Health Care

By Dwight K. Bartlett III

With the level of uninsured and underinsured Marylanders already a problem and health care inflation poised to accelerate, the state must enable better provision of medical care.

The state should:

• Enact no laws or regulations that harm the current employer-provided health care system or that harm the state economy.
• Promote policies that encourage efficient use of health care.
• Reform state mandates on health insurance.
• Raise Medicaid reimbursement rates to market-established levels.
• Make an informed, non-politically motivated decision on the CareFirst issue.
• Re-examine previous reforms to see if they truly have improved access to health care.
• Take up difficult, low-profile problems such as the provision and financing of long-term care.

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BACKGROUND

Statistics suggest that roughly 500,000 Marylanders lack basic health insurance while perhaps another 500,000 are significantly underinsured. In many cases, health care providers will offer services to those persons and either accept direct payment or write off the loss. But the uninsured and underinsured often delay seeking care until a medical problem becomes severe, and the quality of their care is uneven. As a result, the uninsured and underinsured often experience an unnecessary amount of pain and suffering, and they often use more medical resources to treat a medical condition.

Individuals who lack sufficient health insurance and whose income falls below certain levels are eligible for Medicaid, a program jointly funded by the state and federal government and administered by the state. In Maryland, more than 600,000 people are enrolled in the program.

Individuals who do not qualify for Medicaid can apply to a variety of insurers that offer individual health insurance. An estimated 200,000 Marylanders obtain health insurance that way, but for many others it is not a viable option given the average annual cost of as much as $3,000 for an individual and perhaps double that for a family. A modest number of potential applicants might also fail to meet insurers’ good-health underwriting standards.

There are fears that the number of uninsured will grow substantially in future years, in part because of currently increasing levels of unemployment, but much more significantly because of an expected upturn in health care costs. The early 1990s saw a remarkable
Easing in the inflation rate for health care as employers shifted from open-ended fee-for-service plans to more cost-conscious managed-care plans like HMOs and PPOs. But, with those organizations having already wrung many inefficiencies out of the health care system and with the emergence of expensive new miracle drugs and technologies, health care inflation is now re-emerging. Predictions of the likely future annual inflation rate for medical care typically run in the seven- to nine-percent range, which is more than twice the general rate of inflation.

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**Health Insurance Coverage of Non-Elderly Adults in Maryland, 1999-2000**

Insurance Proposals

Maryland has been a leader in efforts to improve access to health insurance, as exemplified by the state’s 1993 small-group health insurance reforms and, more recently, through individual health insurance reforms in response to the 1996 federal Health Insurance Portability and Accountability Act (HIPAA). Nevertheless, Maryland continues to have an unacceptably high level of uninsured, primarily resulting from the high cost of health insurance.

Policymakers and analysts from across the political spectrum are increasingly agreeing that ways must be found to reduce the number of uninsured and underinsured. However, there is a wide range of viewpoints on how that can best be achieved. The following is a sort of “laundry list” of insurance-related proposals now under discussion in Maryland:

Universal coverage In response to the uninsurance/underinsurance problem, a group of concerned individuals led by Dr. Peter Beilenson, Baltimore City’s health commissioner, formed an organization called the Maryland Citizens’ Health Initiative Education Fund (MCHI). MCHI has proposed a Canada-style health insurance program to cover all non-Medicare-eligible Marylanders. Their first formulation of that proposal was greeted with significant negative public reaction; in response, MCHI plans to introduce a more modest proposal in the 2003 General Assembly.

The more limited plan is quite complex. The proposal would involve the creation of a new entity, the Maryland Health Care Trust, that would provide health insurance to people who are otherwise uninsured and
who volunteer to accept the coverage. The trust would offer a comprehensive benefits plan. Health care providers would be paid on a fee-for-service basis, with fees based on prevailing commercial rates. Persons enrolled in the plan would not have to pay a yearly deductible for health care, but would have to cover a per-visit co-pay. They would also pay an annual premium based on a sliding scale related to their income.

To provide for the fund, employers would pay a payroll tax of ultimately three percent. (Employers that offer their own insurance would be given an offsetting tax credit.) The fund might also draw on revenue from the state’s tobacco tax, “uncompensated care” fund, and other state subsidies already in place for the uninsured.

Supporters of the plan argue that it would replace a multiplicity of state programs with a single program for providing health benefits to the uninsured. The simplified administration would be a major contributor to the affordability of the program. Most importantly, they argue, it should substantially reduce, if not eliminate, the extent of uninsurance.

Critics assert that the plan would undermine the existing, largely successful employment-based health insurance system that presently covers most non-Medicare-eligible Marylanders. The three-percent payroll tax on employers would drive a significant number of businesses out of state and result in the loss of many jobs. And the proposed system would inevitably lead to the state setting reimbursement rates for health care providers. Furthermore, the critics charge that the program would cost far more than the estimates provided by MCHI.
State-mandated benefits reform  Several benefits that insurers offer to Marylanders are required by state law. Some estimates place the cost of those benefits as high as 20 percent of the premium’s cost. Several analysts have recommended decreasing the number of state-mandated benefits in an effort to provide “economy-sized” insurance coverage to the uninsured.

It is unclear, however, how far prices would fall if the General Assembly were to eliminate the mandates. No doubt, in many cases, plan sponsors would maintain some of the benefits, which would retard the cost savings. What is more, self-insured plan sponsors are already exempted from state mandates under the federal Employment Retirement Income Security Act (ERISA). Thus, though elimination of some mandates would apply an increasing level of market forces to Maryland’s insurance prices, it is debatable whether such deregulation would provide the magic solution to resolving the state’s uninsurance and underinsurance woes.

Rating standards reform  As with many other states, Maryland sets limits on the rates that insurers can charge to some groups. For example, insurers active in the small-group field must establish a community rate based on the medical expenses experienced by such small groups. By law, the rates charged to particular groups can deviate by no more than 40 percent of the community rate, and then only for reasons of geography and age composition of the group. Some analysts argue that relaxing the 40-percent standard would allow insurers to price their coverage more appropriately to various groups. That could lead to lower rates
for groups comprised of younger-than-average employees who often have small children.

**Tax credits** Perhaps the most significant proposals for improving insurance affordability fall under the rubric of “refundable tax credits.” Under the proposals, a person would receive a credit against his federal or state income tax liability if he purchases health insurance and his income is below a defined level but he is not eligible for Medicaid. The credit would be “refundable” in the sense that if it exceeds the taxpayer’s tax liability, he would be sent a check for the difference. The size of the credit would be graded down as the taxpayer’s taxable income increased.

At the federal level, the suggested credit has typically been $1,500 for an individual and $3,500 for a family. Those amounts represent a substantial portion of the typical annual premium for comprehensive health insurance and should be enough to induce many of the presently uninsured to purchase health insurance.

However, the tax credit proposals are not without their problems. On the state level, it is difficult to see how Maryland could afford a sufficiently large credit, given looming state budget woes. What is worse, the proposals could fall prey to the law of unintended results; employers may be inclined to abandon their present group health insurance programs if the state were to subsidize employees in purchasing their own coverage. That could throw many more persons into the notoriously inefficient individual health insurance market where benefit payments typically run at 65 percent or less of premium. Finally, administration of the credits likely would be a formidable administrative task.
Other Concerns

Besides improving access to health insurance, Maryland policymakers have a number of other problems. Many of those problems, like contending with the cost of prescription drugs for seniors and encouraging utilization of federally provided health insurance for children, are problems faced by states across the United States.

**Prescription drug prices** Nationally, policymakers have expressed concern over the rising cost of prescription drugs for the elderly and the poor. However, federal lawmakers have been unable to resolve that concern because of philosophical differences over what form of program should be implemented. In Maryland, prescription cost woes have been especially difficult because financially strapped insurers are withdrawing from the Medicare + Choice program. It is estimated that 200,000 of Maryland’s 600,000 Medicare beneficiaries now lack prescription drug coverage.

In the absence of federal action, states are considering steps they can take to assist individuals. Maryland has already enacted a program that will allow seniors with income below 175 percent of the poverty level to purchase drugs with up to a 50-percent discount on the price. The cost of the discount is to be shared by the drug manufacturers, pharmacies, the federal government and the state. However, there is concern that people who do not qualify for the benefit will continue to struggle to afford medications.

**CHIP** Perhaps the most meaningful recent effort by Maryland to expand health care coverage has been the expansion of the Children’s Health Insurance Program, funded largely by the federal government and adminis-
tered as part of the state’s Medicaid program. Children are eligible for the program if their family income is less than 300 percent of the federal poverty level (or approximately $50,000). Astoundingly, in Maryland there are an estimated 35,000 children who are eligible for coverage under CHIP who have not been enrolled by their parents or guardians. Other states face similar under-enrollment problems.

**CareFirst** A politically heated issue that the General Assembly has already encountered is the desire of CareFirst to relinquish its role as Maryland’s health insurer of last resort and instead convert to for-profit status with out-of-state ownership. Like the Blues in other states, CareFirst’s predecessor, Maryland Blue Cross Blue Shield, formed when hospitals (Blue Cross) and doctors (Blue Shield) organized to provide health insurance for their services. Health providers who joined the network agreed to discount their fees submitted to the insurer by five percent in exchange for servicing those insured by the Blues.

The state of Maryland became the de facto owner of the Maryland Blues and arranged for them to act as the state’s “insurer of last resort” and offer coverage, under an annual enrollment period, for purchasers that could not gain coverage on the private market. In return, the state exempted the Blues from the two-percent state premium tax imposed on other health insurance plans.

The last-resort policies offered limited benefits at high premiums, so only several thousand were in force at any period of time. But it did give otherwise uninsurable individuals access to coverage. CareFirst officially gave up the last-resort role in 2002, but de facto it had abandoned that role many years earlier.
Prospective CareFirst buyer Wellpoint Health Networks, which is an amalgam of former non-profit Blues in California and several other states, has offered to pay $1.3 billion in stock and cash for the insurer. The lion’s share of that money would go into a pool to provide for Marylanders who have difficulty acquiring health insurance. The balance of the payment would go to form similar pools in Delaware and the District of Columbia, where CareFirst also operates. Besides Wellpoint, CareFirst has drawn attention from other prospective buyers, including Trigon Blue Cross Blue Shield of Virginia.

Any organizational change by CareFirst is subject to approval by the insurance commissioners of Maryland, Delaware, and the District of Columbia. Each commissioner must decide whether the change is in the public interest.

The Maryland General Assembly is clearly nervous about CareFirst and the revelation that the deal arranged by CareFirst’s top officers with Wellpoint would pay those officers more than $30 million for managing the sale. In response, the Assembly adopted several pieces of Carefirst legislation in 2002, including a provision that empowers the lawmakers to override the state insurance commissioner’s upcoming decision.

**Long-term care** A ticking time bomb in health care policy is the question of how to finance and provide access to long-term care. Long-term care was the subject of much national debate some years ago, but it seems to have been pushed to the backburner in light of other health care issues. Yet the rapid aging of our society has caused a dramatic increase in expenditures for long-term care, largely funded by Medicaid, and to a
lesser extent by Medicare, private insurance, and payments from individual resources. In Maryland, for example, approximately $700 million of the current Medicaid budget goes to long-term care, and that number will only increase—rapidly—over the coming years.

A decade ago, the Maryland General Assembly gave lip service to the unsustainability of financing the bulk of long-term care through Medicaid. Lawmakers adopted several programs that were intended to improve the affordability of private long-term insurance. They also mandated that the state insurance commission would carry out educational programs promoting the purchase of private insurance by state residents. But those efforts have not been very successful; in Maryland, there has been very slow growth in the number of such policies. Recent changes in federal tax law concerning the deductibility of premiums and non-taxability of benefits for such policies may accelerate that growth, but there remains a great misunderstanding by the public concerning Medicare’s limited coverage of such expenses.

POLICY RECOMMENDATIONS

When taking the Hippocratic oath, physicians pledge to, above all, “do no harm” to their patients. In other words, they promise not to let their compassion for their patients lead them into risky courses of treatment. The same admonition should be given to policymakers who act out of compassion for Marylanders’ health care—especially the care of the uninsured and underinsured. Thus, it is appropriate to begin a list of health
insurance reform recommendations in Maryland with a list of what should not be done:

- Lawmakers and state regulators should not make regulatory changes that would undermine the relatively efficient and cost-effective employment-based health insurance system that covers most non-elderly Marylanders.
- Lawmakers should not make changes that would throw large numbers of individuals into the inefficient and selective individual health insurance market.
- Lawmakers should not make changes that increase the tax burden on Maryland business relative to the burdens imposed by neighboring states. Increasing that burden would lead to a loss of jobs in Maryland.
- Lawmakers and regulators should not get the state further into the business of setting reimbursement rates for health care providers. Doing so would produce a shortage of providers.
- Lawmakers should not provide tax subsidies or other encouragement to health insurance programs that create such problematic distortions as over-utilization of health care.
- Finally, all state officials should not exceed the state’s capacity to pay for programs intended to extend health insurance to the uninsured. That point is especially important given the state’s precarious budgetary situation at present.

Given those cautionary statements, there remains much the state can do:

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Eliminate Questionable Mandates

Where the state regulates insurance plan benefits, it needs to recognize that plans that provide first-dollar coverage of routine medical services contribute in a major way to the inflation in medical care costs resulting from over-utilization. Lawmakers and regulators should review existing benefit mandates to eliminate questionable requirements. They should also increase the cost sharing by insured individuals to motivate more cost-efficient decision-making by insured individuals seeking medical care. That same rethinking should be applied to the Medicaid program as more generous income limits are put in place under CHIP.

Increase Medicaid Reimbursement Rates

Maryland is between a rock and a hard place with respect to Medicaid's rising costs and limited budget. Already, the program consumes approximately seven percent of the state's budget, and its share will grow in the years ahead. Nevertheless, Medicaid reimbursement rates to health care providers need to be raised to a level so as to keep an adequate supply of providers in the field.

Lawmakers and program officials should also act on proposals to improve the efficiency of the reimbursement system, which would reduce the administrative burdens on providers and, by extension, lower their costs.

Resolve the CareFirst Issue

So far, CareFirst has failed to demonstrate that its lack of access to capital (because of its non-profit status) seriously handicaps its ability to offer affordable, acces-
sible, and comprehensive products to Marylanders. If lawmakers believe that it is important to maintain an insurer of last resort—and I believe it is—then it should reject CareFirst’s for-profit designs and direct the firm to return to its historic mission of insurer of last resort with an open enrollment period and affordable premiums.

If policymakers agree with that course of action, then they must also recognize that CareFirst should be allowed to manage its financial affairs so it can live up to its benefit promises. Put bluntly, CareFirst must set policies and prices that reflect economic conditions, not lawmakers’ political conditions. Given the firm’s dominant position in the Maryland market, the worst-case scenario would be if state officials, with their eyes to political concerns, would direct CareFirst into financial difficulty.

On the other hand, if lawmakers choose to let CareFirst go for-profit, the state should create a high-risk pool that would either provide insurance to those with poorer-than-average risk, or cover insurers that take on those risks.

Review the ’93 Reforms

State analysts and lawmakers should review the small-group health insurance reforms of 1993 to determine how effective they have been in making health insurance more affordable and accessible in Maryland. For example, have the community-rating rules benefited residents, or have they discouraged firms with younger employees (who have lower health care costs) from providing health insurance?
In closing, I feel compelled to return to a point of overwhelming centrality: The hyperinflation in the costs of health care and health insurance will continue unabated as long as insured individuals are covered under programs—either governmental or private—that remove their incentive to make cost-effective choices about what care they seek. In the absence of those incentives, no reforms will have lasting effect in making health insurance more affordable and accessible. The consequence of such a failure will be a complete government takeover of our health care system, with the loss of the dynamics of the marketplace in offering consumers choices among competitively priced products and among health care providers that are motivated to provide the highest quality services at competitive prices.