as people have become more educated on the reform.[26] This support is tied to income level; those with incomes over $75,000 support individual mandates by 60 percent while individuals with incomes of less than $25,000 are less likely to favor individual mandates (43%).[27]

Employer Responsibilities. The Massachusetts reform has been criticized for its somewhat light requirements on employers. Massachusetts, however, has thus far managed to avoid ERISA challenges. Employer assessments and other requirements on employers may be grounds for challenges to ERISA. However, Massachusetts' requirement that businesses offer Section 125 plans may escape ERISA action given that the Department of Labor does not consider 125 plans as ERISA plans. This, in addition to the relatively low assessment amounts and public support for the concept of near universal coverage decreases the likelihood that business interests will file ERISA-based suits. In fact, a recent survey found broad support among Massachusetts businesses both for the concept of employer responsibility for health benefits and for the specific provisions of the Massachusetts reforms.[28] Seventy-seven percent of employers in the state either "strongly" (34%) or "somewhat" (43%) agreed with the statement that "all employers bear some responsibility for providing health benefits to their workers." The statement garnered majority support among firms of all sizes and even among firms not offering health benefits, although those non-offerers were significantly less likely to strongly agree than were firms offering benefits.

Difficulty with Minimum Creditable Coverage. Minimum creditable coverage is the floor set by the Connector for what an individual is expected to buy for purposes of the individual mandate. Minimum creditable coverage has two different aspects that might best be described as breadth and depth. Breadth of coverage relates to the range of services that must be provided by the plan. Although often described in general terms such as hospitalization and ambulatory care, states frequently adopt mandates that specify additional types of required covered services such as emergency services, maternity care stays, in vitro fertilization, etc. If minimum creditable coverage definitions simply adopt unusual state mandates, many self-insured plans that are not subject to the mandates might become non-

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[26] Kaiser Family Foundation. *Chartpack: Massachusetts Health Reform Tracking Survey*. http://www.kff.org/kaiserpolls/upload/7657.pdf

[27] Ibid.

[28] Gabel, J. et al., "Report from Massachusetts: Employers Largely Support Health Care Reform, And Few Signs of Crowd-Out Appear." *Health Affairs, Web Exclusive*. November 14, 2007.

qualifying. Depth of coverage, in contrast, refers to the cost sharing provisions of the policy, including deductibles, coinsurance/copayment, and maximum out of pocket expenditures. If these are specified in detail, plans with innovative incentives may be non-qualifying. Detailed minimum creditable coverage standards can expose individuals with perfectly appropriate coverage to penalties. This particular occurrence was reported in the Massachusetts newspapers when the individual mandate first became effective. Detailed standards may also causing certain carriers to stop offering in Massachusetts if they are unwilling or unable to alter their benefits packages to meet the new state coverage criteria, or if individuals stop buying their plans because of the requirements of the individual mandate.

There were a number of debates on various aspects of setting the minimum creditable coverage standard.[29] The Connector originally proposed there be no maximum cap on costs to be paid in a lifetime. However, it became clear that a large number of self-insured plans include lifetime caps. The Connector postponed any decision on this until a better understanding of market products is available. When the Connector started to insist that drug coverage be included, the business and insurance companies reacted strongly. There were as many as 200,000 insured people with plans that did not include any drug coverage. A compromise was reached that all plans will have a minimal drug coverage benefit for all preventative and maintenance drugs by the end of FY08.[30]

Affordability. Affordability refers to how much an individual can afford to pay for health insurance and may be set as a percentage of income (e.g., individuals should not pay more than 5 percent of their annual income). There is an important correlation between affordability and minimum coverage; if minimum coverage standards are high, plans will be correspondingly expensive and, thus, less affordable. As the individual mandate takes effect, affordability will be a very important and difficult issue to come to agreement on. As illustrated in Massachusetts, advocacy and social justice groups will make this a central issue. While the original proposal called for all families and individuals making under 100 percent FPL to be entitled to fully subsidized Commonwealth Care products, the affordability debate caused the Connector Board to expand this income threshold for fully subsidized coverage to 150 percent FPL, at a greater cost to the state.[31]

Brokers. The participation of the brokers is integral to the success of the Massachusetts reforms. There are more than 1,400 brokers in Massachusetts, and they have strong ties with the legislature. Brokers sell all of the products to the small group market, with the exception of Blue Cross Blue Shield products. Incentives vary by plan but are usually a percentage on the premiums they sell. Brokers will be allowed to send their clients to the Connector, but they will only be paid a flat fee of $10 per subscriber. The Connector has been very concerned that brokers might enroll their sickest clients into the Commonwealth Choice, while keeping their healthier clients outside of the Connector because the private market pays better than the Connector.[32]

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[29] MHCC Staff analysis of Connector Board meeting minutes.http://www.hcfa.org/act/implementation.asp
[30] Ibid.
[31] Ibid.
[32] Ibid.

Cost to State. Enrollment in the state's new subsidized health plan is growing so quickly that the state could face a funding gap as large as $147 million by the end of the fiscal year, according to a state projection. In addition, there is concern that financial pressures will grow for fiscal 2009, which begins July 1, since insurers who participate in the subsidized program are expected to ask for significantly higher payments from the state. Also driving up the cost was a decision to eliminate premiums in Commonwealth Care for thousands more people than originally planned, in an effort to make insurance more affordable. Additionally, there is uncertainty about how much the federal government will contribute toward the total cost. As a result of the shortfall, the Legislature would likely need to appropriate more money in a supplemental budget or take funds set aside for hospitals that serve a large number of uninsured patients.[33]

In November, 2007 the Patrick Administration released information on the "Fair Share Assessment."[34] Under Chapter 58, employers with 11 or more full-time equivalent employees must make a "fair and reasonable" contribution toward insurance for their workers, or be subjected to a $295 annual fee per employee. Of an estimated 60,000 employers, nearly 44,000 complied with the law and filed forms regarding their contribution toward health insurance of their employees. Of 44,000, nearly 25,000 businesses have fewer than 11 FTEs and therefore are not subject to the assessment requirements. An estimated 518 eligible businesses failed to meet the contribution requirements and have an estimated liability due to be paid to the state of $5.01 million.[35] In April 2006, legislators estimated $50 million in first year revenue from the "Fair Share Assessment." The Patrick Administration adjusted this projection to $23 million in the summer of 2007.[36] Therefore, the $5.01 million in expected penalties is illustrative of the potential budgetary issues arising from such a comprehensive reform plan.

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[33] Dembner, A. "Success could put health plan in the red," *Boston Globe*, November 18, 2007
[34] Commonwealth of Massachusetts. Executive Office of Health and Human Services. "Division of Health Care Finance and Policy and Division of Unemployment Assistance Announce Preliminary Fair Share Data." Press Release. November 21, 2007.
http://mass.gov/?pageID=pressreleases&agId=Eeohhs2&prModName=eohhspressrelease&prFile=071121_employer_fair_share
[35] Ibid.
[36] Dembner, A. "Success could put health plan in the red," *Boston Globe*, November 18, 2007

POLICY OPTIONS FOR MARYLAND

While comprehensive reforms are gaining attention across the nation, several states are focused on incremental reforms to target specific segments of the uninsured, including a focus on uninsured young adults, targeted subsidies, a health insurance exchange, and individual and employer responsibility provisions.

Target Uninsured Young Adults

The Commission was required to look at the high rate of uninsurance among young adults through the enactment of Chapter 639 of the Acts of 2007 (House Bill 1057), which extended the maximum age at which a dependent could remain eligible for coverage up to age 25. The following section provides demographic data on the State's young adult population as well as a review of current health care coverage options available in the State and in other states.

Demographics. In Maryland, the number of uninsured young adults ages 19 to 29 climbed to 240,000 in 2005-2006, from 200,000 in 2004-2005.[37] The resulting uninsured rate among 19-29 year-olds in 2005-2006 was 30 percent, which was the same as the national average uninsured rate for this group during the same period. While the national rate did not change from 2004-2005 to 2005-2006, Maryland's adjusted rate rose significantly from 26 percent from 2004-2005 to 30 percent in 2005-2006.

Young adults from low-income households (below 200 percent of the federal poverty level) are disproportionately represented among the uninsured. In Maryland during 2005-2006, about 25 percent of adults ages 19 to 29 lived in households with an income below 200 percent of the poverty level, but this group made up 40 percent of the 240,000 uninsured young adults. However, uninsured young adults are no more likely to be low-income than are uninsured adults ages 30 to 64 in Maryland, of whom 44 percent were low-income (compared to 15 percent of all 30 to 60 year olds). The 40 percent low-income share of uninsured young adults in Maryland was significantly lower than the national average of 55 percent in 2005-2006.

Although the 19 to 29 population in Maryland is equally distributed between male and female, the uninsured young adults in this age group are somewhat more likely to be male (59%). In addition, 84 percent of all uninsured young adults are single. Hispanics are very disproportionately represented among uninsured young adults: 24 percent versus 12 percent of the overall Maryland population in this age group. Non-citizens are also very disproportionately represented among uninsured young adults: 33 percent of the uninsured young adults despite making up just 15 percent of the Maryland population ages 19 to 29. Hispanics account for about two-thirds of these uninsured non-citizens. Non-Hispanic Whites are under-represented in these uninsured: 33 percent of uninsured young adults despite making up 47 percent of Maryland's young adult population.

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[37] All demographic data are based on MHCC Staff calculations from revised CPS data, September 2007.

Causes of Being Uninsured. Lack of insurance is in part attributable to preferences and choice. Young adults are generally relatively healthy and are commonly in the early, lower income stages of their lives. The likelihood of major medical expenses may seem remote and health insurance relatively low on the hierarchy of needs and desires. Some observers suggest that young adults underestimate risks, including health risks, or may be less risk averse early in life.

Depending on the way rates are set, young adults may also correctly judge that insurance is not a particularly good bargain. A fully underwritten market may produce rates that correspond well to the rather low risk associated with being a young adult. However, markets with various forms of community rating – and indeed even self-insured employer programs – may produce rates that are relatively higher than their actual risk. Community rating or modified community rating generally results in the young subsidizing the old, and the healthy subsidizing the sick. Employers tend to charge all employees the same employee contribution, without regard to age, even though the law allows different employee shares based on actual differences in the cost to the employer to provide the benefit, as long as health status is not used as a factor in determining an employee's premium contribution. Depending on the percentage of the premium paid by the employer, this may or may not represent a good deal for the young adult.

Lack of insurance is also in part attributable to lack of ready access to insurance. For those in Medicaid and SCHIP, eligibility for low-income children extends through age 18 and ends at age 19. Medicaid coverage for childless adults is limited to those who are disabled, elderly, or pregnant. In private coverage, at age 19, most young adults are removed from their parents' health plans unless they are full-time students. Dependent coverage for full-time students typically ends between ages 23 to 25 under most private health insurance plans. The transition from high school to college or the working world is unpredictable. Many jobs available to young adults are typically low-wage or temporary – the type of jobs that generally do not offer health benefits.

Implications of Being Uninsured. A lack of continuity and stability in coverage puts young adults' health at risk. Although young adults are generally healthy and have lower health care expenditures, going without coverage disrupts access to care. The uninsured are far less likely than those with coverage to have a regular doctor, thereby disrupting access to needed medical care and preventative services. In addition, going without coverage leaves young adults and their families at risk for high out-of-pocket costs in the event of a serious injury or illness. Consider the following statistics:

- Obesity is growing faster among young adults ages 19-29 than any other adult age group.[38]

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[38] Mokdad, A. H. et al, "Prevalence of Obesity, Diabetes, and Obesity –Related Health Risk Factors, 2001," *Journal of the American Medical Association*, Jan. 1, 2003 289(1):76-79; T.A. Hillier and K.L. Pedula, "Complications in Young Adults with Early Onset Type 2 Diabetes: Losing the Relative Protection of Youth," *Diabetes Care*, Nov. 2003 26 (11):2999-3005.

- There are 3.5 million pregnancies each year among the 21 million women ages 19-29.[39]
- One-third of all HIV diagnoses are made among young adults.[40]
- Injury related visits to the emergency room are more common among young adults than they are among either children or older adults.[41]

Insurance Products Targeted to Young Adults. Research on lifestyles and preferences of uninsured young adults indicated that they are interested in health insurance, if it meets their needs and is offered at the right price. Health insurers have begun to market basic, individual plans to adults ages 18 to 34. Several large carriers currently offer such plans, with a monthly premium of $39 to $160 and annual deductibles of as much as $5,000. Based on U.S. Census Bureau data, individual health plans sold to young adults increased by 6.2 percent to 3.8 million from 2000 to 2005.

In 2004, Blue Cross Blue Shield introduced Tonik Health; a health insurance product targeted toward young adults, age 19 to 34.[42] Tonik Health is available in California, Colorado, Nevada, Connecticut, New Hampshire, and Georgia. Tonik Health is partnered with Sound Health, which is administered by UniCare in Texas and Illinois. Since the introduction of these health plans, Tonik Health reports that approximately 78 percent of current Tonik enrollees were previously uninsured.

The goal of Tonik Health and Sound Health is to make it easier for young adults to understand the terminology associated with health insurance and provide easy access to a health insurance product they can understand. These plans cost between $60 to 144 per month; have a user friendly Web site; no waiting period to use coverage after approval; and minimal paperwork. If enrollees are out of state, they continue to have coverage under the Travel Access Program. Health plans offered by Tonik Health and Sound Health cover dental benefit, generic drugs, and discounted vision benefits. However, these plans do not cover maternity health benefits, mental health benefits, and brand name drugs.

State Legislation to Cover Young Adults. States have extended dependent benefits to young adults by age and student status, as well as for specific population who take a leave of absence from school due to illness or injury. These state legislative changes to extend eligibility for dependents under private coverage regardless of student status may be supported by health insurance companies due to the fact that age extensions could keep young, healthy adults in their insurance pools as well as increase profits. The National Conference of State Legislatures tracks state legislative actions on the age of dependency.[43] Examples of such measures include the following:

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[39] Quinn, K. et al., *On Their Own: Young Adults Living Without Health Insurance*. The Commonwealth Fund, May 2000.
[40] Ibid.
[41] National Center for Health Statistics, *Health, United States, 2005*. NCHS, Nov. 2005. Table 89.
[42] All data regarding *Tonik Health* are available at www.tonik.us.
[43] National Conference of State Legislators. "The Changing Definition of 'Dependent.' Who Is Insured and For How Long?" http://www.ncsl.org/programs/health/dependentstatus.htm

- Colorado: A child is considered a dependent until age 25 as long as they are unmarried, financially dependent, or share the same permanent address as their policyholder (e.g., insured parent).
- Massachusetts: Dependents are allowed to stay on their parents' coverage for two years after they are no longer claimed on their parents' tax returns, or until age 25, whichever occurs first.
- Michigan: Dependents may be covered while they are enrolled in school (either full or part time), and are required to continue to be covered as a dependent for up to 12 months if they take a leave of absence from school due to injury or illness. If the student ages out of coverage in the 12 month period, the insurance is terminated.
- New Jersey: A dependent may be covered up to the age of 30 as long as they have no dependents of their own.
- Rhode Island: A dependent may be covered up to age 25 as long as they are financially dependent.
- South Dakota: Students have dependent status until age 24. If an individual is not enrolled in an educational institution, the maximum age of dependency is age 19.
- Utah: Coverage for unmarried dependents is required until age 26, regardless of whether or not the dependent is enrolled in an educational institution.
- Vermont: If insurance companies cover dependents after the age of 18, coverage is required to continue even if they take a medically necessary leave of absence from school for up to 24 months.

Maryland's newly enacted legislation is in line with the national trend of expanding the age of dependents, which ranges from age 24 to 30, with most states settling at age 25. In general, these laws apply to plans covered under state insurance regulation and thus do not apply to self-insured employers. Some of the new laws are part of broader efforts to expand coverage. For example, under the Massachusetts reform legislation young adults may remain on their parents' policy for two years past the loss of their dependent status, or through age 25, whichever occurs first. Young adults (19-26) who do not receive employer-sponsored insurance will be able to purchase lower cost, less comprehensive products available only through the Connector.[44]

Recently, Pennsylvania Governor Ed Rendell proposed a health care reform plan called "Prescription for Pennsylvania." This legislation calls for the creation of a program called Cover All Pennsylvanians (CAP), which would provide affordable health coverage to the uninsured and small businesses. In addition, CAP includes provisions to extend the age of dependent to age 29 and require that all full-time and graduate students have health insurance coverage that meets a certain minimum requirement.[45]

According to a 2007 report by the Commonwealth Fund, about 38 percent of public universities and 79 percent of private universities and colleges require students to have health

[44] Commonwealth of Massachusetts. Commonwealth Connector. Massachusetts Healthcare Reform: Summary of the Legislation. http://www.mass.gov/legis/summary.pdf
[45] Governor's Office of Health Care Reform. State of Pennsylvania. January 2007. http://www.gohcr.state.pa.us/prescription-for-pennsylvania/index.html

insurance as a condition of enrollment.[46] Six states (California, Idaho, Illinois, Massachusetts, Montana, and New Jersey) have either a state mandate or a higher education governing board mandate that full-time undergraduate students who are U.S. citizens must have health insurance in order to enroll. Half (50%) of full-time students age 19 to 23 receive health insurance through their parents' employer-sponsored plans, while another 18 percent have individual coverage, including college and university plans.

In order to ensure that college students have access to adequate health care coverage, colleges usually follow one of these four models:

- Voluntary – Students have the option of purchasing the institution's health insurance plan, but are not required to show any proof of insurance to the institution.
- Soft Waiver – Students are required to purchase the institution's health insurance plan, or have health insurance coverage comparable to the institution's plan. Students who claim to have comparable coverage can waive the college plan, and are not required to provide evidence of comparable coverage.
- Hard Waiver – Students are required to purchase the institution's plan or have health insurance coverage comparable to the institution's plan. Students who claim to have comparable coverage must provide evidence of this coverage.
- Mandatory – All students are required to purchase the institution's student health insurance plan regardless of whether they have outside insurance coverage. There is no ability to waive the institution's plan.

Since the majority of these college-based models require some form of health insurance, many universities are looking into ways to help students afford adequate health insurance coverage by broadening the school's definition of cost of attendance (COA). In general, the COA covers tuition, room and board, transportation, books and miscellaneous expenses. In some states, COA includes the cost of a college health care plan. COA expenses qualify for financial assistance from scholarships, work studies, federal aid and student loans. Students may find health insurance coverage more affordable if health care coverage is included as a component of COA.

Potential benefits for mandatory health insurance coverage for college students include avoidance of adverse risk selection and spreading risk over a larger number of individuals; access and affordability for un- and under-insured students; better student retention; increased use of preventable services and lower health care costs.

<u>Options for Providing Coverage to Young Adults Transitioning from Foster Care.</u> States provide health care for children and youth who are in foster care through Medicaid. Foster children who are eligible for federal funds (by meeting technical criteria such as citizenship) are categorically eligible for Medicaid. States have taken on the responsibility of providing Medicaid coverage with state-only funds for the small number of remaining children in foster care who do not qualify for federal funding. Each state establishes its own age limit for foster care eligibility, which may vary between 18 and 21 years. Maryland's foster care age limit is

[46] Collins, S. et al., "Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help." The Commonwealth Fund. Updated August 8, 2007.

21. Therefore, in Maryland, Medicaid coverage is maintained up to age 21 for foster children. However, this is only the case if youth stay within the foster care system. After they turn 18, youth in Maryland can voluntarily opt out of the foster care system.

Maryland also has exercised the option to cover children who meet the former welfare program's financial criteria (1996) but do not qualify as a "dependent child." This is called the Ribicoff option. Since Maryland covers children up to age 19 through the MCHP program, Ribicoff has little meaning for most children under the age of 19. Lastly, children who leave the foster care system, but do not live with their families and have incomes below 116 percent of the federal poverty level would qualify for Medicaid coverage under the "childless adult" expansion specified in the Working Families and Small Business Health Coverage Act (Senate Bill 6 of the 2007 Special Session). This population would currently be eligible for primary care, pharmacy, and some limited additional services under the Primary Adult Care program (PAC).

Maryland could consider implementing the Chafee Option. The Chafee Foster Care Independence Act, introduced by the late Sen. John Chafee, allows states to further extend coverage to children who have left the foster care system and are below the age of 21.[47] The Chafee Option covers children whose incomes exceed the former welfare program's financial criteria (1996) required under Ribicoff. The Chafee Option would extend Medicaid coverage up to age 21 for those youth age 18 and over who voluntarily opt out of the foster care system. Youth who are too high income to meet the Ribicoff income eligibility standards could be eligible for the Chafee Option. Youth ages 18 and over make up a small proportion of the approximately 12,000 foster children in Maryland. It is difficult to estimate the number of individuals who would be eligible for the Chafee Option given movement across coverage groups. Some individuals age 19 and over may leave foster care but still maintain Medicaid eligibility as a parent, pregnant woman, or individual with a disability.

The American Public Human Services Association (APHSA) in January 2007 released a report that analyzes the implementation of the Chafee Foster Care Independence Act.[48] All 50 states and the District of Columbia provided information to the APHSA survey on how they currently provide Medicaid coverage or plan to provide coverage to this population. The report finds that since 1999 17 states have extended Medicaid coverage: Arizona, California, Florida, Indiana, Iowa, Kansas, Massachusetts, Mississippi, Nevada, New Jersey, Oklahoma, South Carolina, South Dakota, Rhode Island, Texas, Utah, and Wyoming. Five other states may also consider extending that health coverage in the near future: Maryland, Missouri, New Mexico, North Carolina, and Wisconsin. See Appendix B for a summary of state activities.

<u>Feasibility of a Medicaid or MCHP Buy-in.</u>[49] One option for extending coverage to the uninsured is through a Medicaid or MCHP buy-in program. This option would allow individuals who lack access to affordable coverage to purchase coverage by buying into

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[47] P.L. 106-169. See Appendix A for the eligibility category for this population, which can be found under section 1905(w)(1) of the Social Security Act.
[48] American Public Human Services Association. Medicaid Access for Youth Aging Out of Foster Care. January 2007. http://www.aphsa.org/Home/Doc/Medicaid-Access-for-Youth-Aging-Out-of-Foster-Care-Rpt.pdf
[49] This section was prepared by the Department of Health and Mental Hygiene.

Medicaid. The costs would be an amount equal to the cost of coverage to the state – this includes both service and administrative costs. Medicaid coverage for children in MCHP is approximately $170 per child per month (including carved-out services, and excluding any costs for administration). At premium costs greater than $2,000 annually, many families may be precluded from considering a buy-in program as an option.

Expanding Private Insurance through Targeted Premium Subsidies

While some uninsured individuals can afford coverage and choose not to purchase or are temporarily uninsured between jobs, a majority of the uninsured do not purchase insurance because it is unaffordable. Expanding public programs provides one option for coverage, but providing premium subsidies to low to moderate income individuals and families to assist in the purchase of private coverage provides an option that can leverage existing offers of employer sponsored coverage, reducing the net cost of coverage expansions.

When considering the implementation of a targeted subsidy program there are several factors to take into account.

Costs of plans. Crafting an affordable plan requires restraint in breadth of benefits and mandated services and providers. Benefits would ideally reflect evidence-based medicine and high value with affordable cost sharing to help control utilization. States may either define the benefit plan to be offered or define the state's contribution based on the actuarial value of a core plan, without requiring that all plans have specific benefits.

Affordability to purchaser. Sliding scale premiums will need to be set at a level that is affordable. Currently there is not a consensus about what percentage of income is the "magic number." Similarly, there is no agreement about how to handle cost-shifting (deductibles and coinsurance) in determining affordability. Since most subsidy proposals phase out at 300 percent FPL, affordability might be determined as a percentage of that income level. Most experts believe the percentage of income should be lower at lower levels of income.

Crowd-out. Crowd-out speaks to the concern that publicly subsidized health insurance will result in individuals dropping private coverage in favor of public coverage. Crowd out results in public coverage displacing existing private coverage rather than expanding coverage. Massachusetts attempts to guard against crowd-out by providing that only those who are uninsured for at least six months are eligible. It also creates a mechanism by which those who are presently covered by employer-sponsored insurance may also qualify for the subsidy, but only if their employer continues to contribute to their premium costs. Along with the employer mandate, this provision offers an interesting approach to avoiding crowd-out by giving employees access to more affordable insurance products without the imposition of additional financial obligations.

Targeted population. Subsidies can be directed specifically to the currently uninsured –either to employers that are not currently offering insurance, to employees that are offered but are not taking up the coverage, or to uninsured individuals. However, some may question the

fairness of a policy that rewards those employers that have not been offering coverage or individuals who have remained uninsured in preference to employers and individuals who have been doing the "right thing" all along. A program could also opt to subsidize specific markets, similar to the Healthy New York reinsurance program. Small businesses could be targeted; however, small businesses that do not offer insurance and small business employees that do not take up coverage are not very price sensitive, so substantial premium subsidies would be necessary to produce modest increases in coverage.

A Health Insurance Exchange

A health insurance exchange such as the Connector in Massachusetts aims to connect individuals and small employers to private insurance products to make it easier for individuals and small businesses to find affordable policies.

There are many different structures an "exchange" can take:

- At one end of the spectrum is **a "virtual exchange"** that merely serves to provide information about available plans in a specific market, such as the small group market. This exchange helps inform a business owner about coverage options and facilitate enrollment through an agent. If there is a premium subsidy program, the exchange may facilitate application. This "virtual exchange" makes no structural changes in the market. It leaves intact existing relationships, rating methodologies, and risk selection.
    - The cost of initiating and maintaining a virtual exchange would be relatively low.
    - Governance could be handled by government agencies (the Maryland Health Care Commission and/or the Maryland Insurance Administration), with an advisory committee representing carriers, agents/brokers, and the public.
    - The roles of plans, TPAs, and agents/brokers would be fundamentally unchanged.
    - Its impact is likely to be quite modest.
- **A small group market exchange** could allow small businesses to appoint the exchange as their health plan administrator, providing all employees a choice among all products offered by the exchange. This concept has many features in common with so-called purchasing pools that held out the promise of administrative savings for small businesses through group purchasing. Experience has shown that these arrangements fail to generate expected savings and eventually dissolve because of adverse risk selection. However, if the small group market exchange were the only avenue for a small business to get a fully insured product, adverse selection between exchange products and other insurance would be reduced substantially, leaving only the problems of adverse selection due to non-participation and adverse selection among plans in the exchange.
    - The cost of initiating and maintaining a small group market exchange that provided for individual choice by employees would be moderate, since the exchange would have to provide information about choices, a process for

enrollment in different plans, and a financial structure that directs employer contributions and employee withholding to multiple plans.

  - Although governance could be handled through a government agency such as the Maryland Health Care Commission, at this level of restructuring, an independent public-private entity should be considered to provide greater independence in setting policies and greater capacity to recruit individuals with the skills necessary to operate an exchange. Presumably, in either case, functions would likely be contracted to existing entities such as third party administrators.
  - The role of TPAs might broaden to include contracted administrative services for the exchange. Broker responsibilities are made easier by the extensive administrative support and decision support information provided by the exchange, and more difficult by the responsibility to market to and serve employees rather than employers.
  - Because an exchange limited to the small group market would not easily coordinate with broad individual responsibility provisions and with low income premium subsidies (since there would be no easy way to administer the premium subsidies in the individual market), impact on the uninsured would be modest – although more employers might offer insurance since they would no longer have to choose the insurance and could merely choose the level of employer contribution they would provide.

- **A subsidy exchange** would function in either the individual or the small group market and would limit participation to individuals or small businesses eligible for a premium subsidy. Specific products eligible for a premium subsidy could be defined, and participants could be offered a range of plan choices from different carriers. The small business subsidy exchange could be developed based on either employer choice of plan or employee choice of plan.
  - The cost of initiating and maintaining a subsidy exchange would depend greatly on whether the exchange provided for individual choice of health plan. If provided for individual choice, the costs would be similar to the small group market exchange noted above. If employer choice were retained, the program could look very much like the Small Group Health Benefit Premium Subsidy Program being developed to implement Senate Bill 6 from the 2007 Special Session, a relatively low cost administrative structure that makes extensive use of existing business relationships to deliver a premium subsidy within the small group market.
  - Governance of an individual choice subsidy exchange would mirror the small group market exchange. Governance of an employer choice plan would best be handled by the MHCC with an advisory committee.
  - The role of TPAs might broaden to include contracted administrative services for the exchange. Changes in broker responsibilities would depend on whether choice is made at the employer or employee level.
  - Premium subsidies directed specifically to those small businesses that have not offered health insurance in the previous 12 months (or individuals that have not been insured in the previous 12 months) provide a relatively cost-effective way to increase coverage, since it leverages the contributions by the employer

and employee. The experience of the coming year will provide a clearer sense of the take-up of subsidized insurance by employees of small businesses and its impact on the uninsured.

- At the other end of the spectrum is an **exchange that merges the individual and small group markets**, establishes a single risk pool in which all eligible individuals participate, uses the same rating methodology across the merged market, allows individuals and families to choose their own health plans, provides coverage to participants that is portable across jobs and periods of unemployment, strengthens the pool by requiring that all individuals acquire basic insurance coverage, encourages employer participation by simplifying the employer's decisions and administrative burden, and provides a simple means of merging employee, employer, and premium subsidy contributions.
    - Because of the multiple components of this broad reform strategy – including structuring a new, merged insurance market; setting subsidies; establishing minimum acceptable coverage standards; managing enrollment, disenrollment, and open season choices; enforcing individual responsibility provisions; delivering a premium subsidy to low income individuals; and providing initial and ongoing education to employers, employees, and the public about the elements of the reform proposal and about their choices in health plans, this option would involve the most extensive infrastructure and administrative effort. Massachusetts provides the best example of this scope of effort.
    - Governance should be through a public-private collaboration, with broad representation of affected parties on the board. Ideally, the board would have broad authority to set policies, including policies regarding covered services currently covered by mandates.
    - The role of TPAs would likely broaden to include contracted administrative services for the exchange. Broker responsibilities are made easier by the extensive administrative support and decision support information provided by the exchange, and more difficult by the responsibility to market to and serve employees rather than employers. Brokers/agents could be compensated by either the exchange or, as today, by the carriers.
    - This comprehensive reform model is potentially both the most effective at achieving near-universal coverage and the most complex and costly option. Its possible structure, design issues, and effects are discussed in the review of the Massachusetts plan and in the reform proposals modeled later in this report.

Design choices. Developing an exchange requires fundamental choices about the features of the exchange. Any exchange addresses, explicitly or implicitly, the following design issues.

- **Individual or Employer Choice.** Currently, an employee's plan is chosen by the employer and is tied to that employment. Apart from COBRA provisions, it is not portable. Individual choice of plans has greater potential to address individual needs. It may also contribute to greater consumer attention to health care expenditures and advance value-based purchasing, since individuals may be more willing to accept trade-offs between price and coverage that they have chosen, compared with trade-offs chosen for them by their employer. Of course, individual choice also leads to more

risk selection than employer choice, requiring more attention to the possible use of risk-adjusted premium payments to plans.

- **Individual or Group Policies.** This design issue is closely related to the previous design question. Products in the small group market today are clearly employer sponsored group policies tied to a specific employer, and products in the individual market are clearly individual policies. An exchange could offer these same individual and small group products, leaving the markets fundamentally unchanged, or like Massachusetts, could seek to create a policy that has features of employer-sponsored insurance (including HIPAA and COBRA protections and tax deductibility) and features of individual insurance (including portability and premiums that differ among employees based on age).

- **Adverse Risk Selection into the Exchange.** A pool must attract a representative range of risks, both low and high, to be able to spread risk fairly. Two types of troubling pool risk selection can occur, resulting from decisions to purchase elsewhere and decisions to remain uninsured. For the first group, premiums must be low enough that low-cost individuals will use the pool rather than purchase policies on their own outside the pool. This adverse risk problem always arises when voluntary purchasing pools must compete with what individuals can buy on their own, and is particularly problematic when the pools have different rating methods. The community rated product tends to attract higher risk individuals. Adverse risk selection can be reduced by assuring that there is a single market for fully insured small group products or by merging the individual and small group markets. Risk selection related to remaining uninsured is also problematic. If the choice is due solely to low income, risk selection may be less of a problem. However, if the choice is related to being young and/or healthy and deciding insurance is unnecessary until becoming ill, there is a selection problem. Personal responsibility provisions with penalties for remaining uninsured would be a partial remedy. Both forms of adverse selection can be decreased by establishing deterrents to jumping into the community pool after becoming ill, such as invoking preexisting condition exclusions (limited by HIPAA) or charging premiums in the first few years of a group's participation that reflect health risk, transitioning gradually to community rated premiums.

- **Benefit Designs for Plans Offered Through the Exchange.** Exchanges may adopt a laissez faire approach that allow individuals a choice of a broad range of products or may adopt a prescriptive approach that defines specific covered services and cost-sharing arrangements for all plans offered in the exchange, or only for health plans that are eligible for premium subsidies.

- **Risk Selection among Health Plans within the Exchange.** The final risk selection problem occurs among plans within the exchange – if some plans attract more healthy participants than others. There are several mechanisms to manage risk selection among plans including adjusting premiums based on risk upon enrollment, adjusting premiums based on actual plan experience, or instituting a mandatory reinsurance program to redistribute some of the premiums.

Merging the Individual and Small Group Markets. Because merging the individual and small group markets involves a major shift in market structure and rating principles and has complex ramifications, the Maryland Insurance Administration was asked to address the impact of merging the individual and small group markets.

MIA assessment of the impact of merging the individual and small group markets

As part of its reform effort, Massachusetts merged its individual and small group markets. The Maryland Insurance Administration (MIA) has been asked to comment on the potential impact of merging Maryland's individual and small group market.

This is not an easy question to answer. A complete assessment would require an actuarial analysis of Maryland's individual and small group markets. Absent such an analysis, the MIA offers the following observations about the individual and small group markets in Maryland to help guide future discussions on this important topic.

Maryland's Individual Market

The individual market is the most susceptible to adverse selection. Adverse selection results from asymmetry of information in the insurance market. Insurance buyers have a better idea of their risk than carriers.

If a carrier sets a premium to reflect the general health risk of the population, lower risk individuals will perceive the premium as to high and opt not to purchase health insurance. The average risk of those insured will rise because fewer people of lower average risk will be insured. As a result, premiums will increase and additional lower risk individuals will opt not to purchase health insurance.

To minimize adverse selection, Maryland law permits carriers to medically underwrite individual buyers of health insurance. Medical underwriting allows a carrier to have a better idea of the actual risk and to charge premiums more likely to be attractive to lower risk individuals. Based on the results of medical underwriting, a carrier may elect to increase the premium for higher risk individuals or decline to cover a higher risk individual.

Medical underwriting, however, can leave high risk individuals uninsured. To address this, Maryland created a high risk pool, the Maryland Health Insurance Plan (MHIP). If a carrier refuses to issue a policy to certain individuals, these individuals may obtain health care coverage through MHIP. Although MHIP's premiums are required by statute to be higher than the standard risk rate, the collected premiums fall short of the medical losses. Monies for the short-fall come from the all-payer hospital rate setting system.

These particular features of Maryland's individual market should result in premiums attractive to lower risk individuals. The negative social consequences of medical

underwriting are offset by MHIP. Thus, we would expect Maryland residents to have access to affordable health insurance in the individual market.

Maryland's Small Group Market

The small group market has evolved differently than the individual market. Prior to 1993, carriers were permitted to medically underwrite small employer groups. As a result, some small employers could not obtain health care coverage for their employees.

Policymakers reasoned that adverse selection is less acute in the small group market because employers offer health care coverage to their employees as a way to attract and retain a qualified workforce. Subsidies from employers, coupled with the federal and state tax advantages of purchasing group health insurance, made it less likely lower risk individuals would opt not to purchase health insurance priced on the basis of the average risk of the population.

Thus, in 1993 the General Assembly enacted insurance reforms requiring carriers to: (1) sell a policy to any small employer; and (2) base the price for this product on adjusted community rating. With adjusted community rating, the premium is based on the overall health care costs for all small employers with an adjustment for each group based on the group's geographic location and average age. Carriers are prohibited from considering the group's health status in determining the premium.

Impact of Merging the Individual and Small Group Markets

When Massachusetts merged its individual and small group market, the state estimated a premium reduction of up to 25 percent for individuals. Unlike Maryland, Massachusetts did not permit medical underwriting in the individual market, resulting in higher risks in the individual market. The estimated premium reduction was attributed to moving a high risk individual market to a lower risk small group market and to further decreasing the negative consequences of adverse selection by mandating the purchase of health insurance by all individuals.

Maryland's insurance market is quite different. Our individual market has two components – a lower risk market with premiums based on medical underwriting and the high risk market. In the lower risk market, individuals purchase coverage directly from a carrier; in the higher risk market individuals purchase coverage through MHIP.

Estimating the premium impact of merging these two markets into Maryland's small group market depends upon the actual average risk in the small group market. We do not have empirical information readily available to ascertain the relationship between the average risk in the small group market and the risks in the individual market.

However, we would expect moving the lower risk individual market to the small group market would result in higher premiums for these individuals. Moving the higher risk

individual market to the small group market would result in lower premiums for these individuals.

If this outcome occurred, we would further expect to see greater adverse selection. Lower risk individuals will perceive the premium as to high and opt not to purchase health insurance. The average risk of those insured will rise because fewer people of lower average risk will be insured. As a result, premiums will increase and additional lower risk individuals will opt not to purchase health insurance. This resulting spiral, over time, would result in even higher premiums for small employers.

Clearly, the negative impact of merging the individual and small group market could be mitigated by requiring all individuals to purchase insurance.

Based on this analysis, the MIA does not recommend merging the individual and small group market at this time. The MIA urges caution in significantly modifying the individual or small group markets until a more robust study of our insurance markets is completed.

The Commission concurs that a merger of these markets would have wide-ranging consequences and should only be contemplated in the context of broad reform including a requirement that all individuals purchase insurance. The merged market could then adopt modified community rating as its basic rating principle.

Clearly, one of the two major drivers of reform in Massachusetts was their dysfunctional individual insurance market, a result of community rating in a market particularly prone to adverse selection. At the present time, that driver does not exist in Maryland. Full underwriting in the individual market works in Maryland because, in essence, all other insurance markets and state and federal payers subsidize a high risk pool for the individual market. However, MHIP is rapidly approaching its maximum enrollment given current funding, and the MHIP Board is discussing an enrollment cap. That development will spur discussions of the best way to cover the uninsured, both high and low risk, while protecting our modified community rated small group market.

<u>Impact on the Cost of Health Care</u>. The Commission was requested to address the impact of an exchange on the cost of health care. Three types of cost impact must be addressed:

- **Total expenditures on health care**. To the extent that an exchange is coupled with personal responsibility provisions and low income subsidies, substantial expansions in the number of insured individuals could result. As noted elsewhere, insured individuals incur more health care expenditures than the uninsured, so expanded coverage would increase total expenditures on health care. Savings from uncompensated care and other benefits derived from coverage do not offset the increased demand for services.

  On the other hand, an exchange that provides for individual choice of health plan could help engage individuals in balancing health insurance benefit design with

cost of premium. To the extent that individuals choose consumer directed benefit designs with lower premiums, individual choice of plan could help change how individuals make decisions about health care expenditures by making them more conscious of value and reducing the volume of unnecessary procedures.

- **Cost of services**. Increased demand for services, particularly when at least some types of providers are in short supply, may have a slight impact on prices. More importantly, expanded coverage is likely to increase the need to rethink how we deliver health care – how we improve efficiency and value and how we use new models of service delivery with better health information systems and different personnel for routine services.

- **Cost of health insurance**. To the extent that health care reform including an exchange, personal responsibility, and subsidies produces near universal coverage, the insurance risk pool will improve. Currently the uninsured are predominantly young and healthy. Drawing these lower risk individuals into the risk pool would make the pool more representative and should lower the average cost of premiums.

Personal Responsibility

In the context of health insurance, individual or personal responsibility principles require that all individuals who can afford to purchase basic insurance (often defined as catastrophic coverage) must do so or face penalties. The underlying ethical and economic principle is simple: individuals have a responsibility to take reasonable steps to avoid being a burden on their fellow citizens. Those who can afford insurance but do not purchase it are “free-riding” on others’ responsible actions. They force others to subsidize their care when they become seriously ill and incur catastrophic health care expenditures.

Personal responsibility can be established without other health care reform if “affordability” is defined, either by applying penalties above a certain income level or by identifying an affordable percentage of income that can reasonably be spent on health care or on health insurance premiums.

Personal responsibility can also apply universally if coverage is made “affordable” to all. Proponents of the Massachusetts reform legislation viewed the individual mandate as a necessary component of a multi-strategy plan to move the state to near universal coverage. In Massachusetts, as of July 1, 2007, residents were required to obtain insurance if an acceptably comprehensive plan is available at an affordable price.[50] The determination of what coverage people must have and what “affordable” means was established by the Connector Board. Massachusetts is the first state to pass an individual mandate. From a political perspective, the individual mandate represents a significant shift in state policy. This has been compared to state requirements that individuals who register cars must continually carry automobile insurance policies. It makes the purchase of health insurance coverage a personal responsibility and obligation for those who are able to afford to purchase coverage. It also requires state policy makers to engage in a public debate about what is affordable and adequate health insurance, and to develop mechanisms for subsidizing health insurance costs for those deemed unable to afford the full price of coverage.

<u>Modeling a Stand-alone Personal Responsibility Provision.</u> The Commission contracted with The Lewin Group to study the cost and coverage impacts of a Personal Responsibility proposal which would require that all individuals and families above a certain income level obtain health care coverage.[51] Those Maryland residents who do not have coverage would face a penalty of varying degrees. This modeling assumes no changes to the current market; therefore; no premium subsidies would be offered at any income level and the proposal would make no changes to the current Maryland insurance market or to public programs such as Medicaid or the Maryland Children’s Health Program (MCHP). The Maryland Health Insurance Plan (the state’s high risk pool) would be available to qualified individuals under the mandate.

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[50] Due to the fact that the requirement is enforced through tax returns, Massachusetts residents effectively have until December 31, 2007, to enroll in coverage before facing a financial penalty.
[51] The Lewin Group. *Modeling a Health Insurance Exchange under an Individual Responsibility Proposal*. Dec. 2007.

The Commission developed four penalty options for analysis (Figure 1). The penalty would be based on the premium cost for a High Deductible Health Plan (HDHP) for people, based on their characteristics, according to the current rating practices in Maryland as specified below.

Figure 1
Penalty Options

	Income Level	Penalty
Option 1	Families over 300 percent FPL	75 percent of a HDHP Phased-in for families between 300-500 percent FPL Families over 500 percent FPL pay full penalty
Option 2	Families over 400 percent FPL	75 percent of HDHP premium Sliding scale for families between 400-500 percent FPL Families over 500 percent FPL pay full penalty
Option 3	Families over 300 percent FPL	$1,000 per individual/$2,000 per family Sliding scale for families between 300-500 percent FPL Families over 500 percent FPL pay full penalty
Option 4	Families over 400 percent FPL	$1,000 per individual/$2,000 per family Sliding scale for families between 400-500 percent FPL Families over 500 percent FPL pay full penalty

One key aspect of the Personal Responsibility proposal is that people who do not have coverage are penalized, therefore making it more costly for people to not seek coverage under the mandate than under current law. Therefore, the modeling assumes that individuals are more likely to seek coverage under the mandate if the cost of the penalty is more than the cost of obtaining coverage.

Impact on Coverage. The change in coverage for Maryland residents for each of the penalty scenarios is presented in Figure 2, below.

Under the first scenario (Option 1) the number of people who would take-up employer coverage would increase by 33,000. An estimated 20 percent of workers have an offer of coverage but turn it down. Under the mandate, these people would begin to take coverage. An additional 83,000 people would take private non-group coverage under current insurance market rules. This would primarily be those who would face a penalty for not having health insurance. Lewin assumed that those who do not face a penalty are less likely to obtain coverage. Overall, Lewin estimated that the proposal would result in a 14.7 percent reduction in the uninsured (the number of uninsured is reduced by 116,000).

Under the second scenario (Option 2), the penalty amount is the same (i.e., 75 percent of HDHP); however, people below 400 percent FPL are exempted. A sliding scale penalty would apply for people between 400 percent of FPL through 500 percent FPL. People above 500 percent FPL would pay the full penalty amount. Under this scenario 32,000 more people would take employer coverage. Also, 79,000 more people would take private non-group

coverage and there is a 14 percent reduction in the number of uninsured. The reduction in people taking coverage is lower under this scenario compared to the previous one because more people are exempted from the penalty (in this case all people below 400 percent FPL compared to the previous 300 percent FPL).

Figure 2
Changes in Coverage under the Maryland Personal Responsibility Proposal in 2007 (thousands)

Primary Source of Coverage	Number of People Covered under Current Law	Changes in Coverage Under the Policy Options			
		Alternative Option 1	Alternative Option 2	Alternative Option 3	Alternative Option 4
Employer	3,293	33	32	33	31
Private Non-Employer	139	83	79	100	87
CHAMPUS	82	0.0	0.0	0.0	0.0
Medicare (incl. Dual Eligibles)	643	0.0	0.0	0.0	0.0
Medicaid/SCHIP (excl. Dual Eligibles)	471	0.0	0.0	0.0	0.0
Uninsured	789	(116)	(111)	(133)	(118)
Total	5,417	0.0	0.0	0.0	0.0

Source: Lewin Group estimates using the Health Benefits Simulations Model

Under the third (Option 3) and fourth (Option 4) scenarios, the penalty is a flat fee ($1,000 individual/$2,000 family) but also based on a sliding scale for lower income people. Under the third scenario the penalty begins with people over 300 percent of the FPL and phased-in up to 500 percent the FPL. People above 500 percent pay the full penalty. Under this scenario, 33,000 more people would take employer coverage, 100,000 more would take private non-group coverage and there would be a 16.9 percent reduction in the number of uninsured. The fourth scenario results in 31,000 more people covered through their employer, 87,000 more people through private non-group, and overall results in an almost 15 percent reduction in the number of uninsured. The fourth scenario also results in fewer increases in people taking up coverage in comparison to the third scenario because more people are exempt from the penalty (i.e., the penalty kicks in at 300 percent FPL in the third compared to 400 percent under the fourth scenario).

Overall, Lewin estimates show that having the flat penalty amount has greater effectiveness in enforcing the mandate. Individuals are more likely to seek coverage under the mandate if the cost of the penalty is more than the cost of obtaining coverage. Generally, HDHPs have lower premiums and higher out-of-pocket costs. Thus using a penalty such as 75 percent of a HDHP premium is probably less expensive than the flat fee in the third and fourth scenarios.

Impact on Spending. Figure 3 presents the estimate of the impact of the Personal Responsibility proposal on governments, private employers and households, under each of the

penalty scenarios. The state and local government would generate more tax revenue under Options 1 and 3. In addition, as more people get coverage, State and local governments would see savings resulting from the reduction in uncompensated care as more people obtain health insurance.

State and local governments would save an estimated $58 million under Option 1, and $42 million under Option 3, compared to smaller savings of $26 million under Option 2 and $20 million under Option 4. These savings reflect the combined effect of tax penalty and the reduction in uncompensated care.

The costs to private employers would also increase as a result of the mandate as more people take employer coverage when offered. Lewin estimates that private employers would spend $62 million more under Option 1, $57 million more under Option 2, $61 million more under Option 3, and $55 million more under Option 4.

Figure 3 - Change in Health Spending by Stakeholder Group under the Personal Responsibility Proposal in Maryland in 2007 (millions)

	Alternative Option 1	Alternative Option 2	Alternative Option 3	Alternative Option 4
Without Wage Effects				
State and Local Government	($58)	($26)	($42)	($20)
Federal Government	($20)	($18)	($24)	($22)
Private Employers	$62	$57	$61	$55
Households	$179	$145	$177	$145
Total Health Spending	**$163**	**$158**	**$172**	**$158**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

Households spending on health care would increase as coverage is mandated, no subsidies are provided and a penalty is imposed for those who do not have coverage. People who do not have employer coverage would rather pay the penalty and remain without insurance, if the cost of coverage is more expensive.

Implementation. When considering the implementation of a personal responsibility provision there are several factors to consider.

- **Affordability standard.** One of the biggest challenges for lawmakers will be setting an affordability standard. This requires identifying, explicitly or implicitly, an amount that individuals and families at different income levels can reasonably be expected to spend on health care, encompassing premium alone or premium plus expected out of pocket expenditures. The Lewin model implicitly assumes that individuals at 300 percent or 400 percent FPL are able to afford at least catastrophic coverage. The Massachusetts plan uses affordability standards both to determine the subsidy for individuals with incomes below 300 percent FPL and to determine whether an

individual should be exempted from the penalty because he or she cannot find an affordable policy.

- **Affordable insurance policy.** This concept requires a balancing of the richness of the insurance benefits (breadth of covered services and degree of cost sharing) against what is "reasonably affordable" for an unsubsidized individual or family – usually assessed at the point where any subsidies phase out. Thus, if the subsidy phases out at 300 percent FPL and the affordability standard is 10 percent at that income, an "affordable policy" would have to have a premium below roughly $3000 for an individual or $6000 for a family of four. If policies regarded as providing "reasonable benefits" cannot be obtained at that price, the policy makers would have to either change their definition of "reasonable benefits," change the affordability standard, or extend the eligibility for premium subsidies.
- **Other factors**. The specifics of any legislation requiring a personal responsibility provision and the rules and regulations governing its implementation are critical. Among many details that will need to be addressed are the minimum benefits package, out-of-pocket limits, and possibly Health Savings Accounts accompanied by catastrophic health insurance plans. Key factors include monitoring and enforcement and establishing the requirements of a qualified plan to satisfy the provision. While the personal responsibility provisions in Massachusetts are tied to the tax system, it is important to consider alternative mechanisms.

Issues in the Implementation of a Personal Responsibility Provision. Because the penalty provisions are so central to the success of a personal responsibility provision and so controversial, the Office of the Comptroller was asked to analyze issues in the implementation of a personal responsibility provision.

Office of the Comptroller response regarding implementation of individual mandate

In recent years a number of proposals have been made to use the individual income tax system as a tool to encourage residents to purchase health insurance. These proposals generally penalize those who do not have insurance, whether through various tax mechanisms (such as reducing the amount allowed as a personal exemption) or through a straight penalty added to the bottom line of the tax return. Such mechanisms may provide the appropriate incentive, but in order to be effective a number of issues must be addressed.

The fundamental issue is that existing proposals have largely relied on self-reporting of the lack of health insurance, and self-assessing a penalty. In the absence of means of verifying that an individual does indeed have health insurance and of enforcing collection of the penalty, the level of compliance would be an open question and the incentive effect of this program would be minimized.

Verifying ownership of a health insurance policy must be done on an automated electronic basis in order to be effective. There are a number of ways this could be accomplished. Insurance companies could be required to provide to the Comptroller an electronic list of all policy holders as of a date specified in law to verify the

insurance status reported on an income tax return. Alternatively, employers could be required to report to the Comptroller all employees who do not have health insurance through the employer. The latter method may be preferable as it could also tie loosely in to income eligibility for a waiver from the insurance requirement.

Assuming appropriate, automated verification of insurance status can be achieved, actually collecting the penalty (whether determined through the tax calculation or a surtax) will still be difficult. Collection problems would be mitigated if employers are required to withhold additional amounts for those to whom the surtax applies. Without some sort of withholding requirement, the Comptroller will be left with a large number of collection cases which could ultimately require additional resources and which would likely take several years to resolve (many would remain unresolved). For more information on these issues, see the October 5, 2004 letter from Deputy Comptroller Stephen M. Cordi to Delegates Peter Hammen and Michael Gordon (Appendix C).

At least one model exists for a different approach which may be more efficient for the State, insurance providers and employers, and at least as effective as using the income tax system--the program to verify compliance with automobile insurance laws. The Motor Vehicle Administration selects a sample of vehicle registrations each year, notifying the owners that they must confirm, through their insurance company, that they have vehicle insurance which covers that vehicle or they are subject to certain penalties. A State agency could require something similar for health insurance. A sample of residents (drawn from income tax, drivers' license, unemployment insurance or another fairly comprehensive State database) could be contacted each year and required to provide verification, through insurance companies, of coverage. Those who cannot provide verification or prove they are exempt from holding required coverage would be subject to a penalty (perhaps with a grace period for purchasing insurance), which, in order to be effective, would probably still have to be withheld from paychecks. With a large enough sample, certain verification and enforcement, and appropriate publicity and other notice, the incentive effect of the penalty would be much greater than that of a self-reported penalty which would be difficult to collect. Regardless of the mechanism chosen, the Comptroller's Office will provide whatever assistance it can to ensure the success of such a program, should one be enacted.

Impact on Employer-sponsored Coverage. It is important to structure the personal responsibility provision in a way that would not disrupt or change the role of the employer-based insurance system in Maryland. Employer sponsored insurance will likely remain attractive to employers because of the federal tax exemption for employer contributions, and health benefits will remain one of the ways employers compete for workers. Moreover, middle- and high-income employees will still be better off financially by obtaining coverage through their employers, given that most will not be eligible for income-based premium assistance subsidies provided in the purchasing pool.

Impact on Uncompensated Care. Under the HSCRC's methodologies, bad debt (based on generally accepted accounting principles) is considered that which the hospital, at the time of

admission, expected to collect from the patient but did/could not. Charity care is that care which, at the time of admission, the hospital never intended to bill or collect payment from the patient. Charity care and bad debt are inseparable in the HSCRC data base.

Literature indicates that the amount of total uncompensated care attributable to the uninsured is typically in the range of 60 to 80 percent - meaning that the remaining 20 to 40 percent is a result of unpaid co-payments and deductibles (bad debt). (See Appendix D for an additional information on HSCRC's methodologies).

According to the HSCRC, the modeling assumption that $60 to $70 million in hospital uncompensated care would be averted if individuals above a certain income were required to obtain health insurance is reasonable. However, this amount could be lower depending on the percentage of inpatient and outpatient bills that these individuals are currently paying.

What is clear is that significantly reducing the number of individuals without insurance in Maryland will significantly reduce hospital uncompensated care and will, in turn, reduce hospital rates in Maryland. However, uncompensated care will persist since a portion of it is attributable to unpaid co-payments and deductibles.

<u>Public and Private Strategies to Educate Individuals.</u> The Consumer Education and Advocacy Unit of the Maryland Insurance Administration was established to educate consumers all over the State about various insurance products and explain to consumers their rights and obligations under the terms of their insurance policies. The Unit participates in fairs, tradeshows and other events all over the State where they provide educational materials to consumers and answer questions on various insurance issues including, automobile, homeowners, health and life insurance. The Commissioner and his staff have also given presentations to community groups around the State on insurance topics. This program could be expanded to educate individuals about a personal responsibility provision, should one be enacted.

Private strategies will also need to be developed to educate individuals about the importance of health insurance coverage and the details surrounding a personal responsibility provision. Massachusetts has relied heavily on community and faith-based groups as well as employers to educate individuals on the various aspects of their reforms. The State has used public service announcements at major league sporting events to promote the availability of subsidized plans to meet the personal responsibility requirement. Similar mechanisms could be employed in Maryland.

<u>Need for Exemptions.</u> Legislation that requires individuals to purchase and maintain health insurance coverage may pose a concern for individuals based on certain religious as well as philosophical beliefs.

> **Religious concerns:** Some individuals, such as Christian Scientists, choose to rely on religious, non-medical treatment to meet their health care needs. While such individuals may have health insurance for a variety of reasons, others may not object to minimum

insurance coverage requirements if those requirements also include coverage for religious nonmedical care and treatment

To date, the Massachusetts Health Care Reform Act addresses some of these issues through the inclusion of "any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs" in the regulations defining "minimum creditable coverage," as of January 1, 2009.[52] Additionally, the public's access to spiritual care may be addressed by making it a part of covered benefits in some of the state approved affordable plans which meet minimum creditable coverage requirements. As mentioned previously in this report, the minimum creditable coverage debate was particularly contentious in Massachusetts. One could expect a similar situation should Maryland choose to define minimum coverage standards.

Some individuals still may object to maintaining any form of health insurance on religious grounds, regardless of covered benefits.[53] Therefore, consideration should be given to the need for exemptions to a personal responsibility requirement. The Massachusetts law also provided an opportunity for an exemption through the following language:

> An individual shall be exempt from [maintaining minimum creditable coverage] if he files a sworn affidavit with his income tax return stating that he did not have creditable coverage and that his sincerely held religious beliefs are the basis of his refusal to obtain and maintain creditable coverage during the 12 months of the taxable year for which the return was filed. Any individual who claimed an exemption but received medical health care during the taxable year for which the return is filed shall be liable for providing or arranging for full payment for the medical health care and be subject to the penalties in subsection (b) of section 2.[54]

Philosophical concerns: As the concept of personal responsibility continues to be debated among policymakers it is clear that some individuals will oppose a requirement to purchase health insurance coverage on philosophical grounds, regardless of any benefit to the community by protecting against increased premiums as a result of uncompensated care. Former Governor Romney's original reform proposal gave state residents the option to either purchase health insurance or, if they chose not to do so, "self insure" by posting a $10,000 bond that could be put towards the cost of any hospital care they might use but be unable to afford. The $10,000 figure was taken from the Massachusetts auto insurance law, which also requires the posting of funds if one does not wish to purchase auto insurance.[55]

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[52] Mass. 956 CMR 5.00: Minimum Creditable Coverage. Effective July 1, 2007. http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet

[53] Christian Science Committee on Publication for Maryland. *Concept Paper: Religious Nonmedical Care and Treatment and Maryland Healthcare Reform Legislation.* November 2007.

[54] Mass. Stat. Ann. §111(M)(3). http://www.mass.gov/legis/laws/seslaw06/sl060058.htm

[55] Owcharenko, N. and Moffit, R." The Massachusetts Health Plan: Lessons for the States." *The Heritage Foundation.* July 18, 2006. http://www.heritage.org/Research/HealthCare/bg1953.cfm

While Massachusetts has attempted to make regulatory changes that will result in the personal responsibility requirement being less burdensome and costly, there is still a strong likelihood that some individuals, particularly those of a higher income, will opt to take the penalty for non-compliance rather than purchase coverage.

Employer Responsibility

The strategy proposed in Massachusetts (and Vermont and California) is similar to the play or pay proposals introduced in a number of states across the country. These laws do not require employers to offer insurance, but instead require employers who do not offer insurance (play) to pay a tax to the state (pay). In 2006 alone, 28 states introduced "pay or play" legislation.[56]

ERISA Preemption. The crucial issue facing states considering an employer mandate is the preemption clause of the Employee Retirement Security Act of 1974 (ERISA). ERISA clearly prohibits states from enforcing laws that require employers to provide health insurance for the employees. Only Hawaii has such a law; Congress specifically granted Hawaii an exemption from ERISA's preemption provisions. As popular as play or pay provisions have become, it is unclear whether courts will uphold them. In July, 2006, a federal district court struck down Maryland's Fair Share Health Care Fund Act that requires large employers to contribute 6 to 8 percent of employee wages to health care or pay the difference to a public fund. The court held that the law violated ERISA preemption because it required employers to segregate a separate pool of expenditures for its Maryland employees and structure their health care contributions with an eye toward the law's spending requirement.[57] Careful consideration should be given before sending Maryland down this path again.

Effect of an Individual Mandate on Employers. While ERISA prevents states from legislating that employers offer their employees a specific level of health insurance coverage - an individual mandate can specify a minimum level of benefits that must be held by each person, possibly providing a strong incentive for employers to provide policies that would, at a minimum, allow their workers to meet that standard.

[56] National Conference of State Legislatures, "2006-2007 Fair Share Health Fund or 'Pay or Play Bills: Can States Mandate Employer Health Insurance Benefits." http://www.ncsl.org/programs/health/payorplay2007.htm
[57] *Retail Industry Leaders Assoc. v Fielder*. 2006.

ANALYSIS OF REFORM MODELS FOR MARYLAND

The Original Maryland Health Model

After considering the strategies involved in a Massachusetts-like plan, the Commission chose to model a reform option based on the following principles:

- **Individual choice**. Each Marylander participating in the exchange has a choice among a variety of health plans and benefit designs.
- **Personal responsibility.** Each Marylander must have at least catastrophic coverage.
- **Public responsibility.** Maryland provides premium support to help low income residents purchase affordable coverage.
- **Employer responsibility.** Employers offer either a self-insured plan or access to the exchange, collect health insurance payments through payroll deduction, and provide a Section 125 premium conversion plan. Each employer is encouraged but not required to contribute.
- **A single health insurance market for individual and small group coverage.** The exchange structures the market, providing a framework for choice and a method to merge contributions from the employer, the individual, and the state. Agents and brokers continue to provide the primary access points for coverage.
- **Broad participation.** Remaining uninsured results in substantial penalties (75% the cost of a high deductible health plan). High participation is also assured through premium subsidies based on a generous affordability standard, under which required individual or family contributions to premium range from 0 percent of income at incomes below 100 percent FPL up to 7.5 percent of income at incomes from 250 to 300 percent FPL.
- **Rich benefit design**. The benefit design modeled is equivalent to BC/BS Standard plan offered under the Federal Employees Health Benefits Plan (FEHBP).

This set of principles and design features was intended to produce an outer limit on reform costs. At every choice point, the model intentionally adopted a reasonable but expensive option. Thus the benefits modeled are those of the FEHBP, a generous set of benefits. Subsidies are delivered to all individuals meeting the income criteria, whether they are already insured or not. The affordability standard used was also generous, requiring only a 7.5 percent of income contribution at 300 percent FPL. No special efforts were made to integrate meaningful cost controls and effective incentives into the benefit designs.

MHCC contracted with The Lewin Group to model this reform option.[58] This reform design resulted in near universal coverage of Marylanders (less than 2 percent of Marylanders remain uninsured), but at a high total cost to the state.

[58] This model was originally analyzed in late 2006 and reanalyzed in late 2007 with minor changes in the model regarding how uncompensated care is treated. We use the figures from the new analysis in this report.

Insuring over 98 percent of the population with an FEHBP-like set of benefits results in an increase in total health care spending of $1.318 billion. This increase in utilization results from better access to health care, both appropriate and inappropriate. Because of this increased utilization, health care reform proposals can never pay for themselves entirely from the savings in uncompensated care costs.

Although total spending increases by $1.3 billion, the effects on individuals, employers, and government are complex. Household spending decreases $1.640 billion, while state and local spending increases $2.579 billion, federal spending increases by $331 million, and employer spending increases by $48 million. Small businesses would actually experience a reduction in expenditures. In essence, this design results in a wealth transfer from high and moderate income taxpayers to low and moderate income individuals, to provide them with the premium subsidies necessary to purchase health insurance coverage.

Under this model, reductions in uncompensated care are returned to every payer in the form of reduced rates. Given that these funds are already in the health care system, it may be more reasonable (and more affordable) for the state to capture these savings in uncompensated care – specifically the roughly $450 million in hospital uncompensated care included in rates – and to use the funds to reduce the net cost to the state. The state and local spending estimates would also be reduced by any federal matching achieved through state plan amendment or waiver, and by reductions in public health services used primarily by the uninsured.

The cost to Maryland state and local governments per newly-insured individual would be approximately $3,700 before offsets from the existing uncompensated care fund and approximately $3,000 after the offsets. This figure is similar to John Kerry's 2004 health reform proposal and is half the cost of President Bush's 2007 plan, expressed as cost per newly insured individual.

Alternatives to Reduce the Cost of Expanded Coverage

The Commission then set out to analyze alternative options that could reduce the cost of the initial reform option, while still achieving near universal coverage. Strategies include developing a high performance plan design with narrower benefits (rather than basing the plan on the FEHBP) and using a high performance provider network and/or provider incentives for high quality and low cost. Additional strategies include restricting subsidy eligibility to those uninsured for at least 6 months or using less generous affordability criteria to determine the subsidy. Compared with the 2006 Maryland Plan, these strategies will increase household expenditures – although household expenditures will still be well below current household expenditures for health care - and thus decrease the necessary government expenditures to achieve near universal coverage. Efforts to increase employer expenditures - thereby reducing the required funding from government - include requiring employer contributions (although there are issues with ERISA) and redesigning the subsidy eligibility in an effort to reduce employer crowd out.

Options Modeled. Strategic options included the following:

- **Option 1: Expand Medicaid to 100 percent FPL for Parents**.[59] As illustrated in Massachusetts, Medicaid provides an important foundation for expanding health care coverage. The Massachusetts plan builds on a broad base of public coverage for the poor and near poor and relies on federal Medicaid funds to finance the plan.
- **Option 2: Option 1 Plus a Six Month Anti-crowdout Provision**. In addition to the provisions of Option 1, restrict state premium assistance to the currently uninsured by providing premium subsidies only to individuals who (1) have been uninsured over the six months preceding the effective date of the personal responsibility provision and (2) had not been eligible for employer-sponsored coverage as an employee or family member during that same six month period.
- **Option 3: Option 2 Plus Employer Contributes at Least 1/3 of Premium**. In addition to the provisions of Option 2, require employer to pay one-third of premium and pro-rate a contribution for part-time employees. The modeling assumes that legislation would be passed enabling such a requirement. This option is likely to encounter a strong legal challenge based on ERISA, but was felt to be worth modeling nonetheless.

Summary of Changes in Health Care Coverage. As illustrated in Figure 4, near universal coverage is achieved. Only 60,000 of the estimated 789,000 individuals remain uninsured – slightly over 1 percent of Maryland's population. This increase in coverage is primarily due to an increase in take up of employer-sponsored and non-group (individual) coverage rather than expansions of public coverage.

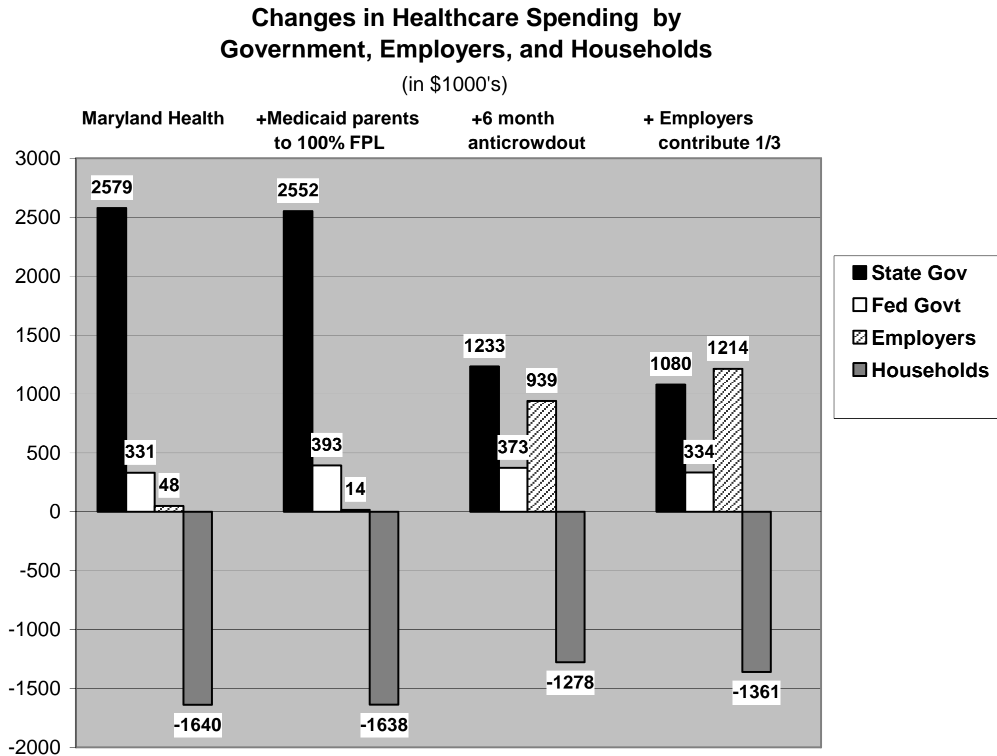
Figure 4

Primary Source of Coverage	Number of People Covered under Current Law	Changes in Coverage Under the Policy Options (in 1,000s)					
		Maryland Health Proposal	+ Medicaid Parents to 100% FPL	+ 6 Month Anti-Crowd out	+ 1/3 Premium Paid by Employers	Benefits Reduced 15%	Expenditures Reduced 5%
Employer	3,293	577	554	554	554	553	554
Private Non-Employer	139	110	103	103	103	105	103
CHAMPUS	82	0.0	0.0	0.0	0.0	0.0	0.0
Medicare	643	0.0	0.0	0.0	0.0	0.0	0.0
Medicaid/SCHIP (	471	41	72	72	72	72	72
Uninsured	789	(728)	(729)	(729)	(729)	(730)	(729)
Total	5,417	0.0	0.0	0.0	0.0	0.0	0.0

[59] The Commission's RFP with The Lewin Group was executed prior to the introduction of Senate Bill 6 during the 2007 Special Session. Senate Bill 6 expands Medicaid to parents up to 116% FPL; therefore, Option 1 has been superceded by the Medicaid expansion in Senate Bill 6. Since different FPL eligibility criteria are used, Lewin's estimates will not correspond with the legislation's fiscal note.

<u>Summary of Changes in Spending.</u> Changes in spending are shown in Figure 5. Because the addition of Medicaid parents to 100 percent was implemented (to 116% FPL) by Senate Bill 6, the summary of spending effects will focus on Option 2, imposition of a 6 month uninsurance requirement to qualify for a subsidy - the most effective and most feasible single option to reduce the cost to the state of near universal coverage.

Figure 5



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

- **Total health care spending.** Insuring 729,000 of the estimated 789,000 uninsured will increase total health care spending by approximately $1.3 billion no matter which option is chosen. (For each option, the change in total health care spending is the sum of the changes for government, employers, and households shown in Figure 5.) The increase in total spending emphasizes again an important point – expansion of coverage cannot be financed through savings in uncompensated care alone. Being insured leads to greater utilization of health care.
- **Spending by families.** Household spending on health care decreases dramatically from current spending – by $1.64 billion in the original Maryland Health modeling and by $1.28 billion in Option 2.
- **State spending.** The introduction of a 6 month anti-crowd-out provision has a tremendous impact on state expenditures for subsidies. Total state spending increases by only $1.23 billion instead of $2.58 billion. Interestingly, requiring at least a 1/3 contribution to premium from every employer does not dramatically

reduce state spending (-$150 million), but does open the program to legal challenge on the grounds that it violates ERISA pre-emption.

- **State spending after recapturing uncompensated care savings.** The modeling assumes that the reductions in uncompensated care and thus the reductions in hospital rates are passed back to all payers. Since these funds are already in the health care system and since the state is paying far more in premium support than the reduction in hospital uncompensated care, the estimated $450 million could be recaptured by the state. Taking into account some minor offsetting increases in costs to the state because hospital rates would not be reduced, we estimate that net state expenditures would increase only $800 million, a cost per newly insured life of approximately $1150.[60]
- **Employer spending.** Without an anti-crowdout provision, employer spending goes up for some employers whose employees take up insurance because of the mandate and down for employers of low wage workers who drop coverage and allow the state to pick up the full subsidy. With the anti-crowdout provision, employer spending increases by $939 million.
- **Income redistribution.** This reform has strong progressive elements, decreasing total healthcare expenditures by households, predominantly those households with low-income subsidy recipients. Since the subsidies are paid by the taxpayer, the net result is a modest redistribution of income to low income working families in Maryland.

Wage Effects Analysis. Economists note that benefits are a form of wages and that enhanced benefits reduce the amounts available for wages. If increases in employer spending are expressed as reductions in net benefits to individuals and families, then a somewhat different picture of net gains and losses results and is illustrated in Appendix E, summarizing changes in expenditures with the so-called "wage effects" included.

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[60] **The Health Services Cost Review Commission reviewed the Lewin Group's modeling of averted uncompensated care** and provided the following analysis:

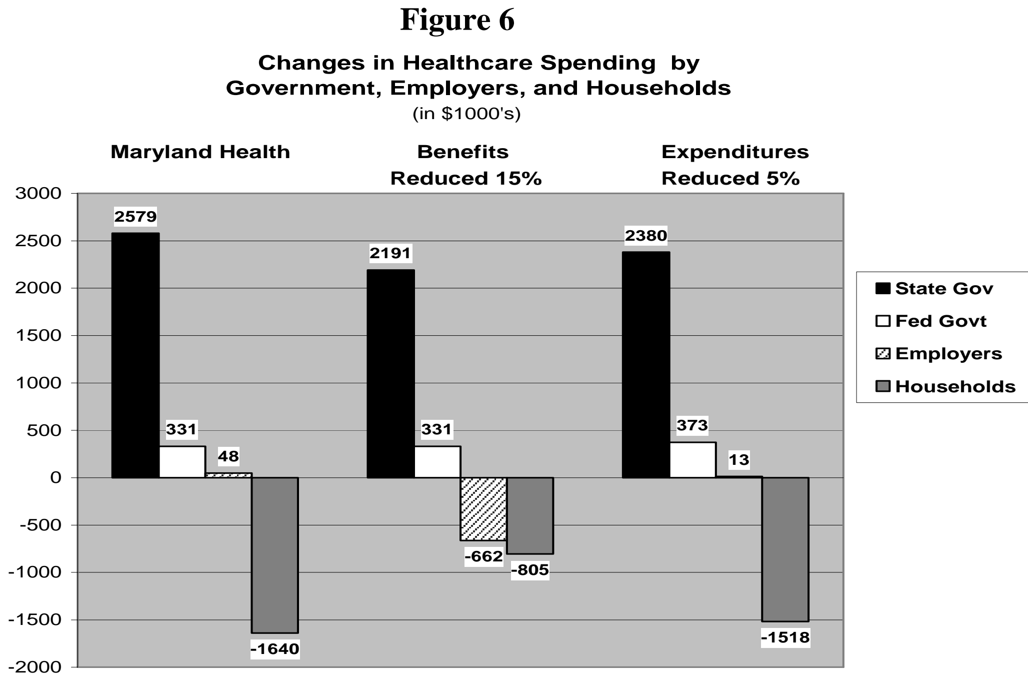
This study has included modeling of the potential impact that significantly reducing the uninsured population would have on hospital uncompensated care. Initial estimates seem undervalued but the final modeling conforms to initial HSCRC modeling on the impact on hospital uncompensated care. Total hospital uncompensated care provided in hospital rates exceeds $900 million.

Modeling from *The Lewin Group* shows that certain options for market reform and personal responsibility could reduce the uninsured population by about 90 percent. The HSCRC defers to *The Lewin Group* and MHCC on the expected reduction in the number of uninsured in the State that would be demonstrated by each proposed option. However, *The Lewin Group's* initial analysis estimates that hospital uncompensated care would be reduced by $180 million which was later revised to be about $500 million. The HSCRC believes that hospital uncompensated care could be reduced by $400 to $500 million (assuming that charity care is 60 to 80 percent of $900 million in total hospital uncompensated care and that those who become covered would demonstrate a similar level of unpaid co-payments and deductibles as the existing insured population). Therefore, the revised estimate by *The Lewin Group* seems reasonable.

While it is clear that significantly reducing the number of individuals without insurance in Maryland will significantly reduce hospital uncompensated care and will, in turn, reduce hospital rates in Maryland, it is important to note that some degree of uncompensated care will persist.

Strategies to Reduce Overall Health Care Expenditures. Because the Commission did not introduce any assumptions about strategies to reduce health care expenditures into the 2006 analysis, the Lewin Group was asked to evaluate the potential impact of two cost-control strategies. Each strategy used the updated Maryland Health model as a starting point and examined two options:

Figure 6



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

- **Reduce benefits by 15 percent.** In this option, benefits were reduced 15 percent by increasing cost sharing (rather than by narrowing covered services). Because of the changed incentives, increasing cost sharing produces a $263 million decrease in health care spending. As might be expected, this option lowered premiums and the required subsidies, while increasing out-of-pocket spending. In comparison to Maryland Health, spending by employers and state government decreased (-$710 million and -$388 million respectively), while household spending increased (+$835 million).
- **Reduce health care expenditures by 5 percent.** In this option, health care expenditures were assumed to be 5 percent lower because of changes in health care delivery, including high performance networks and better incentives to both providers and patients. A 5 percent increase in efficiency yields an 8 percent reduction in state expenditures.

Sensitivity Analysis – Changing the Affordability Standard. Since the subsidy required to purchase health insurance depends on assumptions about the family contribution to premium that should be required at different income levels, the Lewin Group was asked to assess how a change in the affordability standard would affect the cost of the expansion to the state.

- **Increase the affordability standard at 300 percent FPL from 7.5 percent of income to 10 percent of income.** Assuming that individuals and families can spend a larger share of their income on health insurance reduces the state spending only $40 million (not illustrated).

A Closing Comment

Modeling gives neither definitive estimates nor definitive recommendations to guide policy choices, but it can help us understand some of the economic and social implications of policy choices. The original Maryland Health model proved to be prohibitively expensive, but a combination of better targeting of the subsidy to the uninsured and recapture of uncompensated care savings suggests that a broad reform option may reasonably be included among the policy options to be considered by the Administration and General Assembly.

Appendix A

Changes to Title XIX in the Foster Care Independence Act of 1999, (Public Law No. 106-169)

§1902. State plans for medical assistance
(a) Contents
A State plan for medical assistance must –

(ii) at the option of the State, any group or groups of individuals described in section 1905(a) of this title (or, in the case of individuals described in section 1905(a)(i) of this title, any reasonable category of such individuals) who are not individuals described in clause (1) of this subparagraph but –

(XVII) who are independent foster care adolescents (as defined in section 1905(w)(1) of this title), or who are within any reasonable categories of such adolescents specified by the State.

§1905. Definitions
(w) Independent foster care adolescents

(1) For the purposes of this subchapter, the term "independent foster care adolescents" means an individual –

(A) who is under 21 years of age;
(B) who, on the individual's 18th birthday, was in foster care under the responsibility of the State; and \
(C) whose assets, resources, and income do not exceed such levels (if any) as the State may establish consistent with paragraph (2).

(2) The levels established by the State under paragraph (1)(c) may not be less than the corresponding levels applied by the State under section 1931(b) of this title.

(3) A State may limit the eligibility of independent foster care adolescents under section 1902(a)(10)(A)(ii)(XVII) of this title to those individuals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of subchapter IV of this chapter before the date the individuals attained 18 years of age.

Appendix B

Description of How States Provide Medicaid Coverage to Former Foster Youth[61]

Alabama

A state plan category exists for foster youth who remain in state custody to retain Medicaid eligibility. Youth are allowed to remain in custody until age 21.

Alaska

Denali KidCare: Using an 1115 Waiver, Alaska developed a program called Denali KidCare. The program is designed to ensure that children and teens of both working and non-working families can have the health insurance they need. There is no cost for eligible children, teens, and pregnant women. However, youth who are 18 years old may be required to share a limited amount of the cost for some services. This program is available to youth for a 12-month period, but the youth need to reapply every six months. The program is designed to assist beneficiaries whose income exceeds 150 percent of the federal poverty level (FPL), but does not exceed 175 percent of FPL. Native Health Care Program: Another program that Alaska uses to provide Medicaid to youth who age out is the Native Health Care Program. The majority of Alaska's youth in foster care are Alaska Natives and have access to health care through this program.

Arkansas

If former foster youth meet the eligibility criteria for an existing population group (such as the medically needy group), they will qualify for the Medicaid program.

Arizona (Chafee Option Enacted)

The Chafee option program for these youth is known as the Youth Adult Transitional Insurance (YATI) program. All youth who meet the residency and citizenship requirements are pre-enrolled into a Medicaid health plan of their choosing the month they turn 18. The state has a streamlined referral process that allows youth to choose their health care plan and provider for physical and dental health services. All youth are required to undergo an annual review of their eligibility similar to other enrollees in the program. This coverage group is available for these young adults until their 21st birthday.

California (Chafee Option Enacted)

Youth who age out of foster care in California are transitioned into the extended Medi-Cal program on their 18th birthday and will continue until age 21 without requiring the foster care youth or foster care parent to complete an application. There are no income or resource

[61] Data provided from American Public Human Services Association. Medicaid Access for Youth Aging Out of Foster Care. January 2007. http://www.aphsa.org/Home/Doc/Medicaid-Access-for-Youth-Aging-Out-of-Foster-Care-Rpt.pdf

requirements for this group. Redetermination is limited to verification of any remaining factors that affect eligibility, for example, residency. Each foster youth is requested to provide information on change of residency, whenever appropriate.

Colorado

Youth who age out of foster care may be eligible to continue to receive Medicaid coverage based on eligibility using their income and resources as requirements. If an individual is ineligible for Medicaid, eligibility for Colorado's Health Initiative Plan (CHIP) will be determined. CHIP is a public health insurance program for adults ages 19 and over who do not have health insurance—either on their own or through their employer—but have incomes or resources that are too high to qualify for Medicaid.

Connecticut

These youth may qualify, just as any other individual, under the medical component of the State-Administered General Assistance (SAGA) program, which is a 100 percent state-funded program. Individuals who are 18 years of age or older and do not qualify for Connecticut's HUSKY A or Medicaid programs may qualify for SAGA. The individual must be a U.S. citizen or have permanent resident status, have assets under $1000, and have automobile equity below $4,500. The individual's income must be below the "medically needy" income limit. Connecticut is also conducting a pilot program under which 100 youth who have aged out of foster care with both a significant behavioral and physical diagnosis continue to receive Medicaid benefits through SAGA without income or asset requirements.

Delaware

Medicaid benefits are available to these youth through programs that are available to any individual who qualifies. Youth who have income at or below 100 percent of the FPL are covered through age 18. Delaware also provides coverage through the state's 1115 demonstration waiver to uninsured youth age 19 and up who have family income at or below 100 percent of FPL. The youth can call an 800 number to obtain an application, which they then need to mail in to begin the application process.

District of Columbia

A state plan category exists for foster youth who remain in state custody to retain Medicaid eligibility until the month of their 21st birthday.

Florida (Chafee Option Enacted)

Youth who exit foster care at age 18 are eligible for Medicaid services until age 20. Youth who exit foster care and are receiving Road to Independence scholarship benefits are eligible for Medicaid up to age 21. Youth are automatically enrolled in the program.

Illinois

Youth who remain in state custody continue to be eligible for Medicaid coverage until age 21. If the youth's case does close at age 18, the youth maintains Medicaid eligibility until age 19 as a result of Illinois' policy of granting 12 months of continuous eligibility for children.

Idaho

Foster youth are eligible to receive Medicaid until age 19 under Title XIX whether they exit or stay in continued care. After age 19, these youth, just like the general population, may still qualify for Medicaid if they fall under the TANF, SSI or disability criteria. They would apply through the Department of Health and Welfare's self-reliance unit.

Hawaii

The Hawaii QUEST 1115 Demonstration program includes coverage for single, able-bodied individuals over age 18. The state is using this program to qualify former foster care recipients for Medicaid. Hawaii QUEST is a Medicaid managed care program that provides medical and mental health services for eligible residents. Dental services are provided on a fee-for-service basis. Former foster youth must meet an asset and income test to qualify for this program.

Georgia

Georgia receives Chafee funds for the Independent Living Program and Educational and Training Vouchers for youth aging out of foster care. Some youth in the Independent Living Program receive assistance with medical expenses, but it is limited to $500 annually. Some youth remain in foster care past age 18 and continue to receive Medicaid (42 CFR 435.222, 435.308). It is also possible for some youth who are no longer in foster care to meet the criteria for another Medicaid category of assistance (e.g., pregnancy, SSI, etc.).

Indiana (Chafee Option Enacted)

Youth who exited foster care at age 18 are eligible for Medicaid services through age 21. The youth's case manager must submit a form to Medicaid indicating the youth's continuing eligibility for Medicaid due to aging out of foster care. The youth must then sign an application to continue their connection to Medicaid. Youth who aged out of foster care without maintaining their Medicaid eligibility may apply at the Department of Family Resources office in the county of their residence.

Iowa (Chafee Option Enacted)

Youth who exited foster care at age 18 and have countable income under 200 percent of FPL are eligible for Medicaid services through age 21. An automatic redetermination is completed when the youth ages out of foster care. Annual reviews/redeterminations are required for ongoing eligibility.

Kentucky

Youth who age out of foster care at 18 have a reduced benefit medical card until their 19th birthday. Kentucky is covering medical expenses for aged-out youth with Chafee room and board contracts up to their 21st birthday, Education Training Voucher funding up to their 23rd birthday, and the new state Foster Youth Transition Assistance funding that will soon be available to aged-out youth up to their 24th birthday.

Kansas (Chafee Option Enacted)

Youth who are age 18 or older when exiting foster care qualify under the program and are eligible for Medicaid services up through the month of their 21st birthday. Youth are enrolled with the assistance of their social worker when exiting foster care. A special application form has been created for use with youth existing foster care. Youth may apply at any SRS office in Kansas and are not obligated to receive any other services to be eligible for the medical card program. The full Medicaid benefit package is available to the youth enrolled under this Medicaid group.

Louisiana

Medicaid can be extended to these youth through the Young Adult Program. This program allows those who turn 18 to continue to receive Medicaid if they sign a contract agreeing to enroll in a vocational or educational program. As long as the youth are making satisfactory progress in the vocational or educational program, they will remain in the Young Adult Program until they reach age 21.

Maine

Youth aging out of the foster care system can reapply for MaineCare as a "family of one." Youth are declared eligible for services based solely on income and the federal poverty guidelines. Since youth rarely have enough income to put them over the income limit, most qualify for Medicaid.

Massachusetts (Chafee Option Enacted)

The MassHealth program provides comprehensive health insurance or help in paying for private health insurance to over one million Massachusetts children, families, seniors, and people with disabilities. MassHealth includes Massachusetts' Medicaid program, which is implemented in part through an 1115 demonstration project, as well as the State Children's Health Insurance Program (SCHIP). Massachusetts has enacted the Chafee option and is in the process of extending MassHealth coverage to independent foster care adolescents under

that option. These are youth who were in the care or custody of the Department of Social Services on their 18th birthday. Independent foster care adolescents would be covered until their 21st birthday. The state does not intend to impose an income or asset test on this population. Currently, many of these youth already may qualify for MassHealth. For example, MassHealth already covers children in families with income up to 300 percent of FPL up to their 19th birthday, either directly or through premium assistance. Through the 1115 demonstration project, Massachusetts provides subsidized health plan coverage to many low-income families as well as to individuals without children. Individuals with special health care needs may also qualify for other MassHealth coverage types, some of which have no income limit but require cost sharing.

Maryland

The state may pursue the Chafee option in the future.

Michigan

If the former foster youth meets the eligibility criteria for an existing population group, they will qualify for the Medicaid program.

Minnesota

Minnesota allows youth aging out of foster care to remain covered for Medicaid in three ways:
There are two options, based on the youth's age, allowed through the Medicaid state plan.

(1) Youth, including those who aged out of foster care, can maintain their standard Medicaid coverage through age 18 if their net income is at or below 150 percent of FPL.
(2) Youth, including those who aged out of foster care, can maintain their standard Medicaid coverage if they are age 19 to 21 and have a net income at or below 100 percent of FPL. Under a third option, youth can be covered using the state's 1115 waiver program, MinnesotaCare.
    - Youth would be entitled to be covered up to age 21 if they have a net income up to 275 percent of FPL, but would be required to pay a premium on a sliding scale.
    - Youth apply for the program by filing an application in their county of residence or at the state MinnesotaCare office.
    - Youth in the MinnesotaCare program do pay sliding fee premiums based on family income, but those with income at or below 150 percent of FPL pay premiums of $4 per month. Youth whose income exceeds the application income standard may be eligible by incurring medical expenses equal to the amount their income exceeds the income standard.
    - Minnesota provides broad health coverage for these youth enrolled in Medicaid or MinnesotaCare including physician office visits, inpatient and outpatient hospital care, dental care, prescription drugs, some over-the-counter drugs, dental care, vision care, mental health care, and EPSDT care.

Mississippi (Chafee Option Enacted)

Youth who were in foster care on their 18th birthday are eligible for Medicaid services to age 21 without regard to their income or resources. Cases are referred to the state Medicaid agency by the Department of Human Services, which manages the foster care programs; therefore, youth do not need to apply for continuing coverage. Eligibility for Medicaid is continued until the former foster care youth reaches age 21. These youth are eligible for the full range of Medicaid services.

Missouri

The state plans to pursue the Chafee option in the near future.

Montana

These youth may be eligible for a few different programs until age 19 if they meet the criteria:

- The Family Medicaid program: Montana's 1931 program. It covers children and their parents or one specified caretaker relative. Eligibility depends on household size where income limits range from about 30 percent of FPL for large families up to about 36 percent of FPL for families of four or fewer. The resource limit is $3,000. For this program, the youth are required to live with a specified caretaker relative.
- The Child-Age 6 to 19 program: the income limit is 100 percent of FPL, and the resource limit is $15,000.
- The Child-Medically Needy program: the income limit is the same as Family Medicaid, but the child cannot be living with a parent or specified relative. The state uses this program for youth who do not qualify for other coverage and who are not living with a parent/specified caretaker relative. The resource limit for this program is $3,000.
- Eligibility for these programs depends on the youth's living circumstances, income, and resources. Each of these programs covers an individual through the month of their 19th birthday, and coverage is for all Medicaid payable services that are medically necessary. To apply, the youth (or the youth's guardian) would need to complete an application, bring/mail it to an Office of Public Assistance, and provide all information necessary to determine eligibility.

Nebraska

These youth can access these services under the "former ward" program. Medicaid coverage is provided up to age 21 for youth who were wards of the state through a court action or relinquishment, are successfully participating in school, and fall within the medically needy income and resource limits. Youth apply for the program through their case manager, and the income maintenance worker completes the enrollment.

Nevada (Chafee Option Enacted)

Youth who were in foster care on their 18th birthday are eligible and will be given the opportunity to apply through their state or county Family Service worker when they are

exiting foster care. Youth who choose not to apply at that time, but later decide they need assistance, can apply at any time prior to their 21st birthday. These individuals are required to keep their address updated with the state agency. There are no income or resource requirements for this group. Young adults who age out of foster care in another state may also apply for benefits in Nevada. These individuals will need to provide proof they aged out of foster care at age 18 in addition to providing proof they meet the other eligibility requirements.

New Hampshire

Many of these youth are eligible for the Aid to the Permanently and Totally Disabled Program (APTD). Through APTD, qualified youth can receive Medicaid coverage until age 19. Older youth participating in Aftercare Services have access to a limited amount of Chafee funds for their medical needs.

New Mexico

The state has submitted a state plan amendment to include the Chafee option, which is currently being reviewed by CMS.

New Jersey (Chafee Option Enacted)

Youth who were in foster care on their 18th birthday are eligible for Medicaid services up to age 21 without regard to income or resources. Enrolled youth are required to keep their address updated with the state agency. Currently, foster youth can apply for this coverage via a toll-free phone number. The state is working to implement an automatic enrollment process.

New York

The child welfare agency makes a referral when a youth ages out of foster care to have eligibility determined for the Medicaid program, the Family Health Plus program, and the Family Planning Benefit program.

- Medicaid program: for youth who age out of foster care to continue to receive Medicaid coverage, eligibility must be redetermined based on income and resource requirements.
- Family Health Plus: if an individual is ineligible for Medicaid, eligibility for Family Health Plus will be determined. Family Health Plus is a public health insurance program for adults between the ages of 19 and 64 who do not have health insurance—either on their own or through their employers—but have income or resources too high to qualify for Medicaid. Family Health Plus is available to single adults, couples without children, and parents with limited income who are residents of New York State and are United States citizens or fall under one of many immigration categories. Youth who age out of foster care who qualify under one of those categories may be eligible for Family Health Plus.
- Family Planning Benefit: if the former foster care youth is not eligible for Family Health Plus, eligibility for the Family Planning Benefit Program will be determined. The

Family Planning Benefit Program provides Medicaid eligibility to men and to women of child-bearing age who are not eligible for Medicaid and who meet income guidelines. Recipients qualify for comprehensive family planning services through the Family Planning Benefit Program, which is provided through an 1115 demonstration waiver. There is a 12-month renewal for all three programs. Both the Medicaid Program and the Family Health Plus Program provide comprehensive coverage, including prevention, primary care, hospitalization, prescriptions, and other services. The Family Health Plus Program is available through managed care organizations. The Family Planning Benefit Program includes all FDA-approved birth control methods, devices, and supplies; comprehensive reproductive health history and physical/ gynecological examination; male and female sterilization; pregnancy testing and counseling; and preconception counseling.

North Carolina

The state plans to bring the Chafee option before the next legislative session.

North Dakota

Youth who age out of foster care are enrolled into other existing Medicaid categories, and the coverage can continue up to age 21. The youth do not need to complete a new application for Medicaid because the individual's continued eligibility is established through the redetermination process. Earned income for full-time and part-time students who have aged out of foster care, up to age 21, is considered as follows:

- Full-time students' earned income is disregarded.
- Part-time students' earned income is disregarded if the youth is working less than 100 hours per month.
- Assets are disregarded unless the youth is eligible under a disability category.

Individuals who are age 18 and whose income is less than 100 percent of FPL are eligible for full Medicaid benefits. Individuals with higher income and those ages 19 and 20, may be eligible under the Medically Needy Group, and are subject to a spend-down. Recipient liability (spend-down) begins when the individual's net adjusted income exceeds $530 per month (includes a $30 work/training allowance). Individuals who are age 18 and have income between 100 and 140 percent of FPL may opt to have coverage under SCHIP.

Ohio

Youth who emancipate from care may request independent living services from a Public Children Services agency. In addition to income eligibility requirements set by the Medicaid agency, youth accessing independent living services after emancipation may be eligible for Medicaid if they are in an appropriate independent living arrangement. Emancipated youth who do not access independent living services can qualify for Medicaid if they meet the general Medicaid eligibility requirements.

- An independent living arrangement is defined in the Ohio Administrative Rules as a domicile of the person's own choosing that is used by the individual for his principal place of residence. The shelter may be fixed or mobile and located on land or water. Examples

of an independent living arrangement include a house, apartment, mobile home, motor home or houseboats, rooming house, or room and boarding home.

Oklahoma (Chafee Option Enacted)

Oklahoma extends Medicaid to youth aging out of foster care through an 1115 Waiver program called SoonerCare and the state plan based on the Chafee option. Youth who are in custody as reported by the Oklahoma Department of Human Services (OKDHS) on their 18th birthday and living in an out-of-home placement are eligible for Medicaid services until their 21st birthday. SoonerCare eligibility is determined by OKDHS. An application for SoonerCare can be made at, or mailed to, one of the OKDHS county offices. Reapplication is required every 12 months. To qualify, the youth's monthly countable income must be equal to or less than 185 percent of FPL.

Oregon

Foster youth have been designated as a special population under Oregon's State Plan and can continue their medical coverage if they apply and qualify for the Oregon Health Plan (OHP). To qualify, application must be made during the same month that the youth's final substitute care placement is terminated. Youth who qualify must continue to reapply every six months. There is no maximum age limit for participation in the program, but there is an income requirement. Youth who have an income at or below 100 percent of FPL qualify for the program without a premium requirement. Youth whose income is above 10 percent of FPL must pay a small premium (ranging from $9 to $20 per month). These youth receive the OHP standard benefit package.

Pennsylvania

If former foster youth meet the eligibility criteria for an existing population group (such as the medically needy group), they will qualify for the Medicaid program.

Rhode Island (Chafee Option Enacted)

Youth can remain in foster care up to age 21, which allows them to retain Medicaid eligibility. For those youth who age out of care and attend college, the state also offers coverage under the Chafee option.

- If youth, under the Chafee option, exceed the age of 21, the Rhode Island Department of Children, Youth and Families (DCYF) covers their medical expenses until graduation or until they reach the age of 25, whichever comes first. The DCYF generally purchases coverage through the college or university and provides state-sponsored wrap-around medical coverage on a fee-for-service basis. Rhode Island currently does not have a program to extend Medicaid coverage for youth who do not remain in care and do not attend college.

South Carolina (Chafee Option Enacted)

Youth who were in foster care on their 18th birthday are eligible for Medicaid services up to age 21 without regard to their income or resources. Cases are referred to the state Medicaid agency by the Department of Social Services, which manages the foster care program; therefore, youth do not need to apply for coverage. Typically, these youth are already in an established foster care case, and their coverage is protected from ages 18 to 21. These youth are eligible for the full range of Medicaid services.

South Dakota (Chafee Option Enacted)

Youth who were in foster care on their 18th birthday are eligible for Medicaid services through age 21. When the youth ages out of the state system, the office of Medicaid eligibility automatically enrolls the youth into the special program covered under the state plan.

Tennessee

Former foster youth may be eligible for an open Medicaid category, such as the Poverty Level Income Standard category, if they are under 19 and have an income below the FPL. Youth who are over age 19 and under age 21 may be able to qualify in the Medically Needy category. There is no set income level for Medically Needy individuals, but they must meet a spend-down threshold (i.e., they have enough unpaid medical bills that can be spent down to a state-established level). These youth may also be eligible for the state's 1115 waiver if they apply soon after their Medicaid coverage as a foster care child ends. To be eligible for the 1115 waiver, they must be under age 19, lack access to insurance, and have incomes under 200 percent of FPL. Youth who have a medical condition that renders them uninsurable can be eligible at any income level if they are under 19 and lack access to insurance. Eligibility in the 1115 waiver ends when the individual turns 19. These young adults may also qualify under a newly approved demonstration population of non-pregnant adults aged 21 and older who meet criteria similar to those of the Medically Needy program. The state hopes to add this new demonstration group in the near future. To apply for any of these options, these youth can contact the Department of Human Services in the county in which they live.

Texas (Chafee Option Enacted)

Youth who were in foster care prior to turning age 18, and who are not otherwise eligible for medical assistance, are eligible for Medicaid services up to age 21 through the Chafee option. Eligibility is based on an income level at or below 400 percent of FPL, resources at or below $10,000, and an exemption for one vehicle. Under this option, youth receive the full range of Medicaid benefits. Youth are automatically enrolled when they turn age 18 and are required to undergo a recertification every 12 months, which can be completed via mail or phone.

Utah (Chafee Option Enacted)

Youth who were in foster care on their 18th birthday are eligible for Medicaid services up to age 21. When youth are no longer in state custody, they are considered for all Medicaid programs. If the "aging out" program is the only option, the child welfare agency verifies the

youth was in foster care at age 18. The youth must continue to be a resident of the state, must meet citizenship criteria, and must complete application and subsequent certification to qualify under the Chafee option.

Vermont

If former foster youth meet the eligibility criteria for an existing population group (such as the medically needy group), they will qualify for the Medicaid program.

Virginia

Medicaid benefits are available to these youth through programs that are available to any individual who qualifies. Individuals with income at or below 133 percent of FPL are covered up to age 19. Eligibility in other Medicaid-covered groups will be evaluated through the redetermination process at the time the youth ages out of foster care; no new application is needed.

Wisconsin
A request has been made to extend the Chafee option in the Department of Health and Family Services 2007-2009 Biennial Budget Request.

Wyoming (Chafee Option Enacted)
Youth who were in foster care on their 18th birthday are eligible for Medicaid services up to age 21 without regard to their income or resources. Youth can apply through the eligibility worker in each area of the state.

Appendix C

Letter from the Office of the Comptroller Regarding Personal Responsibility Provisions

COMPTROLLER
Of MARYLAND
Serving the People

William Donald Schaefer
Comptroller

Stephen M. Cordi
Deputy Comptroller

October 5, 2004

The Honorable Peter A. Hammen, Chairman
The Honorable Michael R. Gordon, Chairman
House of Delegates
160 Lowe House Office Building
Annapolis, Maryland 21401-1991

RE: Tax Incentives for Purchasing Health Insurance

Dear Delegates Hammen and Gordon:

You have requested the Comptroller's Office to comment upon administrative issues arising from the proposal to create tax incentives for purchasing health insurance. Such a proposal was made in House Bill 967 as introduced by Delegate Hammen at the 2004 session of the General Assembly. The Comptroller's Office has not been a party to discussions of any other proposals, and so I will address my comments to administrative issues arising from House Bill 967 as originally introduced. The Comptroller's Office has no position on the underlying policy.

House Bill 967 would have denied an individual whose income exceeded 300% of the applicable federal poverty level the right to claim either a personal exemption or standard or itemized deductions unless the individual had health insurance meeting the requirements of the legislation. While the proposal had both significant unanswered questions and administrative problems, I believe that it could have been administered at some level of effectiveness. Having said this, it is my judgment that the administration of the proposal could be improved in ways which would contribute to achieving the objectives of the legislation.

The administrative issues that I see presented by House Bill 967 are as follows:

1. The legislation does not address joint returns. It is not clear whether or not, or to what extent, itemized deductions are to be permitted where only one spouse has insurance.

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MRS 711 (MD) or 1.800-735-2258 • TDD 410-260-7157 • scordi@comp.state.md.us

2. The legislation specifies that the personal exemption is lost for each taxpayer or dependent without insurance but that the right to claim standard and itemized deductions is lost only if the taxpayer does not have insurance. This is a significant administrative complexity and seriously diminishes the incentive to insure dependents.

3. The loss of personal exemptions, with its per person computation, is a fairly rational, though regressive, means of encouraging the purchase of health insurance. The loss of itemized deductions, on the other hand, is a lot more arbitrary. While itemized deductions may rise with income levels in some cases (but keep in mind that the Maryland income tax is excluded from Maryland deductions), in many cases, the amount of itemized deductions is driven by casualty losses, mortgage interest payments and extraordinary medical expenses, so that the denial of the deduction is likely to be regressive and bear an inverse relationship to the ability to either buy insurance or pay additional taxes.

4. The loss of personal exemptions and deductions comes before the computation of Maryland taxable net income and thus this loss will automatically increase the local income tax as well as the state income tax. There may or may not be a reason for local government to benefit from the additional taxes which would be collected. Trying to prevent additional local income tax collection by providing, for instance, that the loss of personal exemptions land deductions would apply only to the state talc would hopelessly complicate; income tax returns. Leaving it as it is, though, results in similarly situated taxpayers paying significantly different tax penalties depending upon the county in which they reside. This is because local rates vary from 1.25% to 3.20%. I suspect that this difference in tax penalties will not be found sufficiently arbitrary and capricious so as to constitute the denial of equal protection of the laws, but I can offer you no guarantees.

5. The legislation makes no provision for withholding additional taxes from wages. As a consequence, the Comptroller's Office will be faced with thousands of difficult collection cases that it would not otherwise have had to handle. Sooner or later additional resources will be required.

6. As written, the legislation leaves compliance to the Comptroller but is missing key provisions that would permit compliance to be performed on an automated basis. As a consequence, compliance efforts 'are likely to limited to the relatively few taxpayers whose returns are subjected to, manual audit each year.

Most of the foregoing issues could be resolved with essentially four relatively simple changes in the proposal: (1) change the tax incentive to an insurance surcharge on the state's highest bracket; (2) require employers to withhold on the basis of that bracket from those employees who meet the income test and for whom the employers do not provide qualifying insurance and the employee has not presented evidence of qualifying insurance obtained from another source; (3) in addition to the 6-month test, require taxpayers to have the prescribed insurance as of a date certain, such as December 31st; and (4) require employers; upon request of the Comptroller, to provide automated records of employees whose income exceeds the threshold who do not have employer-provided insurance.

- A rate surcharge would work by increasing the current top bracket of 4.75% to: 5%, 5.25%, 5.5% or some other rate, once a Maryland taxable income threshold determined by the General Assembly was passed. The General Assembly would probably wish to consider higher thresholds for joint returns. For a single taxpayer, if the threshold were $40,000 per year Maryland taxable income, a 5.25% rate would produce an initial surcharge of $200. By the time the income rose to $100,000, the surcharge would be $500. The General Assembly would be free to provide, or not provide, for a flat county surcharge that would produce the same additional incentive regardless of the, residency of the taxpayer. From a public policy point of view, a rate surcharge has the advantages of tying the penalty to ability to pay and creating an incentive that increases as income rises. At the very highest income levels, taxpayers will have no practical alternative but to purchase 'health insurance.

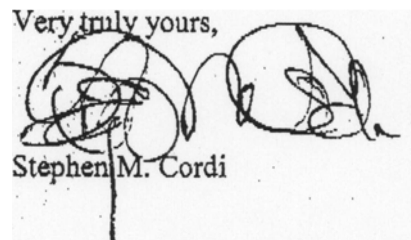
- Collection problems would be ameliorated and compliance would be substantially improved, if employers were required to withhold additional taxes from those employees making more than the threshold who neither carried employer-provided insurance nor presented evidence of other qualifying-insurance. The burden for employers who provide employee health insurance will be modest since they will only be required to obtain documentation from employees over the threshold for whom they do not provide insurance. Employers who chose not to provide health insurance will need to make a determination on only those employees over the threshold.

Page Four
Honorable Peter A. Hammen
Honorable Michael R. Gordon
October 5, 2004

- Making qualification dependent upon having health insurance on December 31st (in addition to the 6-month requirement) will make it possible for the Comptroller to do automated compliance checks from employer records of their insured as of a date certain, (A case can be made that those receiving unemployment insurance payments as of that date should be excluded.) Without the requirement of a date certain, the Comptroller's ability to identify potential non-compliant taxpayers on an automated basis is substantially diminished.

- While it is likely that existing law could be interpreted to allow the Comptroller to require an employer to identify employees with or without health insurance, requiring employers to identify such employees with electronic records is essential to any meaningful compliance and should not be left to interpretation.

The Comptroller's Office very much appreciates the opportunity to comment on the subject of today's hearing. Please feel free to call upon us if we can provide assistance with your deliberations.


Very truly yours,

Stephen M. Cordi

SMC:cc

Appendix D

Health Services Cost Review Commission Methodology Related to Uncompensated Care

Background

The Health Services Cost Review Commission (HSCRC) was created in 1971 in response to concerns about rising hospital costs and the solvency of certain hospitals that treated a significant number of non-paying patients (uninsured or underinsured persons). The HSCRC started setting hospital rates in 1974. At that time, the HSCRC-approved rates applied only to commercial insurers and health maintenance organizations (HMOs). In 1977, the HSCRC negotiated a waiver from Medicare hospital payment rules to bring federal payments under Maryland control. Medicare reimburses Maryland hospitals according to rates established by the HSCRC as long as the State meets a two-part test.

With this waiver, the Maryland system became "all-payer"; the rates established by the HSCRC must be charged to all patients regardless of their insurance status and all payers must reimburse hospitals based on these rates. The waiver is an essential feature of the all-payer system because it: 1) requires Medicare to pay its fair share of hospital costs, including uncompensated care; 2) allows Maryland hospitals to operate under a consistent set of incentives for all patients, regardless of insurance status; and 3) gives the HSCRC greater control over hospital performance than partial regulation would allow. In other states, hospitals must artificially mark-up their charges by 100-200 percent to cover shortfalls due to uncompensated care, discounts to large HMOs and other third party payers, and inadequate reimbursement from Medicare and Medicaid. These marked up charges make payment difficult for self-pay patients and other third party payers not granted discounts and present a serious dilemma in health care today.

Because Maryland hospitals receive an amount in rates to provide reasonable compensation for treating the uninsured, Maryland also does not need to operate public acute care hospitals. Public hospitals are a burden on the taxpayers and the state budget, and typically offer lower quality of care to patients. Maryland has had a policy of opposing two-tiered hospital care for its citizens for several decades.

Funding for Uncompensated Care in Hospital Rates

In Maryland, the hospital rate setting system's provision for uncompensated care is one of the hallmarks of rate regulation in Maryland. By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those citizens who cannot pay for care.

Specifically, the rate setting system builds the reasonable cost of uncompensated care (charity care and bad debt) into the rates of hospitals, and all payers pay the same rates for hospital care. Under the HSCRC's methodologies, bad debt (based on generally accepted accounting principles) is considered that which the hospital, at the time of admission, expected to collect

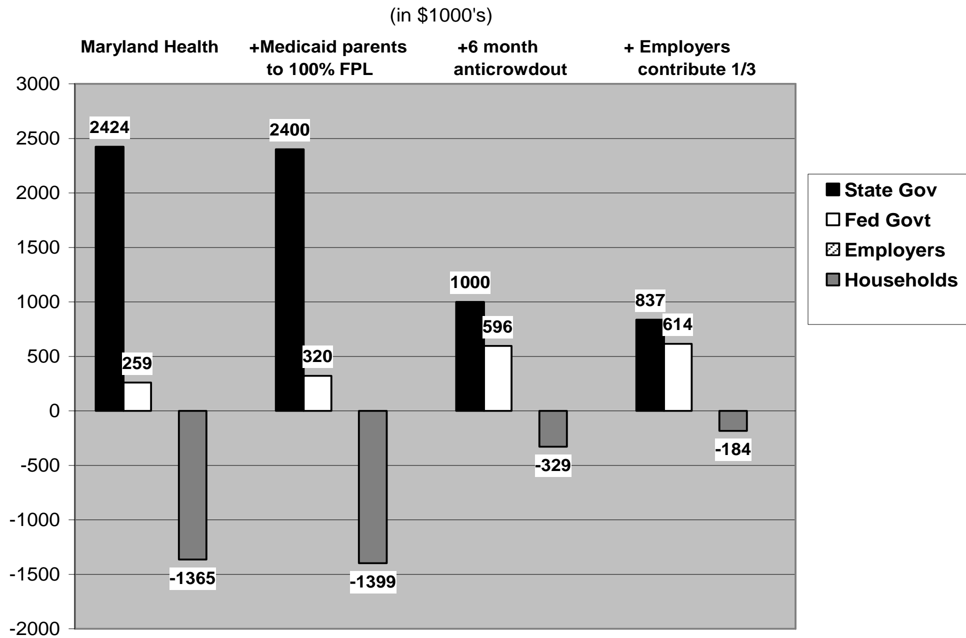
from the patient but did/could not. Charity care is that care which, at the time of admission, the hospital never intended to bill or collect payment from the patient. Charity care and bad debt are inseparable in the HSCRC data base.

The policy uses a methodology to prospectively determine the expected level of uncompensated care for each hospital using 1) the proportion of a hospital's days from Medicaid, self-pay, and charity, and 2) the proportion of a hospital's days from non-Medicare admissions through the emergency room. To protect hospitals and payers from large changes in uncompensated care from year-to-year, the HSCRC also employs a three-year moving average of each individual hospital's reported uncompensated care. Uncompensated care was $842 million in FY 2006 (8% of gross patient revenue), compared to $738 million in FY 2005 (also 8% of gross patient revenue). Approximately 84 percent of the statewide uncompensated care expenditure originates in the state's metropolitan areas.

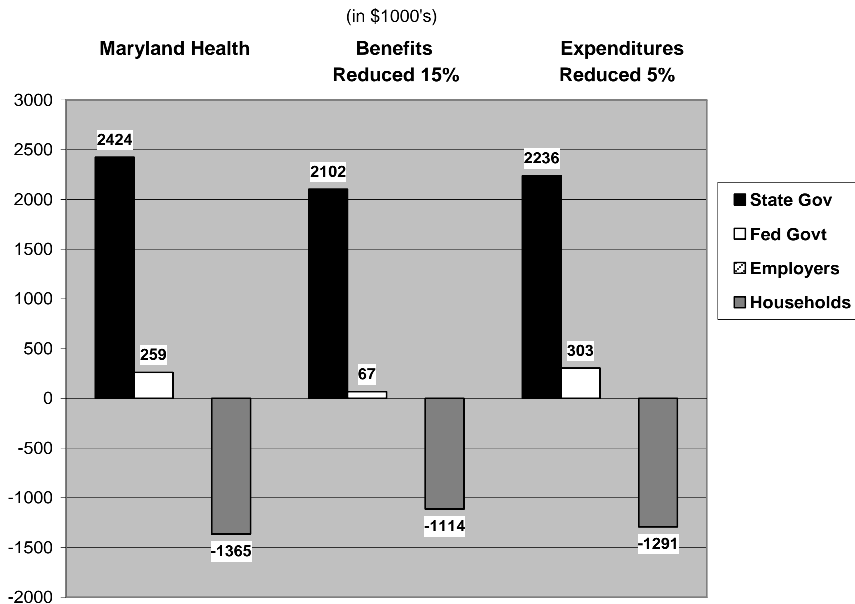
To minimize large differences between the rates of hospitals with the highest and lowest levels of uncompensated care (and to address concerns regarding patient steering), the HSCRC also employs an uncompensated care fund (UC Fund). The HSCRC builds in a 0.75 percent assessment on the rates of all hospitals, pools the funds, and redistributes those funds to hospitals with the highest levels of uncompensated care (those over 7.25% of net patient revenues). The highest amount of mark-up associated with uncompensated care in any hospital's rates, therefore, is limited to 7.25 percent. In Fiscal Year 2006, the UC Fund redistributed approximately $70 million to the State's sixteen highest uncompensated care hospitals.

Appendix E

Modeling Illustrating Wage Effects



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)