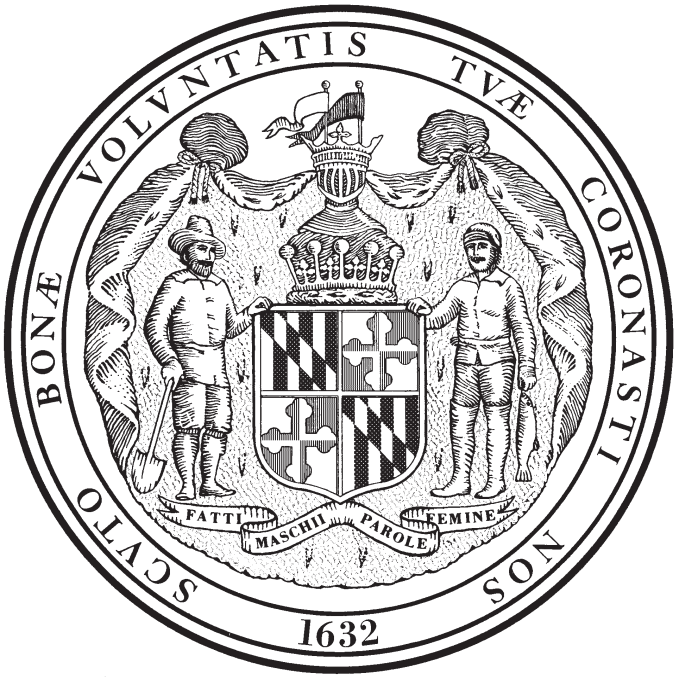
Joint Legislative Task Force on Universal Access to Quality and Affordable Health Care

Final Report



Annapolis, Maryland
January 2007

Joint Legislative Task Force on Universal Access to Quality and Affordable Health Care

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January 16, 2007

The Honorable Robert L. Ehrlich, Jr.
Governor of the State of Maryland

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate

The Honorable Michael E. Busch
Speaker of the House of Delegates

Members of the General Assembly

Ladies and Gentlemen:

Pursuant to the requirements of Chapter 280 of 2005 and Chapter 21 of 2006, the *Joint Legislative Task Force on Universal Access to Quality and Affordable Health Care* respectfully submits its final report.

The final report outlines the creation, charge, and meetings of the task force. The report also gives a snapshot of the uninsured in Maryland. The task force voted to not include specific recommendations in the report but to instead describe the many options that were presented to the task force on how to expand access to care and to summarize the advantages and disadvantages of each type of option. Options that were presented include Medicaid expansions, subsidies for the current health care safety net, individual mandates to purchase health insurance, employer mandates to provide health insurance for their employees, using an insurance connector to facilitate the purchase of health insurance, and making changes to the State's regulation of health insurance.

We would like to take this opportunity to thank the members of the task force, the public, and other stakeholders who participated in the study process by sharing their information and insights on Maryland's health care system.

The task force appreciates your support for its work and looks forward to your consideration and deliberation of our findings.

Sincerely,

Senator Thomas McLain Middleton
Senate Chair

Delegate James Hubbard
House Chair

TMM:JH/LS/kjl

Maryland General Assembly
Joint Legislative Task Force on
Universal Access to Quality and Affordable Health Care
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Delegate James W. Hubbard, **House Chairman**

Senator Joan Carter Conway

Senator Edward J. Kasemeyer

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Delegate Donald B. Elliott

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Dr. Rex W. Cowdry

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Contents

Transmittal Letter iii

Membership Roster v

Introduction 1

A Snapshot of Maryland's Uninsured 2

Options for Expansion of Access to Quality and Affordable Health Care 4

Low to Moderate Income Options 5
- Healthy Maryland Initiative 5
- Medicaid Expansion 6
- Safety Net Subsidies 7
- REACH-type Discount Program 7
- Pharmacy Discount Programs 8
- Medicaid Buy-in or Premium Assistance Programs 8
- Low Income Insurance Subsidy 9

Moderate to High Income Options 10
- Individual Mandate 10

Strategies That Cut Across Income Levels 11
- Employer Mandate 11
- Insurance Connector 11
- Combine Individual and Small Group Markets 12
- Allow Young Adults to Stay on Their Parent's Insurance Policy 12
- Loosen Restrictions on Insurance Offerings 13
- Promote Consumer-directed Plans/Health Savings Accounts 13
- Chronic Disease Management/Wellness Incentives 14
- Expand Availability of Urgent Care Centers 14
- Single-payer Health System 15

Appendix 1 List of Contacts 16

Joint Legislative Task Force on Universal Access to Quality and Affordable Health Care

Final Report

Introduction

The Joint Legislative Task Force on Universal Access to Quality and Affordable Health Care was established by Chapter 280 of 2005 to:

- study and make recommendations on how to make quality, affordable health care (including primary care, specialty care, hospitalization, and prescription drug coverage) accessible to all citizens of the State; and

- analyze the feasibility and desirability of implementing aspects of the "Dirigo Health" plan, the California employer mandate, or other innovative State health care coverage programs in Maryland.

The task force was appointed late in 2005 and held one meeting in January 2006. Chapter 21 of 2006 extended the task force until June 30, 2007, and required the task force to report its findings and recommendations by December 31, 2006.

The task force held five meetings and public hearings in 2006:

- August 30 in Baltimore (Central Maryland)

- September 27 in Bowie (Metro Washington/Southern Maryland)

- October 11 in Hagerstown (Western Maryland)

- October 25 in Wye Mills (Eastern Shore)

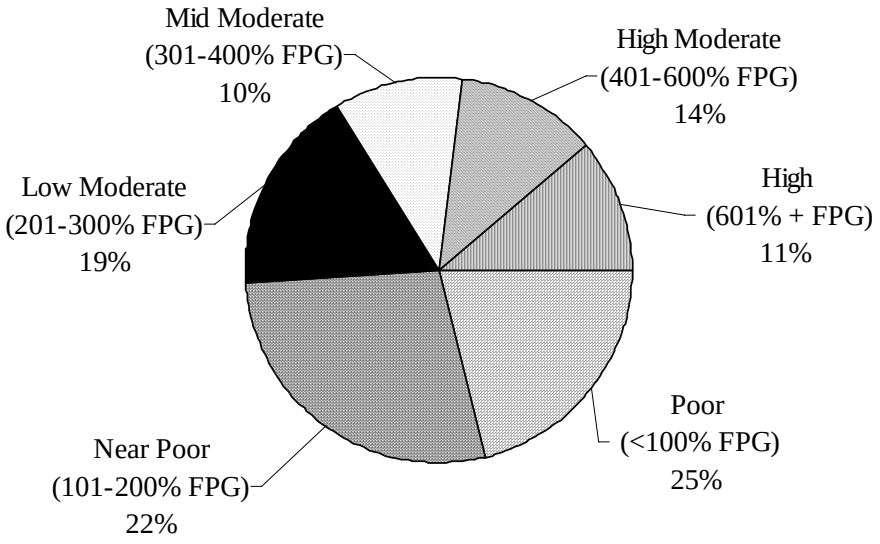
- December 6 in Annapolis

At each of the first four meetings, the task force heard from invited witnesses, as well as public testimony. At the December 6 meeting, the task force reviewed and approved a list of possible options for expansion of health care coverage. The task force voted to forward all options to the Senate Finance Committee and House Health and Government Operations Committee for their consideration during the 2007 session.

A Snapshot of Maryland's Uninsured

In 2005, about 784,000 Marylanders were without health insurance, making the State's uninsured rate about 14 percent. While a lack of insurance is tied to such obvious factors as having a lower income or working for a small business, some statistics are surprising. While those who earn 200 percent of the federal poverty level guidelines (FPG) or less comprise almost half of Maryland's uninsured, those who earn more than 400 percent FPG make up about 25 percent of the uninsured.[1] (See **Exhibit 1.**) In 2006, that means about 195,000 people in Maryland earn at least $39,200 (or $80,000 for a family of four) and do not have health insurance.

Exhibit 1
Maryland's Uninsured by Poverty Level
(Nonelderly Population)

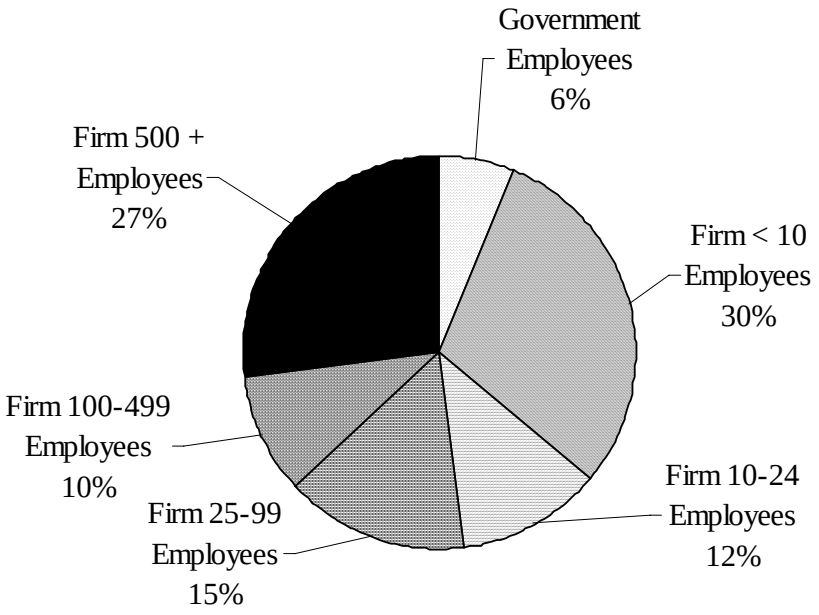


Source: Maryland Health Care Commission

Most of Maryland's uninsured are working adults. About 57 percent, or 440,000, are currently employed. For these workers, firm size factors significantly in whether an individual has health insurance. Fifty-seven percent of uninsured workers work for businesses that employ 99 or fewer workers. Thirty percent work for businesses that employ fewer than 10 employees. (See **Exhibit 2.**)

[1] "Health Insurance Coverage in Maryland Through 2005," Maryland Health Care Commission (January 2007).

Exhibit 2
Uninsured Workers by Sector and Firm Size
(Ages 19-64)

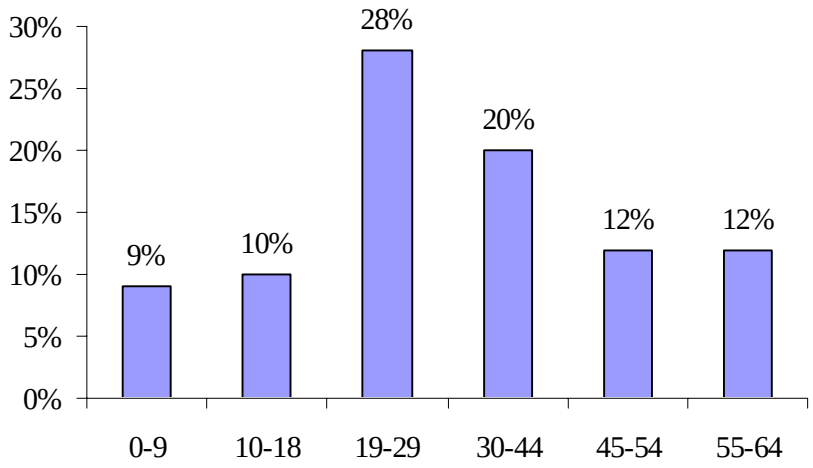


Source: Maryland Health Care Commission

Another significant group with high uninsurance rates are young adults. Young adults ages 19-29 are the least likely to have employer-based insurance coverage, with an uninsured rate of 28 percent. (See **Exhibits 3** and **4.**) Only 56 percent of this age group has coverage through an employer.[2] The uninsured rate for young adults is highest in the lowest income brackets, where 46 percent of all people ages 19-34 have no insurance.

[2] "Health Insurance Coverage in Maryland Through 2005," Maryland Health Care Commission (January 2007).

Exhibit 3
Percentage of Uninsured within Various Age Groups



Source: Maryland Health Care Commission

Exhibit 4
Uninsured Rates in Maryland, by Age and Income[3]

	Uninsured Rate		
Age	**Up to 200% FPG**	**201-400% FPG**	**401% FPG and Over**
0-18	19%	7%	4%
19-34	46%	28%	13%
35-64	40%	18%	7%

Source: Maryland Health Care Commission

Options for Expansion of Access to Quality and Affordable Health Care

To facilitate consideration of options for expanding access to quality and affordable health care, options are grouped by income level, where possible. Some options cut across

[3] "Health Insurance Coverage in Maryland Through 2005," Maryland Health Care Commission (January 2007).

income level and are presented separately. Also listed separately is the Healthy Maryland Initiative, a package of options that received testimony at each of the task force public hearings.

Low to Moderate Income Options

Healthy Maryland Initiative

The initiative uses a $1 increase in the tobacco tax to support:

- expansion of Medicaid eligibility to parents with household income below the federal poverty level;
- tobacco use prevention and cessation efforts;
- drug treatment;
- specialist care for patients of community health centers;
- tax credits for small businesses that purchase health coverage for low income workers; and
- reduction of health care disparities.

The tobacco tax increase would raise $211 million in revenue in the first year, declining to $170 million in subsequent years. Spending under the initiative would remain within available revenues.

Advantages

- Targets low income uninsured. The Department of Legislative Services estimates approximately 24,000 additional adults and, as a result of the "woodwork effect," 15,000 additional children would be served in Medicaid.
- Provides incentive for small businesses to purchase insurance, in addition to expanding public coverage.
- Deters tobacco use, a significant source of health care costs.
- Provides funding for specialty care and drug treatment – important gaps in the State's health care safety net.
- Addresses health care disparities.

Disadvantages

- Requires a tax increase.

Medicaid Expansion

Although Maryland covers children with family income up to 300 percent of FPG under Medicaid and Maryland Children's Health Care Program (MCHP), income eligibility for adults is much more stringent. Currently, Medicaid only covers adults with incomes of approximately 40 percent of FPG and who are (1) aged, blind, and disabled, (2) in a family where one parent is absent, disabled, unemployed, or underemployed, or (3) a pregnant woman. Pregnant women are also eligible for coverage under MCHP if they have incomes up to 250 percent of FPG. Raising Medicaid eligibility for adults to 100 percent of FPG would provide coverage for an estimated 67,000 individuals who now lack health insurance, at a cost of $420 million (including $210 million in federal funds).

Advantages

- Uses existing infrastructure of Medicaid.
- Targets individuals unlikely to afford coverage on their own.
- Federal government pays half the cost (at least for parents of dependent children).
- Under the federal Deficit Reduction Act, it is possible to offer a reduced benefit package to certain groups of enrollees.
- Could achieve savings by moving individuals from other State-funded programs such as the Breast and Cervical Cancer Program.

Disadvantages

- Expensive.
- Coverage of adults without dependent children requires a federal waiver and, if the waiver is denied, the State would pay full cost.
- Could get some people to drop private coverage if able to get more generous Medicaid coverage.

Safety Net Subsidies

In addition to establishing the task force, Chapter 280 of 2005 also created the Community Health Resources Commission and provided funding for grants to community health resources through the commission. The commission has held several meetings but has not yet awarded grants and did not have information on how many uninsured individuals could be served with grant money. However, the Mid-Atlantic Association of Community Health Centers projected in a 2003 paper that community health centers could serve 144,256 new users, including 50,572 uninsured, at a projected cost of $90.6 million ($32.8 million in capital costs and $57.9 million in operating costs).

Advantages

- Uses existing infrastructure of community health centers.
- Targets low income needy population, including non-citizens.
- Leverages additional federal and other funds.

Disadvantages

- While community health centers can provide a medical home for individuals without health insurance, they do not provide specialty or hospital care.
- Greater access to community health resources may discourage individuals from attempting to purchase health insurance.

REACH-type Discount Programs

The Anne Arundel County Health Department contracts with local physicians to care for low income individuals without health insurance for a discounted cash fee. The Health Department does case management and handles the paperwork. The budget for the REACH program, serving 1,500 to 2,000 enrollees, is approximately $430,000. An additional case manager is needed for every 300 to 400 enrollees.

Advantages

- Uses local infrastructure.
- Targets needy individuals, including non-citizens, who may not be eligible for or may be wary of Medicaid.
- Little red tape.

Disadvantages

- Relies on cooperation and coordination between local health departments and local medical societies, which varies across the State.

- Requires providers to sharply discount usual fees.

- Continuity of care depends on who is in the network.

Pharmacy Discount Programs

The Anne Arundel County Health Department contracts with local pharmacies to provide discounts to low income individuals without pharmacy coverage. Administrative costs are absorbed by the REACH staff. Nine other counties participate in the pharmacy discount program offered through the National Association of Counties (NACo). Discounts in the NACo program average 20 percent off retail price, depending on the particular drug. Enrollment as of October 2006 was 7,654. Administrative costs are absorbed by the pharmacy benefit manager that runs the program.

Advantages

- Saves money on drugs at little or no cost to the State.

Disadvantages

- Only improves access to prescription drugs.

Medicaid Buy-in or Premium Assistance Programs

Several states (*e.g.*, New Mexico, Oklahoma, Arkansas, and Tennessee) are experimenting with new insurance products for small firms with low-wage workers. Employers, individuals, and Medicaid all contribute to the premium. Participation requirements and program benefits vary by state. While these programs are still in the early stages of implementation, Arkansas plans to serve 80,000 individuals, New Mexico plans to serve 40,000 individuals, and Oklahoma plans to serve 50,000 individuals within five years. Cost information is not readily available.

Maryland had a premium assistance option in its MCHP from July 2001 to June 2003, which was discontinued for lack of participation. Enrollment in the premium assistance option was only 194 children by June 2003. The State determined the overall administrative costs were too expensive to continue the program, citing lack of enrollee participation as well as difficulty in qualifying employers for participation in the program. One study indicates the State lost $85 per member per month on the buy-in program, compared to providing traditional MCHP coverage for the same enrollees.

Advantages

- State funds leverage federal and private money.
- Potential to reach large numbers of low income individuals.

Disadvantages

- Requires a federal waiver.
- Benefits may or may not be comprehensive.
- Administratively difficult.

Low Income Insurance Subsidy

Some states (Montana, Kentucky, New York, and Massachusetts) subsidize insurance for small employers and/or individuals with 100 percent state funds. Montana's Small Business Health Care Affordability Act provides premium assistance and tax credits to small businesses with two to nine employees. The fiscal note projects expenses of approximately $13 million to provide coverage to 6,200 individuals. Kentucky's new Insurance Coverage, Affordability and Relief to Small Employers Program provides premium assistance payments, including additional payments for employees with high-cost medical conditions, to small employers, with 2 to 25 employees, that have not offered coverage to their employees in the past 12 months. The budget bill provides $20 million for the program, and the fiscal note estimates that 4,000 small businesses with 20,000 employees would be eligible. Healthy New York is a reinsurance program for individuals, sole proprietors, and small businesses. The program enrolls over 110,000 people and spent $34.5 million in 2004. The new Massachusetts Commonwealth Care Program subsidizes insurance for individuals with income between 100 and 300 percent of FPG who do not qualify for Medicaid. A program in Maryland that would be similar to the Massachusetts program is projected to cover 90,000 to 270,000 individuals at a cost of $101 to $304 million.

Advantages

- State funds supplement private funds.
- As these programs are funded through State funds, they can be set up as the State desires.

Disadvantages

- If the program targets small businesses that have not previously provided insurance, employers that are "doing the right thing" by insuring their employees are penalized; if the program assists small businesses that are already insuring their employees, as well as those that do not, state funds are not buying new coverage.

Moderate to High Income Options

Individual Mandate

Massachusetts requires all individuals to have health care coverage by July 1, 2007, and subsidizes coverage for individuals with income up to 300 percent of FPG. In Maryland, HB 1121 of 2006 would have required individuals with income over 500 percent of FPG to have health care coverage or face an income tax surcharge. Under a Massachusetts-style health care plan in Maryland, it is estimated that 66,000 to 198,000 people would purchase health insurance. State revenues from a tax penalty like that in Massachusetts could grow by $3.8 to $11.0 million, depending on the number of individuals complying with the insurance mandate. Revenues would be much higher in the second year under a Massachusetts-type health initiative, as the penalties are much more significant ($74 to $222 million). Under HB 1121 of 2006, it was estimated that 103,000 individuals (75 percent of those affected) would purchase health insurance and that 26,000 would pay the subsidy, resulting in $19.5 million in State revenue that would be used to pay subsidies for people with income below 300 percent of FPG.

Advantages

- Reinforces the principle that those who can afford insurance are obligated to purchase it.

- Increases the size of the insurance pool, providing more stability and, potentially, lower rates.

- Reduces uncompensated care.

Disadvantages

- Forces people to do something they would not otherwise do.

- Not clear where to draw the line in terms of income level at which insurance is affordable.

Strategies That Cut Across Income Levels

Employer Mandate

Massachusetts requires employers with more than 10 employees to pay an assessment of $295 per year for each employee, if the employer does not offer health insurance; employers are also required to set up a "cafeteria plan" for employees, and they are subject to a "free rider" surcharge for uncompensated care incurred by employees. The Vermont Health Care Affordability Act also includes an employer assessment. In Maryland, an employer assessment could generate $9.8 to $29.0 million, depending on how many employers elect to offer insurance coverage.

Advantages

- Consistent with principle of "everybody pays their share."
- Increases the size of the health insurance pool.
- Could generate significant revenue.

Disadvantages

- Could violate the Employee Retirement Income Security Act.
- Could be viewed as anti-business.
- Cafeteria plan would reduce State income tax revenue, by making insurance premium contributions pre-tax income.

Insurance Connector

An insurance connector facilitates the purchase of health insurance that meets quality and other standards. SB 530/HB 1416 of 2006 would have established a similar entity or "exchange." In Massachusetts, the Commonwealth Health Insurance Connector is also charged with overseeing the Commonwealth Care insurance subsidy program and with establishing an affordability standard to be used with the individual insurance mandate. Establishment of a Massachusetts-type connector in Maryland is estimated to cost approximately $66.70 per policy, which could be recouped from participating insurers.

Advantages

- Reduces administrative burden for small business.

- Allows part-time and seasonal employees to combine employer contributions.

- Lets employees carry their policy with them when they transition from one employer to another.

- Gives the choice of insurance plan to the employee, rather than the employer.

Disadvantages

- Unless the connector responsibilities are given to an existing agency, such as the Maryland Health Care Commission, requires a new State or possibly quasi-state agency.

- While concept has promise, it is unproven.

Combine Individual and Small Group Markets

Massachusetts has combined the two markets, claiming that the merger will reduce the cost of an individual plan. While this may be true in Massachusetts, which requires community rating for individual insurance policies, merging the two markets may not reduce the cost of individual plans in Maryland, which does not require community rating.

Advantages

- Creates a larger insurance pool, which could promote stability in the market.

Disadvantages

- Unclear which rules would apply.

- Much uncertainty as to how insurers would price their policies.

Allow Young Adults to Stay on Their Parent's Insurance Policy

Massachusetts, New Jersey, and a few other states are requiring insurers to allow young adults up to age 25 or 30 to remain on their parent's policy. HB 882 of 2006 would have required this up to age 30. In 2005, 28 percent of young adults ages 19-29 were uninsured in Maryland.

Advantages

- May keep more, generally healthy individuals, who might otherwise go without insurance, in the market.

Disadvantages

- Allows such individuals to "game" the system by staying on a parent's policy only if they cannot get insurance in the individual market.

- May increase health care costs for employers, including the State.

Loosen Restrictions on Insurance Offerings

The small business community and the health insurance industry have frequently complained about restrictions in Maryland that stifle innovation. The Comprehensive Standard Health Benefit Plan required to be offered in the small group market is a particular target of complaints.

Advantages

- Provides greater choice of products.

- Promotes competition among insurers.

Disadvantages

- Eliminates a standard for comparison.

- May negatively impact amount and quality of care people receive.

Promote Consumer-directed Plans/Health Savings Accounts

Although the Comprehensive Standard Health Benefit Plan in the small group market permits a high-deductible plan that can be tied to an Health Savings Account (HSA), the business community has suggested the State could do more to promote HSAs and provide incentives for individuals to purchase lower-cost insurance plans.

Advantages

- Lower premiums make consumer-directed plans more affordable.

- High deductible makes consumers more cost conscious.

Disadvantages

- May discourage consumers from seeking needed care.

- Providers may have a harder time getting paid by consumers than by insurers.

Chronic Disease Management/Wellness Incentives

The task force heard repeatedly that 20 percent of the population accounts for 80 percent of health care costs. Providing incentives for patients to manage chronic disease and thereby reduce hospital costs is an approach that may reduce overall health care costs. Currently, hospital costs are estimated to be 30 percent of health care spending in the United States. Several studies coming out of the Asheville Project, which followed members of two self-insured employee health benefit plans in Asheville, North Carolina, showed that training patients on proper medication usage for asthma and diabetes as well as waived co-pays for medication associated with asthma or diabetes resulted in lower overall health care costs for diabetes patients and asthma patients over a period of five years. The lower overall costs reflected decreases in hospital costs and other medical care visits for the patients but did include increased costs for prescription medications.

The Vermont Act establishes a Blueprint for Health, which is designed to prevent and manage chronic disease. The programs will emphasize early screening, support patient self-management, and financially reward health care providers for pro-actively managing chronic disease. The Vermont Act also authorizes a 15 percent premium reduction for compliance with a health promotion program.

Advantages

- Could reduce hospitalizations associated with unmanaged chronic disease.

Disadvantages

- May require short-term cost to achieve long-term benefit.

Expand Availability of Urgent Care Centers

Urgent care centers offer a less expensive alternative to hospital emergency departments for non-life threatening acute illness. Availability of urgent care centers during evening and weekend hours varies across the State.

Advantages

- Reduce demand for emergency department services.

- Provide urgent care in less costly setting.

Disadvantages

- May not integrate easily into local health care system.
- Unlike hospitals, no obligation to provide charity care.

Single-payer Health System

Under a single-payer system, as in Canada, health care services are paid for primarily through taxes, rather than private insurance.

Advantages

- Everyone has access to health care, regardless of income or insurance.
- May reduce administrative costs.
- May reduce overall health care costs, if subject to budget constraints.

Disadvantages

- May lead to rationing.
- May lead to significantly increased tax burden.
- Those with resources may be able to get better or additional care.

Appendix 1

List of Contacts

Laura Tobler, Program Director, Health Program, National Conference of State Legislatures
303.856.1545

Melissa Shannon, Massachusetts Health Care for All
www.hcfa.org

Vincent DeMarco, President, Maryland Citizen's Health Initiative
410.235.9000

Pam Kasemeyer, representing MedChi and the MidAtlantic Association of Community Health Centers
410.269.1618

Dr. Daniel Levy, President, Maryland Chapter of the American Academy of Pediatrics (contact through Pam Kasemeyer)

Pegeen Townsend, Senior Vice President, Legislative Policy, Maryland Hospital Association
410.379-6200

Tom Liberatore and Carol Antoniewicz, Medicaid Matters
301.473.4816

Melodye Berry, La Leche League International
301.603.0331

Quincey Gamble, SEIU 1199
410.332.1199

Virginia Richardson, Montgomery Health Care Action
301.530.4498

Edward E. Smith, Health Action Forum of Prince George's County
301.839.9410

Leigh Cobb, Advocates for Children and Youth
301.469.6545

Darrin Brown, AARP of Maryland
410.895.7613

Joan Alker, Center for Children and Families, Georgetown University Health Policy Institute
Jca25@georgetown.edu

John Hurson, former Chairman, House Health & Government Operations Committee

Alice Burton, Director, State Coverage Initiatives, Academy Health
202.292.6733

Alycia Steinberg, Deputy Director for Planning and Data Analyses, Department of Health and Mental Hygiene
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Dr. Samuel Lin, Chairman, Community Health Resources Commission
c/o Grace Zaczek, Department of Health and Mental Hygiene
410.767.5746

Adrienne Hughes, Health Care Administrator, REACH Program, Anne Arundel County Department of Health
410.222.0005

Phyllis Borzi, J.D., M.A., Research Professor, Department of Health Policy, School of Public Health and Health Services, The George Washington University Medical Center
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Ron Wineholt, Maryland Chamber of Commerce
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Richard Humphrey and Jeffery Kaplan, Physicians for a National Health Plan, and MD Universal Health Care Action Network
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Elizabeth Benson, Maryland Nurses Association
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John Strube, Executive Director, Choptank Community Health System
410.479.4306

Kathy Harvey, Ombudsman, Caroline County Health Department
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Janet Pfeffer, Director of Substance Abuse Programs, Talbot Partnership
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Patricia Hanberry, CEO, Frederick County Mental Health Association
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