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Health Care Reform in Maryland: Doing It Right

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Maryland is considering major legislation to overhaul its health insurance market, which, in turn, could lay the foundation for dramatically expanding and improving its health coverage while more efficiently and effectively utilizing the hundreds of millions of taxpayers' dollars that are already in the system.

These policies to expand both consumer choice and market competition are embodied in legislation recently introduced by Senator E. J. Pipkin (District 36): the Consumer Health Open Insurance Coverage Act of 2007 (Senate Bill 617).[1] This bill, if enacted, would reorganize Maryland's health insurance market. The core concept behind the reform is to create a single market for the buying and selling of health insurance coverage through the mechanism of a state-sponsored health insurance exchange.

Personal and Portable Insurance

The health insurance exchange mechanism facilitates personal, portable health insurance independent of the place of work, just as is currently the case with other kinds of coverage such as life insurance or auto insurance. Far from being an incidental consideration, the creation of truly portable health insurance coverage addresses the central defects of the current health care system in the three ways:

- It meaningfully addresses the problem of the uninsured by creating a practical mechanism for enabling the insured to *keep* their coverage. It is based on the recognition, supported by analysis of longitudinal data (discussed in detail later),

Talking Points

- A health insurance exchange facilitates personal, portable health insurance independent of the place of work, just as is currently the case with other kinds of coverage such as life insurance or auto insurance.
- It is based on the recognition that the problem of the uninsured is as much the result of the obstacles to *keeping* coverage in the current system as it is of the obstacles to *gaining* coverage.
- By making it easier to keep coverage from job to job, a health insurance exchange makes efforts to insure the uninsured more targeted and effective, breaking the cycle of people rotating in and out of coverage and reducing the number of uninsured.
- A health insurance exchange also provides the administrative framework needed to reach the hardest to insure and get them coverage efficiently and effectively.

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that the problem of the uninsured is as much the result of the obstacles to *keeping* coverage in the current system as it is of the obstacles to *gaining* coverage.

- By making it easier to keep coverage from job to job, a health insurance exchange makes efforts to insure the uninsured more targeted and effective. If continuity of coverage can be created, thus breaking the cycle of people rotating in and out of coverage, the number of individuals who are uninsured at any given time will steadily diminish. What will be left will be the smaller population of the hardest to insure. They can then become the focus of subsidies and outreach efforts to get them coverage through the same system, and policymakers can be confident that once those individuals are also in the system, they too will be able to maintain coverage though job and life transitions.
- A health insurance exchange also provides the administrative framework needed to reach the hardest to insure and get them coverage efficiently and effectively. Most of the individuals in that target subpopulation are in working families. Thus, between workers, their employers, and government, there are funds available to purchase coverage. So the questions become ones of amounts (i.e., who needs how much help from the state) and efficiency (such as using the exchange in combination with employer Section 125 "cafeteria plans" to maximize federal tax subsidies for employer and worker premium payments). Furthermore, because in Maryland this residual population includes tens of thousands of individuals working for thousands of employers, having one centralized administrative mechanism in place (the exchange) vastly simplifies the administrative issues entailed in enrolling and subsidizing those individuals.

It was this fundamental insight that led Massachusetts to combine insurance reforms and uncompensated care payment reforms into a unified legislative design. In advancing a similar approach in Maryland, Senator Pipkin has sponsored two other bills: Senate Bill 619, providing for a low-income premium support fund, and Senate Bill 620, which would repeal the Health Services Cost Review Commission and provide for a study of alternative financing of uncompensated care.[2] They would, if enacted, create the mechanism through which Maryland policymakers would similarly redirect the majority of current federal and state spending on uncompensated care into a premium support program: a set of government subsidies to buy the uninsured into private, portable coverage. In Maryland's case, those funds are currently embedded in the state's all-payer hospital rate-setting system through the associated federal Medicaid and Medicare waiver.

The creation of a near universal system of stable, continuous, and portable coverage is also a necessary precondition for achieving further improvements in the structure of any state's health care delivery system, including more appropriate utilization of health care services and enhanced population health measures.

How Much Maryland Could Expand Its Coverage

The uninsured are far from a static population. Rather, as numerous national and state-level studies have shown, there is high turnover among the uninsured as individuals constantly lose and gain coverage. Studies also show that the frequency and duration of spells of uninsurance vary widely among individuals. Those characteristics not only make it hard to measure the uninsured population accurately, but also complicate efforts to design effective solutions.

Initiatives designed to cover the uninsured will invariably be frustrated by the constantly changing composition of the target population if they do not have as their starting point establishing a system of more stable and continuous coverage for the general population. At the same time, state

1. Senate Bill 617 is cross-filed as House Bill 1068 by Delegate Adelaide C. Eckardt (District 37).
2. Senate Bills 619 and 620 are cross-filed, respectively, as House Bills 1076 and 1070 by Delegate Adelaide C. Eckardt (District 37).

policymakers trying to design solutions are often misled as to the size and nature of the problem by flawed data.

Flawed Data. The most commonly cited source for data on the uninsured is the Census Bureau's Current Population Survey (CPS), but the CPS is not a reliable planning tool because it is an annual "snapshot" survey and also has further, significant methodological flaws.

For example, two studies commissioned by the United States Department of Health and Human Services (HHS) concluded that flaws in the design of the CPS result in that survey's underestimating the number of Medicaid enrollees by 4 million–9 million and overestimating the uninsured by the same 4 million–9 million.[3] In other words, it would appear that state Medicaid, or SCHIP (State Children's Health Insurance), programs in fact covered nationally about 10 percent to 20 percent of the reportedly 45 million uninsured in 2003. Similar results were found in Maryland when the Maryland Department of Health and Mental Hygiene (DHMH) commissioned a study of the Medicaid undercount in this state.[4]

In contrast, analysis of longitudinal data collected through the Census Bureau's Survey of Income and Program Participation (SIPP) yields a much better understanding of the dynamics of the uninsured population and a clearer sense of how the specific health policy proposals, such as those advanced in Senate Bills 617, 619, and 620, might address those dynamics.

The advantage of SIPP is that it is a more accurate and useful survey mechanism at the national level. The disadvantage is that SIPP is not designed to be statistically valid at the state level. Thus, while the overall patterns revealed by analysis of SIPP data are broadly valid for all states, the extent to which selected population characteristics vary in a given state from the national norm is not.

Facts on the Uninsured. With that caveat in mind, Table 1 summarizes findings from a detailed analysis of SIPP data, completed by two researchers at Pennsylvania State University, on individuals reporting one or more spells of uninsurance over a four-year period.[5] Some other insights can also be drawn from the published analysis of the SIPP data.

First, the uninsured who repeatedly cycled between coverage and uninsurance and those who experienced one coverage gap (with or without other coverage changes) collectively constitute almost two-thirds (62 percent) of the total population that were uninsured over the four-year period. Given their coverage patterns, it is reasonable to presume that in most of their cases, poor health status was not a barrier to gaining coverage.

Nor does affordability seem to have been a major obstacle. Rather, since those individuals had coverage more often than not during the 48 months, it is reasonable to infer that if offered access to more stable, affordable coverage, they will take advantage of the opportunity presented and remain insured.

Thus, it is plausible that a substantial share of the uninsured population could effectively gain permanent coverage if insurance markets were reformed along the lines of Senate Bill 617 to enable them to *keep* coverage once they got it. For some of them, particularly the subset with incomes above 200 percent of poverty, ensuring continuity of coverage could be achieved simply by reforming the system to ensure that coverage attaches to the individual and not to the job, with little or no need for additional subsidies. For others, particularly those

3. Actuarial Research Corporation, "Estimating the Number of Individuals in the U.S. Without Health Insurance," April 8, 2005, at *http://aspe.hhs.gov/health/reports/05/est-uninsured/index.htm*, and Linda Giannarelli, Paul Johnson, Sandi Nelson, and Meghan Williamson, "TRIM3's 2001 Baseline Simulation of Medicaid and SCHIP Eligibility and Enrollment: Methods and Results," *TRIM3 Microsimulation Project Technical Paper*, April 2005, at *http://aspe.hhs.gov/health/reports/05/medicaid-schip-simulation/index.htm*.
4. University of Maryland Baltimore County, Center for Health Program Development and Management, "The Maryland Current Population Survey Medicaid Undercount Study," July 25, 2005, at *www.dhmh.state.md.us/mma/pdf/CPSSurvey_Report.pdf*.
5. Pamela Farley Short and Deborah R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, Vol. 22, No. 6 (2003), pp. 244–255.

whose incomes fluctuate above and below the eligibility thresholds for Medicaid and SCHIP, converting those programs from an "all or nothing" proposition into a sliding scale of premium support to buy coverage through the exchange could also solve much of the problem, again with little additional public spending.

Second, about 20 percent of the uninsured consisted of individuals who experienced one transition either into or out of coverage during the four years. This group is a collection of individuals with a mix of circumstances. Some might be individuals who became uninsured after losing employment. Others might be individuals who gained coverage after finding a job with an employer that offered benefits. Still others might have lost Medicaid coverage by taking a job without benefits or gained Medicare coverage upon reaching age 65. While health insurance market reforms that create continuity and stability of coverage through an exchange mechanism can provide a good foundation for closing the gaps created by these transitions, to be completely effective, those reforms will need to be augmented by premium subsidies for at least the lower-income portion of this category.

Finally, 12 percent were uninsured for the full four years, and another 6 percent were similarly uninsured except for one limited period of coverage. Collectively, this 18 percent can be considered the hardest to insure subset of the uninsured. These are the individuals for whom insurance market reforms are only a precursor to the bigger task of enrolling them and subsidizing their coverage. For this group, a state-sponsored health insurance exchange serves mainly as the administrative mechanism for implementing the state government's outreach efforts and subsidy system. As in Massachusetts, the logical funding source for the necessary subsidies for these individuals is the state and federal funds currently dedicated to defraying hospital uncompensated care. Senate Bills 619 and 620 propose the first steps toward making a similar transition in Maryland.

Table 1 HL 1002

Uninsured Population by Coverage Pattern

Coverage Patterns (48 month period)	Number (millions)	Share	Potential to Solve
Repeatedly uninsured	28.2	33%	Easiest (62%)
One coverage gap	24.4	29%	
Transition in or out of coverage	17.2	20%	Varied (20%)
Temporary coverage	4.8	6%	Hardest (18%)
Always uninsured	10.1	12%	
Total	**84.8**	**100%**	

Source: Pamela Farley Short and Deborah R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, Vol. 22, No. 6 (November/December 2003), pp. 244–255.

Table 2 presents figures extrapolated from the data reported in the same study to give an approximate guide for how state lawmakers should think about distributing subsidies to build on the infrastructure of a state health insurance exchange. Table 2 disaggregates the total four-year uninsured population not only by coverage patterns (as in Table 1), but also by family income.

Table 2 also shows the effects of overlaying two plausible assumptions about the need for subsidies to ensure that coverage is *affordable* once it has been made more *accessible*. The first assumption is that those with fewer and/or shorter coverage gaps will generally need less subsidy to get and keep coverage once the opportunity for coverage continuity has been created by the health insurance exchange. The second assumption is that low-income individuals will be more likely to need subsidies than higher-income individuals. The aggregate figures at the bottom of Table 2 summarize the results of applying both of these assumptions to the data.

Those in the first three categories who also have higher incomes are assumed to need the least subsidies, since they are more likely to be able to afford coverage and have a demonstrated history of obtaining coverage. Collectively, they constitute 41 percent of the uninsured population.

Those in the first three categories who also have lower incomes are assumed to need some subsidy by

virtue of their low income, even though they have usually been insured. Added to this group are those who, despite being in the highest-income category, were consistently uninsured or had only temporary coverage. Presumably, their lack of coverage can be attributable to some factor other than income. For some, it may be poor health status that causes them to be denied coverage. For others, it may be superior health status that induces them to decline coverage when it is offered. In any event, the conservative assumption is that some of those individuals might also need some subsidy. Collectively, these two groups constitute 43 percent of the total.

Table 2 HL 1002

Distribution of the Uninsured Population by Coverage Pattern and Family Income

Coverage Patterns (48 month period)	Family Income (Percent of the Federal Poverty Level)			
	<100%	100–199%	200–399%	400%+
Repeatedly uninsured	8.0%	12.1%	10.1%	3.0%
One coverage gap	4.5%	7.1%	11.5%	5.7%
Transition in or out of coverage	3.3%	6.7%	7.4%	2.9%
Temporary coverage	1.2%	2.4%	1.7%	0.4%
Always uninsured	2.7%	5.4%	3.0%	0.8%

Shares of Uninsured by Likelihood of Needing a Coverage Subsidy

Little or none = 41%	Moderate = 43%	Substantial = 16%

Source: Pamela Farley Short and Deborah R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, Vol. 22, No. 6 (November/December 2003), pp. 244–255.

Finally, those who have lower incomes and little or no coverage experience can be presumed to be the ones who will need the greatest level of subsidy on account of their incomes as well as other factors that may impede them in getting coverage. For example, immigrants who lack English proficiency and/or legal status are more likely to remain uninsured, regardless of income. Whatever the mix of factors, it is reasonable to assume that the state will need to spend more money on these hardest to insure—either in premium subsidies or in outreach efforts—if they are to gain and keep coverage. Collectively, this group constitutes 16 percent of the total.

Thus, a reasonable working assumption for policymakers is that, at the national level, about 59 percent of the uninsured will require moderate to substantial subsidies to afford coverage, while 41 percent should be able to keep coverage with little or no need for additional subsidies, *if the coverage is made personal and portable*.

What the Data Mean for Maryland

For Marylanders, the good news is that they live in a state with a robust economy that has incomes and health insurance coverage rates above the national norms.

In addition, the state's uninsured population is likely less than reported in the Census data. The findings of the Maryland Medicaid undercount study strongly suggest that many low-income uninsured Marylanders may, in fact, already be covered by Medicaid. That would mean that the bulk of the remaining uninsured Marylanders are predominantly in families with one or more full-time workers and family incomes that are lower-middle-class or higher. Thus, extending coverage to all of Maryland's uninsured need not require large expenditures of additional tax dollars. It also means that, at least in Maryland, the lack of health insurance among part of the population is more related to issues of availability and value than to issues of affordability *per se*.

The data also indicate that many of the uninsured are part-time or contingent workers, including significant numbers employed by federal, state, and local governments and large private employers. Anther significant share consists of those working for small businesses, particularly "micro" businesses with 10 or fewer employees and the self-employed. Finally, almost all of the remaining uninsured individuals are the dependents of workers in the first two categories.

Needed: Stable Coverage. The simple reality is that employment-based health insurance works

well only for those who are long-term employees of large firms, and Medicaid is reliable coverage only for the very poor. Neither system, alone or in combination, is doing an acceptable job of ensuring health care coverage for the people who don't fit either of those categories.

Nor can it be said that past reform efforts have done much to improve the situation. The 1993 reforms in Maryland that standardized coverage in the small-group market did initially result in increased enrollment; but since 1998, the number of individuals covered in the small-group market has been steadily declining. At the same time, this system has lead to reduced health insurance coverage options to the point that today, only two carriers account for over 90 percent of the Maryland small-group coverage market.

Senate Bill 617 would replace the present system with a new, more flexible one. It is designed to reverse those trends by ensuring greater continuity of health insurance coverage, providing enhanced opportunities for all Marylanders to get and keep coverage, and opening up the market to greater plan competition and innovation in plan design.

The Function of the Exchange. The core of the proposal would be to restructure Maryland's health insurance markets by creating a statewide health insurance exchange through which insurers would offer policies that combine the best features of the current group and non-group insurance markets. As in the current group market, the exchange would offer an annual open season during which participants could select or switch coverage, and health status would not be a rating factor. However, as in the current non-group market, coverage would be fully portable, with participants able to keep their chosen coverage when changing jobs or employers.

The Maryland Health Insurance Exchange would be overseen by the Maryland Health Care Commission and would serve as a market organizer, providing a single centralized system facilitating the buying and selling of heath insurance. It would essentially perform the same function for health insurance that stock exchanges routinely do in facilitating the buying and selling of securities and other financial products.

Similarly, like a farmers market or stock exchange, the health insurance exchange would be a market organizer only. It would *not* be a product regulator. The regulation of health insurance sold through the Maryland Health Insurance Exchange would continue to be the responsibility of the Maryland Insurance Administration. Thus, health insurance sold through the exchange would continue to comply with all applicable Maryland insurance laws and consumer protections.

Open Market. A free and open market is essential to make the new system work. Any willing health insurance plan approved for sale through the exchange by the Maryland Insurance Administration would be offered through the exchange. At the same time, anyone living or working in the state would be able to purchase personal, portable health insurance through the exchange, either on their own or as part of an employer group that designates the exchange as the employer's health insurance plan.

In essence, the Maryland Health Insurance Exchange would consolidate the currently fragmented non-group and small-group health insurance markets into a single statewide system offering personal and portable coverage. Large employers would also be encouraged to designate the Maryland Health Insurance Exchange as their health plan, thus giving their workers as well the benefits of portable health insurance and the ability to obtain the coverage that best meets the specific needs and preferences of each employee.

It is also important to note that SB 617 is crafted in such a way as to enable employers of any size to designate the exchange as their group health benefit plan for purposes of federal regulation and tax law. That way, their workers would be able to buy their preferred coverage through the exchange using any combination of tax-free employer contributions and pre-tax payroll deductions.

Under SB 617, the Maryland Health Insurance Exchange would administer "premium aggregating" mechanisms, including a uniform payroll withholding system, to facilitate the collection of premium payments. Those mechanisms would be able to combine contributions from multiple sources. For example, a two-earner couple would no longer have

to choose coverage from one spouse's employer and forgo the coverage contribution offered by the other spouse's employer. Instead, they could combine the contributions from the two employers and use the total amount to buy the coverage they really want for their family through the exchange. Similarly, an individual with two part-time jobs could ask for a prorated contribution from each employer and then combine them to buy coverage through the exchange.

With these features in place, small employers would no longer face the risks and administrative burdens associated with trying to obtain separate group coverage for their handful of employees. Rather, a business could designate the exchange as its group health benefit plan and give its employees whatever tax-free contribution the business can afford to help them buy coverage.

Insurance brokers would continue to receive commissions for bringing employer groups and individuals to the exchange. They would earn their commissions by providing workers with benefits counseling on picking the best plan for their personal situations and by assisting employers in setting up arrangements, currently permitted under federal and state tax law, that make the share of the premium paid by their workers also tax-free to the workers. While such arrangements are common among large firms today, small firms frequently don't offer them.

A Large Pool. Senate Bill 617 also requires Maryland's state government to take the lead by providing health insurance to its own employees through the exchange. This provision would have several positive effects.

First, state government workers would gain a wider choice of coverage options.

Second, it would facilitate getting coverage to those state government employees, particularly contractual and contingent workers, who are currently uninsured.

Third, the presence of such a large number of workers (about 96,000) plus their dependents would be a catalyst for ensuring the exchange's success. Insurers would have a huge market incentive to offer attractive benefit packages at attractive premiums through the exchange, while small businesses and their employees would be eager to join.

Finally, the costs of coverage for state workers might actually decline somewhat under such an arrangement. This is because the average age of workers with employment-based insurance tends to be significantly higher that the average age of the uninsured. For example, 15 percent of Maryland workers are aged 55–64, but they account for only 8 percent of the uninsured, while, in contrast, 12 percent of Maryland workers are aged 19–24, but they account for 18 percent of the uninsured. Thus, expanding coverage to uninsured workers who are generally younger and healthier should have a favorable impact on premiums for all covered individuals.[6]

Maryland's health insurance markets are among the most overregulated in the nation. Indeed, Maryland leads all other states in the Mid-Atlantic region in the number of mandated health insurance benefits imposed on health insurance policies. Maryland has also standardized coverage in the small-group market into a one-size-fits-all package of benefits administered by the Maryland Health Care Commission. Only recently has the commission made modest changes to the status quo. SB 617 would reverse those policies not only to make health insurance more affordable, but to also address the somewhat justified perception among young, healthy individuals in Maryland that buying coverage is today a bad value.

Reversing Overregulation. Under SB 617, the overregulation of health insurance in Maryland would be scaled back. The remaining health insurance regulations would be those provisions essential to ensuring four things: (1) insurer business practices that are financially sound; (2) rates for each product that are reasonably commensurate with the actuarially anticipated costs and risks associated with the particular product; (3) fair and truthful advertising and sales practices; and (4)

6. Maryland Health Care Commission, "Health Insurance Coverage in Maryland Through 2005," January 2007, at *http://mhcc.maryland.gov/health_insurance/insurance_coverage/insurance_report_thru_2005.pdf*.

coverage mandates that are limited only to broad categories of benefits, such as hospital, physician, drug, and mental health benefits.

The specific forms of coverage, the size and types of coverage deductibles and co-pays, and the restrictions, if any, on access to providers under the various plans would be the product of insurer responses to market demand and not predetermined by politicians or committees of experts.

With a foundation of universal access to personal and portable health insurance in place through the Maryland Health Insurance Exchange, it then becomes possible to take further steps both to reduce the cost of health insurance and to further expand coverage to all working families in Maryland.

Table 3 HL 1002

Distribution of the Maryland Uninsured Population by Coverage Pattern and Family Income

Coverage Patterns (48 month period)	Family Income (Percent of the Federal Poverty Level)			
	<100%	100–199%	200–399%	400%+
Repeatedly uninsured	9.9%	7.8%	8.9%	5.7%
One coverage gap	5.5%	4.6%	10.0%	10.8%
Transition in or out of coverage	4.1%	4.4%	6.5%	5.5%
Temporary coverage	1.4%	1.5%	1.5%	0.8%
Always uninsured	3.4%	3.5%	2.6%	1.5%

Shares of Uninsured by Likelihood of Needing a Coverage Subsidy

Little or none = 47%	Moderate = 39%	Substantial = 14%

Sources: Heritage Foundation calculations based on data in Pamela Farley Short and Deborah R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, Vol. 22, No. 6 (November/December 2003), pp. 244–255, and Maryland Health Care Commission, "Health Insurance Coverage in Maryland Through 2005," January 2007.

Help for the Uninsured. SB 619 and SB 620 put those next health reform steps on the table by proposing to redirect the majority of Medicaid and Medicare dollars currently subsidizing hospital uncompensated care into premium support subsidies for the low-income uninsured.

Adjusting the national data in Table 2 to reflect differences from the national norm in the distribution of uninsured Marylanders by income yields some rough estimates of the extent to which subsidies will be needed to cover the remaining uninsured in Maryland, as shown in Table 3.

The results presented in Table 3 show that there are more middle- and upper-middle-income uninsured in Maryland than the national norm. This indicates that Maryland should be better positioned to cover all of its residents than are many other states. While the figures in Table 2 suggest that about 41 percent of the national uninsured population could gain coverage with the right market reforms, and with little or no need for additional subsidies, in Maryland, the likely share is somewhat higher at 47 percent.

Consequently, SB 619 proposes to redirect 85 percent of the federal and state funding embedded in the Maryland all-payer hospital rate-setting system that is now used to defray uncompensated care costs into a system of premium support payments to cover low-income uninsured Marylanders. The remaining 15 percent of the existing spending would be used to fund a residual, all-payer hospital uncompensated care pool to offset any remaining uncompensated care costs and address any remaining uneven distribution of those costs among Maryland hospitals.

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