MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FY2002 STATE PLANNING GRANT APPLICATION

SUBMITTED TO

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

APRIL 4, 2002

PROJECT ABSTRACT

Current Status of Health Care Insurance Coverage in Maryland
Maryland's uninsured rate of 12% (1999 and 2000 Current Population Survey [CPS]) for the non-elderly is well below the comparable national figure of 16%. The average uninsured rate for all Maryland residents in 1999-2000 was 10.4%. Maryland ranks in the top 15% of all states in terms of its low rate of uninsurance. The state's lower rate of uninsured is principally due to higher levels of workplace-provided coverage.

In Maryland, as compared to the U.S. as a whole, both a higher percentage of private firms offer health insurance to their employees, and a larger share of workers are employed in the public sector, making well-subsidized health care coverage available to nearly all Maryland employees. As a result, considerably more of Maryland's residents are covered primarily by employer-based insurance than in the U.S. as a whole. Moreover, because Maryland's poverty rate is among the nation's lowest, the portion of residents covered by Medicaid is below the nationwide rate.

Maryland's Earlier Efforts to Expand Access to Health Coverage
Maryland has employed a number of different strategies in both the private and public sectors to ensure that residents have access to health insurance coverage. In general, three types of strategies have been utilized:

- *Publicly funded, comprehensive health insurance coverage programs*: Medicaid; HealthChoice, the state's Medicaid managed care 1115 waiver program; Maryland's S-CHIP programs, Maryland Children's Health Program (MCHP) and MCHP Premium, the latter of which features an option to provide coverage through employer-sponsored insurance; the State Omnibus Budget Reconciliation Act (SOBRA) and S-CHIP Medicaid coverage expansions for pregnant women;
- *State-sponsored initiatives to increase private sector health insurance coverage*: The 1993 small group market reform effort; the Substantial, Available and Affordable Coverage (SAAC) program for the medically uninsurable, which is aimed at the individual insurance market; and the state's all-payer hospital rate-setting program; and
- *Publicly funded supplemental health care and medical services programs, which strive to fill gaps in existing health insurance coverage, by covering or providing limited medical services for specific groups of (mostly) low-income, needy individuals:* The Maryland Pharmacy Assistance Program, which provides medications to low-income individuals who are ineligible for Medicaid; the Kidney Disease Program, which provides financial assistance for treatment of end-stage renal disease; the Maryland Primary Care Program, which provides ambulatory services to low-income, medically needy adults; the Breast and Cervical Cancer Diagnosis and Treatment Programs; the Short-Term Prescription Drug Subsidy Program, which provides drug coverage for individuals with Medicare who lack pharmaceutical coverage; the Maryland Medbank Program, which provides prescription drugs to individuals enrolled in drug manufacturer-sponsored assistance programs; the public mental health system; alcohol and drug abuse treatment services; and Children's Medical Services, which serves children with chronic medical conditions.

Proposed Project: Goals and Description
The overarching goal of this project is to develop a viable, realistic, and effective series of comprehensive coverage expansion strategies that could lead to a reduction in the number of the state's uninsured.

To achieve these objectives, Maryland's specific goals for the proposed State Planning Grant (SPG) Project include the following:

(1) To collaborate with public and private sector partners to develop options to provide access to coverage for Maryland's uninsured population.

(2) To increase the level of understanding concerning Maryland's uninsured population through further analysis of existing quantitative data sources and through additional data collection that will help us design more effective expansion options for specific target groups.

(3) To collect and analyze additional quantitative and qualitative data that will directly inform options for the expansion of health insurance coverage, including: (a) research with employers and key segments of the low-income employed population in order to better understand the characteristics of firms not currently participating in the state's small group market and to inform marketing strategies aimed at increasing take-up rates in the small group market; (b) data to better understand businesses' and eligible individuals' willingness to participate in the state's S-CHIP Premium program and Employer-Sponsored Insurance program; and (c) data on coverage of young adults (ages 19-25), as well as ways to effectively include them as dependents under existing policies.

(4) To develop comprehensive options to expand insurance coverage and to project associated enrollment and cost estimates for key segments of the state's uninsured population – including low-income adults and children, young adults, and uninsured workers in the small-group, large-group and self-insured markets.

(5) To carry out a comprehensive assessment of the costs of non-insurance, including costs for the state, health care providers, employers, philanthropic organizations, and uninsured individuals themselves.

(6) To develop a report to the Secretary of Health and Human Services, outlining an action plan to continue improving access to insurance coverage, including developing recommendations that respond to the SPG's qualitative and quantitative findings and identifying necessary next steps and key partners to respond to the recommendations.

By performing additional analyses of several rich data sources, including a state-specific survey of the uninsured conducted at the end of 2001, conducting a follow-up survey to better understand specific sub-groups of the uninsured, conducting a survey of MCHP Premium applicants who terminated the application process or were disenrolled, and developing economic models for selected coverage expansion options, the state hopes to build support for and increase the viability of certain coverage options. Additionally, by exploring issues surrounding take-up rates using qualitative research methods, the state hopes to build on the success of two existing employer-based insurance programs, namely, the small group market reform program and the public sector MCHP Premium Employer Sponsored Insurance coverage option.

Lead Agency and Collaborating Partners

The Maryland Department of Health and Mental Hygiene (DHMH) will be the lead agency for this project. A team of staff from within DHMH's Deputy Secretariat for Health Care Financing, under the direction of Deputy Secretary Debbie I. Chang, M.P.H., will be responsible for general oversight and critical decision making for this project. The team will consist of Alice Burton and Susan Milner from the Office of Planning, Development and Finance (OPDF) and Enrique

Martinez-Vidal, Linda Bartnyska and Kristin Helfer Koester from the Maryland Health Care Commission (MHCC).

Ms. Milner will serve as project director. She will oversee the day-to-day operation of the project and will facilitate communication and coordination between those individuals responsible for executing the project's key components. With assistance from the Office of Planning, Development and Finance's Budget Office, she will also be responsible for oversight of the grant funds. A similar governance structure proved very effective in the execution of the Maryland Health Insurance Coverage Survey in 2001.

The OPDF and MHCC team will work collaboratively to oversee the project and its various components. Since a sizeable proportion of the work involved in this proposal will be carried out by researchers from the Johns Hopkins Bloomberg School of Public Health, team members will meet weekly either by conference call or in person with Laura Morlock and Hugh Waters, the two Co-Principal Hopkins Investigators. These meetings will be used to track the progress of the researchers' and staffs' work, to discuss and coordinate the various components of this project and to make decisions at key points during the course of the project.

Projected Results

At the conclusion of this project, Maryland will have in hand an action plan for expanding coverage to the uninsured either through improvements in existing programs or through new coverage options. The action plan will include recommendations for expanding coverage, and it will identify the key partners and next steps to respond to the recommendations. The recommendations will be developed following a thorough review of information derived from a series of models simulating offer rates, take-up rates, utilization and costs for multiple Medicaid and private sector coverage expansion options. The development of these models, in turn, will be the result of a thorough analysis of Maryland's existing uninsured data and proposed new data collection efforts. These models will be shared with other states so that they too may use them as a template for determining costs and enrollment for similar programmatic expansions. Most importantly, these cost and coverage models and the recommendations that result following their review will allow Maryland's executive and legislative leadership to make more informed decisions on how the state may guarantee full access to health insurance coverage for all Marylanders.

CURRENT STATUS OF HEALTH CARE INSURANCE COVERAGE IN MARYLAND

Status of Access to Health Insurance in Maryland

Employer-based and public insurance coverage are more widely available in Maryland than in the majority of states.[1] In 1999, 67% of Maryland's private establishments offered health insurance to their employees, compared to 58% nationwide. Insurance coverage availability by industry type (e.g., mining, retail, agriculture, etc.) is generally greater in the state than it is nationally for most industry categories. Moreover, the success of the state's small group market reform effort, now in its ninth year, has also greatly increased access to employer-based coverage for residents, as evidenced by the state's small group offer rate of 57% compared to 47% nationally. However, we do not know whether access to employer-based insurance differs by geographic region, nor do we understand why small group employee take-up rates have stagnated and declined in recent years. Most importantly, however, we have little

[1] Maryland Health Care Commission, *Maryland Health Insurance Coverage Through 1999: A Graphic Profile,* February 2002.

understanding of why certain Maryland firms choose not to offer insurance and why certain employees decline coverage.

Because private sector employees tend to be concentrated in firms that offer health insurance, only 8% of private sector employees in Maryland worked in places that did not offer health insurance to their employees in 1999, compared to 11% nationwide. But the overall percentage of Maryland's private employees that enrolled in their employer's health insurance in 1999 (57%) was similar to the national rate (58%). Higher percentages of Maryland's private sector employees were eligible for coverage in 1999 than in 1998 (80% vs. 70%), but about the same percentages enrolled in each year and the proportion declining coverage increased (from 12% to 15%). Although some of the decliners have coverage through a spouse or parent, or even a public program, many do not. Unfortunately, we do not know their reasons for declining coverage, or the relationship between a person's demographic characteristics and their reason(s) for being uninsured.

Additionally, public insurance coverage in Maryland is more readily available to certain populations than is the case in most states. Maryland is one of only five states in the country to have expanded coverage up to 300% of the Federal Poverty Level [FPL] ($53,000 for a family of four) for children through MCHP (initiated in July 2001). Maryland provides relatively few public coverage programs for low-income adults, however. Because this population has less access to employer-based coverage than most groups in the state, and because Medicaid coverage for non-pregnant adults is limited to those in families with children that have incomes below 46% of the FPL, single, low-income adults in Maryland, in particular, have less access to coverage relative to their counterparts in states that have expanded Medicaid coverage to parents and single adults.

Grant activities could improve our understanding of insurance availability. Additional information will help us determine whether access to coverage and/or the employers' share of premiums varies by geographic location and/or industry, why those eligible for coverage through their employer decline to enroll and why employers fail to participate in the small group market. Additionally, grant activities would allow us to better understand how Maryland might structure programs for low-income adults that will have high take-up rates and will be affordable for the state.

Rates of Uninsurance

Maryland's 2-year, non-elderly uninsured (for all 12-months) rate of 12%, is well below the comparable national figure of 16% (1999 and 2000 Current Population Survey data). The difference is principally due to higher income levels and higher levels of health care coverage at the workplace in Maryland, through:

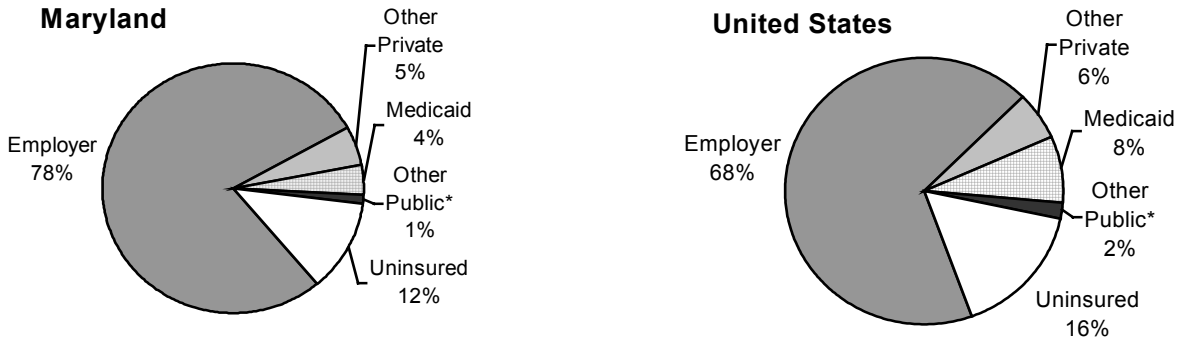
- a higher percentage of private firms offering health insurance to their employees (discussed above), and
- a larger share of workers employed in the public sector,[2] which makes well-subsidized health care coverage available to nearly all employees.

Consequently, considerably more of Maryland's residents are covered primarily by employer-based insurance than in the U.S. as a whole, as shown in Figure 1. Because Maryland's poverty rate is among the lowest in the nation, the portion of residents covered primarily by Medicaid is below the nationwide rate. The average uninsured rate for all Maryland residents in

[2] About 18 percent of all Maryland jobs are in the public sector compared to about 14 percent of all jobs nationwide.

1999-2000 was 10.4%. Maryland ranks in the top 15% of all states in terms of its low rate of uninsurance.

Figure 1: Health Insurance Coverage For the Nonelderly, 1999-2000



We know a considerable amount about the uninsured in Maryland through our analyses of the Current Population Survey (CPS)[3] and the Maryland Behavioral Risk Factor Surveillance Survey (BRFSS). In Maryland, as nationwide, the most significant risk factors for being uninsured include being a young adult, having low income, being Hispanic, and not having a high school diploma. Maryland's age-specific uninsured rates are about one-fourth smaller than the national rates for all age groups except young adults ages18-24, where the gap is much smaller in spite of the greater availability of health insurance in the workplace in Maryland. In order to address the reluctance of young adults to buy insurance, we will need to understand the reasons underlying their low take-up rates.

Because incomes in Maryland are above the national average, the income distribution of Maryland's uninsured population is quite different from that of the nation as a whole. Maryland's non-elderly residents with incomes above 300% of the FPL account for 36% of the state's uninsured, compared to only 19% nationally. Because state-sponsored programs have generally ignored those with higher incomes, there is little information on why these individuals forgo insurance and what might motivate them to enroll. Similarly, we need to understand why the state's Blacks, who comprise 30% of Maryland residents, have lower coverage rates than Whites, whether below or above 200% of the FPL, and why the relative difference between the two groups increases with higher income, as in the nation as a whole. An understanding of Blacks' and Whites' differing priorities and/or habits of obtaining health care is critical to designing programs that yield high take-up rates.

Another important gap in our understanding of the factors underlying enrollment decisions is how differing priorities and/or habits of obtaining health care vary within income and racial/ethnic groups across the state and the implications for successful programs. Preliminary data analyses of the Maryland Health Insurance Coverage Survey (MHICS) indicate there are important differences in the characteristics of the uninsured living in rural counties compared to those in metropolitan areas, but more analyses are needed to identify, validate, and quantify these differences.

[3]Maryland Health Care Commission, *Maryland Health Insurance Coverage Through 2000: A Graphic Profile*, February 2002 (www.mhcc.state.md.us).

If programs to provide coverage for the uninsured in Maryland are to reach the majority of the uninsured, they will have to address barriers and attitudes to insurance coverage that differ with income, race/ethnicity, and likely geographic location. Grant funds would enable us to do more detailed analyses on existing data, especially the MHICS, and to collect and analyze new information on the uninsured.

Key Health Issues Related to Access to Care and Uninsurance in Maryland
Research indicates that the uninsured are less healthy and do not enjoy the same level of access to care as do those with insurance coverage. Preliminary results from the MHICS substantiate these findings. Uninsured Marylanders are more than twice as likely as their insured counterparts to report being in fair to poor health. Moreover, those without coverage are less likely to report having a usual source of care – an important access indicator -- and hence are less likely to receive routine preventive care than those with insurance. Preliminary results from the MHICS indicate that over 30% of the uninsured versus only 9% of the insured report having no usual source of care. Because the uninsured postpone obtaining treatment until absolutely necessary, they tend to be sicker when they do seek care, which they are more likely to obtain through an emergency room. In Maryland, those without insurance are 40% more likely to have had an emergency room visit in the past year than those with coverage. Insurance coverage is significantly related to several factors – including improved health and better access – that are associated with increased longevity and reduced mortality. Preliminary information from the MHICS indicates Maryland's uninsured are less healthy and enjoy less access to care.

Description of Maryland's Current Health Delivery System
Maryland's health care delivery system differs from that of the nation in at least three significant ways. The state has a greater supply of physicians, especially specialists; it has a higher concentration of its insured in HMOs; and its hospital rates are established by a rate-setting Commission, the Health Services Cost Review Commission.

The number of non-federal physicians in patient care per 100,000 residents in Maryland was 312 in 1997, compared to 230 physicians per 100,000 residents for the country as a whole.[4] Two-thirds of the state's physicians are specialists as opposed to primary care physicians, above the nationwide specialist share of 58%. However, the state's doctors are disproportionately concentrated in Maryland's metropolitan areas, which have about 355 physicians per 100,000 residents, while the more rural counties are well below the national average. The state's supply of practicing physicians should be able to absorb more insured residents.

More than 2 million insured Maryland residents were enrolled in HMOs in 2000, amounting to 38% of the state's population.[5] In spite of a slight decline in HMO market share since 1998 (likely a result of the jump in health care costs), rapid and sustained growth in HMO enrollment in Maryland during the first half of the 1990's has given HMOs a share of the insured market well above the national average. The large supply of physicians coupled with the significant influence of HMOs in Maryland's health care market has helped all Maryland insurers to restrain practitioner health prices in the state compared to nationwide. On average, the fees that health

[4] MHCC analysis based on U.S. Department of Health can Human Services, Health Resources and Services Administration, Bureau of Health Professions, Area Resource File: February 1999 Release.

[5] MHCC analyses based on: (1) Current Population Survey; (2) The InterStudy Competitive Edge 9.1 HMO Industry Report; (3) HCFA, Medicare Market Penetration – Quarterly State/County/Plan Data Files for Maryland Medicare HMO enrollment; and (4) Maryland Medicaid eligibility data.

care practitioners received for treating non-HMO, privately insured Maryland residents in 2000 were 4% to 5% above Medicare's 2000 rates. This is a relatively small differential compared to published studies of private payers' data nationwide. Although there was no increase in non-HMO payment rates from 1999 to 2000, Maryland experienced a 10% increase in practitioner payments for non-HMO insured residents over this period, driven principally by a growth in the number of insured persons using practitioner services. If the ability of insurers to contain rate increases for practitioner services continues, it will help to contain the costs associated with insuring more residents.

Maryland is the only state in the country that currently uses a public utility-like approach to set hospital rates. This approach has had an important impact on Maryland's health care delivery system. Maryland's all-payer rate-setting system requires all payers – insurance companies, managed care organizations, Medicare, Medicaid, and the self-pay – to pay the same service rates for care at any particular hospital. Medicare continues to participate in Maryland's all-payer system so long as the rate of growth in Medicare payments to Maryland hospitals since 1981 is no greater than the rate of growth in Medicare payments to hospitals nationally over the same time period.

Maryland's public insurance programs fill a critical gap in the state's health care delivery system. All told, these programs help close to 550,000 residents, around 10% of the state's population. The largest of these programs, serving nearly 408,000 non-elderly Marylanders and 97,000 children are the state's Medicaid and S-CHIP programs, respectively.

Maryland also has a strong network of providers who function as a safety net for the state's underserved. There are 12 Federally Qualified Health Centers and 16 Maryland Qualified Health Centers throughout the state that provide access to primary care. Maryland's 24 local health departments also form a link in the health care safety net by providing many clinical services in underserved areas.

Benefiting from the Experiences of Other States

Maryland will have the benefit of learning from the experiences of other states that received State Planning Grants during the first and second rounds of HRSA funding. We will be able to review policy options considered by other states, as well as reasons underlying their decisions to propose or abandon various alternatives. For example, one private market option that we would like to explore is extending the ability of young adults without access to employer-based coverage to continue to be included as dependents on their parents' health insurance policies. We know that several other states, including Minnesota, Kansas and Colorado, have been examining the desirability and feasibility of this strategy, and we hope to learn from the results of their efforts. Similarly, at least two other states—Texas and Massachusetts—have examined costs of providing health care to the uninsured. Their efforts will be carefully reviewed as we design our approach to studying this issue. Throughout the project we will benefit from consultation with the state Health Access Data Assistance Center (SHADAC).

DESCRIPTION OF EARLIER EFFORTS TO REDUCE THE NUMBER OF UNINSURED

Maryland has employed an incremental approach to expanding health care coverage to the uninsured, targeting publicly funded initiatives and private health insurance market incentives to areas of identified need. An analysis of CPS data from 1999 and 2000 shows that, through these efforts, the uninsured rate in Maryland has decreased by about 2 percentage points since 1998 to 12% of the non-elderly population.

In recent years, Maryland has developed and implemented a number of creative financing strategies that have contributed to reducing the number of uninsured in the state. These include the Substantial, Available and Affordable Coverage (SAAC) program for the medically uninsurable that recently was expanded to include a financing component for the Short-Term Prescription Drug Program for seniors and the Maryland all-payer hospital rate-setting system that finances more than $450 million in uncompensated care each year. The following provides background information on these and other public and private programs that improve access to health care coverage and medical services.

State Efforts To Reduce The Number Of Uninsured: Successes And Implementation Problems

Existing Private Sector Programs

Several state-sponsored initiatives currently exist that address the issue of creating access to health insurance and health care services to Maryland residents. Discussed below are three such initiatives that have considerably decreased the number of uninsured or increased access to services for the remaining uninsured.

Small Group Market: In 1993, the Maryland legislature responded to concerns about the unavailability of health insurance in the small group market (2-50 employees) by passing a series of reforms in the way insurance was sold. At that time, the small group market was in disarray. Premiums were increasing rapidly for many employers in this sector. Insurance carriers were dropping coverage for an entire employer group when just one employee had increased claims experience. Pre-existing condition requirements were excluding coverage for those very diseases and conditions that were in the most need of coverage. Small employers were the most likely to not have human resources personnel to analyze competing benefit plans, thus making it difficult for them to comparison shop across carriers.

The legislature's Small Group Market Insurance Reform Act (HB 1359 of 1993) requires that any insurance plan or product that is sold to small group employers have guaranteed issue and renewal, have adjusted community rating (for age and geography only), and include no pre-existing condition limitations. In addition, only the Maryland Comprehensive Standard Health Benefit Plan (CSHBP) may be offered to employers in this market so that employers can have identical products to review when choosing a health insurance carrier. While insurers may sell riders to enhance the plan, they cannot provide fewer or different benefits than are included in this plan. The CSHBP in effect serves as a floor to include a minimum level of benefits that must be offered. In addition, to maintain affordability in the market, the CSHBP may not cost more than 12% of the Maryland average annual wage. Premiums and benefits are reviewed annually.

As a result of the state's small group market reform efforts, there has been a growth in the number of covered lives – a 16.5% increase between the inception of the program in 1995 and 2000. Almost 470,000 individuals are covered through the small group market. More than 57% of all small employers offer coverage (over 64,000), which is an increase from only 40% offering insurance in 1994. Eighteen carriers participate in the small group market.

In 2001, the Maryland legislature passed House Bill 695/Senate Bill 457, which required a study to compare the performance of Maryland's small-group health-insurance market reform law to that of other states. The fundamental question which the study was to address was: Are there elements of Maryland's reforms that might be altered in a way that would improve access to affordable coverage—that is, to cause more small employers to offer coverage and more

employees to accept it—without creating other adverse consequences? Special scrutiny was directed to the scope of benefits in the CSHBP and to the reforms that limit insurers' ability to vary premiums based on the characteristics of small groups. The study concluded that the small-group market in Maryland is functioning well. Maryland's performance on key measures is generally comparable to, and in some instances better than, the states studied and the U.S. as a whole. Two problems were cited —rapidly rising premiums and a reduction in the number of health plans offering coverage in the small-group market. But the study also concluded that these do not seem to be related in any significant way to Maryland's market reform rules. Hence, it is difficult to see how changes in reform laws could solve these problems. The study recommended that improvements to the operation of the small-group market could be accomplished through fine-tuning, not a major overhaul.

The two issues noted in the study have presented on-going challenges to the Maryland Health Care Commission, which is the agency responsible for regulatory oversight of the small group market reforms. Increasing costs have pushed the premiums close to the 12% affordability cap on several occasions. Premium increases, while also experienced by large employers as well as by small employers nationally, impact many of the smallest of the small employers who operate on very thin margins. The state has stayed under the premium affordability cap by increasing cost sharing arrangements by employees and by not accepting a number of proposed benefit inclusions (Note: the small group market is exempt from all mandated benefits enacted by the legislature but the Commission considers each proposed or enacted mandate annually).

The second issue of continued concern is the decreasing number of carriers offering coverage in the small group market. Between 1995 and 2000, the number of small group carriers declined from 37 to 18. In addition, market share has become more concentrated with 12 carriers in Maryland that the Commission considers "prominent carriers" accounting for about 80% of small-group business in 1995 and about 94% in 2000. While control of large market share by a few carriers is neither a new phenomenon nor unique to Maryland, the degree of concentration seems to be higher in Maryland than in a number of other states. However, it seems unlikely that the state can do anything to reverse the decline in the number of carriers competing in the state, since the trend is national. It is equally unlikely that the state could do anything that would cause market share to be more evenly distributed among carriers operating in the state. While the state's small group market reform effort has been successful relative to such programs in other states, significant problems remain. For example, greater understanding of why program enrollment is no longer growing and, in fact, has experienced a slight decline in the number of covered lives recently is critical if we are to reverse this trend. By conducting focus groups with participating and non-participating employers alike, we will gain insight into potential programmatic and regulatory changes that the state can make that will allow us to better retain participating employers and to reverse the program's recent declines.

<u>The Medically Uninsurable</u>: Most insurance purchased by individuals (as opposed to by a group) is medically underwritten, that is, offered only after a review of pre-existing conditions. There are a number of people in this market who are medically uninsurable, however, and must buy insurance through an open-enrollment policy – a policy that accepts all people who apply for coverage regardless of health status. These policies are not medically underwritten and are very expensive. The aggregate number covered through an open-enrollment policy has been stable over the past several years although evidence indicates individuals move in and out of this market with some frequency due to its high cost. In Maryland, the open enrollment product is offered through the Substantial, Available and Affordable Coverage (SAAC) program. The three carriers who participate in the SAAC program are currently given a 4% differential which lowers regulated hospital charges for all of their policyholders in order to subsidize the carriers'

coverage of the medically uninsurable. Overall, compared to high-risk pools utilized by other states, the program has been successful – it covered approximately 7,000 individuals in 2001. However, it is quite troubling that the number of people served is quite small relative to the subsidies the program provides to participating carriers. Successive legislative efforts to reform the program by ensuring that a larger proportion of the savings resulting from the hospital rate differential would be used to subsidize premium costs have failed. Thus, individuals in Maryland who are medically uninsurable do not enjoy the same access to coverage as their counterparts in states that have been more successful in regulating and equitably subsidizing this market.

Hospital Rate-Setting: Through Maryland's all-payer hospital rate-setting system, the cost of care provided to the uninsured is built into hospitals' rates. In excess of $450 million of uncompensated care is financed annually through this system. Each hospital's rates include a "mark-up" to reimburse it for its actual volume of bad debt and charity care, up to a rate increase of 8%. Hospitals whose losses due to uncompensated care exceed the 8% cut-off are reimbursed from an uncompensated care fund financed with a small portion of each hospital's revenues. Because of the all-payer system, there is no need for public or charitable hospitals in Maryland. However, some of the hospitals with relatively high levels of uncompensated care complain that their uncompensated care "mark-up" makes them less attractive to private insurers because their rates are higher. If a portion of the residents that account for the charity care and bad debt become insured, it would reduce the level of mark-up for uncompensated care for at least some hospitals. This would, in turn, reduce hospital spending for payers whose enrollees use these hospitals (e.g., Medicaid) and possibly make these hospitals more competitive with regard to private payers.

Existing Public & Quasi-Public Programs

Publicly Funded Coverage in Maryland (Appendices 1 and 2): The Maryland Medicaid program and the state's S-CHIP program, the Maryland Children's Health Program (MCHP), provide coverage to approximately 550,000 low-income Marylanders. Together these programs comprise the majority of those enrolled in the state's 1115 waiver Medicaid managed care program, HealthChoice. Maryland has been at the forefront of expanding insurance coverage to children. In 1998, Maryland implemented MCHP, which expanded Medicaid coverage to children in families up to 200% of the Federal Poverty Level (FPL). In 2001, the MCHP Premium program was created. This program expanded MCHP coverage to children in families with incomes up to 300% of the FPL – making Maryland a state with one of the highest income standards for children. Maryland is one of only ten states approved to expand MCHP coverage with an Employer Sponsored Insurance coverage option. Through MCHP Premium, a family is required to pay a small premium for coverage. If a family has access to dependant coverage through an employer-sponsored insurance plan that meets specific criteria, MCHP Premium will buy the child into the qualifying employer-sponsored plan. If dependant coverage is not available through qualifying employer-sponsored insurance, the child will be enrolled in HealthChoice – Maryland's Medicaid managed care program. In addition to MCHP and MCHP Premium, other recent Medicaid expansion efforts include a 1998 Medicaid eligibility expansion for pregnant women with incomes up to 200% of the FPL, and a 2001 coverage expansion for pregnant women up to 250% of the FPL.

In addition to expanding coverage, Maryland has created a streamlined eligibility process and has aggressively marketed the MCHP and MCHP Premium programs. This expedited process simplified the requisite forms and allowed families to apply through the mail for insurance coverage. Maryland has also used a comprehensive marketing approach, including a radio

campaign and outreach at schools and libraries, among other activities to promote program enrollment.

Despite these efforts, 17% of Maryland children living in families with incomes below 200% of the FPL remain uninsured[6]. Moreover, enrollment in the MCHP Premium program, which requires that families pay a premium ranging from $45 to $55 per child depending on income, remains far below projections. Understanding the barriers businesses face in participating in the state's MCHP Premium Employer Sponsored Insurance option, as well as the barriers families face in enrolling and retaining coverage in MCHP Premium will allow the state to increase the effectiveness of these programs and provide comprehensive coverage to more Maryland families.

State Supplemental Health Care and Medical Services Programs (Appendix 2): In addition to Medicaid and MCHP, the state has developed a significant number of programs aimed at filling the gap in health insurance coverage and specific medical services for various low-income or ill individuals. These programs, which include coverage for primary care services for low-income adults, family planning coverage for postpartum women, and several recently enacted drug subsidy programs are described in detail in Appendix 2. The newest of these programs, implemented in July 2000, is the state's Short-Term Prescription Drug Subsidy Plan, financed through the SAAC program, which provides access to prescription drug coverage for Medicare beneficiaries in counties that are no longer served by Medicare+Choice plans. In its first year, the program had low enrollment due to the cost-sharing requirements. During the 2001 legislative session, however, start-up problems were addressed and the program was expanded statewide. Currently, close to 27,000 seniors are served by the program.

Prior Activities to Address the Uninsured:

Legislative Efforts: In 1998 and 1999, bills were proposed in the Maryland General Assembly that attempted to promote the concept of universal health care coverage. In 1998, Senate Bill 313 would have amended the Maryland Constitution to establish health care as a fundamental right of every resident in Maryland. The constitutional amendment would have called on the state of Maryland to ensure that every citizen was able to realize that fundamental right. In 1999, Senate Bill 579 would have required the Maryland Health Care Commission to develop a plan to provide universal coverage to all eligible Marylanders. The bill outlined the issues that the Commission would have had to address in the development of the recommendations included in the plan. Neither of these bills was enacted.

In 2000 and 2001, joint resolutions were introduced to create a Panel on Comprehensive Health Care that would have been charged with collecting testimony from the public on the likely effects of adopting state policies for and the best approaches to providing affordable, quality health care coverage for all Marylanders. The Panel was charged with preparing an objective report on its findings and presenting them to the legislature. Neither of these resolutions was enacted. No comprehensive health care bills were introduced in the 2002 Session of the General Assembly.

Consumer-Led Efforts: In addition to these legislative efforts, there has been a consumer-focused effort to expand coverage and build support for universal coverage proposals. A consumer advocacy group, the Maryland Citizens' Health Initiative, was formed two years ago to build support in the state for the concept of universal health coverage. Under the leadership

[6] Maryland Health Care Commission, *Maryland Health Insurance Coverage Through 1999: A Graphic Profile*, February 2002.

of Vincent DeMarco, executive director, and with support from local foundations, the group has held town meetings and convened stakeholder groups throughout the state. More than 2,100 community, religious, business and labor groups have formally endorsed its principles of affordable quality health care for all Maryland citizens (www.healthcareforall.com). Currently the group is seeking to make health care coverage a major issue in this year's state legislative and gubernatorial elections.

2001 Maryland Health Insurance Coverage Survey: To date, the aforementioned legislative and consumer-led efforts have been unsuccessful in expanding coverage to the uninsured, due largely to questions about their affordability and projected take-up rates. In 2001, the state began an effort to collect more specific information about the uninsured in Maryland and to address some of the uncertainties surrounding these and other proposed coverage expansion options. Our allocation of resources to the Maryland Health Insurance Coverage Survey (MHICS) demonstrates our commitment to reducing the number of uninsured in Maryland. The survey is an important first step in assessing the problem of uninsurance in Maryland. This initiative is discussed in further detail under Goal 2 of our Project Narrative.

REQUESTING PREFERENCES

Over the years, Maryland has maintained a low rate of uninsured residents. The overall level of uninsurance for all ages, including the elderly, is 10.4% for 1999-2000, substantially below the national average of 14.2% (SHADAC Data Brief: Table 2 – CPS 1999-2000).

The Maryland Health Care Commission (Commission) has studied and documented the rate of insurance coverage among Maryland residents over the past three years, analyzing data collected from nationally conducted federal surveys (e.g., the Current Population Survey, the Behavioral Risk Factor Surveillance Survey, and the Medical Expenditure Panel Survey – Insurance Component). The Commission recently released a chart book to outline the basic characteristics of insurance coverage – or lack thereof – in Maryland to be utilized by state and private organizations, as well as by individual consumers (*Maryland Health Insurance Coverage Through 2000: A Graphic Profile*).

Combined 1999 and 2000 data indicate that Maryland's 2-year uninsured rate for the non-elderly (12%) is well below the comparable national figure of 16%. The difference is principally due to higher levels of health care coverage at the workplace in Maryland, through a higher percentage of private firms offering health insurance to their employees, and a larger share of workers employed in the public sector, which makes well-subsidized health care coverage available to nearly all employees. Consequently, considerably more of Maryland's residents are covered primarily by employer-based insurance than in the U.S. as a whole. Because Maryland's poverty rate is among the nation's lowest, the portion of residents covered primarily by Medicaid is also below the nationwide rate.

Recently, researchers have projected a significant jump in the national non-elderly uninsured rate in 2001, based on the rise in the unemployment rate during 2001. However, the unemployment rate in Maryland at the end of 2001 was essentially the same as the rate at the start of 2001, and there is no difference in the annual average unemployment rates for 2000 and 2001, 3.9%. Consequently, the uninsured rate in Maryland in 2001 is projected to be similar to that of 2000, at least with respect to employment-based coverage.

Although in comparison to many other states, our rate of residents without insurance coverage is relatively low, efforts to cover the existing population of uninsured are a continuing concern for the State of Maryland. Several programs designed to provide comprehensive coverage and supplemental coverage to the uninsured and underinsured have been created (see Appendices 1 and 2). In addition to these publicly funded health insurance programs, initiatives have been implemented to increase private sector coverage (for example, the small group market reforms) and to provide publicly funded supplemental health care and medical services programs for low income individuals.

Improving coverage among the uninsured requires a clear understanding of who the uninsured are. Efforts to improve insurance coverage in the state must take into consideration the characteristics, attitudes and concerns of the uninsured if they are to be successful. The availability and cost of health insurance coverage in Maryland are of concern to most residents and organizations in the state. Consequently, there is public and private interest in finding ways to improve health insurance coverage among the state's residents. Although Maryland has an uninsured rate that is substantially below the national rate, a State Planning Grant will enable the project team to work with other state agencies and private organizations to develop strategies for providing access to insurance coverage to all Maryland residents.

STATEMENT OF PROJECT GOALS

The overarching goal of this project is to develop a viable, realistic, effective series of comprehensive coverage expansion strategies that will lead to a reduction in the number of the state's uninsured.

Toward this end, Maryland's goals for the proposed State Planning Grant Project are as follows:

(1) To collaborate with public and private sector partners to develop options to provide access to coverage for Maryland's uninsured population.

(2) To increase the level of understanding concerning Maryland's uninsured population through further analysis of existing quantitative data sources and through additional data collection that will help us design more effective expansion options for specific target groups.

(3) To collect and analyze additional quantitative and qualitative data that will directly inform options for the expansion of health insurance coverage, including: (a) research with employers and key segments of the low-income employed population in order to better understand the characteristics of firms not currently participating in the state's small group market and to inform marketing strategies aimed at increasing take-up rates in the small group market; (b) data to better understand businesses' and eligible individuals' willingness to participate in the state's S-CHIP Premium program and Employer Sponsored Insurance program; and (c) data on coverage of young adults (ages 19-25) and ways to effectively include them as dependents under existing policies.

(4) To develop comprehensive options to expand insurance coverage, and to project associated enrollment and cost estimates, for key segments of the state's uninsured population – including low-income adults and children, young adults, and uninsured workers in the small-group, large-group and self-insured markets.

(5) To carry out a comprehensive assessment of the costs of non-insurance, including costs for the state, health care providers, employers, philanthropic organizations, and uninsured individuals themselves.

(6) To develop an action plan to continue improving access to insurance coverage, including developing recommendations that respond to the SPG's qualitative and quantitative findings and identifying necessary next steps and key partners to respond to the recommendations.

By performing additional analysis of several rich data sources, including a state-specific survey of the uninsured conducted at the end of 2001, conducting a follow-up survey to better understand specific sub-groups of the uninsured, conducting a survey of MCHP Premium applicants who terminated the application process or were disenrolled, and developing economic models for numerous coverage expansion options, the state hopes to build support for and increase the viability of these options. Additionally, by exploring issues surrounding take-up rates using qualitative research methods, the state hopes to further build on the success of two employer-based insurance programs, namely the small group market reform program and the public sector MCHP Premium Employer Sponsored Insurance coverage option.

PROJECT DESCRIPTION

Goals 1 through 6 are explained in the detailed project narrative that follows. Each goal includes tasks, which are subunits within the goals. The narrative is supplemented by the Project Management Plan matrix, which summarizes the narrative and provides additional information concerning the anticipated timing for tasks and action steps with the tasks, the responsible organization and individuals within the project team with primary responsibility for the activity, the anticipated results, and the principal deliverable that will be used to measure progress and completion of the activity.

Goal 1: Collaborate with Public and Private Sector Partners to Develop Options to Provide Access to Coverage for Maryland's Uninsured Population

The first and, in many respects, most important task to be undertaken as part of Maryland's proposed State Planning Grant project is the establishment of a Health Care Coverage Workgroup. The purpose of the Workgroup is threefold:

- to provide input into the development of politically and economically viable coverage options that, when implemented, would provide access to comprehensive, affordable health insurance coverage for Maryland's existing uninsured;
- to ensure the participation and representation of key public and private stakeholder constituencies in this process; and
- to create an informed stakeholder group that will serve to highlight the importance of insurance coverage issues.

The Health Care Coverage Workgroup will be comprised of approximately thirty members, composed of five individuals from each of the following constituencies: (1) employers and other purchasers; (2) advocates and consumers; (3) health care providers; (4) insurers and health plans; (5) policymakers; and (6) researchers. This composition should allow for a full range of perspectives with respect to proposed coverage options.

The Health Care Coverage Workgroup will have three primary responsibilities, namely:

- to review the analytic goals of the SPG and provide comments to assure that the analytic efforts support the assessment of politically viable coverage options. These include:
    - ranking by priority the coverage options to be examined by the grant; and
    - determining key variables which should be included in estimating the costs of coverage options, such as benefit package, cost-sharing, etc.;
- to review the presentation and interpretation of the proposed quantitative and qualitative data collection efforts and studies, in order to develop a common understanding of the issues and to begin to disseminate the findings; and
- to identify key partners and necessary next steps to respond to the findings and recommendations of the SPG.

The Health Care Coverage Workgroup will meet at least three times, each facilitated sessions. The initial Workgroup meeting will take place in the fall. Health Care Coverage Workgroup members will be briefed about Maryland's uninsured population, the project and its purpose. Members will provide input into the project's proposed work plan. A second facilitated meeting will take place in the winter in order to review the findings of completed project components, to track the progress of the grant and to review coverage options developed up to this point. A final facilitated Health Care Coverage Workgroup meeting will take place in the late spring to review and prioritize coverage options and determine recommendations for the action plan and the Report to the Secretary of Health and Human Services (as discussed in Goal 6). During the final meeting, the Health Care Coverage Workgroup will determine the next steps necessary to move forward on the SPG findings and recommendations, including identifying additional stakeholders who are critical to addressing the findings and recommendations of the SPG.

The Health Care Coverage Workgroup will be staffed by members of the Office of Planning, Development and Finance and the Maryland Health Care Commission, both under direction of the Deputy Secretariat for Health Care Financing. A consultant will be hired to facilitate and coordinate each of the Health Care Coverage Workgroup meetings.

Anticipated Results for Goal 1
The Health Care Coverage Workgroup will result in: an analysis which supports politically viable options for expanding coverage; an informed stakeholder group; and identification of key partners and next steps for responding to the findings and recommendations of the SPG.

Goal 2: Perform Data Analysis and Additional Data Collection to Increase Understanding of the Uninsured
Our second goal is to increase the level of understanding regarding Maryland's uninsured population through more in-depth analysis of existing quantitative data sources and through additional data collection. Together, these will help us design more effective expansion options for specific target groups.

As a result of efforts during the past year, there now exist multiple data sources from which the numbers of uninsured in Maryland can be estimated. These include the recent benchmark Maryland Health Insurance Coverage Survey 2001 (MHICS), the soon to be released re-weighted, expanded sample version of the Federal Current Population Survey (CPS) for CY 2000 in which the number of Maryland households has been doubled, and the most recent Medical Expenditure Panel Survey-Insurance Component (MEPS-IC).

The HRSA State Planning Grant (SPG) funding will allow the state to conduct a comprehensive statistical assessment of the baseline MHICS, including the development of strategies for weighting the survey responses to accurately reflect the state's current population. The grant

funding will also enable us to compare the survey responses with the CPS and MEPS-IC data, including an assessment of which data source is the most reliable for different types of investigations. A summary of these findings will be compiled and widely distributed. SPG funding will also enable the state to conduct a follow-up survey of the uninsured in order to obtain more detailed information for specific target groups.

These activities will yield more detailed information on the state's uninsured population, allowing us to better understand the dynamics of uninsurance within the Maryland family and workplace. A deeper understanding of these issues will allow Maryland to develop coverage options to ensure that every resident has access to affordable health insurance.

Goal 2/Task 1: Assessment, Refinement, and Further Analysis of Existing Household Surveys

Maryland Health Care Commission (MHCC) staff are currently examining the preliminary data produced by the survey vendor for the recent benchmark MHICS and reviewing the vendor's methodology. Although the quality of the data looks promising, the information in the MHICS will have to be thoroughly assessed before any results can be released or the data can be made available to other researchers. This will entail both weighting the survey responses to accurately reflect the state's population characteristics and comparing results from the MHICS to data from the Current Population Survey (CPS), which is regarded as the standard by the research community. Data results will also be compared to Maryland's Behavioral Risk Factor Surveillance Survey (BRFSS). Any significant discrepancies will be investigated in order to identify the most reliable data source for a particular type of analysis related to insurance status.

As a first step, HRSA funding will allow us to obtain assistance from a vendor in creating weights for survey responses so that the responses can be better used to represent the current Maryland population. The accuracy and utility of the MHICS results would be improved if the weights reflected the 2000 Census rather than the projected 2000 numbers from the 1990 Census, as is currently the case. In addition, a weighting scheme will be developed in order to weight the responses more heavily for households reporting that they have had their telephone service interrupted in order to compensate for excluding households without telephones at the time of the survey. We will also be able to create county-specific weights for counties with sufficient observations.

The Census Bureau will soon replace the existing CY2000 Current Population Survey (CPS) file with an expanded sample version with new weights that reflect the 2000 Census demographic information. With HRSA funding, it will be possible to compare these data to our newly weighted MHICS results. We will also compare the county-specific results on adults from the MHICS to county-level results from the Behavioral Risk Factor Surveillance Survey (BRFSS), produced with county-level weights that staff have constructed for the BRFSS. The MHICS results will be used to assess the accuracy of the county and regional information generated from the BRFSS. If there is general agreement, then we will be able to use the BRFSS to generate sub-state uninsured rates for adults in future years when there are no Maryland-specific state surveys.

Finally, the accuracy of estimated counts of the volume of persons projected to need insurance assistance or who will utilize a particular program will be improved if the proportion of "ever-insured" who have lapses in coverage during the year can be estimated, along with the duration of their lapses. MHCC staff recently analyzed the 1997 MEPS-Household Component (HC) data file for this information and estimated annual risk and duration of lapses for different demographic subgroups. However, since state-level data are not available in the MEPS-HC, we

limited our analysis to respondents in the Northeast Census region as a proxy for Maryland residents. HRSA funding will allow us to perform a more detailed analysis of these data, including the recently released files for 1998 and 1999. The objective will be to identify relationships among (1) risk and duration of coverage lapses, (2) employment and income characteristics of the population, and (3) the availability of insurance in the different Census regions and for different years. Analysis results will enable us to better estimate "lapse" information for Maryland residents in general, and for years in which the MEPS-HC is not yet available. This type of multivariate analysis, performed using the various data sets, will help us identify critical differences between the uninsured and their insured peers, as well as "actionable" barriers to insurance coverage among various subgroups of the uninsured.

Guidance in planning and conducting the database assessments, as well as the weighting project, will be accomplished through contracts with outside "expert" vendors. Access to a version of the CPS that is suitable for multivariate analysis requires use of Census facilities.

Goal 2/Task 2: Follow-up Survey of the Uninsured and a Matched Comparison Group
In order to better develop strategies for meeting the needs of the various sub-groups among Maryland's uninsured population, HRSA grant funding will be utilized to conduct a follow-up survey of the 1,588 uninsured individuals identified in the MHICS. We will also include in the follow-up study an equal number of insured individuals who are matched on the basis of age category, household income, and rural/urban residence. The follow-up study will utilize a methodology similar to the baseline survey. Data will be collected using computer-assisted telephone interviewing (CATI). We will contact and interview the adult in the identified household who was judged to be most familiar with the health care and health insurance of the individuals living in the household. It is important to note that over 96% of the "most knowledgeable adults" interviewed in the baseline survey responded "yes" to the question: "We might like to call you back in a year to ask additional questions about your family's health care. Would that be all right?"

Approximately 30 states have conducted household surveys in order to develop more accurate estimates of the numbers and characteristics of the uninsured to aid in policy development and program design. To date there has been relatively little opportunity to examine at the state level changes over time through longitudinal studies, despite the advantages of this approach. Our follow-up survey will have two major objectives:

First, we will repeat selected questions from the initial survey. This strategy will create a panel design, similar to the Medical Expenditure Panel Survey (MEPS) at the national level, which will make it possible to determine how changes in an individual's health status, income, employment, eligibility for public and private insurance coverage, use of services, and payment for care are related. This analysis will deepen our understanding of factors affecting lack of insurance.

Second, we will design interview modules for specific high-risk sub-groups (e.g., rural young adults ages 19-24) regarding factors related to lack of coverage. Examples of issues to be examined include: intentions to add coverage; willingness to pay a percentage of the premium (price elasticity of take-up rates); awareness of public programs; level of interest in expansion options; likely responses to subsidies or tax credits; and coping strategies. We will use this information in order to develop strategies for improving the "take up" of employer-based coverage and to increase enrollment in public programs by individuals who are already eligible. We will develop the new interview modules using results from focus group interviews (see Goal

3), a review of other state surveys, and consultation with the State Health Access Data Assistance Center.

Goal 2/Task 3 Maryland Health Insurance Coverage Survey Public Use Dataset
The Maryland Health Insurance Coverage Survey 2001 individual and family level data files will be made available to the research community, together with comprehensive documentation for the data set, including a methodology report and data dictionary. In addition, if there is interest in analysis of the data by novice users, a public access data file will be created without the sampling variables, including only those variables of greatest reliability and utility, as identified in the data set assessment. A protocol for researchers to obtain the full data set with sampling variables will be designed and a web-based application form will be constructed. This information will be posted on the MHCC and DHMH web sites in an effort to encourage researchers to further analyze these data in ways that might benefit the state.

Anticipated Results for Goal 2
A thorough assessment of the benchmark MHICS that identifies its strengths and weaknesses and sources of discrepancies between the MHICS and the CPS and BRFSS will identify for us and other researchers the most reliable data source(s) for different types of analyses on Maryland's uninsured. This knowledge, along with improved weights for the MHICS, will help insure that the conclusions drawn from analyses of available data are as accurate as possible.

The general analyses of the baseline and follow-up surveys will define the characteristics of the uninsured and how they differ from their insured counterparts in both urban and rural parts of the state. The multivariate analyses will help identify which characteristics of the uninsured are the most critical, hopefully illuminating why individuals of similar socio-economic status make different decisions about purchasing insurance or, if economically disadvantaged, enrolling in public insurance. These analyses will provide more detailed information on the state's uninsured population and thus enable us to better understand the dynamics of uninsurance within the Maryland family and workplace. The analytical results will also help the state identify "actionable" barriers to insurance coverage and how the actionable barriers vary by age, geographic location, family composition, and other characteristics. This knowledge will help policy-makers develop more targeted options for various uninsured subgroups in different parts of the state to ensure that every Maryland resident has access to affordable health insurance.

The information from the detailed analysis of the MEPS-HC data will result in a model that will project estimates of the numbers of Maryland residents who lack insurance for one or more months during the year using information from the MEPS-HC adjusted for Maryland insurance, employment, and income characteristics. The model will improve both the projected numbers of residents that might enroll in insurance assistance plans and the anticipated program costs. If the model tests well, we will seek to disseminate information about the model to other researchers through a journal article or other publication.

Results from these analyses will be summarized and disseminated, principally in chart book form since that is accessible to the widest audience. The planned reports include: a chart book of findings from the various surveys, a report on the strengths and weaknesses of the MHICS, a chartbook of county-level information for counties with sufficient numbers of observations, and an issue brief that reports results from the more complex multivariate analyses, with comparisons between the MHICS and the CPS. The reports will also be available on the MHCC and DHMH web sites with links to sites with additional information on the uninsured at the national and state levels.

The reports and website will be made available to county health officers, other state agencies, and the public for use in studying the findings from the baseline MHICS, such as the number of uninsured children and adults by region (and possibly by county); characteristics of the uninsured (e.g., federal poverty level, employment and insurance status, and family structure/type); and access and utilization data. The information will also be shared with the Health Care Coverage Workgroup. In addition, data obtained from the analyses of the surveys will be used to study health insurance expansion efforts to populations for which there exists significant legislative and public support.

Making a public use data file available to other researchers will permit further examination of issues regarding the uninsured. Because it will enable others to use the data base to assess the possible utility of legislative or community programs targeted at the uninsured, it may facilitate the proposal of such programs and encourage public dialogue regarding these issues.

Goal 3: Collect and Analyze Additional Quantitative and Qualitative Data that will Inform Options for the Expansion of Health Insurance Coverage

The collection of additional information and the subsequent analyses of issues of primary concern to key participants in Maryland's health care system is crucial to understanding the factors that affect the availability of and access to health insurance coverage in both the public and private sectors. In addition, more in-depth information on firm characteristics and employment-based enrollment statistics can help provide a foundation for the development of potential options for expanding coverage. While it may appear that the tasks contained in Goal 3 are somewhat unrelated, each contributes to a better understanding of the preferences and resource limitations of employers, employees, and public program participants. The additional information gained through these efforts will provide valuable insight into the development of effective coverage options that will yield improved take-up rates and a reduction in the number of uninsured.

Goal 3/Task 1: Quantitative Research on Employer-Based Insurance MEPS-IC Buy-In

The Medical Expenditure Panel Survey (MEPS) is conducted on a yearly basis through the Agency for Healthcare Research and Quality (AHRQ). The Insurance Component of the MEPS, MEPS-IC, consists of two sub-components – the household sample and a list sample of business establishments and governments. With SPG grant funds, Maryland will purchase additional list sample of small and large businesses to allow for estimates at the regional level stratified by industry type and size. This buy-in or purchase would enable the state to determine how the availability of insurance coverage to private employees as well as the employee insurance participation rate differs by establishment characteristics at the regional level. Purchase of additional MEPS sample would also provide Maryland with additional information on insurance availability in the large group market, as well as better knowledge of firms that currently do not participate in Maryland's small group market.

Additionally, SPG funding will be used to obtain a special report from MEPS-IC staff that includes: a count of total enrollment; the total costs of coverage; and employer contribution by firm, within both the public (i.e., state government employees) and the private sector in Maryland by several variables, including type of enrollee (active or retired), scope of coverage (single or family coverage), and type of indemnification (purchased or self-insured plan). This information will enable cost and enrollment comparisons between the sectors and by type of indemnification. This information will also provide a denominator for the number of enrollees that are affected by state legislative mandates.

Anticipated Results for Goal 3/Task 1
Additional in-depth information on the characteristics of firms that offer and fail to offer health insurance coverage, as well as employer-based enrollment statistics that would allow Maryland to better calculate and verify insurance take-up rates for various segments of the population will provide an important foundation for the development of valid, credible and viable options for expanding health care coverage to Maryland's uninsured.

Goal 3/Task 2: Focus Groups with Employers
The Maryland small group health insurance market consists of businesses with two to 50 employees and the self-employed. Under Maryland law, the only benefits package that can be sold in this market is the Comprehensive Standard Health Benefit Plan (CSHBP) whose benefits are determined annually by the Maryland Health Care Commission.

A 2001 legislatively-required study that assessed the performance of the small-group market health insurance reforms noted that expanding employer offer rates beyond the program's current 57% by altering the benefits package and/or premium costs would be difficult and likely fruitless because of the extreme price inelasticity of this insurance market. Instead, the report recommends that the state investigate ways to better market and inform potential employers about the program.

Accordingly, the state will conduct focus groups with both participating and non-participating employers in order to assess ways in which Maryland could better publicize and promote the small group program. The state will identify focus group participants through the Maryland Chamber of Commerce and the Maryland chapter of the National Federation of Independent Business. The focus groups will be stratified according to firm size and geographic area. Two focus groups in two different areas of the state will be conducted for employers participating in the CSHBP with 10 or fewer employees and with 11 to 50 employees (a total of 4 focus groups). Examples of issues that will be probed in these groups are the costs of coverage; knowledge of the base CHSBP (without riders); reaction to materials developed for distribution to employers and other consumers (see below); and interest in the state's MCHP Premium Employer Sponsored Insurance (ESI) coverage option (see below).

In addition, two focus groups in two separate geographic areas will take place with non-participating employers with 10 and fewer employees, 11 to 25 employees, and 26 to 50 employees (for a total of six focus groups). From these focus groups, we anticipate learning about the employers' knowledge and impressions of insurance; their awareness of the CSHBP; reasons why they do not offer coverage and what it would take for them to do so; and their reaction to the marketing materials.

Employer reaction to and potential issues surrounding participation in Maryland's new MCHP Premium Employer Sponsored Insurance coverage option for children will also be probed in the aforementioned groups. Potential incentives for participation such as payment supports (by the state to the employer) will also be tested in these groups. Employer reaction to and potential issues concerning program expansion to various adult populations will also be examined. Further, participants will be asked to offer ideas for effective marketing strategies and tools for the Employer Sponsored Insurance option to allow Maryland to improve outreach to and capture of eligible employers. These concepts will be folded into Maryland's efforts to develop a comprehensive marketing strategy to attract and keep employers in the program.

Finally, a separate RFP will be issued and awarded to an organization to develop marketing materials for small employers describing the CSHBP and presenting contact information.

Materials will include advertisements in newspapers and business trade publications, as well as brochures or "bookmarks" to be distributed to employers and employer associations. The focus groups will review these materials in order to determine their usefulness and effectiveness.

Goal 3/Task 3: MCHP Premium ESI Option: Key Informant Interviews - Large and ERISA Employer Groups

Maryland will also conduct key informant interviews with large employer groups (51 to 100, 101 to 200 and >200) and with self-insured (ERISA) employers to better understand issues surrounding their willingness to participate in the MCHP Premium Employer Sponsored Insurance coverage option. Participants from these firms will be probed for ideas for effective marketing strategies and tools for improving outreach to and participation of employers in the program. These interviews will also allow the state to test potential participation incentives such as tax credits and tax deductions.

Goal 3/Task 4: Survey of MCHP Premium Applicants who Terminated Process or Were Disenrolled

Additionally, the state will survey individuals who began the MCHP Premium application process but who did not ultimately enroll in the program. Roughly one quarter of those who begin the application process do not complete the process to gain enrollment in a public program. While it appears as though roughly half of these so-called "incomplete cases" either have private insurance coverage or are already covered through a public program, this is not the case with the remaining 12.5%. Moreover, many current MCHP premium enrollees fail to make timely premium payments and, as a result, have been or are at risk of being disenrolled. Additional information on the consumer's perspective concerning Maryland's MCHP Premium would provide the state with the information necessary to reduce these drop-off and disenrollment rates and create a more consumer-friendly process. An improved process would lead to a reduction in the number of uninsured, as more individuals would be purchasing insurance through participation in MCHP Premium.

Anticipated Results for Goal 3/Tasks 2-4

Information from these focus groups will allow the state to determine ways to make existing program information for the CSHBP more consumer- and employer-friendly. Also, information will be collected from non-participating employers on their awareness and perception of the CSHBP, why they choose not to offer coverage, and what options or changes to the CSHBP would encourage them to buy coverage. Our goal is to determine options to increase participation in the small group market.

It is anticipated that the information collected from the focus groups, informant interviews and survey will provide the Department of Health and Mental Hygiene and the Maryland Health Care Commission with data that will assist in modifying and/or marketing the CSHBP and the ESI coverage options more effectively. This, in turn, will lead to increased participation in all three of these programs and thus a reduction in the rate of Maryland's uninsured. Moreover, information from the focus groups, the key informant interviews and the MCHP Premium survey will provide important input into the development of coverage options described in Goal 4 below.

Goal 4: Develop and Assess the Impact of Options to Expand Insurance Coverage

Existing data show that low-income adults have the greatest risk of being uninsured. The non-insurance rate in Maryland is 38% for adults below the federal poverty line (FPL), 23% for those from 1 to 2 times the FPL, and 17% for those from 2 to 3 times the FPL.[7] Considerable

[7] MHCC figures.

legislative and public support exists for expanding coverage to various segments of the low-income adult population. Concrete and actuarially sound estimates on the cost of covering different segments of this population are not currently available. Such estimates would allow state leaders to make sound decisions with respect to coverage expansions.

Goal 4/Task 1: Develop Models for Simulating Insurance Uptake, Utilization, and Costs for Expansion Options

The reality of the policy making process is that proposals are dynamic, and it is critical that key program assumptions can be modified and sound estimates can be generated quickly. To that end, the SPG will be used to develop models for assessing coverage options quickly. The models will allow key program elements, such as cost sharing requirements, to be modified. In addition, the models will estimate the impact of the proposed programs on the number of people eligible, employer offer rates, take-up rates, and program costs. These models will allow state policy makers to clearly identify the underlying assumptions that are included in the models. Once prepared, these models and the data that accompany them will be available beyond the one-year time frame of the SPG for additional analysis of coverage expansion options.

The team at the Johns Hopkins University School of Public Health (JHSPH) will take the lead in simulating and costing out insurance expansion options, with input and assistance from an actuarial firm. Cost estimates will be based on estimates of the costs of a range of benefit packages – priced by specific benefit – based on actuarial statements provided by Maryland's health insurers and additional interviews with the insurers. JHSPH has already conducted a similar analysis for the state's Comprehensive Standard Health Benefit Plan (CSHBP) offered by small employers (50 employees or less), including options for expanding the benefits provided under this plan and varying the cost-sharing arrangements.[8]

We will estimate uptake rates and predicted utilization under insurance expansion based on detailed analysis of utilization by individuals who are currently insured but match the uninsured in terms of socioeconomic and demographic characteristics and, where possible, health status.[9] We will take into account the effect of cost-sharing arrangements, both on costs and predicted utilization and the effect of medical care inflation on future years' costs.

Additionally, we will conduct sensitivity analysis on all of the major inputs into the cost calculations for different insurance expansion scenarios. Specifically, we will vary the cost of the benefits package, the uptake and utilization rates for expanded eligibility, the cost-sharing arrangements, and the medical inflation rate. The Health Care Coverage Workgroup will provide input into the specific models that are developed. The model will be used for simulating the examples described in the subsections below. Additional models and strategies may be developed based on the data analysis efforts discussed in Goal 2.

Goal 4/Task 2: Project and Cost Out Coverage for Adults up to 100%, 150T, 185% and 200% of the FPL, and for Parents of Children Enrolled in HealthChoice

As noted above, available data indicate that adults with incomes below 100% of the Federal Poverty Level (FPL) are perhaps the state's most intransigent uninsured population. Moreover,

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[8] Maryland Citizens' Health Initiative Education Fund, Inc. (2001). *A Proposed Plan for Universal Health Insurance Coverage in the State of Maryland*. William M. Mercer, Inc (2001). *Maryland Health Care Commission Mandated Health Insurance Services Evaluation*.

[9] We will supplement this analysis with the MHICS, which includes health service use and health status indicators. In the 2001 MHICS, uninsured individuals were more than twice as likely as the insured to report that their health status was either "poor" or "fair" (17.5 percent compared to 7.9 percent).

they are believed to have limited access to employer-based coverage, and are thought to be significantly sicker than the employer-based working insured population, making the use of existing employer-based actuarial databases and methods for developing cost estimates for this population difficult. The primary means of increasing coverage for this group is likely to be expansion of eligibility for the Maryland Medicaid Program. Information from our proposed additional data analyses and follow-up survey of the uninsured identified through the MHICS (Goal 2), will confirm or disprove our suppositions about the coverage patterns and illness burden of low-income adults and other populations. This, in turn, will allow us to develop an optimal set of coverage options for this population.

In particular, the MEPS Insurance Component (IC) collects detailed information on the health insurance policies held by and offered to the respondents in the MEPS-HC. The MEPS-IC includes interviews with the employers of the MEPS-HC respondents – providing data that can be linked back to the household level. We will use these data to analyze employer insurance offers – including cost-sharing requirements and benefits offered – by the size and location of the companies included.

We will also use the Maryland Medicaid Claims and Encounter database, which shows health care utilization for those receiving care through the Maryland Medical Assistance program (which includes M-CHIP). Our goal will be to document patterns of care, cost of care and enrollee characteristics (including health status) for major subgroups. Maryland has successfully obtained very comprehensive service level encounter data from all of its contracting managed care organizations (MCOs). The ability to do this has eluded most other state programs as they have shifted from fee-for-service billing to capitated managed care plans.

We will explicitly cost out the Medicaid benefits package, varying assumptions concerning utilization as described above. We will also vary assumptions on the state's ability to obtain waivers for federally matched funding for expansion, using a 50% federal match for parents and a 0% match for childless adults as the baseline. In addition, it is likely that expansion of Medicaid eligibility criteria would need to be accompanied by increases in the provider payment schedule currently offered to Medicaid providers in the state. Also, there will be outreach costs related to publicizing new eligibility criteria and enrollment. At the same time, a reduction in the rate of uninsured Marylanders should enable the state to lower payments to the HSCRC Uncompensated Care Fund and should result in lower expenses for state-run entitlement programs that provide services to the uninsured (see Goal 5 on the costs of non-insurance).[10] We will explicitly calculate and include these costs and potential benefits in the modeling of the costs of insurance expansion.

We will develop cost estimates for insurance eligibility expansion covering all adults up to 100%, 150%, 185%, and 200% of poverty. Since these populations have lower unemployment rates and are more likely to have some access to employer-based coverage, these estimates would include contingencies for Employer Sponsored Insurance (ESI) buy-ins and tax credits. These estimates would also consider alternatives to the standard Medicaid benefits package, including

[10] The Maryland Health Care Foundation estimates that an annual $50 million increase in physician reimbursement under the State Medicaid program is necessary. The Foundation also calculates that substantial expansion of Medicaid would result in additional outreach costs of $500,000. Covering adults to 100% of the FPL would result in 91,000 newly insured adults – 66,000 with children and 25,000 childless, and a $8.5 million rate reduction in hospital rates for Maryland Medicaid. The Foundation estimates that there would be an accompanying $69.5 million reduction in the cost of state entitlement programs.

but not limited to the Maryland Comprehensive Standard Health Benefit Plan (CSHBP) and the Maryland Mandated Benefits Package. In addition, different cost sharing arrangements may be evaluated.

Following a similar methodology, we will also cost out Medicaid program expansions that would include parents of children enrolled in HealthChoice and with incomes up to 100, 150, 185, and 200% of poverty. For the latter groups, we will include actuarial estimates for different benefits packages including the CSHBP and the Maryland Mandated Benefits Package. Estimates will also be developed that include assumptions concerning participation in the state's MCHP Premium Employer Sponsored Insurance (ESI) coverage option as well as possible future federal tax credits for low income individuals and families purchasing or carrying coverage.

Anticipated Results for Goal 4/Tasks 1 and 2

The result of the simulations of expansion of coverage to low-income adults will provide detailed estimates of projected enrollment rates, health service utilization, and costs for the state under each of the scenarios specified – expanding coverage up to 100%,150%, 185%, and 200% of poverty and for parents of children currently enrolled in the state's HealthChoice Program. These calculations will include financial benefits of increasing coverage, including savings to the HSCRC Uncompensated Care Fund and state-run entitlement programs that provide services to the uninsured. The calculations will include sensitivity analysis for each of the major assumptions and inputs, including the cost of the benefits package, federal matching waivers, enrollment and utilization rates, cost-sharing arrangements, and the medical inflation rate.

Goal 4/Task 3: Project and Cost Out Expansion of Coverage in the Small Employer Market

The uninsured rate in firms with less than 25 workers – 25% – is sharply higher than for the state as a whole. At the same time, 80% of uninsured adults are employed or are in families with a wage earner. Maryland's health insurance program for employers with 50 employees or less, featuring the Comprehensive Standard Health Benefit Plan, has a higher offer rate – 57% – than similar plans around the country, but there is room to expand coverage under this program. Goal 3 above describes additional data collection using focus groups to identify the factors restricting additional enrollment under the CSHBP. [11] Based on these results, we will design policy initiatives to promote enrollment under this plan, and we will calculate the cost of potentially expanded coverage. These calculations will differ from these described in Tasks 1 and 2 above primarily in that the costs calculated will not accrue primarily to the state. With the exception of the cost of promoting and regulating coverage in the small employer market, the costs of expanding coverage in this market will be borne by the private sector.

Analysis similar to those proposed for potential public sector expansions would be desirable for the private sector as well. However, expansions in the private market are more difficult to promote, as employer and employee behavior, preferences and resources must be taken into account. As such, this task would build upon the information that will be gathered from private sector participants under Goals 2 and 3, above.

For example, based on additional analysis of the MHICS data, private sector employer offer rates and employee take-up rates may be increased by understanding the reasons for less-

[11] For the year 2000, William M Mercer, Inc. calculated the average cost of the CSHBP at $2,158 per beneficiary. Approximately 17.3% of this cost is due to riders providing services and cost-sharing arrangements beyond the mandated minimum. The basic PPO option for the CSHBP includes deductibles and out-of-pocket limits of $1,000 and $3,400 for individuals, respectively, and $2,000 and $6,800 for families.

than-full participation and by operationalizing methods to encourage increased health insurance coverage. The follow-up survey of those individuals who were uninsured according to the MHIC Survey will also provide insight into what barriers must be overcome in order for those individuals to become insured. Additionally, information gathered during the small employer focus groups, the large group and ERISA employer key informant interviews, and the survey of those who terminated the MCHP Premium application process or were disenrolled will all contribute to a better understanding of how coverage opportunities and options can be created and encouraged.

While it is difficult to be able to precisely predict the exact issues that will be analyzed under this task, we will develop a plan to analyze the information that will have been gathered during the new data collection activities and will provide potential recommendations based on those analyses.

Anticipated Results for Goal 4/Task 3
Results for projections of expansion in the small employer market include a detailed plan for promotion and regulation of the CSHBP, and analysis of the costs both to the state and to private employers and individuals of such expansion in this market. This information will be used to design policy for insurance expansion for individuals working in firms with 50 employees or less, and to promote the benefits of such expansion to the state, to small employers, and to individuals. The information collected from the focus groups, informant interviews, and surveys will underpin the policy analysis that will need to be undertaken under this task.

Goal 4/Task 4: Develop, Project, and Cost Out Options for Young Adults in the Private Market
As in the nation as a whole, young adults in Maryland have the highest risk of being uninsured. As noted in a previous section, the 19-24 year old age group constitutes 9% of the non-elderly population in the state, but 19% of the uninsured. The risk of being uninsured for this age group, 26%, is similar to the national pattern, although the risk of having no health insurance among all other age groups is significantly lower in Maryland than the national average.[12]

National studies suggest a number of reasons for lack of coverage among this age group.[13] Some have lost the private insurance coverage previously held through their parents due to age restrictions. For the majority of insurance carriers, young adults are typically eligible for coverage as dependents under their parents' policies until they reach the age of 25 if they are full-time students. (Some dependent coverage, however, may have limited provider networks that create geographic coverage limitations.) Young adults who are not full-time students are typically covered on family policies through age 19. National studies also suggest that in comparison to older adults, young adults in this age group have lower labor force participation and thus less access in general to employer-based coverage. They also have a greater tendency than older adults to work in part-time or seasonal jobs or for small employers where benefits are not offered or where they are not likely to be eligible for coverage. When employer-based coverage is available, take-up rates are likely to be lower for this age group, partly due to

[12] Maryland Health Insurance Coverage Through 2000. A Graphic Profile. Baltimore, MD: Maryland Health Care Commission, 2002 (www.mhcc.state.md.us).

[13] Committee on the Consequences of Uninsurance. Coverage Matters: Insurance and Health Care. Washington, DC: Institute of Medicine, 2001. (www.iom.edu); Peter J. Cunningham. "Next Steps in Incremental Health Insurance Expansions: Who Is Most Deserving?" Center for Studying Health System Change, Issue Brief #12. April 1998. (www.hschange.com); Kevin Quinn, Cathy Schoen and Louisa Buatti, "On Their Own: Young Adults Living Without Health Insurance." The Commonwealth Foundation, Briefing #391. May 2000. (www.cmwf.org).

their income levels: in Maryland this group has the highest proportion (30%) living in poor or near poor households.

Extending coverage to this heterogeneous age group will require a number of strategies. For example, one private market option that we would like to explore is extending the ability for young adults age 19-25 without access to employer-based coverage to continue to be included as dependents on their parents' health insurance policies. At least three other states, including Minnesota, Kansas and Colorado, are examining the desirability and feasibility of this approach. As part of our analysis we will conduct interviews with key informants among large self-insured employers, other health insurers and brokers regarding their perceptions of the desirability of this approach and how they might be likely to price such an option. For example, would continued inclusion under a family policy be less expensive in general than purchasing coverage in the individual market? Informants will also be asked to discuss their concerns regarding potential risk selection. In addition, we will explore the costs and potential effectiveness of outreach campaigns on the value of health insurance for young adults. We also will seek advice from other states that have designated young adults as a target group for coverage expansion strategies, and we will contract with a vendor who will provide actuarial consulting services to assist us in this effort.

Anticipated Results for Goal 4/Task 4
We will develop a series of options for expanding coverage to young adults between 19 and 25 years of age. We will estimate the potential for expanding coverage to this group under these options, and calculate the costs of doing so to insurers and to individuals – including projected health service utilization for this group and varying assumptions as with the projections described above. As with proposed expansion under the small employer plan, the costs of expanding coverage to this group will not be borne by the state.

Goal 5: Conduct a Study of the Costs of Non-Insurance
In order to propose technically and politically feasible alternatives for reducing the number of uninsured Maryland residents, it is critical to understand current expenditures for and by this population. To date, little is known about the extent of the costs of non-insurance, in Maryland and in the U.S. as a whole. The key questions to be answered are: (1) What are the costs of non-insurance? and (2) Who pays these costs?

At the same time, uncompensated care costs have continued to increase at a substantial rate in recent years, while the rate and number of uninsured in the state is believed to have declined. A better understanding of the drivers of uncompensated care costs in the state would allow the state to identify potential efficiencies. HRSA SPG funding would allow the state to perform a comprehensive assessment of the current costs of non-insurance to the state, providers, employers, uninsured individuals themselves, and philanthropic organizations. This study would be based on quantitative analysis of existing federal and state data sources as well as key informant interviews. The costs of non-insurance in Maryland fall into several broad categories. The calculation of each category is described below as a separate task.

Goal 5/Task1: Calculate the State's and Payers' Costs Related to Non-Insurance
Uncompensated Care: Nationwide, uncompensated care costs represent a serious drain on health systems and on society in general. The Institute of Medicine estimates that nationwide hospital emergency departments or outpatient departments serve as the regular source of care

for one out of every six uninsured patients that report having a regular source of care. [14] According to the Maryland Health Services Cost Review Commission (HSCRC), Maryland hospitals provided $469 million in uncompensated care (including bad debt and charity care) in fiscal year 2000.[15]

We will analyze the hospital financial disclosure statements submitted to HSCRC to calculate the amounts of charity care provided by Maryland hospitals. All discharge data for Maryland hospitals are available through the public use files. HSCRC is responsible for reviewing and approving hospital rates and for making financial and other information about Maryland hospitals available to the public. The data available for each discharge include various patient characteristics including: zip code of residence; nature of admission; source of admission; diagnoses and procedures and charges by category, patient disposition, and source of payment ("expected payer for most of this bill"). In comparison to patients in other payer categories, self-pay patients are more likely to be admitted through the emergency department and to have longer lengths of stay for many diagnoses. Additional detailed analyses of these data will be utilized in our efforts to examine the current costs of treating the uninsured in the state.

In addition, research using hospital financial and discharge databases and key informant interviews with hospital administrators will examine factors contributing to variations in the amount of charity care hospitals provide – for example, the number of uninsured patients treated, and the average cost per case for uninsured patients.

Other Subsidies for the Uninsured: Several sources of funding from the state, detailed in Appendix 2, provide care for the uninsured.

Goal 5/Task 2: Calculate Employers' Costs
Employers' costs related to non-insurance include productivity losses related to time off work for uninsured workers, and disability payments to these workers. We will estimate productivity losses using morbidity, missed work time, and wages, reported in the MHICS, the CPS, and the MEPS. We will estimate disability payments related to non-insurance using the same data sources as well as interviews with several large employers in the state.

Goal 5/Task 3: Calculate Uninsured Individuals' and Households' Costs
The uninsured tend to forego preventive care and to delay necessary curative health services. As a result, they are much more likely than insured individuals to use emergency care services and hospital services in general as a first point of entry in the health system.[16] For these reasons and because they lack insurance, when they do use health services the uninsured can be expected to spend more in out-of-pocket expenditures than the insured. In addition, uninsured individuals pay the price of foregone health care in terms of the economic opportunity cost of preventable illness and disabilities that restrict work time.

We will use the MEPS-HC to quantify these relationships. Initial analysis of the 1997 MEPS-HC by the MHCC uses the Northeast Census region to proxy typical spending patterns in Maryland

[14] *Coverage Matters*. The Institute of Medicine, 2001.

[15] Health Services Cost Review Commission. "Disclosure of Hospital Financial and Statistical Information for Hospitals with Fiscal Years Ending December 31, 1999, June 30, 2000 and August 31, 2000." State of Maryland Department of Health and Mental Hygiene.

[16] The 2001 MHICS shows that 11.6% of uninsured individuals use an emergency room as their regular or most frequent source of health care, compared to 0.7% for the insured. 42.2% of the uninsured use a clinic, urgent care facility, or hospital outpatient facility as their regular source of care, compared to 13.7% of the insured.

and confirms that uninsured individuals are less likely than others to use all types of health care services. About 60% of the uninsured had contact with the health care system in the course of a year, compared to 85% of the under-65 insured population. Among those obtaining any care, median out-of-pocket health expenditures by the uninsured were about one-fifth more than for the insured.

We will supplement this analysis with the MHICS, which includes health service use and health status indicators. In the 2001 MHICS, uninsured individuals were more than twice as likely as the insured to report that their health status was either "poor" or "fair" (17.5% compared to 7.9%).

Goal 5/Task 4: Calculate Philanthropic Spending on the Uninsured
The current amount of charitable care provided to uninsured Maryland residents is unknown. We will use key informant interviews with philanthropic health care providers and social services organizations to estimate these expenditures.

Goal 5/Task 5: Calculate Costs Resulting from Inefficient Use of Health Care Resources
Although hospitals report to the state the amount spent on charity care and bad debt (uncompensated care), there are many "hidden" costs entailed in providing care for an uninsured patient, such as disproportionate use of emergency rooms as a regular source of care; avoidable conditions and hospitalizations due to lack of routine, preventive care; and discharge complications for uninsured hospital patients resulting from lack of insurance.

We will analyze the financial implications of this type of sub-optimal use of health care resources, using hospital financial and discharge databases (examining, for example, average cost per case, avoidable hospitalization rate, and severity level for insured vs. uninsured patients), and key informant interviews with philanthropic health care providers and hospital administrators.

Goal 5/Task 6: Calculate Costs of Physician Services
Only limited information currently exists concerning physician expenditures on uninsured patients.[17] Previous data indicate that, on a nationwide basis, physicians spend a greater amount on care for uninsured patients than do hospitals ($21.14 billion vs. $16.6 billion, respectively, in 1994). To address this question for Maryland, we will obtain data from the Maryland Board of Physicians Quality Assurance (BPQA), which collects information on a biannual basis from all licensed physicians in the state – including data on patients treated who paid partial or no cost due to an inability to pay related to a lack of insurance.

Anticipated Results for Goal 5/Tasks 1-6
The study of the costs related to non-insurance will provide the most comprehensive estimates of this topic currently available in the U.S. This study will serve two important purposes. First, it will provide a strong advocacy tool for promoting insurance expansion and demonstrating the economic benefits to society of such expansion. Documentation of the financing flows that are already being spent by and for the uninsured is very likely to deflect arguments that insurance coverage expansion is too expensive for society to afford.

Secondly, a detailed analysis of these costs – including payments by individuals, households, employers, providers, insurers, and government agencies at the local, state, and federal level –

[17] Cunningham, P.J. and Tu, H. T. (1997). "A Changing Picture of Uncompensated Care." *Health Affairs*, 16:4, 167-175.

will also help calculate the revenues potentially available if funds currently spent by and for the uninsured can be captured to successfully expand insurance coverage instead. For example, expansion of insurance to low-income individuals will reduce utilization of state-subsidized programs that directly provide benefits to uninsured populations. The estimates of the costs of non-insurance will feed directly into the projections of coverage and costs of insurance expansion that are detailed under Goal 4 above, and will provide a useful means for the state to carry out cost-benefit analyses of expansion options.

Goal 6: Develop Action Plan
The final goal of the SPG is to create an action plan to continue improving access to insurance coverage. This includes the development of recommendations that respond to the SPG's qualitative and quantitative findings and the identification of necessary next steps and key partners to address the recommendations.

Each of the prior goals of the proposed grant assist the state in understanding the scope of the problem of the uninsured, the barriers to existing activities designed to reduce the number of uninsured and the specific costs and impacts of new options to provide access to insurance coverage. Based on these analyses, there should be common understanding of the options to expand access to insurance and their specific costs and impacts. The final stage of the grant is to translate the findings into recommendations, which may include improving existing efforts, developing new options for expanding access to insurance coverage, or identifying areas for further study. The recommendations will be developed with input from the Health Care Coverage Workgroup.

Anticipated Results for Goal 6
The action plan will result in recommendations for improving access to insurance coverage either through strengthening existing efforts or through new options, as well as identifying areas for further study. The action plan will also result in an identification of the necessary private and public sector partners and the steps necessary to move forward on these recommendations. A report with action plan will be submitted to the Secretary of the Department of Health and Human Services.

Governance

Structure
The Maryland Department of Health and Mental Hygiene will be the lead agency for this project. A team of staff from within DHMH's Deputy Secretariat for Health Care Financing under the direction of Deputy Secretary Debbie I. Chang, M.P.H. will be responsible for general oversight and critical decision making for this project. The team will consist of Susan Milner and Alice Burton from the Office of Planning, Development and Finance and Enrique Martinez-Vidal, Linda Bartnyska and Kristin Helfer Koester from the Maryland Health Care Commission.

Ms. Milner will serve as project director for this effort. As such, she will oversee the day-to-day operation of the project and will facilitate communication and coordination between those individuals responsible for executing the project's key components. Ms. Milner, with assistance from the Office of Planning, Development and Finance's Budget Office will also be responsible for oversight of the grant funds. A similar governance structure proved very effective in the execution of the 2001 Maryland Health Insurance Coverage Survey.

The OPDF and MHCC staff team will work collaboratively to oversee the project and its various components. Since a sizeable proportion of the work involved in this proposal will be carried out by researchers from the Johns Hopkins Bloomberg School of Public Health, team members will meet weekly either by conference call or face-to-face with Laura Morlock and Hugh Waters, the two Co-Principal Hopkins Investigators to track the progress of the researchers work, to discuss and coordinate the various components of this project and to make decisions at key points during the course of the project.

The Health Care Coverage Workgroup, as discussed in an earlier section of the Project Narrative, will be the vehicle for receiving input from members of the legislature, executive branch staff, health care providers, employers, health care payers, health care consumers, researchers, key grassroots constituency groups and state agencies such as the Department of Human Resources and the Maryland Insurance Administration. A more thorough discussion of the Workgroup's role, its composition and staffing is discussed under Goals 1 and 6 of the Project Narrative.

MONITORING PLAN AND REPORT TO THE SECRETARY

Monitoring Plan

The staff team from the Office of Planning, Development and Finance (OPDF) and the Maryland Health Care Commission (MHCC) will be responsible for self-evaluating and developing a monitoring process to ensure that the goals of this project are met, the aforementioned tasks completed on the appropriate time schedule and a comprehensive, detailed report submitted to the Secretary of the Department of Health and Human Services.

OPDF and MHCC staff has the requisite skills and experience to self-evaluate and monitor the proposed project. OFPD staff, under the direction of Alice Burton, recently completed a comprehensive evaluation of Maryland's 3-year-old HealthChoice program. This effort involved both quantitative and qualitative research components, namely detailed statistical analysis of the state's HealthChoice encounter data comparing health care utilization rates from the state's primary care case management program in 1997 with HealthChoice encounter data in 2000, among other analyses, and 17 focus groups conducted with HealthChoice families throughout the state. MHCC staff has extensive expertise in program evaluation. As the lead agency for reviewing health care performance in the private insurance sector, MHCC staff routinely evaluate and monitor Maryland's HMOs, hospitals and, more recently, nursing homes and ambulatory surgical facilities.

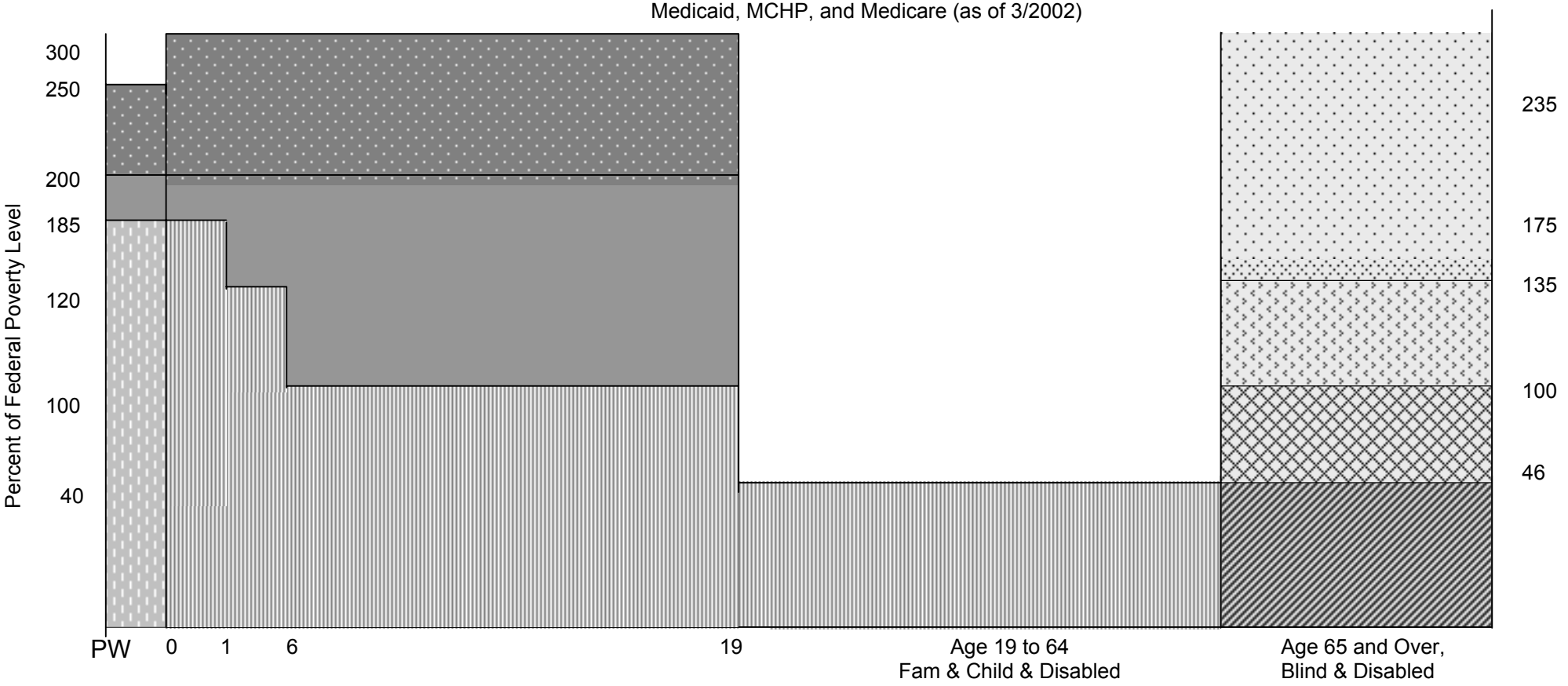
The OPDF and MHCC team will enlist technical assistance and consultant support from SHADAC and potentially other sources in developing a detailed work plan and overall project evaluation strategy. Staff will use a series of detailed work plans and budgets for each of the projects tasks, and components together with Gantt charts to assist us in managing the project, in allocating resources as efficiently as possible, and in tracking the project's progress through the attainment of various intermediate goals. At weekly meetings of the OPDF, MHCC and JHSPH team, we will review budgets against projected spending, and we will chart work plans against work performed to ensure our adherence to the projected plan, timeline and budget. Such tools and techniques proved highly effective in tracking and monitoring progress over the year-long course of OPDF's HealthChoice evaluation. Additionally, the OPDF and MHCC team will also rely on assistance from the Health Care Coverage Workgroup in evaluating and monitoring the progress of the proposed project.

Report to the Secretary
Maryland is committed to working with HRSA staff and with SPG grantees from other states to develop a universally applicable framework for the report to the Secretary to be submitted at the conclusion of the grant. Most importantly, Maryland is committed to sharing and disseminating the work that would result from this grant in order to assist and benefit other states.

As discussed in an earlier section, the contents of this report, the proposed options for expanding coverage to the uninsured and the priority given to each will reflect the deliberations and the consensus opinion of the Health Care Coverage Workgroup. The Report to the Secretary will be prepared by OPDF and MHCC staff with assistance from Johns Hopkins researchers and the consultant who facilitates the Workgroup meetings. Drafts of the report will be reviewed by the Health Care Coverage Workgroup. Once the Workgroup's revisions have been incorporated, the draft will be reviewed by the Deputy Secretary, Health Secretary and the Governor's office. Additional revisions will be made and the final report will be submitted to the Secretary of the Department of Health and Human Services on the designated date.

APPENDIX 1

Publicly Funded Coverage in Maryland
Medicaid, MCHP, and Medicare (as of 3/2002)



Pregnant Women

Medically Needy

Dual Eligible:
Medicare and Medicaid
Wrap Around

Maryland Children's Health Program

Poverty Level:
2 persons =$11,940
4 persons = $18,100

As of 3/25/02

QMB:
Part B and Cost Sharing

QI2:
Portion of Part B

Maryland Children's Health Program Expansion

SLMB +QI1:
Part B Premiums

Medicare

APPENDIX 2
OVERVIEW OF FINANCIALLY ASSISTED SERVICES IN MARYLAND
(March 2002)

Program	state Operating Budget for FY02	Eligibility Requirements	% of Federal Poverty Level or Other	# of Enrollees	% of Enrollees Uninsured or Underinsured	What is covered? Benefits?
HealthChoice	$962,603,538 (capitation payments for non-MCHP enrollees only)	Families and children receiving temporary cash assistance or enrolled in Maryland Children's Health Program (MCHP), SOBRA pregnant women and children (children born after 9/30/83, pregnant women, and infants), disabled (non-Medicare)	Approximately 50% (depends on coverage group)	438,637 (as of 12/31/01)	0%	Primary care, inpatient care, early and periodic screening, diagnosis and treatment (EPSDT) services for children, pregnancy-related care, pharmacy, lab, dental services
Maryland Childeren's Health Program (MCHP)	$119,453,320	Children ages 0-18 and pregnant women of any age	200%	95,819 (as of 12/31/01)	0%	Primary care, inpatient care, early and periodic screening, diagnosis and treatment (EPSDT) services for children, pregnancy-related care, pharmacy, lab, dental services
Maryland Children's Health Program (MCHP) Premium	$2,782,008	Children ages 0-18 and pregnant women of any age	200%- 300%	984 (as of 2/28/02)	0%	Primary care, inpatient care, early and periodic screening, diagnosis and treatment (EPSDT) services for children, pregnancy-related care, pharmacy, lab, dental services
Medicaid Fee-for-Service Program	$1,837,716,810 (includes wrap-around and other fee-for-service expenditures)	Dually eligible (Medicaid/ Medicare), institutionalized, enrollees in certain home and community-based services waivers, Family Planning program waiver, new Medicaid eligibles prior to enrollment in MCOs, short-term Medicaid eligibles	Approximately 50%	156,250 (as of 12/31/01)	0%	Primary care, inpatient care, early and periodic screening, diagnosis and treatment (EPSDT) services for children, pregnancy-related care, pharmacy, lab, dental services, personal care, institutional care, home and community-based waiver services, specialty mental health services
Family Planning Program	$2,600,000	Women of any age who lose Medicaid coverage after their pregnancy-related period of eligibility	200%	49,804 (as of 12/31/01)	N/A	Office medical visits and hospital outpatient visits for family planning services, tubal ligation, contraceptive devices and supplies, laboratory tests related to family planning

Program	state Operating Budget for FY02	Eligibility Requirements	% of Federal Poverty Level or Other	# of Enrollees	% of Enrollees Uninsured or Underinsured	What is covered? Benefits?
Women's Breast and Cervical Cancer Health Program (To be implemented April 2002)	$317,322	Women ages 40-64 years, uninsured or lacking insurance that covers cancer treatment, not eligible for another Medicaid program or Medicare, Maryland resident, have received screening and biopsy through Breast & Cervical Cancer Screening Program and/or Diagnosis & Treatment Program	250%	122 projected to be enrolled between April 1, 2002 and June 30, 2002	Majority uninsured or underinsured	Full coverage of medical services (physician, laboratory, pharmacy services, etc.), not limited to cancer treatment services.
Breast & Cervical Cancer Screening Program	$6,200,000	Low-income uninsured and underinsured women in Maryland.	250%	12,000 (as of 3/02)	84% uninsured 16% underinsured	Screening, mammography, pap test, pelvic test, clinical breast exam
Breast & Cervical Cancer Diagnosis & Treatment Program	$9,940,000	Low-income uninsured and underinsured women in Maryland.	250%	5,000 (as of 3/02)	89% uninsured 11% underinsured	Treatment and diagnosis of breast and cervical cancer (e.g. medical equipment, lab work, physician, hospital, pharmacy, home health)
MD Primary Care	$6,251,250 for client services	Chronic health condition significant enough to require a plan of care	100% and a MD Pharmacy Assistance Program Card	7,247 (as of 3/02)	100% uninsured	Primary care visits, lab, Maryland Pharmacy Assistance Program (MPAP) co-pay, substance abuse screening, diabetic equipment and supplies, simple x-ray
Children's Medical Services	$319,000	<22 years with chronic medical condition. >18 years and aged out of CHIP or parental coverage. Extension of 3 years for specific reasons. Uninsured or underinsured.	200%, or 250% with spenddown to 200%	500 (as of 3/02)	Majority uninsured	Specialty services related to chronic medical condition.
Alcohol & Drug Abuse Treatment Services	$117,149,264	Any individual presenting for services and who is determined to have an addiction(s) problem	250%	63,129 (as of 3/02)	54.1% uninsured	Multi-modality treatments for alcohol and drug abuse, including out patient, short & long term residential, pharmaco-therapy and transitional living

Program	state Operating Budget for FY02	Eligibility Requirements	% of Federal Poverty Level or Other	# of Enrollees	% of Enrollees Uninsured or Underinsured	What is covered? Benefits?
Kidney Disease Program	$8,646,979	Permanent Maryland resident; end-stage renal disease; affiliated with a certified dialysis or transplant facility	5% premium based on income>175% of FPL and/or 5% premium based on liquid assets >200% of FPL	2,250 (as of 3/02)	95%-98% qualify for Medicare; at least 50% on Medicaid	Payment for approved hospital services, renal transplantation, chronic maintenance dialysis, physicians and laboratory services required as a direct result of end-stage renal disease; medications listed on the KDP Reimbursable Drug List
Maryland Pharmacy Assistance Program (MPAP)	$58,800,000	Ineligible for Medicaid	116% or $10,300 for one person; 93% or $11,150 for two people	47,000 (as of 12/01)	35% of all MPAP enrollees are over age 65 years, therefore approximately 35% are covered by Medicare	Legend drugs used to treat chronic conditions and anti-infection drugs. $5.00 co-pay
Pharmacy Discount Program (pending approval)	$8,000,000 (if waiver is approved)	Medicare-eligible and do not have prescription drug coverage	175%	44,000 (projected)	0% (all have Medicare)	Same drugs as those covered by Medicaid
Short-Term Prescription Drug Subsidy Program	$22,000,000	Medicare-eligible and do not have prescription drug coverage	300%	26,229 (as of 2/02)	0% (all have Medicare)	All medically-necessary drugs, up to $1,000 per year
Medbank Program	$2,500,000	Determined by individual patient assistance programs sponsored by drug manufacturers	Determined by individual patient assistance programs sponsored by drug manufacturers	5,513 (as of 11/01)	Unknown	Free prescription drugs offered under patient assistance programs sponsored by drug manufacturers
Public Mental Health System	$269,090,518 (Medicaid) $57,517,831 (Uninsured/ state Only)	Uninsured or underinsured	Approximately 250%	66,343 (Medicaid) 15,702 (Uninsured)	19% uninsured	Medically necessary mental health services
Maryland AIDS Drug Assistance Program (MADAP)	$18,232,815 (all federal funds)	Ineligible for Medical Assistance or Pharmacy Assistance, HIV+, Maryland resident	400%; $35,440 for a single person	2,000 (as of 3/02)	Not tracked--Clients not eligible for Medicaid or Pharmacy Assistance, but many may be underinsured	HIV/AIDS related medications
MADAP-Plus	N/A	Ineligible for Medical Assistance, Pharmacy Assistance, or MAIAP; HIV+, Maryland resident	400%; $35,440 for a single person	115 (as of 3/02)	Not tracked—0% uninsured. Clients not eligible for Medicaid or Pharmacy Assistance, but many may be underinsured	Payment of eligible health insurance premiums (COBRA, Medigap, individual or group benefits obtained on open market, etc.)

Program	state Operating Budget for FY02	Eligibility Requirements	% of Federal Poverty Level or Other	# of Enrollees	% of Enrollees Uninsured or Underinsured	What is covered? Benefits?
MADAP –90	N/A	Ineligible for Medical Assistance or Pharmacy Assistance, HIV+, Maryland resident	400%; $35,440 for a single person	175 (as of 3/02)	Not tracked--Clients not eligible for Medicaid or Pharmacy Assistance, but many may be underinsured	HIV/AIDS related medications for a maximum of 90 days while client applies for MA or MPAP
Maryland AIDS Insurance Assistance Program (MAIAP)	$271,360 (all state funds)	HIV+, Maryland resident, unable to work due to HIV-related problems	300%; $26,580 for a single person; less than $10,000 in assets	250 (as of 3/02)	Not tracked--0% uninsured, but many may be underinsured	Payment of eligible health insurance premiums (COBRA, Medigap, individual or group benefits obtained on open market, etc.)

*Note: These numbers will fluctuate depending on enrollment.