The Committee on Health Care Finance has a lot of additional work to complete this fall and winter. It plans to meet health care stakeholders and groups proposing different recommendations regarding federal and state health system reform. In an attempt to provide an initial position on health system reform for the MedChi House of Delegates we present the following:

Federal Reform
We suggest that MedChi not support any Federal Health System reform that does not include tort reform and a final Stainable Growth Rate (SGR) fix. However, after careful review of the American Medical Association principles for health system reform we agree with the following principles:

Principles for Health System Reform (HSR) and improving the U.S. health care system

- Provide affordable, essential health insurance coverage for all
- Promote a robust private insurance market
- Ensure sustainable public programs for vulnerable populations
- Provide real time data at point of care
- Use measurement as a tool, not an end point
- Correct problems with the Physicians Quality Reporting Initiative (PQRI)
- Ensure adequate payments
- Enable balance billing and private contracting
- Replace Medicare sustainable growth rate (SGR)
- Allow public subsidies for purchasing private insurance
- Enact medical liability reforms
- Streamline insurance claims processing
- Align insurance benefit design with prevention evidence
- Make public investments in education, community projects, and nutrition
• Eliminate racial, ethnic, and gender disparities
• Promote medical home and other steps to reward care coordination of chronic disease
• Provide antitrust relief to improve quality and care coordination
• Conduct adequate testing of new payment models

**State Reform**

During the 2009 General Assembly there were various legislative proposals to address health care coverage for the uninsured. Med Chi did not take a position on any of the reform legislation, opting instead to provide comments both in support of and in opposition to specific components of the various plans. Three of the proposals that were considered in 2009 will definitely be under consideration again in 2010. To that end, this document is intended to be a summary comparison of the basic components/approaches to coverage expansion that are reflected in the three proposals. Note that these bills range in length from 27 to 52 pages and therefore this document is not intended to provide a thorough review of all the provisions of the various plans. Rather, the document is to serve as a starting point for Med Chi’s formulation of its position on the direction Maryland should take as it seeks to provide health care coverage for all Marylanders.

The three bills summarized in this document are: House Bill 860/Senate Bill 515 – *Healthy Maryland Program* sponsored by Delegate Peter Hammen and Senator Mac Middleton respectively (both are Chairman of their respective committees). This legislation originated as a result of a proposal advanced by CareFirst and uses the current Maryland Health Insurance Plan as the starting point. House Bill 1186/Senate Bill 881 – *Maryland Health System Act of 2009* sponsored by Delegate Montgomery and Senator Pinsky respectively is a universal coverage/single payer proposal for reform; and House Bill 951/Senate Bill 813 – *Health Care Affordability Act of 2009* sponsored by Delegate Hubbard and Senator Jones respectively is the current “Health Care for All” proposal.

Each of the three proposals reflects a very different approach to reform. To that end, an “apples to apples” comparison is difficult. In order for Med Chi to formulate a position on reform, it may be helpful to look at the differences in various aspects of the three proposals such as benefit structure, financing, who is covered, etc. This document attempts to provide summaries for each bill in these various categories. As Med Chi deliberates on these and other options, a more detailed analysis of any particular provision can be conducted.

**House Bill 860/Senate Bill 515 – Healthy Maryland Plan**

Summary: This bill modifies the Maryland Health Insurance Plan (MHIP) to be the Healthy Maryland Plan. Every Maryland resident without access to employer sponsored health care coverage must enroll in the program. Employers with nine or more full-time employees that do not offer and contribute to a group health plan must pay a per-employee contribution. Individuals with incomes over 300% of poverty that do not maintain coverage will be subject to a tax penalty. Per-employee and tax penalties are used to subsidize lower-income individuals in the program.
**Coverage Requirements:** Guaranteed-issue, include benefits approved by the program Board (uses current MHIP Board structure), no preexisting conditions. The Board will define a standard benefits package that is affordable and comprehensive that may exclude mandated benefits and reimbursement requirements otherwise required in other health benefit plans. Must include incentives for healthy behavior and provide first-dollar coverage for preventative services.

**Rating:** The Board establishes a community rate for program coverage that can only be adjusted for age, family composition and incentives for healthy behavior. Carriers are allowed a reasonable administrative fee and a 2% margin. Participating carriers must charge the standard premium rates and report annually on their experience and request for rate increases.

**Carrier Requirements:** Carriers that participate in the small group market must participate in the program. Participation by other carriers is voluntary. If a carrier ceases participation, it is prevented from participating again for 5 years.

**Funding/Penalties:** Funding for the program will be a combination of the current MHIP assessment, program premiums, mandated per employee contributions and tax penalties. Mandated per employee contributions will be determined by the Maryland Health Care Commission based on the annual premium contribution made by employers in the small group market. All employers with nine or more employees that do not offer and/or contribute to health care coverage for their employees will pay the per-employee contribution. Tax penalties are $1000 per individual or $2000 per married couple.

**House Bill 1186/Senate Bill 881 – Maryland Health System Act of 2009**

**Summary:** This bill establishes a single-payor Maryland Health System to provide comprehensive and coordinated health care coverage to all Maryland residents. The plan is not dependent on employment or income parameters. All residents of Maryland will be members of the plan. The State will administer the plan and waivers will be sought from the federal government to allow all funds from federal programs (Medicare, Medicaid, etc.) to be deposited in the Maryland Health System Trust Fund that will be used to fund the program. Private insurers may only offer services that do not duplicate the benefits of the plan.

**Coverage Requirements:** A “Maryland Health System Policy Board” would be created to establish a benefits package and global budget for the system. There will be no preexisting condition limitations; coinsurance, deductibles or co-payments and everyone would have a choice of provider.

**Rating:** The State of Maryland will be the single payor for this plan and therefore there will be no need for “premiums” or “rating” rules as there is in today’s models. The Maryland Health System Board will determine the Global Budget for the system, evaluate requests for capital expenses and evaluate program performance.

**Carrier Requirements:** There will be no carrier “coverage” in the traditional sense. Carriers will be permitted to offer coverage but only for services that are not provided under the single-payor system.
**Funding/Penalties**: A Maryland Health System Trust Fund is established to finance the single-payer system and an Office of the Health Inspector General is created to audit payments. The fund consists primarily of money from State and federal financial participation in Medicaid, the Maryland Children’s Health Program, Medicare and other federal programs that pay for health care services. The State will be required to apply for federal waivers to enable the State to deposit all federal payments under current health care programs to the new State trust fund and to the federal ERISA to ensure total participation in the newly created Health System.

**Other Provisions**: In addition to the “Health System Policy Board”, six other Boards are established to administer and oversee the Health System. They are: 1) *Maryland Health System Administrative Board* to plan for and oversee the transition to the Health System, administer payments and a statewide system of electronic medical records; 2) *Maryland Health System Health Needs, Planning and Improvement Board* to review requests for services not covered by the Health System, develop a proposal for long term care coverage, develop a health database and a comprehensive system of local community health centers, engage in health promotion and approve grants for local communities; 3) *Maryland Health System Quality Board* to establish clinical standards, a prescription formulary, guidelines for prescribing, medical error programs, guidelines for care coordination, and programs to monitor adherence to best practices of care; 4) *Maryland Health System Patient Advocacy Board* to advocate for and educate residents on the Health System, establish a grievance system create a Public Advisory Committee; 5) *Maryland Health System Board* to manage the fund, establish sufficient reserves and recommend funding sources; and 5) *Maryland Health System Payment Board* to establish and negotiate payment rates, negotiate discounts for prescription drugs and medical equipment, and provide incentives to attract health professionals into needed practice fields and geographic areas. Members of all Boards are prohibited from having been employed by a pharmaceutical company, medical supply company or for profit insurance company for the two years prior to appointment and two years following service.

**House Bill 951/Senate Bill 813 – Health Care Affordability Act of 2009**

**Summary**: This bill proposes a significant restructuring of the Maryland’s health care system including establishing a Maryland Health Insurance Pool which is an independent unit of State government governed by a Board of Directors to act as a mechanism for purchasers in the individual and small group markets to obtain affordable health care coverage. The legislation also imposes an individual health insurance mandate, and expands eligibility of Medicaid. The legislation contains multiple other provisions that are described in the “other provisions” section below.

**Coverage Requirements**: The bill repeals the Maryland Health Insurance Plan (the State’s high-risk pool) and instead merges the individual and small group markets within the pool. Eligibility is open to (1) individuals without access to employer-sponsored coverage; (2) employers with less than 100 employees; (3) certain large employers, and (4) dependents of individuals eligible for participation. Large employers are eligible if they agree not to offer any separate or competing health benefit plan or if the coverage they offer does not provide the benefits available through the basic plan offered through the pool. Individual tax penalties are provided for taxpayers who do not maintain health care coverage for themselves and their families. Certain exceptions are provided based on income levels.
Under the legislation, the pool becomes the sole mechanism for credible coverage for an individual without access to employer sponsored coverage and employees of small employers. The pool must offer, through its participating carriers, multiple health benefit plans for choice by individual enrollees. Plans must be classified as basic, typical or generous. Plans must incorporate chronic care improvement and preventative health measures. The pool will subsidize coverage for enrollees that have family incomes up to 400% of federal poverty guidelines and are either without access to employer-sponsored coverage or work for a small employer (less than 100 employees).

Medicaid Eligibility is also increased for parents and caretakers with a dependent child up to 300% of the federal poverty level and childless adults up to 2005 of federal poverty level. There is a small premium associated with this eligibility.

Rating Requirements: Community rating must be used for all health benefit plans without regard to any factor other than age. Each health benefit plan offered through the pool must be offered on a guaranteed-issue and guaranteed-renewal basis, with no preexisting condition limitations or medical underwriting. Carriers may charge a rate that is 50% above or below the community rates. Rates may vary based on family composition.

Carrier Requirements: A carrier may only insure or offer to insure an individual without access to employer-sponsored coverage or an employee of a small employer as a participating carrier in the pool. All carriers must offer at least the basic benefit plan. Carriers’ medical loss ratios will be reviewed and the Board may determine whether adverse selection is occurring and take certain actions.

Funding/Penalties: The legislation is funded through a 2% payroll tax, and increase in alcoholic beverage and tobacco taxes, tax penalties on individuals who do not obtain health insurance, a fee on pharmaceutical manufacturers and labelers and reallocated funds from other programs. A chart is attached to better illustrate the multiple funding sources. The bill creates the Healthy Maryland Fund to support the programs of the legislation. The Fund may be used subsidies and administrative costs of the pool, reinsurance benefits, the cost of Medicaid eligibility and benefit expansion, premium assistance for low income individuals, a new Medicaid eligibility system, additional eligibility caseworkers, expansion of substance abuse treatment services, and funding for Institute initiatives.

Other Provisions: The legislation creates a number of other initiatives related to the provision of and payment for health care services. Among these are the creation of: 1) Maryland Institute for Clinical Value which will develop and implement policies that direct health care spending toward evidence-based services. The Institute will adopt best practices, use clinical and economic assessments, identify priorities for implementation, coordinate implementation efforts and develop patient cost-sharing and provider reimbursement policies for covered services; identify and fund research, subsidize electronic health records and support the cost of a statewide health information exchange; 2) Maryland Prevention Trust for Health Promotion to address the reduction of health disparities through grants, programs and initiatives including a Minority and Low-Income Health Report Card; grants for a Maryland Racial and Ethnic Approaches to Community Health (REACH) community action program, grants and funding to local community health centers, funding for loan forgiveness programs,
and the funding of an advanced directives registry; 3) *Evidenced Based Prescriber Education and Outreach Program* which is funded by a $2500 per company assessment on pharmaceutical manufacturers and used to establish an academic detailing program in the School of Pharmacy. Pharmacists would then provide the information to prescribers regarding prescribing decisions that are now provided by pharmaceutical companies; 4) *Catastrophic Reinsurance Benefit Plan* intended to make health insurance more affordable by removing a portion of the cost of high-cost health care from the health insurance premium. Participation is mandatory for all carriers, state employees and retirees, and county benefit plans. Participation is voluntary for self-insured plans. Reinsurance will include coverage for claims that exceed certain levels and case management requirements for enrollees whose cost indicate a need for review.

Recommendations:

1. **That MedChi only support federal health system reform that includes meaningful tort reform that results in less defensive medicine and a final sustainable growth rate fix that results in payment to physicians commensurate with our education and training.**

2. **That MedChi’s Health Finance Committee review the three State proposals for reform and provide a report and propose a position for all three proposals to the MedChi Board of Trustees prior to the 2010 session.**

As amended and adopted by the House of Delegates at its meeting on September 13, 2009.