MARYLAND CITIZENS' HEALTH INITIATIVE: "HEALTH CARE FOR ALL" PLAN PROPOSAL

Technical Advisory Committee Report – Released November 12, 2008 (updated January 21, 2008)

***SUMMARY*: ENSURING HIGH QUALITY AFFORDABLE HEALTH INSURANCE COVERAGE FOR ALL**

The Maryland Citizens' Health Initiative, its Technical Advisory Committee, and its organizational partners throughout the State are committed to making quality health care affordable for all in a way that is business friendly, economically sound, politically realistic, and fiscally responsible. We seek to ensure that Marylanders with insurance obtain affordable, beneficial care and that the 775,000 uninsured residents get access to the care they need. It is our mission to both identify and implement strategies that move our state toward affordable coverage for all Marylanders in a way that emphasizes high-value medical care and prevention.

We are pleased with the progress made in the state to date, particularly the Governor's Working Families and Small Business Health Care Coverage Act of 2007 that will both expand Medicaid to cover adults under 116% of the federal poverty line and provide subsidies to very small firms with low-wage workers. However, we believe that there remains much more work to be done and that a sound plan of action to both expand health insurance coverage to the uninsured and make private health insurance coverage more affordable for those who are already insured is needed. What follows below is proposal to achieve a fair, responsible, and market-oriented "Health Care For All" system in the state of Maryland. Our proposal seeks to achieve affordable coverage by emphasizing improvements in the efficiency of care, accessibility of coverage, and shared responsibility for financing.

The first section of this proposal describes reforms to the financing and organization of health insurance coverage in the state, including a mandate that all residents obtain coverage. We propose to:

- Create the "Maryland Health Insurance Pool" to make insurance affordable by both merging the individual and small group markets and providing premium subsidies for lower-income residents;
- Provide a "Catastrophic Reinsurance" benefit that covers at least 75% of high annual health spending over $35,000 for all currently uninsured and privately insured residents; and
- Expand Medicaid eligibility for non-parents up to 200% of the federal poverty line and parents up to 300% of poverty in a better coordinated "Healthy Maryland" program.

The second section describes reforms to the delivery of health care in the state of Maryland meant to improve quality and cost efficiency. We propose to:

- Create the "Maryland Institute for Clinical Value" which will implement a "value based" insurance design that emphasizes the provision of care with well-established cost-effectiveness;
- Support projects, in large part based on electronic health records, that will improve the coordination and effectiveness of care for persons with chronic conditions; and
- Emphasize culturally appropriate prevention and health promotion to improve overall public health and reduce health disparities.

The third section describes the financing of this proposal. We propose new revenue sources to fund all additional spending so that there is no use of the state's general funds. We estimate that the plan would have:

- Total costs to the state of about $15.5 billion over five years from FY 2010 to FY2014, comprised of about $4.3 billion for low-income subsidies and other costs in the Maryland Health Insurance Pool, about $7.6 billion for the Catastrophic Reinsurance program, about $3.1 billion for the Healthy Maryland Medicaid expansion, $166.0 million for the Maryland Institute for Clinical Value, and $410.0 million for prevention and promotion activities; and
- Total revenues of about $15.5 billion over five years, comprised of about $13.2 billion from a 2.0% employer payroll tax on wages under the FICA cap, about $1.0 billion from an increase in the alcohol tax, $516.4 million from increased taxes on cigarettes and other tobacco products, $150 million from the tobacco settlement bonus payments, and $590.7 million re-allocated from the state high risk pool.

ACHIEVING QUALITY AFFORDABLE HEALTH CARE FOR ALL IN MARYLAND

The underlying goal of the "Health Care For All" Plan proposal is to make high-quality health insurance coverage affordable for everyone in the state, and in particular for small businesses and individuals. The plan would ensure that everyone would have access to high-quality, affordable health coverage either from their employer, through the new "Maryland Health Insurance Pool" program, or through an existing governmental plan. (Those covered by Medicare or the Federal Employees Health Benefits Program are largely unaffected in our plan proposal though.) To achieve affordable coverage for all, the plan is designed to promote: efficiency of care, accessibility of coverage, and shared responsibility for financing.

Efficiency of Care: The "Health Care For All" plan proposal seeks to make health insurance premiums more affordable by targeting the inefficiencies in our health insurance market and health care system. One primary way in which the plan targets inefficiency is through the formation of a large independent quasi-governmental "Maryland Health Insurance Pool" that bands together purchasers in the individual and small group markets in a more efficient marketplace with significantly lower administrative overhead. A second primary way in which the plan targets inefficiency is through the development of "value based" insurance design for the plans offered in the Health Insurance Pool. The "Maryland Institute for Clinical Value" would develop guidelines for patient cost-sharing that emphasizes the use of medical care care that is evidence-based and effective.

Accessibility of Coverage: We recognize that even with the reductions in health insurance premiums from these improvements to the efficiency of care, many lower-income Marylanders will require some assistance towards affording their health insurance coverage. To this end, we propose to make low-income subsidies available to individuals purchasing private coverage in the Health Insurance Pool. We also propose to expand the state's "safety net" of care by expanding income eligibility to the state's Medicaid program.

Shared Responsibility: We believe that ensuring all residents have access to affordable coverage requires the shared responsibility among individuals, businesses, providers, and government. Specifically, we propose to require that every Maryland resident contribute towards purchasing affordable coverage or face a tax penalty. We also propose to require every Maryland business contribute through a 2% tax on payroll up the FICA cap. Moreover, health insurance plans offering coverage in the Health Insurance Pool would face "community rating" and "guaranteed issue" requirements. Finally, the cost of financing health care for the sickest one percent of the privately insured population would be pooled across everyone with private insurance through a new state-financed "Catastrophic Reinsurance" benefit. These shared responsibilities will collectively result in strong incentives for individuals and employers to obtain adequate health insurance coverage.

These proposed health reforms are described in more detail throughout this document. Specifically, Section 1.1 describes the Maryland Health Insurance Pool program along with its associated low-income subsidies, rating regulations, and individual mandate, Section 1.2 describes the Catastrophic Reinsurance program, and Section 1.3 describes the expansion to the Medicaid program under a renamed "Healthy Maryland" program. Section 1.4 describes the current distribution of health insurance coverage in the state and the distribution of coverage that would result under these proposed reforms. Section 2 of this proposal then describes reforms largely related to the delivery and quality of health care in the state directed by the Maryland Institute for Clinical Value. Finally, Section 3 provides a detailed five-year budget for the proposed reforms. The primary source of revenue is a two percent tax on employer payroll up to the FICA cap.

1.1. MARYLAND HEALTH INSURANCE POOL

Summary: We propose to establish the "Maryland Health Insurance Pool" in FY 2010 to act as a mechanism for purchasers currently in the individual and small group markets to obtain more affordable coverage. A choice of plans would be offered through the Maryland Health Insurance Pool, premiums would not vary with health status, and no one could be denied coverage. Employers with fewer than 100 employees and individuals without access to employment-based insurance would purchase their health insurance coverage through the Insurance Pool. All plans offered in the Insurance Pool would be subsidized by the "Catastrophic Reinsurance" Program described below, and additional subsidies would be available for individuals with incomes below 400% FPL to help further offset their costs. The Board of the Maryland Health Insurance Pool would also administer the Catastrophic Reinsurance Program. The state would impose a mandate that all residents obtain at least a minimum level of coverage or be subject to tax-based penalties, but residents would only be subject to the mandate if an affordable option for coverage is deemed to be available.

Administration: We propose that the state charter a quasi-governmental entity, the "Maryland Health Insurance Pool" (aka "the Insurance Pool" and "MHIP"), to better facilitate the sale of private health insurance coverage for individuals without access to employment-based health insurance and small firms with between 2 and 100 workers. The Maryland Health Insurance Pool would replace the current individual and small group markets. Firms with more than 100 workers would have the option of obtaining coverage through the Insurance Pool, but they could also obtain coverage outside of the Pool. The Insurance Pool would band the purchasing power of these smaller groups together and encourage competition among private insurers to achieve reductions in administrative overhead. Currently, administrative costs average about 22% of premiums for firms of this size and about 35% in the individual market. We anticipate that administrative overhead in the Insurance Pool will be reduced to about 10%, close to those currently seen in large group insurance. (These estimates of administrative loading by the size of firm come from the U.S. Congress' nonpartisan Joint Committee on Taxation.) Employers would be encouraged to establish Section 125 plans to enable the premium contributions to the Insurance Pool to be made with pre-tax dollars. Individuals currently obtaining coverage through the Maryland Health Insurance Plan, the state-sponsored high risk pool, would transition into the new Insurance Pool. All private health insurance offered through the Insurance Pool (as well as insurance sold to large employers and benefits from firms that self insure) would be subsidized by the "Catastrophic Reinsurance" Program described in Section 1.2 below; this public reinsurance program is designed to reduce private premiums by 10%.

The Maryland Health Insurance Pool would serve as a clearinghouse for the private health insurance carriers wishing to sell policies in Maryland. (The small group health insurance market in Maryland is currently concentrated among just a few private insurers.) Carriers would offer multiple plans that vary in the generosity of insurance benefits, hereafter termed a "basic" plan, a "typical" plan, and a "generous" plan. The MHIP Board would seek some level of standardization in the benefit packages across the different types of plans to ease consumers in selecting across plans, but innovation in the value of benefits offered would be encouraged through competition between plans. Moreover, the MHIP Board would define a "floor" level of benefits to be offered in the Pool, and all plans offered through the Insurance Pool would be required to adhere to the "value-based insurance design" criteria outlined below in Section 2.1.

One type of "basic" plan meeting the floor would be a tightly-managed HMO and the other "basic" plan would be a PPO plan whose cost-sharing is structured so that its actuarial value is roughly equivalent to the HMO plan. The MHIP Board would determine the minimum actuarial value or "floor" of benefits of the participating plans and specify the maximum out-of-pocket amounts permitted. At a minimum, the floor would be comparable to the "core" HMO in the Comprehensive Standard Benefit Plan for Small Businesses established

by the Maryland Health Care Commission, but the MHIP Board would decide whether a more generous basic plan (e.g., lower annual deductibles and/or a separate, smaller deductible for drugs) is feasible.[1] However, in both the "basic" HMO and high-deductible PPO, cost-effective preventive care and chronic disease management services would have small copayments, rather than be subject to the PPO's annual deductible – as is currently the case with many HSA-qualified, high-deductible plans. The "typical" and "generous" plans offered through the Insurance Pool would have fewer managed care restrictions and lower amounts of cost sharing, but have correspondingly higher premiums. However, the higher premiums for these more generous plans would reflect differences in the actuarial value of the additional benefits and not any enrollee characteristics by using "risk adjustment" methods.

The design of the Insurance Pool in this manner emphasizes individual choice and insurer competition: people who wish to elect a "basic" plan could choose between lower cost sharing versus fewer restrictions on care to match their preferences, and people who wish to obtain more generous plans with lower cost sharing and fewer restrictions on care would pay the appropriate additional cost for those options. The selection of a plan among the options available in the Pool would be made by individuals rather than employers. Because most small employers currently offer only one plan option to their workers (if they offer a plan at all), the multi-plan offerings in the Pool will be better able to match individual preferences among various types of plans. Insurers would compete to offer more affordable coverage with higher value services. Participating health insurers would be required to disclose their medical loss ratios to the MHIP Board, which would in turn provide this information – along with details on each plan's premium and benefits – to consumers during the open enrollment period. The MHIP Board would clarify what constitutes a medical expense (e.g. case management, utilization review, quality improvement activities) and would have the discretion to audit the health insurers' accounts to ensure that the loss ratios are reported accurately. We believe that this "transparency" in prices and benefits will result in all insurers competing to offer acceptably high medical loss ratios, but the MHIP Board will review the success of transparency towards improving the medical loss ratios after five years. At that time, the Board will consider whether incorporating a public plan option in the Maryland Health Insurance Pool is feasible and desirable.

Rating and Issue Regulations: We propose that the plans offered through the Insurance Pool be subject to "guaranteed issue," "guaranteed renewal," and "adjusted community rating" provisions. Insurers would not be able to discriminate by health status – either by not issuing a plan selectively or by charging a higher premium. Insurers would be allowed to vary their premiums by age but there would be a 3:1 maximum band for age rating. (Regarding the terminology here, "adjusted" community rating allows variation with age, while "pure" community rating does not.) For instance, insurers would be allowed to use the five following categories to base premiums on age: under 18, 18 to 24, 25 to 44, 45 to 54, and 55 to 64.

Several provisions would be enacted to limit any "adverse selection" and the subsequent deterioration of the risk pool that the rating and issue regulations may cause. First and foremost is a mandate that all Maryland residents obtain at least a "basic" health insurance plan; the administration of the mandate and its tax-based penalties are discussed below. A second provision is a requirement that all insurance sold to individuals and firms with between 2 and 100 workers be offered through the Insurance Pool; without this requirement, a secondary market outside of the Insurance Pool (not subject to the same rating and issue regulations) would

[1] For example, the MHCC "core" HMO for Small Businesses cost an average of $3,133 in 2007. As a point of comparison, the "core" PPO had a $2,500 annual deductible and $4,900 out-of-pocket limit for individual coverage (and a $5,000 annual deductible and $9,800 out-of-pocket limit for family coverage) and cost an average of $2,748 in 2007. Because the minimum "basic" plan would be actuarially equivalent to this core HMO, high-deductible plan meeting the Insurance Pool's floor would have annual deductibles that are lower than these $2,500 and $5,000 amounts for single and family coverage, respectively. For more detail about these plans, see http://mhcc.maryland.gov/smallgroup/carrierexp0508.pdf. The "generous" plans' benefit package would be comparable to MHIP+.

likely result in adverse selection for the Insurance Pool. Third, insurers offering coverage through the Insurance Pool would be permitted to implement minimum participation requirements of, for example, 75% of a firm's workers being covered through the Insurance Pool. Fourth, while "risk adjustment" would counter insurer incentives towards engaging in favorable selection into the "basic" plans, the Board would be enabled to require each of the participating insurers to offer at least one "generous" plan along with another plan that meets or exceeds the pre-specified floor of benefits. If there is significant evidence of adverse selection existing after five years, the MHIP Board would have the discretion to phase in other provisions to limit it. These provisions could include, for instance, 1) the establishment of a once-per-year "open enrollment" period for obtaining coverage through the Insurance Pool – except for certain circumstances considered to be a qualifying event under IRS code such as job loss or change, divorce, or death of a spouse; 2) a surcharge of up to 5% of the premium per year upon enrollment if one initially forgoes obtaining coverage (similar to, but less than, that used for Medicare Parts B and D) and/or 3) a pre-existing condition exclusion of six months for non-emergency services if one either does not initially enroll in the Insurance Pool when first eligible.

Low-Income Subsidies for Coverage: People with incomes less than 400% FPL who do not work at firms with more than 100 workers would be eligible for subsidized coverage in the Insurance Pool, in order to help improve their access to affordable coverage. These subsidies would be in addition to the Catastrophic Reinsurance subsidy described below in Section 1.2, which will cover 10% of premiums in the state. For those with incomes less than 300% FPL, a fixed-dollar subsidy equal to 50% of the average premium for the "typical" plans in the Insurance Pool for one's age would be provided; as a result, the magnitude of the fixed-dollar low-income subsidy increases with age to partially offset the higher premiums for older people. For those with incomes between 300% and 400% FPL, a fixed-dollar subsidy equal to 25% of the average premium for the basic plan for one's age would be provided. The fixed-dollar value of these low-income subsidies would be available to the less generous basic plans and the more generous plans, as well. Premium assistance through Medicaid would also be available for all privately insured people who are Medicaid eligible; the "Healthy Maryland" Medicaid expansion is described below in Section 1.3.

Although people with incomes under 300% FPL purchasing plans in the Insurance Pool get a subsidy equal to 50% of the "typical" plan's premium, this subsidy understates the total reduction in costs relative to purchasing in the individual or small group market now. This is because the overall premium is reduced both by 10% due to the reinsurance subsidy (described below) and by the reduction in administrative loading, which firms currently in the small group market, would be about 12% of the premium. Consequently, a person under 300% FPL would face a premium for the typical plan which would be, on average, about 60% less than the current premium. In other words, 0.60 is equal to 1 – (0.50*0.90*0.88) where 0.50 represents the low-income subsidy, 0.90 represents the 10% Catastrophic Reinsurance savings, and 0.88 represents the 12% administrative costs savings. Suppose, for instance, that the single-coverage premium for a typical plan in this small firm is now $5,000. The 10% reinsurance subsidy and 12% administrative costs savings lower this to about $4,000. A 50% low-income subsidy lowers this typical plan's premium to about $2,000. Moreover, if the premium for a basic plan is about $3,000 (after accounting for the 10% reinsurance and 12% administrative cost savings), the subsidized premium, net of the roughly $2,000 low-income subsidy, would be about $1,000. The Appendix includes Exhibits that show the resulting share of income that the typical and basic plans' subsidized premiums would represent for a single adult and a hypothetical family of four, respectively, at different levels of income. As shown there, the subsidy towards the basic plan is progressive, as the resulting premium contributions as a percent of income generally decreases as income decreases; contributions as a percent of income decrease as one moves from over 400% FPL to between 300% and 400% FPL and then decrease further as one moves to between 200% and 300% FPL.

As noted above, firms with between 2 and 100 employees who wish to purchase health insurance for their workers could only obtain that insurance through the Insurance Pool. These firms could self-insure if they choose and receive the Catastrophic Reinsurance subsidy described in the next section, but a self-insured firm's low-wage workers would not have access to the low-income subsidies for people under 400% FPL in the Insurance Pool. Firms with more than 100 workers would be able to obtain coverage through the Insurance Pool, but only if the firm as a whole joins; their workers would not have access to the low-income subsidies though. No firm would be required to offer insurance – a requirement would violate ERISA – but we believe that the incentives put in place will encourage both small and large firms to offer comprehensive coverage. The Insurance Pool's plans will be available, though, to individual workers of firms with more than 100 workers that do not offer a plan that meets or exceeds the basic plan's "floor" level of benefits as specified by the MHIP Board. All workers who qualify for Medicaid would be eligible for premium assistance through Medicaid regardless of their employer's size and whether their employer obtained insurance through the Insurance Pool. The Insurance Pool would base the subsidies on income reported on the prior last year's income tax return, but people who have a significant change in income due to a job loss or some other reason would be able to request a revised report.

Individual Mandates for Coverage: Health insurance coverage will be mandated for all residents of the state. The mandate will be enforced by tax-based penalties, but two groups of people would be exempt from paying any penalties: Penalties would not be imposed on people eligible for Medicaid but not yet enrolled, and penalties would not be imposed on people whom the MHIP Board deems would not ultimately have access to affordable premiums. For the latter, exemptions would be granted to people whose net spending for the basic plan available in the state (i.e., the total premium less the subsidy but plus the plan's associated out-of-pocket payments) does not meet a progressive "affordability" criterion for costs as a percentage of income: we propose exemptions for those under 300% FPL facing total spending of more than 5% of income, those between 300% FPL and 500% FPL facing total spending of more than 7.5% of income, and those over 500% FPL facing total spending of more than 10% of income. The MHIP Board would also outline the special "hardship exemptions" that would limit the application of the mandate's penalty. Individuals would pay a tax-based penalty if they do not obtain insurance – either through their employer or purchased through the Insurance Pool – that at least meets the "basic" plan's floor of benefits. The penalty, once fully phased in over time, would equal up to 50% of the average premium (so that the penalties do not vary by age), net of any low-income subsidies, for the "basic" plan: that is, up to 50% of the average basic plan's premium for those over 400% FPL, up to 37.5% of the average basic plan's premium for those between 300% and 400% FPL (i.e., half of 75%), and up to 25% of the average basic plan's premium for those under 300% FPL (i.e., half of 50%). These penalties would be collected through the filing of state income taxes.

Total Costs: We estimate that about 1.36 million Maryland residents without access to large-group insurance would ultimately obtain their insurance through the Insurance Pool. About 60% of the 1.36 million will have their premium reduced by income-related subsidies: about 603,000 would have access to the 50% low-income subsidy available to those under 300% FPL (with about 324,000 of them receiving premium assistance through Medicaid) and about 219,000 would have access to the 25% low-income subsidy available to those between 300% and 400% FPL.

We estimate the total cost to the state of the low-income subsidies (excluding the Medicaid premium assistance allocated to the Medicaid expansion) will be $4,138.7 million over five years, with a cost of $721.6 million in FY 2010. These cost estimates assume that there will be 100% take-up of health insurance coverage in the state by FY 2014. The total administrative costs incurred by the state from managing the Insurance Pool will be $139.8 million over five years, with a cost of $37.2 million in FY 2010. Total state costs for the Insurance Pool will be $4,278.5 million, with a cost of $758.8 million in FY 2010.

1.2. CATASTROPHIC REINSURANCE FOR HIGH COST CARE

Summary: We propose that, starting in FY 2010, the state provide a "Catastrophic Reinsurance" benefit towards funding high-cost care of all individuals not covered by Medicare, Medicaid, the State Children's Health Insurance Program, or the Federal Employees Health Benefits Program. Employees of state and local governments would be included. The Catastrophic Reinsurance Benefit would be administered by the MHIP Board. By removing a portion of the costs of catastrophic illness from the price of private health insurance coverage, we will make insurance more affordable for all Maryland employers and families. (Practically all private health insurers and self-insured firms currently purchase reinsurance plans on their own; for them, this would displace the costs they currently incur.)

Reinsurance Details: We propose that a statewide reinsurance plan be designed to reduce the cost of private health insurance premiums in the state by 10%. The so-called "attachment points" for reinsurance policies can be devised in a number of ways to cover a portion of high health spending with a particular target subsidy in mind. For instance, we estimate that a reinsurance policy that covers 75% of a person's annual health care costs between $35,000 and $100,000, and covers 95% of annual health care costs over $100,000 up to a lifetime maximum of two million dollars and limited to "medically necessary" services would cover approximately 10% of health care spending for those currently with private health insurance. About one percent of the population has spending over $35,000, demonstrating the concentration of expenditures among a few high-cost people. Because private reinsurers generally provide case management for catastrophic care (in addition to the financial mechanism of pooling risk), we believe that the consolidation and uniformity of a comprehensive reinsurance plan in the state would improve the delivery of care to the sickest Marylanders and thus be embraced by employers and employees.

To administer the reinsurance plan, we propose that the MHIP Board collect bids from existing private reinsurance companies and contract with two companies to provide the reinsurance benefit to all private health insurers in the state – although the state would consider state-sponsored reinsurance after five years if appropriate bids are not received by private companies. Private health insurers selling plans through the Maryland Health Insurance Pool and private health insurers selling plans directly to employers would be reimbursed for a portion of the high-cost medical care by the public reinsurer. Likewise, self-insured firms would be reimbursed for a portion of their high-cost care. By providing access to "no cost" reinsurance for private health insurers and self-insured firms under these parameters, private health insurance premiums would fall by 10%, or perhaps more from competition if the availability of reinsurance improves competition in the state's health insurance market. The state insurance commissioner in conjunction with the MHIP Board would be tasked with ensuring that the reduced costs due to the reinsurance result in corresponding reductions in private premiums.

Total Costs: We estimate that the provision of this Catastrophic Reinsurance benefit for high-cost care will help subsidize the insurance premiums for about 3.61 million Maryland residents. We estimate that the total cost to the state for contracting with private reinsurers will be $7,518.0 million over five years, with a cost of $1,339.6 million in FY 2010. As noted earlier, our cost estimates assume universal coverage in the state by FY 2014. The administrative costs incurred by the state to evaluate the bids and subsequently provide oversight to the reinsurer's activities will be $42.6 million over five years, with a cost of $11.7 million in FY 2010. Total state costs for the Catastrophic Reinsurance program will be of $7,560.6 million over five years, with a cost of $1,351.3 in FY 2010.

1.3. "HEALTHY MARYLAND" MEDICAID EXPANSION

Summary: We propose to increase the number of adults eligible for public health insurance coverage in the state by expanding the income eligibility criteria for the Medicaid program. Currently, children in the state with incomes up to 300% of the federal poverty line (FPL) are eligible for Medicaid or the Maryland Children's Health Program (MCHP). As a result of newly-enacted legislation, adults in the state with incomes up to 116% FPL will become eligible for Medicaid; custodial parents (hereafter, the term "parent" refers to a "custodial parent" while "nonparent" refers to an adult who is not a custodial parent) became eligible on July 1, 2008 while non-parents are scheduled to become eligible in a phased-in manner over three years beginning on July 1, 2009. We also propose to invest in infrastructure of the Medicaid program and add coverage of certain services to the benefit package.

Medicaid Eligibility Details: We propose to increase the Medicaid eligibility threshold for non-parent adults up to 200% FPL and for parents up to 300% FPL in FY 2010 in a newly-named "Healthy Maryland" program. Eligibility will be limited to citizens and legal immigrants that meet the existing non-income eligibility criteria in the state. We use a higher eligibility threshold for parents because we want to keep parents and children in the same insurance system; parents of children enrolled in MCHP will have their insurance coordinated with their children's managed care plan. Parents with incomes between 200% and 300% FPL will face a $50 monthly premium contribution per parent; the total contribution for a two-parent family is at most four percent of income for families between 200% and 300% FPL. Individuals that are Medicaid-eligible and employed with a firm that offers health insurance that meets or exceed the "floor" of benefits specified by the MHIP Board would have access to premium assistance via Medicaid, but they would not be discouraged from enrolling directly in the traditional Medicaid plan. For Medicaid-eligible individuals who are insured through firms with over 100 workers, premium assistance would cover the entire employee-paid premium. For Medicaid-eligible individuals who elect to be privately insured in the Insurance Pool rather than enroll in traditional Medicaid, the low-income subsides (set to 50% of the typical premium) would be funded by the Medicaid program.

This expansion would be accomplished by modifying the state's existing Section 1115 demonstration waiver. We anticipate that an expansion of Medicaid structured in this way would provide access to 50% federal matching funds to help offset the costs of the expansion. In addition to being able to access the federal matching funds for coverage, we believe that a Medicaid expansion to these income levels is appropriate because the Medicaid program is experienced in providing health care to low income families and has a broad benefit package and low or no cost sharing. Because these individuals generally have a difficult time affording private coverage, the amount of "crowd out" (i.e., the substitution of private coverage for public coverage) should therefore be relatively low; evidence for MCHP suggests that it will be minimal. Moreover, "crowd out" will be greatly minimized by the low-income subsidies provided to private health insurance in the "Maryland Health Insurance Pool" and by the "Catastrophic Reinsurance" subsidy towards private insurance.

Infrastructure Investments: We also propose to include funds for improving the infrastructure of the program during the first year of the plan and for expanding the capability of local agencies to process new applications. Improvements would include updating the Medicaid and MCHP eligibility determination and re-determination processes with a state-of-the-art computer system and the use of an enterprise service bus or other middleware to integrate communication across the different incompatible data systems within the state. This system would allow the state to develop state-of-the-art enrollment and re-enrollment mechanisms such as automated verification of income at enrollment and re-enrollment or "express lane" eligibility, vastly streamlining the eligibility determination process. A uniform, simple application for determining eligibility for Medicaid and the Insurance Pool's low-income subsidies would also be created. Additional resources would

also be allocated to the local health agencies and local departments of social services who are currently responsible for eligibility determination for the expansion populations, including funding for additional case managers to handle the enrollment.

Expanded Benefit Package: We also propose to dedicate funds to expanding the following medical services provided in the Medicaid program: dental coverage, residential alcohol/drug treatment for adults, and routine HIV counseling/testing. Dental services are currently covered in the MCHP program for children, but only limited dental services are now provided to adults. We therefore propose to add comprehensive oral exams and cleaning for adults to the Medicaid benefit package. Moreover, Medicaid does not currently cover all levels of clinically-appropriate care for addiction to alcohol and other drugs, particularly for treatment in a residential facility for adults. The Maryland Alcohol and Drug Abuse Administration (ADAA) currently funds several levels of inpatient and residential services for people with alcohol and other drug addictions: partial hospitalization, halfway houses, therapeutic rehabilitation, long-term residential, and medically-managed intensive residential treatment. We propose to provide expanded access to such services by making clinically-appropriate residential treatment for addiction to alcohol and other drugs part of the standard Medicaid benefit package. This will require approval of an IMD waiver (Institutions for Mental Diseases) the State must apply for from the federal government. If the waiver application is denied, the proposed funding would be directed to ADAA to provide residential treatment for adults. (Coverage of addiction treatment for people not insured by Medicaid is discussed in Section 2.1 below.) Finally, while Medicaid does currently reimburse providers for providing HIV/AIDS counseling and testing , these services are currently underutilized because they are generally initiated through the initiative of the patient. We propose to implement routine HIV/AIDS counseling and testing offered at each clinical encounter for Medicaid enrollees. Establishing more routine counseling and testing has been demonstrated as a cost-effective intervention towards reducing the transmission of the AIDS virus.

Total Costs: We estimate that the Healthy Maryland Medicaid expansion would provide coverage to about 107,000 currently uninsured residents. We estimate that the total cost to the state for expanding Medicaid coverage from 116% FPL to 300% FPL for custodial parents will be $371.8 million over five years, with a cost of $48.1 million in FY 2010. The cost to the state for the expansion in eligibility from 116% FPL to 200% FPL for non-parents will be $443.2 million over five years, with a cost of $58.0 million in FY 2010. The cost to the state of premium assistance towards large-firm private insurance will be $512.3 million over five years, with a cost of $67.5 million in FY 2010. The cost to the state of premium assistance towards private insurance in the Insurance Pool will be $1,499.6 million over five years, with a cost of $261.5 million in FY 2010. As noted above, these cost estimates assume that universal coverage is achieved by 2014 with no one remaining uninsured thereafter. As a result, much of the increase in costs by year within the five-year budget window reflect "phased in" enrollment, with the "steady state" of costs achieved by 2014.

The total cost to the state of the computer-related infrastructure expenditures will be $50.0 million, split between FY 2010 and FY 2011. The total cost to the state of the increased funding to county health departments for processing will be $50.0 million over five years, at $10.0 million per year. The total cost to the state of adding dental benefits will be $73.5 million over five years, at a cost of $17.4 million in FY 2010. (The relatively higher expenditures in FY 2010 are related to "pent-up demand" anticipated among this group.) The total cost to the state of adding coverage of alcohol/drug treatment will be $50.0 million over five years, at a cost of $8.9 million in FY 2010. The total cost to the state of adding coverage for routine HIV/AIDS testing and counseling is $17.3 million over five years, at a cost of $3.1 million in FY 2010. These costs to the state do not include the $3,067.7 million in total federal matching funds that we anticipate receiving from CMS towards each of these initiatives. Total state costs for the Healthy Maryland Medicaid program are estimated to be $3,067.7 million over five years.

1.4. SOURCES OF HEALTH INSURANCE COVERAGE IN THE STATE

Exhibit 1 shows the projected sources of insurance coverage for Maryland residents in FY 2010 in the absence of any state or federal reforms.

Exhibit 1: Sources of Coverage in Maryland Under the Status Quo

Source of Coverage:	Thousands of People	Percent of Population
Total population	5,847	100.0%
Federal employees	486	8.3%
Public coverage:		
Medicare	746	12.8%
Champus	230	3.9%
Medicaid/SCHIP	401	6.9%
Private coverage:		
Employment-based coverage	2,954	50.5%
Individual coverage	256	4.4%
Uninsured	775	13.3%

Note: Estimates are based on the pooled March 2005-2007 Current Population Survey.

Exhibit 2 shows the estimated sources of insurance coverage for Maryland residents in FY 2014 after the "Health Care For All" plan takes full effect.

Exhibit 2: Sources of Coverage Under the Maryland Health Care For All Plan

Source of Coverage:	Thousands of People	Percent of Population
Total population	5,847	100.0%
Unaffected coverage:	1,461	25.0%
Medicare	746	12.8%
Champus	230	3.9%
Federal employees	486	8.3%
Healthy Maryland Program:	781	13.4%
Currently in Medicaid/SCHIP	401	6.9%
Uninsured, eligible prior to recent expansion	114	1.9%
Uninsured, eligible after recent expansion	159	2.7%
Uninsured, eligible under HCFA expansion	107	1.8%
Maryland Health Insurance Pool:	1,364	23.3%
Currently insured	1,091	18.7%
Currently uninsured	273	4.7%
Large Group Insurance (100+ workers):	2,241	38.3%
Currently insured	2,117	36.2%
Currently uninsured	123	2.1%

Note: Estimates are simulated using the pooled March 2005-2007 Current Population Survey.

As a result of the creation of the Maryland Health Insurance Pool with its associated low-income subsidies and the expansion of the Medicaid program with its associated premium assistance, people in the state will have the following options based upon their family status and income level:

Consider singles and couples without custodial children first. For those with incomes up to 200% FPL, one can choose whether to enroll in Medicaid (at no cost) or receive a subsidy towards private coverage. For those under 200% FPL at large firms, this subsidy towards private coverage is Medicaid premium assistance and the 10% catastrophic reinsurance subsidy. For those under 200% FPL not employed at large firms, this subsidy towards private coverage is the 50% low-income subsidy for plans in the Insurance Pool and the 10% reinsurance subsidy. For those between 200% and 300% FPL, the subsidy for large-firm workers is the 10% reinsurance subsidy, and the total subsidy for those not working at large firms is the 50% low-income subsidy in the Pool and the 10% reinsurance subsidy. For those between 300% and 400% FPL, the subsidy for large-firm workers is the 10% reinsurance subsidy, and the total subsidy for those not working at large firms is the 25% low-income subsidy in the Pool and the 10% reinsurance subsidy. For those above 400% FPL, the subsidy for large-firm workers is the 10% reinsurance subsidy and the subsidy for those not working at large firms is also the 10% reinsurance subsidy. Those above 200% FPL are mandated to obtain coverage through the Insurance Pool or through their employer, or be subject to a tax-based penalty if not exempt due to an affordability determination.

For families with children and total family income up to 200% FPL, they can choose whether to enroll in Medicaid (at no cost) or receive a subsidy towards private coverage. For those under 200% FPL, the subsidy for large-firm workers is Medicaid premium assistance and the 10% reinsurance subsidy, and the total subsidy for those not working at large firms is the 50% low-income subsidy in the Pool and the 10% reinsurance subsidy. For families between 200% and 300% FPL, they can choose whether to enroll in Medicaid at a cost of $50 per month per adult or receive a subsidy towards private coverage. For those between 200% and 300% FPL, the subsidy for large-firm workers is the Medicaid premium assistance and the 10% reinsurance subsidy, and the total subsidy for those not working at large firms is the 50% low-income subsidy in the Pool and the 10% reinsurance subsidy. For those between 300% and 400% FPL, the subsidy for large-firm workers is the 10% reinsurance subsidy, and the total subsidy for those not working at large firms is the 25% low-income subsidy in the Pool and the 10% reinsurance subsidy. For those above 400% FPL, the subsidy for large-firm workers is the 10% reinsurance subsidy and the subsidy for those not working at large firms is also the 10% reinsurance subsidy. Families above 300% FPL are mandated to get coverage or be subject to a tax-based penalty if not exempt due to an affordability determination.

SECTION 2: **PROMOTING A HIGH-VALUE, PREVENTION-ORIENTED HEALTH CARE SYSTEM IN MARYLAND**

This section describes reforms largely related to the delivery and quality of health care in the state. Our goal is to make Maryland a national model for how to design a patient-centered care delivery system based on knowledge about what works best for patients and public health.

We propose to create the "Maryland Institute for Clinical Value" in order to introduce "value based purchasing" into Maryland's private health insurance system. In addition to the development of value based coverage principles and guidelines by the Institute, this effort will be facilitated by the implementation of both an electronic health record (EHR) system and a Citizens' Advisory Council in Maryland. These initiatives are described in Section 2.1.

As part of our focus on what works and achieving population health, we also propose to implement a series of state-of-the-art prevention and health promotion programs to both improve overall public health and reduce health disparities. These initiatives to be undertaken by the "Prevention Trust for Health Promotion" are described in Section 2.2.

2.1. MARYLAND INSTITUTE FOR CLINICAL VALUE

Summary: Our goal is develop a set of policy strategies that would help ensure that health care spending is Maryland is targeted toward those services that are evidence-based and that provide significant benefit and value to patients and improve the public's health. Health care spending has been rising faster than wages making it more and more unaffordable. We are not spending all of this money wisely. By focusing on reducing wasteful spending and increasing spending on high-value services, we can bring the growth in health care expenditures into line with the growth in the economy. Our multi-faceted approach would be crafted by adopting "best practices" from other public and private payers and purchasers, making use of existing research and policy programs, and designing several novel elements based on cutting-edge regional and national efforts. The "Maryland Institute for Clinical Value" (aka "The Institute") would be established to identify priorities and coordinate the efforts to implement these policies. The Institute would be staffed by experts in clinical effectiveness including clinicians, health care outcomes experts, ethicists and health economists. A multi-stakeholder "Value-Based Advisory Committee" (aka "Committee") would review and approve the Institute's policies and guidelines. The Committee would be appointed by the Governor with representatives from consumers, business, labor, providers, and health plans. The Institute's policies and guidelines would be documented with the scientific evidence used and rationale for decisions. All plans within the Maryland Health Insurance Pool would be required to implement the guidelines set forth by the Institute and approved by the Value-Based Committee. Cost sharing for services reimbursed by the reinsurance plan would also be guided by the Institute's determination. The Institute would also share information about these policies with employers and other public and private insurers in Maryland who could voluntarily adopt these value based programs.

Cost Sharing and Reimbursement: We propose to focus on two aspects of insurance design to improve the value of care provided in the state of Maryland. The first is to have the level of patient cost-sharing for individual services linked to the cost-effectiveness of those services. The second is to craft selected provider reimbursement strategies linked to outcomes of care.

With regard to variable patient cost sharing, considerable research has shown that higher copayments can reduce the use of both necessary and unnecessary services. Currently, so-called "consumer-directed" health plans raise patient cost-sharing without distinguishing between high and low value services. We believe that patients will receive better care and public health will be improved through a clinically sensitive, culturally appropriate, and value-based approach which ties the level of patient cost-sharing to the cost-effectiveness and quality of evidence available for individual services. Treatments that have been established as highly cost-effective would have small or no associated copayments while treatments that are deemed as having lower cost-effectiveness or value to the patient would be available but with higher copayments. Promising but unproven new treatments would in some cases be covered for patients that participate in adequately designed clinical trials. As is currently the case, clinical services for which the evidence indicates no benefit for the patient or potential harm will not be covered by the program. As noted above in Section 1.1, the plans offered in the Insurance Pool – including the high-deductible PPO plans – will provide care deemed by the Institute to be "high value" for those with chronic health conditions with the copayments specified by the Institute.

By preferentially encouraging the use of high value services, value-based copayments are intended to maximize the community health gains achieved at any given level of health care spending. Consumers will have incentives to use health care services that offer the greatest benefit for the greatest number of people. This value-based approach has already been shown to increase adherence to certain high-value medications and can reduce health care spending in the long term by improving health and productivity. The cost-effectiveness of treatments and associated copayments would be determined by the Institute for Clinical

Value. The Institute would use clinical and economic assessments from the Agency for Healthcare Research and Quality (AHRQ), the Cochrane Collaboration, the National Quality Forum, the National Institute for Health and Clinical Excellence (NICE) in the UK, and others as analytic resources in making cost-sharing decisions. Design and actuarial estimates for value-based health plans under development by the University of Michigan and Harvard University will also be adapted as appropriate.

Examples of high-value care with small copayments would potentially include cholesterol-lowering statin drugs for patients with a history of coronary artery disease, inhaled corticosteroids for the treatment of asthma, anti-diabetic medications for diabetes or hypertension, colonoscopies starting at age 50 to detect early colon cancer, SSRI/SNRI for treatment of major depression, and mammography screening for breast cancer. Examples of the low-value care with high copayments would potentially include MRIs for back pain in patients less than 50 years old and with no neurological findings, some off-label uses of FDA-approved biological therapies, and brand-name prescription medications for which effective equivalent generic alternatives exist.

The second approach we will take to improve the value of care provided is to have selective implementation of high-leverage, outcomes-based reimbursement strategies such as: focusing on reduction of readmissions within 90 days, reducing hospital payments for avoidable/iatrogenic complications,[2] identifying and addressing services that are significantly overused and underused compared to other states and national averages, and implementing physician bonus payments for quality and safety. Regarding the latter, the American Heart Association's "Get with the Guidelines" program for hospitals to document and improve their quality performance based on best practices could be used as a model. The Institute will identify and fund research initiatives whose results can be used to establishing and improving these cost-sharing and reimbursement strategies.

Coordination of Chronic Care: As part of our population oriented care improvement and clinical effectiveness program, we propose to implement the following design features that target chronic care improvement and prevention in plans offered within the Insurance Pool. These initiatives will include: creating a "patient centered medical home" for beneficiaries, providing access to culturally and linguistically appropriate chronic care management programs, financial incentives (e.g., reduced cost-sharing) for individuals actively participating in a chronic care management program, rewards to enrollees who complete health risk appraisal surveys and participate in smoking cessation and/or weight loss programs, and incentives for providers to properly diagnose and manage chronic health conditions including obesity. Providers that participate in the patient centered medical home initiative will receive extra care management payments analogous to those being implemented by CMS for its similar pilot program for Medicare beneficiaries. The Institute will identify and fund research initiatives whose findings will improve these efforts to better coordinate chronic care. Moreover, it is important that Maryland also continues to provide treatment through its publicly-funded system of outpatient and residential care and expands it to meet the needs for those without adequate insurance. We therefore propose that additional resources be devoted to the ADAA block grants that fund a continuum of care for adolescents and adults throughout the state.

Funding for Academic Detailing: The practice of "academic detailing" – also known as prescriber support/education or perhaps as "counter-detailing" – sends trained clinicians to physician's offices in order to present the best available, objective, scientific evidence in a given therapeutic area, taking into consideration racial, ethnic, gender, and related factors. These encounters are meant to promote the most appropriate,

[2] For instance, CMS does not reimburse providers for removing objects left during surgery; air embolism; blood incompatibility; catheter-associated urinary tract infection; pressure ulcers; vascular catheter-associated infection; mediastinitis after CABG; hospital-acquired injuries; surgical site infections following certain elective procedures; certain manifestations of inadequate blood sugar level control; and deep vein thrombosis or pulmonary embolism following knee or hip replacement procedures.

clinically judicious use of prescriptions drugs as well as positive overall patient care practices. Though academic detailing is foremost a quality-driven endeavor, in the current context of aggressive marketing of high-priced brand name drugs by the pharmaceutical industry, it has also demonstrated an ability to control costs while improving quality. Dr. Jerry Avorn of Harvard University has been developing the concept since the 1980s and is currently operating the largest program in the country through Pennsylvania's PACE senior prescription drugs program. Academic detailing is not about promoting the cheapest drugs or generic drugs per se; it is about promoting the most appropriate drugs based on safety and efficacy data. The primary focus is on the evidence. In cases where multiple safe and effective therapies exist however, academic detailing encounters may appropriately include discussions of their relative costs.

Implementing a Maryland Electronic Health Record System: The value-based initiatives described above require a coordinated flow of information – both to implement the initial guidelines and to collect data to develop subsequent guidelines. Moreover, many "white papers" (including those by the Maryland Health Care Commission) underscore the importance of health care moving into the digital 21st century to ensure quality, safety and efficiency at many levels. For these reasons, we believe that the state should support a coordinated Health IT system in Maryland by helping to defray the costs of EHR systems for hospitals and physician practices and funding a state-wide "Central Regional Interchange" for health IT.

We propose that health care providers in the state be subsidized to develop a state of the art "Electronic Care Management" (ECM) system that could be the backbone of an EHR-supported care management program. The ECM would include patient registries, care guideline support systems, and e-prescribing modules. This system will be fully compliant with the federal privacy standards and will include the following functions: managing referrals, processing of claims with direct deposit to provider accounts, processing of copayments with direct debits from beneficiary accounts, developing a shared mini-patient record (to eventually grow into a full medical record), ordering of lab/imaging diagnostics and prescriptions, and real-time monitoring of medical errors and quality improvement (e.g., Rx interactions, non-compliance). The Institute will establish these guidelines for the Electronic Health Record system.

We propose to provide subsidies to a subset of providers for acquiring EHR systems in a competitive application process which would allow us to target these resources efficiently. Specifically, we propose to provide subsidies to most of the acute hospital systems in the state, in which the subsidy would cover about one quarter of the cost of each hospital's purchase price. We propose to provide subsidies to about half of the group physician practices in the state, concentrating these resources (though not exclusively) among relatively larger group practices. Grants covering about half of the purchase price for physician practices would be awarded through a competitive process. We would also introduce a pilot project for a subset of solo physicians that target leaders to participate in a shared web based EMR pilot that could be rolled out more widely later. The ECM health IT initiative will be targeted towards providers serving as the "medical home" for the patients covered by the Insurance Pool. After an initial five-year start up, user fees from private health insurers would fund the Central Regional Interchange.

Citizens' Advisory Council: Because of the challenges associated with the implementation of "value-based care" to expand access while controlling costs and the implementation of electronic health records and their associated privacy issues, it will be critical to have a robust mechanism to ensure that citizens are able to fully participate in all these aspects of reforming health care in the state. We propose creating a "Citizens' Advisory Council" (aka "The Council") to face these challenges. The Council would be comprised of citizens and providers and would be a component within the Maryland Institute for Clinical Value. The Council will coordinate an organized program of beneficiary feedback including outreach surveys (such as the federal Consumer Assessment of Health Plan Survey) and formal focus groups; establish a comprehensive dispute

resolution process to handle enrollee and provider complaints and grievances related to health care access, billing, privacy, and quality issues; and produce a set recommendations annually for improving the operations overseen by the MHIP Board. The Council will reflect the racial and ethnic diversity of the state's population.

Total Costs: We propose to allocate funds towards research into comparative effectiveness totaling $22.5 million over five years, with a cost of $10.0 million in FY 2010. We propose to allocate funds to ADAA towards drug/alcohol treatment totaling $50.0 million over five years, with a cost of $10.0 million per year. We propose to allocate funds toward "academic detailing" services totally $2.5 million, with a cost of $0.5 million per year. We propose to allocate a total of $82.0 million over five years towards subsidizing an Electronic Health Record System, comprised of $22.0 million for a Central Regional Interchange, $25.0 million for subsidies to hospitals, and $35.0 million for subsidies to physician practices. Administrative costs for managing the Institute's functions are estimated to total $10.0 million over five years, with a cost of $2.0 million per year. All together, the total costs for the Institute for Clinical Value are estimated to be $166.0 million over five years, with a cost of $96.5 million in FY 2010.

2.2. PREVENTION TRUST FOR HEALTH PROMOTION

Summary: We propose to implement culturally and linguistically appropriate prevention and health promotion initiatives and to collaborate and integrate with those activities that may be ongoing in various public and private organizations. We will emphasize reducing health disparities within the state. A new "Maryland Prevention Trust" (aka "The Trust") would be established as a sub-component of the Maryland Institute for Clinical Value to allocate funds to the different programs described below.

Prevention and Population Health Promotion: First, we propose to support innovation by local public health departments in preventing suffering and death through the following four efforts: (A) We will implement public health efforts to address obesity, cardiovascular disease, alcohol and other drug problems, and diabetes. As the burden of chronic disease rises, it is becoming increasingly clear that effective public health efforts to promote health and reduce complications are urgently needed. For example, evidence-based interventions include: community health worker programs for high-risk patients with cardiovascular disease and diabetes; educational, screening and referral programs based in such community locations as faith institutions, barber shops, and laundromats; early and brief screening and intervention in primary care and emergency department for alcohol and other drug use; and community-wide exercise activity involving parks, schools, and community groups. (B) We will implement public health efforts to address injuries and violence. These are the leading causes of death of young people in Maryland. Examples of effective public health interventions include the distribution of car safety seats, fire alarm programs and programs to prevent underage access to and use of alcohol. (C) We will implement public health efforts to reduce the spread of sexually transmitted diseases and HIV. CDC-endorsed effective interventions to reduce HIV and save substantial health care costs are significantly underfunded in Maryland. (D) We will implement public health efforts to expand vaccination. Maryland ranks in the bottom decile of states in flu vaccination coverage, and thousands of state residents do not receive cost-saving vaccinations each year. A major boost in vaccine funding would prevent thousands of unnecessary illnesses and hospitalizations.

Second, we propose to increase funding towards evidence-based policies and programs to prevent addiction to alcohol and other drugs. The Maryland Alcohol and Drug Abuse Administration currently funds a Prevention Coordinator in each jurisdiction who works closely with all elements of the community to identify needs, develop substance abuse prevention projects, and implement evidence-based prevention programs. We propose to increase funding for these prevention programs. We will also promote the use of other evidence-based prevention policies and programs, such as those recognized by CDC's Community Guide to Preventive Services. Finally, we propose to increase funding towards statewide media-based educational campaigns directed at further reducing alcohol and other drug-related harm, particularly among teenagers.

Third, we propose to dedicate increased funding towards tobacco prevention and cessation services/policies to make sure they are funded at levels recommended by the CDC. Tobacco control programs play a crucial role in the prevention of many chronic conditions such as cancer, heart disease, and respiratory illness. Comprehensive tobacco prevention and cessation programs prevent kids from starting to smoke, help adult smokers quit, educate the public, the media and policymakers about policies that reduce tobacco use, address disparities, and serve as a counter to the tobacco industry, which spends an estimated $190 million a year marketing its products in Maryland. Recommendations for state tobacco prevention and cessation programs are best summarized in the Center for Disease Control and Prevention's Best Practices for Comprehensive Tobacco Control Programs. In this guidance document, CDC recommends that states establish tobacco control programs that are comprehensive, sustainable, and accountable and include state and community interventions, public education interventions, cessation programs, surveillance and evaluation and administration and management. We propose that Maryland spend the amount recommended by the CDC,

$63.3 million per year, to adequately implement these programs. The State now spends $19 million per year on tobacco prevention and cessation, so we propose to add $45 million to this annual expenditure. The empirical evidence regarding the effectiveness of comprehensive tobacco prevention and cessation programs is vast and growing; they reduce smoking, save lives and save money. In 2007, the Institute of Medicine and the President's Cancer Panel all issued landmark reports that concluded there is overwhelming evidence that state comprehensive state tobacco control programs substantially reduce tobacco use and recommended that every state fund such programs at CDC-recommended levels.

Fourth, we propose to increase access to medical care through three mechanisms designed to increase the supply of certain providers. We propose to increase the amount of state funding directed towards community health centers. Because of existing geographic disparities in access to primary care clinicians, we propose to provide loan forgiveness programs for primary care clinicians if their practices focus on underserved populations in either rural areas or inner cities. Because of a system-wide shortage of nurses, we propose to increase funding for training and upgrading of health care workers in the state (e.g., offering training for low-skill workers to become certified nursing assistants and geriatric nursing assistants, offering licensed practical nurse and registered nurse training, and basic skill prerequisites for these programs).

Fifth, we propose to devote funding to promote the use of Advance Directives for improved end-of-life care. Advance Directives were created to ensure autonomy of patients who are unable to make decisions for themselves. Research has shown that they can reduce the use of unwanted and futile life-sustaining treatments at the end of life, resulting in reduced healthcare expenses, improved quality of life, and fewer burdens on family members. Because up to 25% of the total funds spent on healthcare for the average American are spent on end-of-life care, the potential savings are large. Despite these potential benefits, only about 30% of Americans have expressed in writing their wishes for how they want to be treated if they become seriously ill or are unable to communicate their choices for medical care. We believe that every competent adult should have the opportunity to complete an advance directive, that providing better information about them should be part of the state's public health education efforts, and that their completion should be incorporated into appropriate indicators of healthcare quality. We therefore propose that the Advance Directive Registry, created by SB 236 in 2006, be adequately funded and begun.

Health Disparities: Disparities related to race, ethnicity, disability, and socio-economic status (SES) are well documented across the nation. In Maryland these disparities exist in almost all aspects of health care, including those across different health care settings including primary care, dental care, and hospitals; across all dimensions of access to care, including cultural and linguistic barriers to care; across many clinical conditions including HIV/AIDS, infant mortality, mental health and substance abuse; across quality dimensions including appropriate treatment, patient safety, pain management and timeliness; and with subpopulations with disabilities and other special health care needs.

We anticipate that the expansion of health insurance to previously uninsured populations, where racial/ethnic minorities are disproportionately represented, will help close some gaps. For example, while the general population in Maryland is 29.3% African American and 7.1% Hispanic, we estimate that those covered by the Medicaid expansion from 116% FPL to 200% FPL for non-parents and to 300% for parents will be 37.2% African American and 7.4% Hispanic. In addition, we estimate those formerly uninsured people covered through the Maryland Health Insurance Pool with some form of low-income assistance (i.e., 50% of the average premium under 200% FPL and 25% between 300% and 400% FPL) will be 24.1% African American and 49.1% Hispanic. The expansion of the Medicaid program is clearly targeted at low-income populations. We also anticipate that many of the local public health innovations described above will help reduce disparities.

However, available evidence confirms that even when health care coverage is improved, many racial/ethnic and SES health disparities persist. We therefore propose the following initiatives to help address these inequities: (A) We propose funding for the Maryland Office of Minority and Low-Income Health to create a Maryland Minority and Low-Income Health Report Card, which describes the current health status of racial and ethnic minorities and low-income persons with respect to coverage, access to care, quality of care, treatment and health outcomes in terms of morbidity and mortality with respect to specific health conditions. This funding should include resources for improved data collection for racial and ethnic minority groups, in accordance at a minimum with the categories identified by the federal Office of Management and Budget. Data collection will also include primary language and income data for populations of low SES. (B) We propose to provide grants to hospitals in underserved areas and community health centers to develop or expand and offer disease-specific and/or population-specific programs to reduce disparities. (C) We propose to increase funding for health providers translation and other support services to improve services for underserved populations whose primary language is other than English. (D) To strengthen the capacity of communities throughout Maryland to address health disparity and equity issues in culturally and linguistically appropriate ways, we propose that funding be allocated for a Maryland Racial and Ethnic Approaches to Community Health (REACH) community action program, modeled after REACH programs funded by the Centers for Disease Control and Prevention (CDC). The CDC sponsors the REACH program to implement evidence-based programs and approaches to address disparities in the following six disease areas: heart disease, diabetes, breast and cervical cancer, immunizations, infant mortality and HIV/AIDS. Eligible applicants for funding should be community-based partnerships which will offer programs that will identify specific disparities and will engage community organizations and residents in implementing results-oriented strategies.

Total Costs: We estimate the total dedicated funding from the state to the local public health departments will be $25.0 million over five years, with a cost of $5.0 million per year. Total costs to the state for prevention of alcohol and other drug addiction and other related problems will be $50.0 million over five years, with annual costs of $10.0 million per year. Total costs to the state for tobacco prevention and cessation will be $225.0 million over five years, with a cost of $45.0 million per year. Total costs to the state towards increasing funding for community health centers will be $25.0 million, with a cost of $5.0 million per year. The total cost of tuition loan forgiveness for primary care clinicians will be $10.0 million over five years, with a cost of $2.0 million per year. Total cost of training and upgrading for health care workers will be $22.5 million over five years, with a cost of $12.5 million in FY 2010 and a cost of $2.5 million per year thereafter. Total costs to the state towards implementing 2006's SB 236 for Advance Directives will be $2.5 million, with a cost of $0.5 million per year. Finally, total costs to target health disparities will be $50.0 million over five years, with a cost of $10.0 million per year. Total costs administered by the Maryland Institute for Clinical Value allocated to the Maryland Prevention Trust will be $410.0 million over five years, with a cost of $90.0 million in FY 2010.

SECTION 3: FINANCING THE MARYLAND HEALTH CARE FOR ALL PLAN

3.1. COST ESTIMATES FOR THE PLAN:

Exhibit 3 at the end of this section shows the breakdown of the costs described above over the five-year budget window between FY 2010 and 2014. As described in more detail above in Sections 1 and 2, the total cost of $15,482.7 million over five years includes $4,278.5 for low-income subsidies and other costs in the Maryland Health Insurance Pool, $7,560.6 million for the Catastrophic Reinsurance program, $3,067.7 million for the Healthy Maryland Medicaid expansion, $166.0 million for activities conducted by the Maryland Institute for Clinical Value, and $410.0 million for initiatives undertaken through the Prevention Trust for Health Promotion.

3.2. REVENUE ESTIMATES FOR THE PLAN:

The revenue for the plan proposal is from the following five sources:

Payroll Tax: We propose to implement a 2.0% employer payroll tax on wages under the FICA cap (currently set to $102,000 but indexed by the federal government to inflation) starting in FY 2010. We would increase the cap each year to be consistent with the federal FICA cap. The payroll tax would be made on all private employers in the state of Maryland, the state government, and local governments. For private employers, we anticipate that labor market forces would cause the savings in health care premiums, net of the increase in the payroll tax, to yield higher wages and/or more generous benefits to their private-sector workers – so that total compensation remains the same. For state and local governments where wage and benefit levels are instead dictated by legislation, we propose that the documentable savings in the state's health care premiums, net of their increase in the payroll tax, are specified to be passed along to these public-sector workers trough higher wages and/or more generous benefits. Our estimate of the total revenue raised through the payroll tax incorporates an offsetting "behavioral response" to the increased tax rate of employers reducing their total payroll – either by lowering wages or by reducing the number of employees. (We believe that tax-related reductions in employment would be offset, though, by gains in employment in the expanded health care sector.) We estimate total state revenue from the employer payroll tax will be $13,225.9 million over the five-year budget window, with revenue of $2,474.2 in FY 2010.

Alcohol Tax: We propose to increase the state excise tax on alcohol in FY 2010. The state taxes on beer and wine have not increased since 1972, and the state tax on spirits has not increased since 1955. Maryland currently has the eighth-lowest tax in the nation for beer, the thirteenth-lowest tax for wine, and the third-lowest tax for spirits. We therefore propose a "Dime a Drink" increase in the state excise tax to $1.16 per gallon for beer, $2.96 per gallon for wine, and $10.03 per gallon for spirits. In addition to the revenue raised, an increase in the alcohol tax has public health benefits from the reduction of binge drinking, particularly among youths. We estimate total state revenue from the increase in the alcohol tax will be $1,015.0 million over the five-year budget window, with revenue of $197.0 in 2010. This revenue estimate incorporates the likely reduction in alcohol consumption caused by the higher net prices.

Tobacco Taxes: We propose to increase the state tax on cigarettes in FY 2010 from $2.00 per pack to $2.75 per pack and to increase the state tax on other tobacco products from 15% to 90% of the wholesale price (to more closely parallel the new cigarette rate), with minimum tax rates on specific other tobacco products to ensure that any sold with predatory or bargain-basement pricing still pay an adequate state tax per dose or unit. To keep the tobacco tax rates in line with inflation and rising tobacco product prices, we also propose subsequent increases to the tobacco tax rates of 10% or the actual inflation or product price increases every three years.

Because increasing tobacco taxes reduces both adult and, especially, youth smoking and other tobacco use – which in turn reduces related government and business costs – tobacco tax increases continue to be one of the most cost-effective ways to help fund public health needs like health care expansions and prevention policies, including full funding of state tobacco control efforts. These proposed tobacco tax rate increases would likely save at least 15,000 Maryland residents from dying prematurely from smoking, would keep more than 30,000 Maryland kids from ever becoming addicted adult smokers, and would lock-in more than $700 million in future reductions to state government, private sector, and household health care expenditures. Besides the tax rate changes, we propose closing existing loopholes in state law definitions that allow some cigarettes to evade taxes and other state law requirements by improperly qualifying as "little cigars" and that enable some new tobacco products to evade taxation altogether. Finally, we propose to institute new techniques – such as more effective, high-tech tax stamps on cigarettes – to deter tobacco product smuggling and tax evasion and to protect state revenues. We estimate that total state revenue from the increase in the cigarette tax to be $382.1 over the five years, with revenue of $74.4 million in FY 2010 and $86.3 million in FY 2013 after the additional 10% increase in the tax rate. We estimate that total state revenue from the increase in the tax on other tobacco products to be $134.3 million over five years, with revenue of $28.3 million in FY 2010. These estimates reflect both ongoing smoking declines and the tobacco use reductions from the higher tax rates, as well as possible pack sales declines from related increases in smuggling and tax evasion.

Tobacco Settlement's Bonus Payments: We propose, starting in FY 2010, to dedicate the additional $30.0 million per year in "bonus payments" from the 1998 Master Settlement Agreement between the tobacco industry and the states' attorneys general. Additional "bonus payments" to Maryland begun in 2008. These additional funds will be used to help cover the costs of the plan. Total state revenue from the Tobacco Settlement's Bonus Payments is estimated to be $150.0 million over five years.

Reallocation of MHIP Funding: The Maryland Health Insurance Plan (MHIP), the subsidized high risk pool for the state, will be integrated within the Maryland Health Insurance Pool starting in FY 2010. We are, of course, focused on ensuring that this population is made no worse off because of the policy change. Because the plans offered through the Insurance Pool will be community rated with guaranteed issue, people who currently receive insurance from MHIP will pay less in the Insurance Pool than in MHIP, where premiums average between 110% and 150% of the current average rate. Everyone will receive the 10% reinsurance subsidy, and those under 400% FPL will receive a low-income subsidy of either 50% or 25% of the "typical" plan premium to further reduce the premium. Because MHIP beneficiaries under 300% FPL now receive a roughly 25% subsidy towards a "generous" plan, we will provide any additional low-income subsidies (if needed) to those currently covered in MHIP yet still ineligible for Medicaid (i.e., nonparents between 200% FPL and 300% FPL) to ensure that they do not pay more under our proposal. Moreover, current MHIP enrollees will have access to a choice of plans, so that they will be able to enroll in a plan with a benefit package that is at least as generous as the insurance they currently have. Finally, many of those currently enrolled in MHIP will become newly eligible for public insurance as a result of the Medicaid expansion. We estimate the availability of already allocated funds to be $590.7 million over the five-year budget window.

Exhibit 3: Estimate of the Effects on Direct Spending and Revenues of the MD HCFA Proposal

Changes in State's Direct Spending:	**2010**	**2011**	**2012**	**2013**	**2014**	**Total**
Maryland Health Insurance Pool						
Subsidies: 50% to 300% FPL and 25% to 400% FPL	721.6	771.2	824.2	880.7	941.0	4138.7
Administrative costs incurred by the state	37.2	23.5	24.9	26.3	27.8	139.8
Subtotal:	758.8	794.7	849.1	907.0	968.8	4278.5
Catastrophic Reinsurance:						
Contracts with private reinsurers for 10% of costs	1339.6	1417.0	1498.9	1585.5	1677.1	7518.0
Administrative costs incurred by the state	11.7	7.1	7.5	7.9	8.4	42.6
Subtotal:	1351.3	1424.1	1506.4	1593.4	1685.5	7560.6
Healthy Maryland Medicaid Expansion:						
Expansion for parents to 300% FPL from 116% FPL	48.1	59.8	72.9	87.4	103.5	371.8
Expansion for non-parents to 200% FPL from 116% FPL	58.0	71.8	87.0	103.9	122.5	443.2
Premium assistance for large-firm private insurance	67.5	83.3	100.7	119.9	140.9	512.3
Premium assistance for coverage in the Pool	261.5	279.4	298.6	319.1	341.0	1499.6
Infrastructure expenditures	25.0	25.0	0.0	0.0	0.0	50.0
County health departments for processing	10.0	10.0	10.0	10.0	10.0	50.0
Dental coverage for adults in Medicaid	17.4	15.3	12.9	13.6	14.3	73.5
Alcohol/drug treatment coverage in Medicaid	8.9	9.4	10.0	10.6	11.2	50.0
Routine HIV testing/counseling in Medicaid	3.1	3.2	3.4	3.7	3.9	17.3
Subtotal:	499.3	557.3	595.6	668.1	747.3	3067.7
Maryland Institute for Clinical Value:						
Research initiatives	10.0	5.0	2.5	2.5	2.5	22.5
Alcohol/drug treatment in ADAA	10.0	10.0	10.0	10.0	10.0	50.0
Academic detailing program	0.5	0.5	0.5	0.5	0.5	2.5
Electronic health records: central interchange	20.0	0.5	0.5	0.5	0.5	22.0
Electronic health records: hospital subsidies	24.0	0.0	0.0	0.0	0.0	24.0
Electronic health records: physician subsidies	35.0	0.0	0.0	0.0	0.0	35.0
Administrative costs incurred by the state	2.0	2.0	2.0	2.0	2.0	10.0
Subtotal:	101.5	18.0	15.5	15.5	15.5	166.0
Prevention Trust for Health Promotion:						
Various public health initiatives	5.0	5.0	5.0	5.0	5.0	25.0
Alcohol/drug prevention	10.0	10.0	10.0	10.0	10.0	50.0
Tobacco prevention and cessation	45.0	45.0	45.0	45.0	45.0	225.0
Community health centers	5.0	5.0	5.0	5.0	5.0	25.0
Tuition loan forgiveness for primary care clinicians	2.0	2.0	2.0	2.0	2.0	10.0
Training and upgrading for healthcare workers	12.5	2.5	2.5	2.5	2.5	22.5
Advance Directives	0.5	0.5	0.5	0.5	0.5	2.5
Health disparities	10.0	10.0	10.0	10.0	10.0	50.0
Subtotal:	90.0	80.0	80.0	80.0	80.0	410.0
Total Changes in Direct Spending:	**2800.9**	**2874.1**	**3046.6**	**3264.1**	**3497.1**	**15482.7**

Changes in Revenue:	**2010**	**2011**	**2012**	**2013**	**2014**	**Total**
Employer Payroll Tax of 2.0% up to FICA:	2474.2	2544.2	2637.7	2734.6	2835.1	13225.9
Alcohol Tax Increase:	197.0	199.9	202.9	206.0	209.1	1015.0
Tobacco Tax Increase:						
Cigarette tax to $2.75/pack	74.4	71.1	67.9	86.3	82.4	382.1
Other tobacco products' tax to 90% wholesale price	28.3	28.0	27.0	26.0	25.0	134.3
Subtotal:	102.7	99.1	94.9	112.3	107.4	516.4
Tobacco Settlement's Bonus Payments:	30.0	30.0	30.0	30.0	30.0	150.0
Reallocation of MHIP's High Risk Pool Funding:	0.0	3.9	84.1	184.2	318.5	590.7
Total Changes in Revenues:	**2804.0**	**2877.2**	**3049.6**	**3267.1**	**3500.1**	**15498.0**

Net Savings:	**2010**	**2011**	**2012**	**2013**	**2014**	**Total**
Total Revenue less Total Direct Spending	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**15.2**

Note: Figures are in millions of dollars by fiscal year. Components may not sum to totals because of rounding.

APPENDIX

Exhibit A demonstrates the share of income that the typical and basic plans' subsidized premiums (i.e., the total premium minus the low-income subsidy available at that income level) would represent for a single adult and a hypothetical family of four, respectively, at different levels of income. These low-income subsidies are described in Section 1.1. These Exhibits also show the Medicaid expansion described in Section 1.3; there is no premium contribution towards Medicaid for those under 200% FPL and small contributions (of $50/month per adult and $50/month for children) for eligible families between 200% and 300% FPL.

Exhibit A: Average Premiums as Percent of Income in the MD HCFA Proposal

Single People in the Health Insurance Pool (2010$)

Income:		Typical Plan:		Basic Plan:		Lowest Cost:	
Percent FPL	Average Amount	Net Premium	Percent Income	Net Premium	Percent Income	Net Cost	Percent Income
100-200%	17,227	2,075	12.0%	837	4.9%	-	0.0%
200-300%	28,712	2,075	7.2%	837	2.9%	837	2.9%
300-400%	40,197	3,113	7.7%	1,875	4.7%	1,875	4.7%
400-500%	51,682	4,151	8.0%	2,913	5.6%	2,913	5.6%

Unsubsidized typical plan's premium under the status quo would average $5,393

Family of Four in the Health Insurance Pool (2010$)

Income:		Typical Plan:		Basic Plan:		Lowest Cost:	
Percent FPL	Average Amount	Net Premium	Percent Income	Net Premium	Percent Income	Net Cost	Percent Income
100-200%	34,843	5,609	16.1%	2,263	6.5%	-	0.0%
200-300%	58,071	5,609	9.7%	2,263	3.9%	1,800	3.1%
300-400%	81,300	8,414	10.3%	5,068	6.2%	5,068	6.2%
400-500%	104,528	11,218	10.7%	7,872	7.5%	7,872	7.5%

Unsubsidized typical plan's premium under the status quo would average $14,577

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Mary Jo Braid-Forbes	Private Consultant
Lisa Dubay	Johns Hopkins University
Margaret Ensminger	Johns Hopkins University
Darrell Gaskin	University of Maryland
Bradley Herring	Johns Hopkins University
Diane Hoffman	University of Maryland
David Holtgrave	Johns Hopkins University
David Jernigan	Johns Hopkins University
Michael Miller	Community Catalyst
Glenn Schneider	Howard County Health Department
Sean Tunis	Center for Medical Technology Policy
Hugh Waters	Johns Hopkins University
Jonathan Weiner	Johns Hopkins University

The Maryland Citizens' Health Initiative Education Fund, Inc. is comprised by:

Vincent DeMarco	President
Rosanna Miles	Senior Deputy Director
Matthew Celentano	Deputy Director
Suzanne Gilbert	Community Outreach Coordinator

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