Massachusetts' Health Plan and Applicability to Maryland

Department of Legislative Services 2007

Massachusetts' Health Plan and Applicability to Maryland

Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland

January 2007

For further information concerning this document contact:

Library and Information Services
Office of Policy Analysis
Department of Legislative Services
90 State Circle
Annapolis, Maryland 21401

Baltimore Area: 410-946-5400 ● Washington Area: 301-970-5400
Other Areas: 1-800-492-7122, Extension 5400
TDD: 410-946-5401 ● 301-970-5401
Maryland Relay Service: 1-800-735-2258
E-mail: libr@mlis.state.md.us
Home Page: http://mlis.state.md.us

January 29, 2007

The Honorable Thomas V. Mike Miller, Jr., President of the Senate
The Honorable Michael E. Busch, Speaker of the House of Delegates
Members, Maryland General Assembly

Ladies and Gentlemen:

In recent years, there has been a growing national interest in expanding health insurance coverage. Nationally, more than 50 million Americans are uninsured and several states have explored various models for delivering universal health care coverage to their citizens. The one to garner the most recent national attention is Massachusetts' universal health plan, slated for full implementation in July 2007.

Given the importance of access to health care issues and interest in Massachusetts' approach, the Department of Legislative Services prepared this report summarizing Massachusetts' universal health care plan and how such a plan could be implemented in Maryland. The report also outlines potential implementation or funding issues for the General Assembly to consider.

This report was prepared by Susan John and Jennifer Chasse under the direction of Simon Powell and John Rohrer. David Romans also assisted with review and Kim Landry prepared the manuscript.

I trust this report will prove useful to you as the General Assembly considers legislation during the 2007 session.

For further information on this report, please contact Jennifer Chasse of the Office of Policy Analysis at 410-946-5510.

Sincerely,

Karl S. Aro
Executive Director

Contents

Executive Summary

Massachusetts' health care reform plan, enacted in April 2006, targets all insurance markets to assist with providing coverage, imposing mandated coverage on employers and individuals, and expanding Medicaid coverage. The plan may be a model for Maryland and other states, but major differences between the states, as well as key fiscal and policy issues should not be overlooked.

Massachusetts' plan contains the following six major components to expand coverage to the estimated 550,000 uninsured individuals in the state:

***Commonwealth Health Insurance Connector* (the Connector):** The Connector will facilitate the purchase of health insurance by small businesses and individuals. Eligible workers can buy coverage with pre-tax dollars and multiple employers may contribute to an employee's premium.

***Commonwealth Health Insurance Program* (Commonwealth Care):** Commonwealth Care provides subsidized health insurance coverage for low-income uninsured adults with incomes at or below 300 percent of federal poverty guidelines (FPG). Premiums are on a sliding scale based on income with no deductibles. Commonwealth Care is expected to provide subsidized coverage to 207,500 residents.

Medicaid Expansion: Massachusetts' Medicaid program (MassHealth) will expand to cover children with family incomes up to 300 percent FPG and increase existing enrollment caps for the unemployed, people with disabilities, and those with HIV. These changes will cover an additional 92,500 individuals, mostly children.

***Individual Mandate*:** As of July 1, 2007, Massachusetts residents must purchase health insurance when an acceptably comprehensive plan is available at an affordable price or face a financial penalty ($189 in 2007 and half the cost of the lowest available yearly premium in 2008).

Employer Mandate: Employers with 11 or more full-time employees that do not provide a "fair and reasonable" contribution toward employee health insurance coverage must pay a "fair share" contribution of $295 per full-time equivalent. Employers must establish cafeteria plans to allow employees to purchase health insurance coverage with pre-tax dollars or face a surcharge if their employees access certain state-funded care.

Insurance Market Reforms: Along with other reforms, Massachusetts' individual and small group health insurance markets will merge effective July 1, 2007, a change anticipated to reduce individual premiums by an estimated 15 percent.

State and federal spending to expand health insurance coverage in Massachusetts is estimated to be $676 million in the first year, rising to $1.36 billion by fiscal 2009. It has been assumed that the expansion will be primarily financed through the redirection of existing revenue sources currently utilized for uncompensated care. These funds would be augmented by about $125 million in additional state general funds, federal matching funds, and assessments on businesses and individuals

who do not provide or purchase health insurance. It is also assumed that there will be substantial savings to participants through various cost savings measures.

Applying Massachusetts' plan to Maryland would not be a perfect fit. Maryland has a higher percentage of uninsured (14 percent vs. 8.6 percent) and covers fewer individuals under Medicaid (11 percent vs. 15 percent) and in the individual insurance market (6 percent vs. 8 percent). However, with an estimated 780,000 uninsured individuals in 2005, Maryland could explore some components of the Massachusetts plan to expand health insurance coverage:

***The Connector*:** Maryland could establish a connector to facilitate the purchase of health insurance. Approximately 650,000 policies are written in the non-group health insurance market that could transfer to a connector, with an estimated 250,000 new policies. Administrative costs are estimated at $66.70 per policy or a total of about $60 million.

Medicaid Expansion: It is estimated that in 2007 there will be approximately 194,000 uninsured Marylanders below 100 percent FPG. However, this data undercounts Medicaid enrollees; consequently, this number is actually lower. The cost of expanding Medicaid will depend on how many individuals enroll and how many would switch to Medicaid from existing private insurance. The Department of Legislative Services estimates that about 68,000 individuals would enroll in Medicaid and another 18,000 individuals would give up their private insurance in favor of Medicaid if income eligibility were expanded. Total new Medicaid enrollment would be about 85,000. The estimated annual cost per enrollee would be $4,800 for an adult and $1,800 for a child. In fiscal 2008, a Medicaid expansion to 100 percent of FPG would cost about $366 million (50 percent general funds, 50 percent federal funds).

***Subsidized Health Insurance*:** Maryland could subsidize health insurance coverage for the low-income uninsured. In 2007, there will be about 326,000 uninsured Marylanders with incomes between 100 and 300 percent FPG. The cost of subsidizing this population would vary significantly based on enrollment and the level of subsidy provided. For illustrative purposes only, assuming a 50 percent subsidy of enrollees (valued at $2,250 or half the cost of the average premium), enrollment and cost could be as follows: (1) at 25 percent participation, projected enrollment of 82,000 at a cost of $183 million; (2) at 50 percent participation, projected enrollment of 163,000 at a cost of $366 million; (3) at a 75 percent participation rate, projected enrollment of 244,800 at a cost of $549 million.

***Individual Mandate*:** Maryland could implement an individual mandate with similar penalties to Massachusetts. Marylanders who chose not to purchase health insurance would be fined $114 in the first year and about $2,250 in subsequent years. Penalty revenues would greatly depend on compliance with the mandate. It is assumed that individuals with incomes below 300 percent FPG would not be penalized. There will be an estimated 275,400 uninsured Marylanders with incomes above 300 percent FPG in 2007. Using various compliance models, tax revenues could increase between $2.9 and $11.8 million in the first year and

substantially increase to between $77.2 and $231.5 million in subsequent years due to a higher penalty.

Employer Mandate: According to the United States Census Bureau, there are approximately 29,000 firms in Maryland with 10 or more employees (representing 26 percent of all firms). These firms employ an estimated 286,000 uninsured individuals. Maryland could impose a "fair share" assessment on firms that do not offer health insurance and require firms to offer cafeteria plans. If between 69,000 and 207,000 individuals become insured under the individual mandate and employers pay a fair share contribution for half of the remaining uninsured, State revenues could increase by about $13.8 to $29.7 million.

The overall cost to the State of implementing Massachusetts' plan would be mitigated to the extent that the State receives federal matching funds and is able to redirect current spending for inpatient uncompensated care and primary and preventive care. In addition, approximately $700 million is built into Maryland's all-payor hospital rate-setting system for uncompensated care. It is possible that some of the uncompensated care savings resulting from expanding health insurance coverage could be captured to fund coverage expansion.

In considering Massachusetts' plan, several key fiscal and policy issues should be considered:

- Massachusetts had unique motivation: a federal directive to redirect uncompensated care funds to health insurance coverage or lose $385 million in federal Medicaid funding. Maryland does not have such allotted federal Medicaid funds.

- Application of Massachusetts' plan must take into account the state's more robust Medicaid program and lower overall uninsured rate.

- A lack of specificity in Massachusetts' plan could lead to significant unanticipated costs and potentially unforeseen administrative costs.

- The employer fair share contribution requirement could face legal challenge under the Federal Employment Retirement Income Security Act of 1974 (ERISA). A recent federal court ruling held that Maryland's attempt to mandate health insurance spending by certain large employers was preempted by ERISA.

- Coverage and cost estimates of implementing Massachusetts' plan vary widely based on current estimates of the uninsured, the number of eligible individuals that would enroll (take-up rates), and the potential for individuals to drop private coverage in favor of public coverage (crowd-out). The cost of any expansion will ultimately hinge on the specifics of any potential legislation enacted in Maryland.

Massachusetts' Health Plan and Applicability to Maryland

Introduction

As the cost of health insurance continues to increase and more individuals are faced with being uninsured or underinsured, policymakers across the nation are grappling with different ways to provide affordable health care delivery to more people. Nationally, about 50 million individuals are uninsured, and many more are underinsured. Several states have looked at a variety of ways to implement a universal health care coverage system. In 2006, at least eight states considered legislation that would provide some form of universal health care, and two states, Massachusetts and Vermont, recently passed bills that address these issues.

Massachusetts' plan, which is discussed in depth below, targets all markets to assist with providing health care coverage, imposing mandated coverage on employers as well as individuals, and expanding Medicaid coverage to lower-income individuals who are currently uninsured. With these changes, Massachusetts estimates that its uninsured rate could be reduced to as little as 1 percent by 2010.

One significant change in Massachusetts' plan is the merger of the small group and individual health insurance markets. While federal Medicaid funds and state general funds comprise a large portion of the new law's funding mechanism, the plan relies heavily on insurance market reforms that should enable the state to leverage the buying power necessary to purchase lower-priced policies. Even though Massachusetts' market has several unique factors, many states are looking at Massachusetts to see if its model would work for them.

Massachusetts' Current System

Like most states, Massachusetts currently has a variety of health care initiatives in place to provide coverage to its citizens. Its Medicaid program, called MassHealth, covers about 15 percent of state residents.[1] Enrollment in October 2004 was about 960,000 people. Eligibility criteria vary by population. Children in families with incomes up to 200 percent federal poverty guidelines (FPG) qualify for coverage, and parents of these children are eligible with incomes up to 133 percent FPG. (See **Appendix 1.**) Long-term unemployed adults with incomes up to 100 percent of FPG are eligible, as well as pregnant women, disabled adults, people with HIV, and employees of certain participating employers.

In fiscal 2007, Massachusetts is slated to spend about $7.6 billion on the MassHealth program, or about 29 percent of the total state budget.[2] In addition to MassHealth, Massachusetts has several other health care coverage initiatives in place.[3]

[1] Massachusetts Medicaid Policy Institute Fact Sheet (December 2004).
[2] The FY 2007 Conference Committee Budget, Massachusetts Budget and Policy Center (July 7, 2006).

Reinsurance

The state has reinsurance pools for the small group and individual health insurance markets. Carriers that choose to cede risk to the pools pay specified deductibles and coinsurance. The pools pay all claims over $55,000 in the small group market and $50,000 in the individual market.

Uncompensated Care Pool

The Uncompensated Care Pool makes payments to acute care hospitals and community health centers for eligible services provided to low-income uninsured and underinsured people. In fiscal 2004, the pool paid for an estimated 44,000 inpatient and 2.0 million outpatient visits for 454,288 different individuals. Most users of the pool were young adults ages 25-44.[4]

Insurance Partnership

As part of the state's Medicaid program (a Section 1115 waiver), the partnership assists small employers with providing health insurance and aids low-income workers with premiums. Small employers can have part of their premium cost paid on behalf of qualified employees. Workers with family incomes below 200 percent FPG qualify for premium assistance through the MassHealth program.

Children's Medical Security Program

This program provides health insurance for children under the age of 19 who do not qualify for MassHealth and who do not have access to primary and preventive health care. Premiums and deductibles are based on family size and income.

Adult Medical Security Plan

This short-term program assists individuals who have been laid off from work and who receive unemployment insurance payments. The program either provides direct, state-based coverage or helps pay the cost of coverage available through former employers. The state's Section 1115 waiver provides federal Medicaid matching funds for all enrollees.

In addition to these public health programs, about 68 percent of nonelderly Massachusetts residents have health insurance coverage through their employer. About 8 to 10 percent of the population remains uninsured.[5]

---

[3] State Coverage Initiatives, Robert Wood Johnson Foundation (October 2005).
[4] Massachusetts Department of Health and Human Services.
[5] Massachusetts Health Care Reform Plan, Kaiser Family Foundation, April 2006.

A Need for Change

Massachusetts' federal Medicaid waiver requires the state to redirect uncompensated care funds that were being used to support safety-net hospitals to pay for health insurance coverage. If Massachusetts does not make this change, it could lose about $385 million in federal Medicaid funds annually over the next two years.[6] Motivated by the need to redirect funds, the Massachusetts governor and legislature developed a health care reform package aimed at extending insurance coverage to every resident.

Massachusetts' Reform Plan

Massachusetts' reform plan spreads the responsibility and the cost of providing comprehensive health care coverage among the government, private employers, and individuals.

Medicaid Expansion

The plan will expand MassHealth to include all children with family incomes up to 300 percent of FPG. These individuals will be eligible for comprehensive coverage with no premiums or deductibles. In addition, the MassHealth expansion increases enrollment caps for the unemployed, people with disabilities, and those with HIV. It also restores certain dental and vision benefits that had been cut in 2002 for adult MassHealth enrollees. It is estimated that the expansion will cover an additional 92,500 Massachusetts residents, mostly children.[7]

Mandated Individual Coverage

The "individual mandate" requires an individual to purchase health insurance when an acceptably comprehensive plan is available at an affordable price. What is "acceptably comprehensive" and "affordable" have not yet been determined. Beginning July 2007, all residents must purchase health coverage. Individuals will face a financial penalty if they fail to purchase coverage when available. Compliance with this provision will be enforced through the state tax system. In 2007, the penalty for non-compliance will be the loss of the personal exemption ($3,575 for an individual in tax year 2005, resulting in a tax liability of $189).[8] Beginning in 2008, the penalty will be half the cost of the lowest available yearly premium.

---

[6] Massachusetts Health Reform, Community Catalyst, Inc., April 10, 2006.
[7] Massachusetts Health Care Reform Plan, Kaiser Family Foundation (April 2006).
[8] Department of Legislative Services.

Subsidized Health Insurance Coverage

The Commonwealth Care Health Insurance Program, launched in October 2006, provides subsidized coverage for low-income uninsured individuals with incomes below 300 percent of FPG. Premiums are on a sliding scale based on income, with no deductibles. As of January 2007, the lowest available monthly premiums per adult enrollee range from $18 to $106 based on income. Four plan types are available including both low premium and low copayment plans. Those who earn less than 100 percent of FPG will not be responsible for any premiums. This new program is expected to provide subsidized coverage to 207,500 residents.[9] As of December 2006, 47,000 individuals have been determined eligible and 28,875 individuals have enrolled.

Employers

An employer with 11 or more employees that does not provide a "fair and reasonable" contribution toward health insurance coverage for its workers must pay a "fair share" contribution of $295 per full-time equivalent employee. The regulations provide two tests under which an employer can determine whether it meets the definition of "fair and reasonable." The primary test is whether at least 25 percent of the employer's full-time employees are enrolled in an employer-sponsored group health plan. An employer can satisfy this test even if it pays no portion of the premium. In situations where the percentage of enrolled employees is less than 25 percent, the employer is exempt if it offers to pay at least 33 percent of the premium cost toward an individual health plan for full-time employees.

In addition, the new law imposes a surcharge on employers with more than 10 workers who have state-funded employees (such as Medicaid enrollees) for whom the employer does not offer health insurance coverage. To be exempt from the surcharge, employers must either arrange for the purchase of health insurance for such employees, or maintain a cafeteria plan. No employer contribution is required.[10]

Commonwealth Health Insurance Connector (Connector)

In order to facilitate health coverage to small businesses and individuals, Massachusetts has established the Connector, a centralized program that offers health insurance plans to these groups. Eligible workers will be able to buy coverage with pre-tax dollars, and multiple employers may contribute to an employee's premium through the Connector. The Connector program is expected to facilitate portability of coverage, permit multiple source payments for premiums, and make premiums pre-tax.[11] The Connector also sets subsidy levels for the Commonwealth Health Insurance Program.

---

[9] Massachusetts Health Care Reform Plan, Kaiser Family Foundation (April 2006).

[10] "Massachusetts Issues Proposed Health Insurance Regulations," American Staffing Association (July 2, 2006).

[11] Massachusetts Health Care Reform, Stuart H. Altman, Brandeis University (2006).

Insurance Market Reforms

The individual and small group health insurance markets will be merged into one market. It is estimated that this change could reduce individual premiums by about 15 percent. Carriers must offer a lower-premium health insurance product for young adults ages 19-26 years old. Carriers must also offer family coverage to young adults for two years after they lose their dependent status, or up to age 25, whichever occurs first.

Uncompensated Care Pool

Massachusetts' current uncompensated care pool will be changed to the Health Safety Net Care Fund on October 1, 2007, and administered by the state's Office of Medicaid. As more uninsured individuals become covered and uncompensated care drops, these funds will be shifted into the health insurance subsidy program. Currently, the pool reimburses hospitals and community health centers that provide care to eligible low-income uninsured people.

Other Changes

The state will pay hospitals and physicians an additional $90 million annually for three years, increasing rates from about 80 percent of actual costs to about 95 percent of actual costs. Hospitals must meet quality benchmarks to receive rate increases. The new law also restores about $20 million for public health prevention programs, creates an outreach grant program, and establishes an advisory council to study ways to reduce barriers to health care.

Cost of Massachusetts' New Plan

There are various estimates on the new program's cost, and the reliability of funding has been at issue since the law was enacted. Not including existing funding commitments, the new plan is expected to cost about $676 million in fiscal 2007. See **Exhibit 1** for a spending summary. It is assumed that over time, there will be less spending for uncompensated care through the Health Safety Net Trust Fund. As shown in Exhibit 1, there potentially could be a funding shortfall as early as fiscal 2008. One criticism of the plan is that costs could be higher than predicted, and alternative funding sources would be necessary to continue program support in future years.

Exhibit 1
New Spending under Massachusetts' Plan to Expand Health Care Coverage[12]

Program	Fiscal 2007	Fiscal 2008	Fiscal 2009
Commonwealth Care Trust Fund	$450 million	$673 million	$1.1 billion
MassHealth (Medicaid)	$226 million	$240 million	$255 million
Total	**$676 million**	**$913 million**	**$1.36 billion**

Source: Department of Legislative Services

Funding for the expansion comes primarily from existing funds and the new employer assessments. It is difficult to pin down Massachusetts' proposed funding for the new program. **Exhibit 2** illustrates possible proposed revenue sources.[13]

Exhibit 2
Revenue Sources for Massachusetts Health Reform

Revenue Source	Fiscal 2007	Fiscal 2008	Fiscal 2009
Hospital Assessment	$160 million	$160 million	$160 million
Payor Assessment	$160 million	$160 million	$160 million
Individual Mandate Penalties*	$50 million	$40 million	$25 million
Fair Share Assessment*	$45 million	$36 million	$22.5 million
General Fund*	$125 million	$125 million	$125 million
Federal Medicaid Match	$185 million	$242 million	$300 million
Federal Safety Net Revenue		$111 million	$291 million
Total Revenue	**$725 million**	**$874 million**	**$1.08 billion**

*New revenue sources.

Source: Department of Legislative Services

[12] "Massachusetts Health Care Reform," Heller School for Social Policy and Management, Brandeis University, Stuart H. Altman (2006).

[13] "How Much Does It Cost & How Is It Financed?," Health Care For All Massachusetts (April 9, 2006).

These funding and revenue amounts rely on the accuracy of the estimates of the uninsured. If the number of very low-income uninsured individuals was underestimated, program costs could increase significantly. In addition, funds in the Health Safety Net Trust Fund will not be entirely accessible until uncompensated care costs decrease, allowing the state to shift these funds to the subsidy program.

In addition to the state spending component, substantial savings for participants are expected in the individual and small business health insurance markets, slated to be combined and managed under the new Connector. One estimate assumes premiums could be reduced as much as 25 percent due to cost-saving measures such as limiting provider networks, requiring moderate copayments, and managing pharmaceutical costs more efficiently. The Massachusetts Medicaid Administration estimates costs could be reduced to $154 to $280 per month for an individual. Other estimates range at over $300 per month. For those residents with low incomes that qualify for subsidies, it is estimated that premiums will range between $30 and $140 per month.[14]

Massachusetts' Plan in Maryland

Maryland, like many other states, is looking at the Massachusetts plan to see if it could work here. The health care coverage markets in the two states differ in some key respects. **Exhibit 3** illustrates various coverage data.

As these figures illustrate, Massachusetts has a significantly lower percentage of uninsured. There are two notable factors that contribute to this disparity in coverage. Massachusetts has a very robust Medicaid program that covers about 15 percent of the state's population. In contrast, Maryland's program covers only about 11 percent. In addition, coverage in the individual market accounts for 8 percent of all Massachusetts citizens. Maryland has about 6 percent of its citizens covered in the individual market. These two areas are where Maryland could most likely make the most inroads toward substantially reducing or eliminating its uninsured rate.

[14] "Health Premiums for Poor Will Vary," Boston Globe (June 4, 2006).

Exhibit 3
Comparison of Maryland and Massachusetts Markets in 2005

	Maryland	Massachusetts
Population	5.6 million[15]	6.4 million[16]
Median Household Income[17]	$56,763	$52,354
Number of Uninsured	780,000	550,000
Uninsured Rate	14%[18]	8.6%[19]
State Health Care Spending Per Capita	$5,433	$7,082[20]
Number of Medicaid Enrollees*	641,000	960,000
Medicaid Coverage Rate	11%	15%
Medicaid Spending as Percentage of State Budget	21%	23%[21]
Uninsured Rate for Children[22]	9.2%	7.6%
Individuals Covered by Employer-sponsored Insurance	3.9 million	4.4 million
Employer-sponsored Health Insurance Rate[23]	69%	68%
Number Insured in Individual Market	311,000	538,000
Individually Insured Rate	6%	8%

*Includes Children's Health Insurance Program Enrollees.

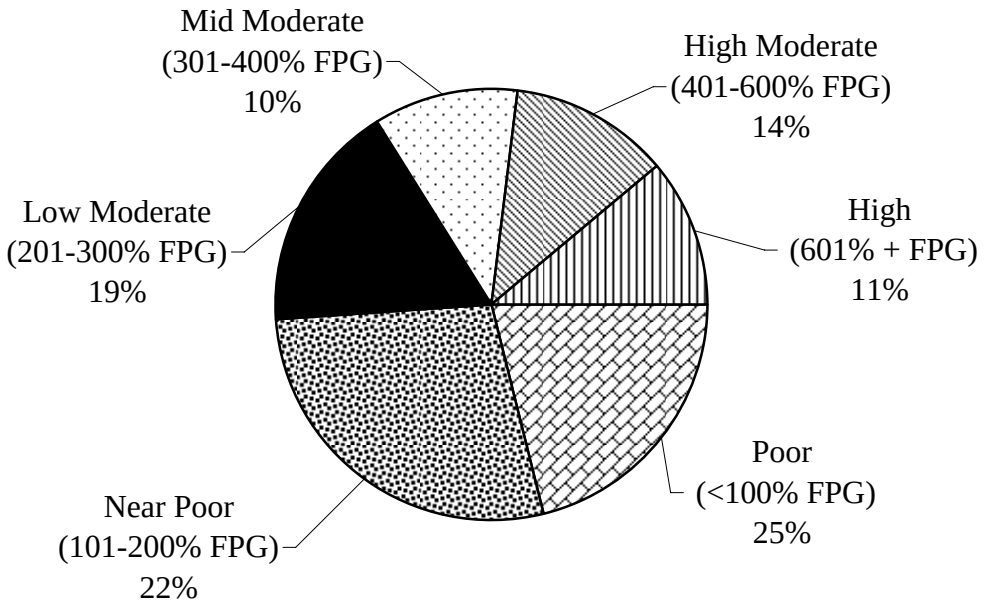
Source: Department of Legislative Services

[15] 2005 Figure, U.S. Census.
[16] 2005 Figure, U.S. Census.
[17] "Income, Poverty, and Health Insurance Coverage in the U.S.: 2004," U.S. Census Bureau (three-year average of 2002-2004 income).
[18] U.S. Census, three-year average: 2002-2004.
[19] Based on 550,000 uninsured and 2005 total population.
[20] National Health Care Expenditure Data, Centers for Medicare and Medicaid Services, 2004.
[21] State Expenditure Report, Fiscal Year 2005, National Association of State Budget Officers (Fall 2006).
[22] Health Insurance Coverage in America 2004 Data Update, The Kaiser Commission on Medicaid and the Uninsured (November 2005).
[23] Health Insurance Coverage in America 2004 Data Update, The Kaiser Commission on Medicaid and the Uninsured (November 2005).

A Snapshot of Maryland's Uninsured

In 2005, about 780,000 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. Low income is not the only factor determining whether someone has health insurance. While those who earn 200 percent of 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.[24] (See **Exhibit 4.**) In 2005, that meant about 195,000 people in Maryland earned at least $39,200 (or $80,000 for a family of four) and did not have health insurance.

Exhibit 4
Maryland's Uninsured by Poverty Level
(Nonelderly Population)



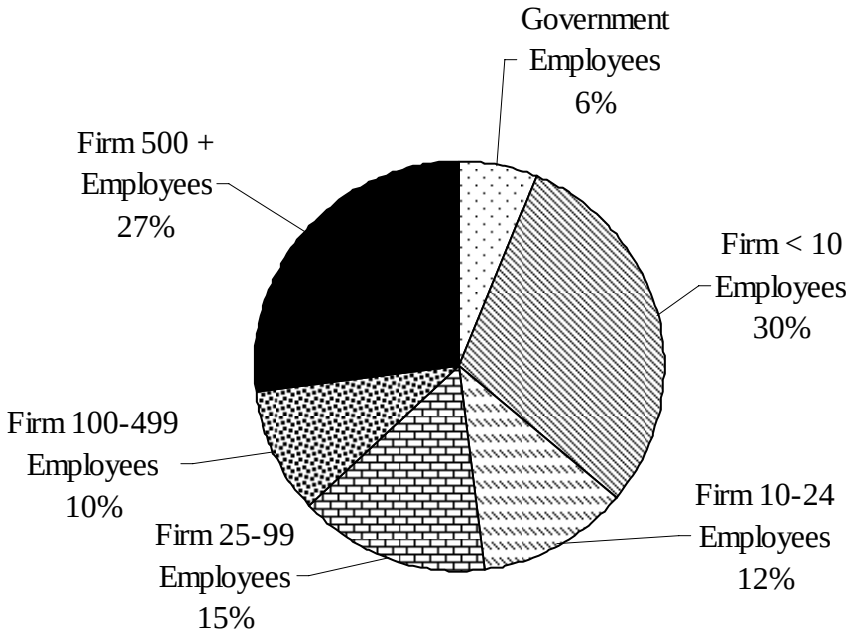
Source: Maryland Health Care Commission

Eight in 10 uninsured individuals in Maryland live in families with at least one working adult. 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

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

fewer workers. Thirty percent work for businesses that employ fewer than 10 employees. (See **Exhibit 5.**)

Exhibit 5
Uninsured Workers by Sector and Firm Size
(Ages 19-64)

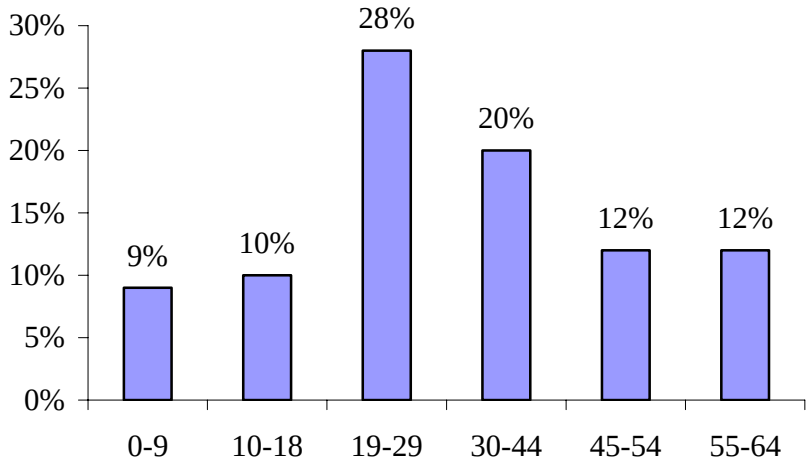


Source: Maryland Health Care Commission

Another significant group with high uninsurance rates is those ages 19-29. Although this group represents about 15 percent of the State's under-65 population, it accounts for an estimated 28 percent of the uninsured population. These young adults are the least likely to have employer-based insurance coverage. (See **Exhibit 6.**) Only 56 percent of this age group has coverage through an employer. About 7 percent purchase insurance in the individual market, and 9 percent are on Medicaid or other public assistance.[25] The uninsured rate for this group is highest in the lowest income brackets, where 46 percent of all people ages 19-29 have no insurance. (See **Exhibit 7**.)

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

Exhibit 6
Percentage of Uninsured within Various Age Groups



Source: Maryland Health Care Commission

Exhibit 7
Uninsured Rates in Maryland, by Age and Income[26]

	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

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

Maryland's Current System

The backbone of Maryland's public health system is its Medicaid program. An adult may qualify for Medicaid if the adult is (1) aged, blind, or disabled; (2) in a family where one parent is absent, disabled, unemployed, or underemployed; or (3) a pregnant woman. Adults with very low incomes also qualify for Medicaid (about 40 percent of FPG). The Maryland Children's Healthcare Program (MCHP) covers children with family incomes up to 300 percent of FPG and pregnant women with incomes up to 250 percent of FPG. There are about 641,000 individuals enrolled in the Medicaid and MCHP programs in fiscal 2007.[27] The fiscal 2007 budget for the Medicaid program is about $4.7 billion. In addition to Medicaid and MCHP, Maryland has several other health care coverage programs.

Maryland Primary Adult Care Program

The Maryland Primary Adult Care Program (MPACP) covers individuals who earn up to 116 percent of FPG. MPACP provides primary care health services. It also provides prescription drug coverage for those who are not eligible for the Medicare Part D prescription drug program. Primary care services are provided through a managed care network. MPACP has about 24,000 enrollees.

Maryland Health Insurance Plan (MHIP)

MHIP is a high-risk health insurance pool that provides comprehensive health coverage to medically uninsurable individuals. There are approximately 9,600 enrollees.[28]

Uncompensated Care Fund

Maryland has an uncompensated care fund that makes payments to acute care hospitals to defray their share of uncompensated care. The fiscal 2007 budget for the fund is $78 million.[29] These funds are collected from a fee imposed on the gross profits of hospitals, and redistributed by the Health Services Cost Review Commission (HSCRC) to hospitals based on their proportional share of uninsured individuals treated.

In addition, HSCRC builds an uncompensated care component into all hospital rates. This includes both charity care and bad debt. For fiscal 2007, hospitals received $701 million for uncompensated care through the rate structure.[30]

---

[27] The Department of Legislative Services estimate, fiscal 2007.
[28] October 2006 enrollment.
[29] Department of Legislative Services Budget Analysis 2006.
[30] Maryland Health Services Cost Review Commission.

Applying Massachusetts' Plan to Maryland

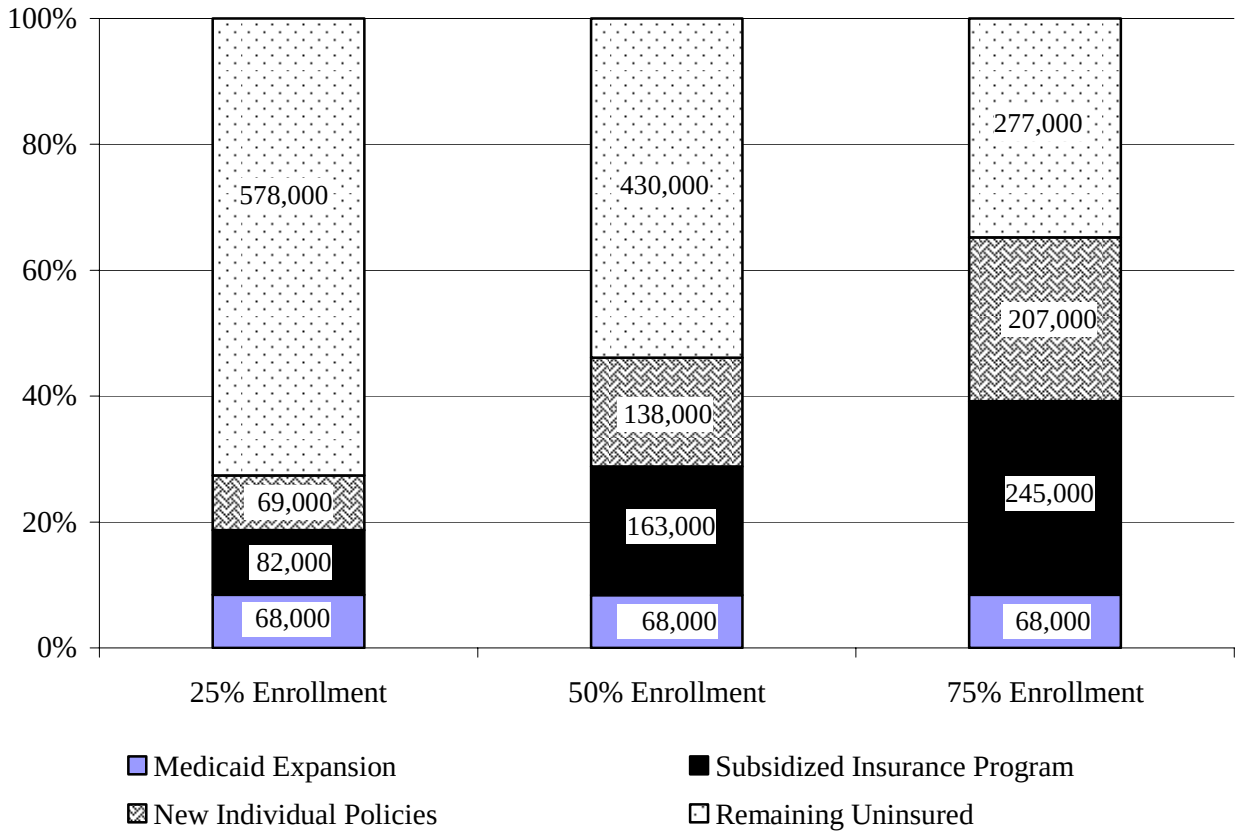
Applying the Massachusetts plan to Maryland would not be a perfect fit due to the demographic differences between the two states. The major components of Massachusetts' plan that could be applied to Maryland are (1) increasing Medicaid coverage for all adults up to 100 percent of FPG; (2) mandating individual health insurance coverage and imposing penalties for noncompliance; (3) mandating employer coverage or a specified contribution; (4) providing subsidized health insurance coverage for individuals who earn less than 300 percent of FPG; (5) creating the Connector as a central clearinghouse for insurance policies; (6) combining the small group and individual health insurance markets; and (7) redirecting uncompensated care savings to pay for subsidized health insurance as uninsured rates and uncompensated care costs decrease.

Assumptions Made for This Report

For some of these proposed programs, such as a Medicaid expansion to 100 percent of FPG, there are sufficient data to estimate both the cost of the expansion as well as the number of new individuals who would obtain coverage. For others, like the individual health care coverage mandate, it is unknown how many people would choose or be able to obtain insurance to avoid paying penalties. In order to give a point of reference for potential costs and revenues under the plan – in programs where data are insufficient to make reliable estimates – examples with 25, 50, and 75 percent enrollment rates are given. The costs provided below assume coverage begins in fiscal 2008 and assume that there would be about 796,000 uninsured Marylanders under existing programs.

Exhibit 8 compares the reduction in the number of uninsured by enrollment rates. Given the following scenarios, Maryland's uninsured rate could drop to anywhere between 5 and 10 percent, with between 27 and 65 percent of the uninsured gaining coverage. Over time, the number of individuals obtaining health care coverage is expected to increase due to program outreach and the various incentives and penalties associated with each program.

Exhibit 8
Reduction of Uninsured by Enrollment Rate



Source: Department of Legislative Services

Crowd-out and Take-up Rate

There are two major factors that impact actual enrollment rates in new programs. A take-up rate is the average number of eligible individuals that actually enroll in new coverage. Take-up rates vary widely in the health insurance industry and are related to the types of benefit packages offered as well as an individual's premium share and out-of-pocket costs. In general, the higher the cost-sharing is, the lower the participation rate. Yet, even when comprehensive coverage is offered to the lowest-income individuals, not all people choose to enroll.

According to one report, the rate for public insurance take-up for population groups below 150 percent of FPG is generally between 55 and 60 percent. Whether an adult has children or not has a significant impact on participation in a Medicaid expansion. It is estimated that for parents earning less than 150 percent of FPG, there is a 90 percent participation rate in

Medicaid expansions. For childless adults earning the same amount, the take-up rate averages only 30 percent.[31]

The other factor that influences enrollment rates is "crowd-out," where people substitute public health coverage such as Medicaid for their private coverage. Crowd-out occurs when a public health offering is more attractive financially than an individual's current coverage. Medicaid plans are very attractive options for lower-income individuals. Plan benefits historically have been more comprehensive than many private-market products. Further, Medicaid generally has minimal or no out-of-pocket costs for participants.

There are sufficient data to reliably predict the impact of these two factors on Medicaid enrollment, as discussed below. For new programs, such as the subsidized health insurance program, it is difficult to predict enrollment patterns, including both take-up and crowd-out rates. For this reason, this paper provides estimates for 25, 50, and 75 percent enrollment rates in the various programs offered. It is assumed that the new programs would be structured to minimize individuals substituting public for private coverage.

Coverage Expansion, Cost, and Revenues

Medicaid Expansion

In Maryland, about 47 percent of adults earning less than 100 percent of FPG are uninsured. This population has limited access to employer-based coverage, and a Medicaid expansion is generally thought to be the most efficient method of extending health care coverage.[32]

In 2007, it is estimated that there will be approximately 194,000 uninsured Marylanders below the federal poverty level. To reflect a potential undercount of Medicaid enrollees, this number is adjusted using current Medicaid enrollment data to 159,000. Of these, it is estimated that about 68,000 would enroll in Medicaid if the income eligibility limit were increased. Another 18,000 individuals would give up their current private health insurance in favor of the Medicaid benefit package. Total new Medicaid enrollment would be about 85,000 people.

Several take-up rates are used to calculate this number based on a recent report on expanding Maryland's Medicaid coverage to higher-income adults.[33] It is assumed that the take-up rate would be 30 percent for children, 40 percent for childless adults, and 60 percent for parents. This rate reflects only those new enrollees who were previously uninsured. Over time through outreach efforts, this enrollment rate would be expected to increase. To account for

[31] Maryland State Planning Grant Final Report, Johns Hopkins Bloomberg School of Public Health (January 23, 2005).

[32] Ibid.

[33] Ibid.

crowd-out, it is assumed that for individuals under 100 percent of FPG, 25 percent of those with private non-group health insurance and 12.5 percent of those with private group health insurance would give up their insurance and enroll in Medicaid.[34]

Assuming that 83 percent of new enrollees would be adults at an annual cost of $4,775 and 17 percent would be children at an annual cost of $1,836, a Medicaid expansion to 100 percent of FPG would cost about $366 million in fiscal 2008. These enrollment costs are estimates based on historical Medicaid expenditures. The actual figures may be less, depending on the overall health of the new enrollees.

Federal Funding Match

Depending on actual enrollment demographics and future federal matches to MCHP, the general fund liability would be about half, or $183 million. While an exact figure is indeterminate at this time, it is important to note that a significant number of new enrollees could be legal immigrants who have resided in the State for fewer than five years. In this case, the State would receive no federal fund match for the cost of this population.

This estimate does not include administrative costs and does not reflect a phased-in enrollment approach. It is estimated that this expansion would reduce the State's overall uninsured rate by about 1.1 percent an 8.4 percent reduction in the total number of the uninsured. The reduction in the number of uninsured is not directly proportional to the number of new Medicaid enrollees since it is estimated that about 21 percent of new Medicaid enrollees would switch from some form of employer-based coverage to the lower cost and often more comprehensive Medicaid program. The shift from employer-based coverage to Medicaid could be mitigated to some extent by the fair share contribution that would be levied on employers that have 10 or more employees on State-based health programs. There are insufficient data at this time to estimate the impact the employer surcharge could have on Medicaid enrollment.

Subsidized Health Insurance

This component calls for the subsidization of lower-income individuals' health insurance premiums. Individuals with incomes over 100 percent of FPG and up to 300 percent of FPG would be eligible for a sliding-scale subsidy based on income. Those with incomes under 100 percent of FPG would be fully subsidized. It is assumed that all eligible individuals who choose to enroll in a program would choose Medicaid (fewer out-of-pocket costs for enrollees), and therefore no enrollment is expected in the subsidized health insurance program by those with incomes under 100 percent of FPG.

There are about 326,000 Marylanders with incomes between 100 and 300 percent of FPG who are uninsured and who could be eligible to participate in the subsidy program.[35] The cost

[34] Ibid.

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

of such a program would vary significantly, depending on the number of individuals who apply for subsidized coverage, any employer contributions, and actual subsidy amounts.

Assuming that 25 percent of those with incomes between 100 and 300 percent of FPG enroll, enrollment could total 82,000. Actual costs would depend on the amount of subsidy provided to enrollees. For illustrative purposes only, if the average premium in fiscal 2007 is $4,500 per individual and the program provides an average 50 percent subsidy for those on the sliding-scale, State costs could total $183 million in the first year. If 50 percent of those with incomes between 100 and 300 percent of FPG enrolled, or 163,000, State costs could reach $366 million. A 75 percent enrollment rate would result in about 244,800 enrollees and cost the State about $549 million.

Individual Coverage Mandate and Tax Penalty

Under this mandate, an individual would be required to purchase an acceptably comprehensive plan at an affordable price. Failure to do so would mean the loss of the personal exemption on the individual's taxes ($2,400 for tax year 2005) during the first year of the program, and one half the cost of the lowest available premium any year thereafter. The average increased tax liability for a Marylander who chooses not to purchase health insurance would be $114.[36] The penalty for noncompliance would be significantly higher in future years, since the penalty is a straight fee paid based on health insurance premiums. In 2004, the average individual premium was $3,279.[37] Based on an annual increase in the average premium of 11 percent, an individual could be penalized about $2,242 in 2008 for failure to obtain health insurance.

Using the various compliance models, tax revenues could increase between $3.9 and $11.8 million in the first year when an individual is subject to a $114 penalty. In the next tax year, penalties could increase substantially to between $77.2 and $231.5 million since the tax penalty would be half of the average premium. These estimates assume 25, 50, and 75 percent compliance with obtaining health care coverage, and of those remaining uninsured, 50 percent would pay the tax penalty. To the extent a potential tax penalty incentivizes people to buy health insurance, tax revenues could be considerably less. Further, the payment of such penalties is strictly based on an honor system. If the Comptroller implemented a system by which to verify coverage, administrative costs could be significant. These figures also assume that those individuals earning less than 300 percent of FPG would not pay any tax liabilities. Faced with a tax penalty, these individuals would most likely enroll in Medicaid or the subsidized insurance program.

These revenues would in all likelihood be collected by the Comptroller during regular annual State income tax collection. Since the Comptroller relies primarily on an honor system and does not audit compliance with most tax credits, compliance with this tax penalty could vary widely.

---

[36] Department of Legislative Services.

[37] "Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits," America's Health Insurance Plans, Center for Policy and Research (August 2005).

Employer Contribution

This component mandates that an employer with 11 or more employees either offer health care coverage for its employees, or pay a "fair share" contribution of $295 per full-time employee. For employers who do provide insurance, they must do so using a cafeteria plan for its employees. This federal tax vehicle permits employees to use pre-tax dollars to purchase health insurance and other related insurance products.

Again there are insufficient data to reliably estimate the number of individuals who will become insured under their employer plans, and how many will remain uninsured, for which certain employers would be required to pay the fair share contribution. If it is assumed that the majority of the 69,000 to 207,000 (depending on participation rate) newly insured individuals discussed under the individual mandate become insured through their employer, there is a definite overlap in the way these two mandates work to increase insurance coverage. If employers pay a fair share contribution for half of the remaining uninsured, State revenues could increase by about $13.7 to $29.7 million.

Requiring employers to use cafeteria plans would result in some additional administrative burdens, including writing and maintaining a plan document, distributing specified communications to employees, and implementing proper changes in tax withholdings.

The Connector

The Connector is a State authority that will serve as the centralized location where individuals and small businesses "shop" for health insurance policies. The Connector will facilitate the purchase and maintenance of health insurance policies because it will allow multiple employers to contribute toward an employee's premium, and the policy will be portable from job to job. Savings are expected to be achieved by combining the small group and individual markets, permitting parents to retain their children on their policies for two years after the children lose dependent status (up to age 25), and encouraging insurers to create lower-cost policies specifically targeted at 19-26 year olds.

The concept of insurance policy portability among jobs could be a significant factor in achieving savings. Many individuals are uninsured for only part of the year, often due to changes in employment. One analyst indicates that tying health insurance to a particular individual, which is what the Connector would do, rather than to the job, the uninsured rate could decrease by one-third to one-half without the need for additional funding.[38]

Projecting administrative costs for the Connector depends on the number of people who purchase their health insurance from it. There are approximately 192,000 policies written in the individual market, 451,000 policies in the small group market, and 9,600 insured through MHIP

[38] "Point-Counterpoint: Connector is Key to New Massachusetts Law," National Conference of State Legislatures (July 24, 2006).

that could transfer to coverage under the Connector.[39] Depending on the number of new insureds, this figure could increase significantly. The "Consumer Health Open Insurance Act of 2006" (SB 530 of 2006) proposed an Exchange that was similar in function to Massachusetts' Connector, combining the small group and individual markets and administering the payment of premiums, both from individuals and contributing employers. The Maryland Health Care Commission, which would have been responsible for administering the Exchange, estimated that 900,000 individual policies would be written, at an administrative cost of $66.70 per policy, or about $60 million. Such a cost would be less than 2 percent of an average premium and could be recovered as a fee.

Funding Issues

Unlike Massachusetts, Maryland does not have allotted federal Medicaid funds that could be used to finance a health insurance coverage expansion. While various constraints exist on traditional federal funding, Maryland could explore the use of federal Health Insurance Flexibility and Accountability waivers to expand Medicaid coverage.

Federal Funding Issues

HealthChoice Funding

Maryland's managed care component of Medicaid, called HealthChoice, is authorized under a federal Section 1115 waiver, which enables the State to receive matching federal funds. Maryland must demonstrate that this waiver program meets specified budget neutrality requirements. Over the first eight years of the waiver, Maryland met the budget neutrality requirements and was able to expand the scope of the waiver to include other programs, such as the primary care and pharmacy programs.

Until recently, it was believed that any proposed Maryland Medicaid or MCHP expansion could face funding issues due to constrains on the availability of federal monies. At issue was whether Maryland's spending was within the limits set by the federal budget neutrality requirement. For the past year, it appeared as if Maryland would not have access to additional federal funding for any potential program expansion.

However, the State Department of Health and Mental Hygiene (DHMH) recently recalculated its Medicaid spending under the budget neutrality requirement, and it appears that Maryland Medicaid spending will be lower than expected, leaving up to a $2 billion cushion under the spending cap at the close of fiscal 2008. This issue is still being explored.

MCHP Funding

[39] SB 530 of 2006 Fiscal Note, Department of Legislative Services.

Many states, including Maryland, are facing the loss or reduction of certain federal fund matches to their States Children's Health Insurance Program (SCHIP) or Section 1115 waiver programs. SCHIP, a federal program enacted in 1997, is nearing the end of its 10-year authorization. Unlike Medicaid, which is an entitlement program, SCHIP is a block grant program with fixed annual spending. In many cases, the federal funding has not kept pace with actual health care cost increases. These shortfalls will be severely exacerbated if Congress maintains a freeze on current SCHIP spending, as is predicted for federal fiscal 2008 to 2012. As a result, the federal match for Maryland's MCHP could decrease from the current 65 percent.[40] Children with family incomes up to 200 percent of FPG are included in the Medicaid expansion, so their expenses would be eligible for the 50 percent match provided in the Medicaid program. For other children, the State would be responsible for paying all expenses once federal block grant funds are exhausted.[41]

Savings Achieved in Other Programs

As the number of newly insured people increases, the need for a variety of public health programs will diminish. Reduction in enrollment is expected to be gradual as the new programs are implemented. Three programs, MHIP, MPACP, and the Breast and Cervical Cancer program could be virtually eliminated over the next several years. MHIP's fiscal 2007 allowance is about $39.0 million, MPACP is about $73.0 million, and the Breast and Cervical Cancer program is $8.7 million.

Overall Fiscal Impact

There are many variables that would impact both cost and enrollment under Massachusetts' plan as applied in Maryland. Massachusetts' legislation leaves many of the coverage and administrative decisions up to the various state agencies that will administer each program. Basic determinations such as what constitutes "affordable" and "acceptably comprehensive" health care coverage have yet to be defined, and how they ultimately are defined will have a significant impact on costs and coverage.

To give an idea of how this program could be implemented in Maryland, the following exhibit shows some possible enrollment, cost, and revenue figures. Actual figures could vary significantly, depending on how policymakers ultimately decide the program should be adopted and administered. To show a range of impact, potential enrollments of 25, 50, and 75 percent are shown. This range excludes a Medicaid expansion, for which specific take-up rates are applied to different populations (30 percent for children, 40 percent for childless adults, and 60 percent for parents). Achieving full enrollment and savings would not be immediate. The one other state that has implemented a universal health care plan, Maine, has seen slower enrollment than

[40] "Freezing SCHIP Funding in SCHIP Reauthorization Would Threaten Recent Gains in Health Coverage," Center on Budget and Policy Priorities (July 7, 2006).

[41] The Department of Legislative Services Budget Analysis, Medical Care Programs (2006).

projected and less savings. It is currently exploring ways to make its program more efficient and cost-effective.

Exhibit 9 shows estimated enrollment in the various programs and cost estimates where available. **Exhibit 10** shows the reduction in the number of uninsured under the various enrollment estimates.

Exhibit 9
Enrollment and Cost Estimates for New Maryland Programs
Fiscal 2008

(25 Percent Enrollment in All Programs but Medicaid)

Program	New Enrollees	State Cost (Total Funds)	State Revenues (Total Funds)
Medicaid Expansion	68,000*	$366 million	$183 million matching federal funds**
Subsidized Health Insurance***	82,000	$183 million	
Individual Coverage Mandate	69,000	$0	$11.8 million from tax penalties in first year
Employer Contribution	(included under individual coverage)		$29.7 million
Connector Administrative Costs		$60 million	
Savings from Other Programs		Up to $120 million	Up to $84.2 million in reduced federal matching funds
Uncompensated Care Fund Savings			Indeterminate
Total	**219,000**	**$489 million**	**$140.3 million**

*Figure illustrates only previously uninsured enrollees. Actual enrollment figure is 85,000. Take-up rate for Medicaid is 30 percent for children, 40 percent for childless adults, and 60 percent for parents.
**If available.
***Assumes a 50 percent subsidy.

Exhibit 9 (cont.)

(50 Percent Enrollment in All Programs but Medicaid)

Program	New Enrollees	State Cost Total Funds	State Revenues (Total Funds)
Medicaid Expansion	68,000*	$366 million	$183 million matching federal funds**
Subsidized Health Insurance***	163,000	$366 million	
Individual Coverage Mandate	138,000	$0	$7.9 million from tax penalties in first year
Employer Contribution	(included under individual coverage)	$0	$21.7 million
Connector Administrative Costs		$60 million	
Savings from Other Programs		Up to $120 million	Up to $84.2 million in reduced federal matching funds
Uncompensated Care Fund Savings			Indeterminate
Total	**369,000**	**$672 million**	**$128.4 million**

*Figure illustrates only previously uninsured enrollees. Actual enrollment figure is 85,000. Take-up rate for Medicaid is 30 percent for children, 40 percent for childless adults, and 60 percent for parents
**If available.
***Assumes a 50 percent subsidy.

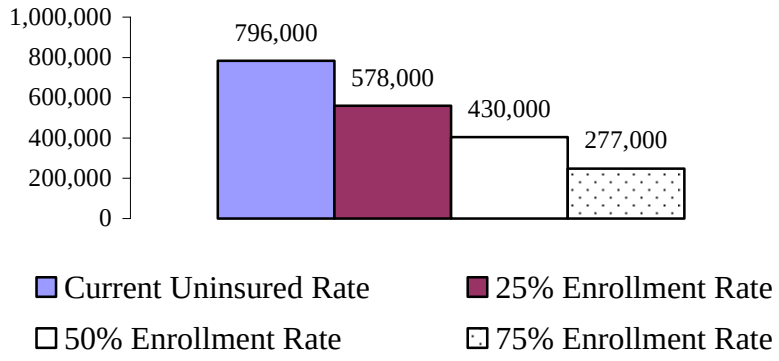
Exhibit 9 (cont.)

(75 Percent Enrollment in All Programs but Medicaid)

Program	New Enrollees	State Cost (Total Funds)	State Revenues (Total Funds)
Medicaid Expansion	68,000*	$366 million	$183 million matching federal funds**
Subsidized Health Insurance***	245,000	$549 million	
Individual Coverage Mandate	207,000	$0	$3.9 million from tax penalties in first year
Employer Contribution	(included under individual coverage)	$0	$13.7 million
Connector Administrative Costs		$60 million	
Savings from Other Programs		Up to $120 million	Up to $84.2 million in reduced federal matching funds
Uncompensated Care Fund Savings			Indeterminate
Total	**520,000**	**$855 million**	**$116.4 million**

*Figure illustrates only previously uninsured enrollees. Actual enrollment figure is 85,000. Take-up rate for Medicaid is 30 percent for children, 40 percent for childless adults, and 60 percent for parents
**If available.
***Assumes a 50 percent subsidy.

Exhibit 10
Number of Uninsured under Various Enrollment Estimates



Source: Department of Legislative Services

Potential Implementation Issues

Undefined Variables

Massachusetts' plan has left many variables undefined, to be determined by the assorted administrative agencies that will oversee implementation and management of the new initiative. A primary concern in Massachusetts is whether the Connector can provide insurance policies that are affordable for lower-income individuals. Massachusetts' target premium rate is between 1.5 and 6.6 percent of an individual's annual income. Premiums should be on the low end of this average to enable the lowest-income individuals to purchase coverage. On the other hand, there is some concern premiums could be too low, especially in the subsidized coverage program. Without specifying crowd-out provisions, there is the risk that insured low-income individuals could switch from employer-based coverage to the subsidy program.

Potentially Unforeseen Administrative Costs

Administrative costs have also been left undetermined by Massachusetts because design issues are not specified in law. In Maryland, this issue could become apparent when requiring the Office of the Comptroller to verify or audit tax payers to ensure compliance with the law. Simply collecting penalties on an honor system would not overly burden the agency; however, requiring verification of health insurance or the alternative payment of a tax penalty could increase agency administrative expenditures by a significant amount.

Sufficient Funding

Potential funding sources could also cause concern. The Massachusetts plan imposes a nominal $295 penalty on certain employers who do not provide required health insurance coverage to their employees. Again, verification of compliance could increase State administrative expenditures by a significant amount. Further, if implementation becomes more expensive than originally foreseen, the State could seek to increase the employer Fair Share fee, which might bring opposition from the business sector.

Absent another funding source, much of the revenue potentially available to Maryland comes from the bad debt and charity care component built into hospital rates. These funds would not be accessible until the State sees a significant reduction in the uncompensated care provided by hospitals. Capturing the additional savings to fund new programs would require statutory changes and modification of the federal Medicare waiver related to the setting of hospital rates.

If policymakers choose not to access uncompensated care funds to pay for universal health care, the reduction in uncompensated care could result in lower hospital rates. As a result, there could be savings to State-funded health care costs such as Medicaid.

The Federal Employment Retirement Income Security Act of 1974 (ERISA) Preemption

Another cause for concern in Maryland is whether requiring certain employers to contribute $295 per uninsured employee violates federal law. ERISA exempts certain employers from state insurance law, allowing them to design and manage uniform employee benefits, including health insurance, for employees in multiple states. A recent federal court ruling held that Maryland's attempt to mandate health insurance spending by certain large employers was preempted by ERISA.[42] Implementing portions of Massachusetts' law requiring a Fair Share contribution or Free Rider surcharge could face similar legal challenges.

Vermont and Other States

Vermont also enacted a health care reform initiative in 2006. Vermont's Health Care Affordability Act creates a program called Catamount Health, which is slated to provide affordable coverage for as many as 96 percent of its currently uninsured individuals, beginning October 1, 2007. Catamount will combine all uninsured individuals into one group to leverage purchasing power in the individual health insurance market, thereby lowering average premium prices. In addition, Vermont will provide subsidies to income-eligible individuals. Vermonters who have access to an employer-sponsored plan but who have incomes at or below 300 percent

[42] *Retail Industry Leaders Association vs. James D. Fielder, Jr., Maryland Secretary of Labor, Licensing and Regulation,* U.S. District Court of Maryland (July 19, 2006).

of FPG will receive assistance paying for their employer sponsored insurance according to an income-based sliding scale.

Another significant component of the legislation is the Blueprint for Health, a chronic disease management tool. This program will emphasize early screening, patient self-management, and financial rewards for health care providers who are proactive about chronic care management. This program will be open to all Vermont residents, not just those enrolled in Catamount.

Vermont intends to fund the program using tobacco taxes and matching federal funds. In addition, employers must pay $365 per year for each uninsured employee. The program provides for enrollment caps to limit the state's financial liability.[43]

Maine

Maine was the first state to implement a universal health care initiative in 2003. Its program, Dirigo Health, attempts to provide all state residents with health care coverage by 2009, covering about 141,000 individuals. Coverage is available to uninsured individuals, businesses, and municipalities with 50 or fewer employees, and the self-employed. Dirigo Health provides coverage though carriers and will pay providers at private insurance market rates. The program also includes disease management, health promotion, and prevention services. Dirigo Health is funded by individual and employer contributions, as well as federal matching funds for qualifying individuals. After the first year of operation, the program charges insurers and third party administrators an offset charge equal to savings achieved under the program.[44]

Coverage under Dirigo is off to a slower start than expected. As of June 2006, Dirigo covers 15,400 individuals, including 2,300 small businesses. The program has saved $78 million in health care costs over the past two years. Governor John Baldacci recently appointed a commission to oversee Dirigo, looking for ways to make it more effective and find other funding sources and methods of cost containment.

Other States

At least eight other states have proposed legislation that attempts to achieve universal health care. California, Connecticut, and Hawaii have bills that would create a single-payor system. Missouri has one bill that would create a single-payor system and one that would structure a health care system similar to the Canadian system. Florida is examining legislation that provides universal health care for all children. New Hampshire's bill would expand its Health Kids Corporation to cover adults. New York's legislation would require all employers with 25 or more employees to pay at least 80 percent of insurance premiums into a fund. The

[43] Vermont Public Interest Research Group, The 2006 Vermont Health Care Affordability Act, Frequently Asked Questions.

[44] Universal Health Care Legislation, National State Conference of Legislatures (February 2005).

state's Civil Service Commission would then use collective bargaining power to purchase insurance coverage for all. Wisconsin's bill would require mandatory health care coverage for all employed individuals and their dependents.[45] Several other states have introduced bills to study universal health care.

Conclusion

Massachusetts has provided key policy changes in its new universal health care plan, primarily in the private health insurance market, that could aid it and other states in the effort to combat the growing problem of the uninsured. Other states could benefit from examining its model and applying it, or aspects of it, to each state's unique health care market. It is important to note, however, that Massachusetts' current health care delivery system varies significantly from those in many states, including Maryland. Most notably, Massachusetts already has a more robust Medicaid program and a much lower overall uninsured rate. Any use of Massachusetts' plan in Maryland would have to take these differences into account.

Another significant difference between Massachusetts and other states is that Massachusetts faces almost certain change in its health insurance market due to the federal mandate to use federal funds (currently earmarked for uncompensated care) to reduce the number of uninsured in the state. Maryland does not have access to similar federal funding. Further, traditional Medicaid expansions in Maryland may face funding problems if a federal match is unattainable.

Maryland policymakers may want to tailor a Massachusetts plan by adopting or modifying State-funded initiatives such as Medicaid expansions and subsidized health insurance coverage, or look to private market changes such as combining the small group and individual health insurance markets in an effort to leverage lower premiums.

Policymakers should also be aware that the lack of specificity in many aspects of Massachusetts' legislation could lead to significant unanticipated costs. In particular, defining what constitutes "affordable" or "acceptably comprehensive" will greatly impact overall costs. Many policy analysts who have scrutinized Massachusetts' new law are recommending that lawmakers in other states be sure to define such items to better determine costs and potential enrollment.

[45] "2006 Bills of Universal Health Care Coverage," National Conference of State Legislatures (June 30, 2006).

Appendix 1

2007 Federal Poverty Level Guidelines[46]

Family Size	100%	133%	200%	300%	400%
1	$10,210	$13,579	$20,420	$30,630	$40,840
2	$13,690	$18,208	$27,380	$41,070	$54,760
3	$17,170	$22,836	$34,340	$51,510	$68,680
4	$20,650	$27,465	$41,300	$61,950	$82,600

[46] Federal Register Volume 72, Number 15, Pages 3147-3148 (January 24, 2007).