



Health Care Reform Coordinating Council

Interim Report

July 26, 2010

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Executive Summary

Introduction

Maryland's implementation of the Patient Protection and Affordable Care Act (PPACA) offers a once-in-a-generation opportunity to make a profound impact on the health and well-being of every Marylander. If implemented well, we will have the good fortune of overseeing a transformation of our health care system, which will improve the lives of all Marylanders.

Opportunity to effect change comes with the weighty responsibility of doing it well. Thus, immediately following the enactment of PPACA, Maryland Governor Martin O'Malley created the Health Care Reform Coordinating (HCRCC) to ensure that Maryland implements federal health care reform as thoughtfully, collaboratively, and effectively as possible. Charged with the tasks of representing the major government branches and agencies that must execute reform and conducting a transparent and inclusive process to assure the meaningful input of all public and private stakeholders, the HCRCC aims to develop recommendations on the major aspects of reform implementation. Its objective is to chart a course for the state to realize the full potential of the transformative changes in our health care system either required or made possible by the new federal law.

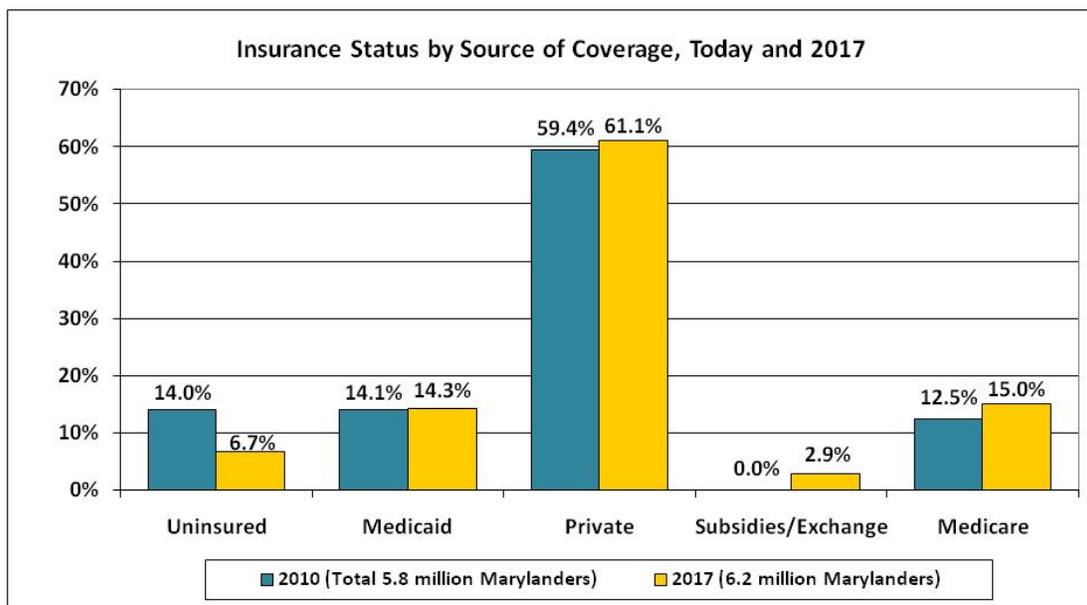
This interim report constitutes the first milestone in the HCRCC's development of a recommended blueprint for the state's implementation of the mandates and opportunities presented by federal health care reform. It sets forth the following: 1) an overview of PPACA and its general implications for reform in Maryland; 2) the role and mission of the HCRCC; 3) the opportunities and challenges presented by reform implementation and the principles by which it must be guided; 4) the state's unique health care landscape and regulatory environment against which implementation decisions must be made; 5) the projected fiscal impact of reform over the next decade; 6) the workgroup process through which the HCRCC will formulate its recommendations on the decisions most critical to our success; and 7) a timeline for planning and key activities. Along with multiple appendices that afford more detail and supporting documentation, this report provides a roadmap for the HCRCC's work over the coming months. It seeks to set the stage for seizing our opportunity—and discharging our obligation—to create a better health care system for ourselves and future generations.

Overview of Federal Health Care Reform

Federal health care reform both requires and creates potential for states to undertake fundamental changes to virtually every aspect of their health care systems. Through coverage expansions, changes in how insurance is obtained, and subsidies for individuals and employers, reform places access to health care, for the first time, within reach of everyone. The new law changes what it means to have insurance; people will actually be able to count on it when they become sick. It promotes affordability by encouraging personal and employer responsibility to ensure that everyone has insurance to help spread risk. It strengthens Medicare, makes investments in prevention and public health, and addresses racial and ethnic disparities. It establishes the means and incentives to improve many other features of health care—payment methods, long-term care, the safety net, quality and cost containment, mental health parity and access to behavioral health

care, and workforce development. In short, the expanse of PPACA's reach offers states a historic chance to make far-reaching and profound improvements in their health care delivery systems and the health status of their populations.

When PPACA is fully implemented, Maryland's uninsured rate is estimated to be cut in half. Many of the currently uninsured will get coverage in the exchange with the help of new premium subsidies. Others will receive coverage through Medicaid Expansion. Many others will age into Medicare as an increasing number of baby boomers hit age 65. Finally, many people are projected to return to employer-sponsored insurance from the ranks of the uninsured (and from the Medicaid program, which swelled during the recession), as strong job growth continues through 2017. A comparison between the current distribution of Maryland's population and the distribution after the full ramp-up of health care reform is found in the figure below.



Role and Mission of the HCRCC and the Opportunities and Challenges of Reform Implementation

In leading Maryland's implementation of federal health care reform, the HCRCC will embrace the full possibility of what it can mean for the state. The HCRCC will promote creative examination of how the federal law can best be harnessed both to preserve and enhance what has served us well, and to redesign and rebuild what has not. Of course, significant reform of any system, and particularly one as complex and multi-faceted as health care, is not easy. Meaningful reform will likely mean that both individuals and institutions will be called upon to make changes that may initially be complicated and challenging. As such, while seeking to reap the full benefits of reform, the HCRCC will carefully consider all perspectives on the pace, nature, and scope of change that should characterize Maryland's implementation. In addition, the HCRCC will give substantial weight to the potential costs and savings to be realized. Fiscal impact, although just one among many factors to consider in making choices among various

options, must figure prominently in the HCRCC's exercise of its obligations to the state and its residents.

Accordingly, in developing its recommendations, the HCRCC will be guided by several core principles and objectives. Of overarching importance will be actually making everyone healthier; transformation of health care means little if it does not ultimately improve health status and equity. The HCRCC will also seek a consumer-centric approach to both coverage and care, and will use the tools of reform to improve quality and contain costs. It will promote expanded access to affordable coverage without erosion by risk selection, and will prepare an expanded workforce to meet new demands.

Finally, the HCRCC has worked hard to establish—and will continue to refine—a process that solicits and incorporates the expertise and input of all its private and public sector partners, as well as effectively communicates its progress and the implications of reform to the public. In sum, while its task of bringing together and balancing the wide range of perspectives at stake will be difficult, the HCRCC will work with all stakeholders to enable Maryland to lead the nation in tapping the full potential of health care reform.

Foundation for Reform: Maryland's Health Care and Regulatory Environment

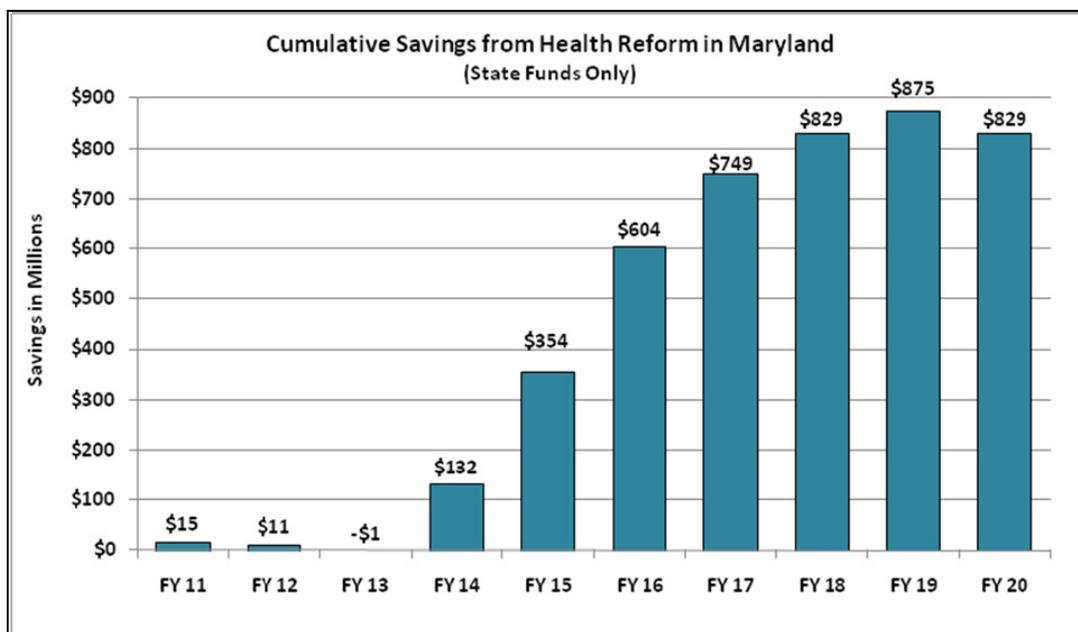
With a large share of decisions left to the states, Maryland policymakers have the flexibility and obligation to consider the state's health care and regulatory environment when evaluating choices about how to implement reform in a way that best serves Marylanders. Efforts will necessarily build on the state's long history of financing and delivery system innovations and coverage expansion. For example, in recent years, Maryland has extended coverage to over 200,000 people by expanding Medicaid eligibility for low-income adults, helping small employers offer coverage, creating a high-risk pool for individuals barred from insurance for health reasons, and making commercial insurance more accessible for young adults. In some areas, federal health care reform presents a logical extension of these and other initiatives, while in other cases, federal mandates may require rethinking existing efforts. In addition, characteristics of the state's unique hospital rate-setting system, small group and non-group insurance markets, safety net programs, and public health system must inform and provide context for decisions about how best to advance reform.

Fiscal Impact of Reform

Federal health care reform and states' implementation of its mandates will have an enormous fiscal impact on health care costs and savings in both the public and private sectors. These fiscal implications must be front and center as the state begins to make critical decisions about how to proceed with reform. Yet, current and future projections about relative costs and savings will necessarily be fluid. They may be affected by implementation choices and by how various components of the delivery system—from the insurance markets to providers and consumers—respond to reforms as they evolve. The goal of the HCRCC's financial model is to be a dynamic tool capable of facilitating projections that can be adapted and updated as data become available, conditions and factors change over time, and decisions are made by policymakers, providers, employers, and consumers.

These variables notwithstanding, health care reform will generate substantial savings to Maryland over the next ten years. The current estimate of the state’s projected savings between fiscal years (FYs) 2011 and 2020 is \$829 million, the midpoint of a projected range from \$622 million - \$1.036 billion in savings. Underlying this estimate are multiple components. Some elements, like administrative and infrastructure expenses for the enrollment process into the exchange and the Medicaid Expansion, will increase the state’s costs. Other components, like more federal assistance for children’s health insurance and increased revenue from premium assessments on insurance products, will result in substantial savings and new revenues.

The savings grow over time and peak in FY 2019. The cumulative savings level declines in FY 2020, when Maryland is projected to spend \$46 million more in that year as a result of health care reform than the state would have spent in that year in the absence of health care reform. For this reason, the state must focus on bending the cost curve early in order to improve the outlook at the end of the decade. The cumulative savings, by year, are shown in the figure below.



This favorable forecast, however, must not be permitted to weaken the state’s commitment to reduce the overall cost of health care. First, net savings begin to decline toward the end of the decade, as PPACA shifts a greater share of the financial responsibility for Medicaid Expansion to the states. Second, our health care system will soon be unsustainable, regardless of these savings, unless we succeed in improving quality while reining in the runaway growth in costs. Thus, in addition to realizing the projected savings, the state must reaffirm and strengthen its commitment to immediately begin serious and sustained efforts to bend the cost curve and align incentives toward quality, safety, and efficiency. We must expand and leverage initiatives such as increasing access to primary care through patient-centered medical homes, building a health information technology infrastructure, and reducing hospital acquired infections. Everyone—consumers, employers, providers, insurers, and taxpayers—has a stake in promoting quality and access while improving efficiencies and incentives to reduce costs.

Workgroups, Critical Decisions, and the Process for the Development of Recommendations

The importance of implementing health care reform as effectively as possible invites the temptation to tackle everything immediately; yet, the enormity of reform requires the opposite. To be effective, states must set priorities and pursue implementation in appropriate stages. Thus, the HCRCC, as well as the many public and private sector leaders and institutions involved in this effort, must focus initially on the major aspects of reform that are critical to laying the foundation for Maryland's long-term success.

The HCRCC has established workgroups open to public participation to allow for comprehensive work on these most important issues because it is imperative to get them right from the start. Addressing the full scope and complexity of these fundamental aspects of reform, the workgroups will provide a structured forum for meaningful dialogue on specific implementation issues with a diverse group of stakeholders. In addition, because the effort necessary to complete reform will go well beyond the timeframe and scope of the HCRCC's mandate, it will need to consider long-term strategies for coordinating and providing leadership for this ongoing work.

Through focused research, analysis, and evaluation of options, the workgroups will provide a summary of different perspectives on the core issues and will seek to identify and establish common areas of agreement to offer suggestions to the HCRCC. The HCRCC will then have the benefit of this comprehensive analysis and input when it formulates its recommendations to the Governor. Many decisions ultimately will require consideration and action by the Maryland General Assembly. The workgroups, therefore, will constitute the beginning of a deliberative process to craft Maryland's approach to the major issues of reform implementation.

The HCRCC has identified the following six areas that require a workgroup's focus because of their central importance to reform and the need to meet implementation timeframes. These areas of focus involve complex issues with transformative potential that are best explored and vetted through the workgroup process. They go beyond any reform initiatives already underway, and they also affect other cross-cutting implementation issues that will require input and collaboration among different agencies and branches of government.

1. Health Insurance Exchange and Insurance Markets

Maryland has never before attempted to create a state-based health insurance exchange. This workgroup must undertake a comprehensive conceptual analysis of how such an exchange should be developed in order to advance our goal of expanding access and affordability and to function in concert with the state's existing insurance markets. Many of the issues related to the health insurance exchange are fundamentally linked to how these insurance markets currently operate, and they also raise questions as to whether the structure and function of our markets should be altered in any way.

2. Entry to Coverage

Achieving the goal of reducing the number of Maryland's uninsured ultimately depends on whether individuals actually enroll in health coverage options available. Of fundamental importance, therefore, is facilitating simple and seamless entry to coverage and transition

between types of coverage. This workgroup will address design, technology, and human resources needed to establish and maintain a system that accomplishes these objectives. The group will also need to partner with other agencies with respect to funding and technology procurement.

3. Outreach and Education

Both the passage of PPACA and state implementation of its mandates have and will continue to create uncertainties on the part of all stakeholders about the future of health care. In addition, much of the success of health care reform will depend on how individuals and organizations respond to and utilize the new health care delivery system. Thus, engaging the public in health care reform implementation is essential. A critical component of the HCRCC's role must be to provide information about how reform may affect different individuals and stakeholders, and how they may participate in the implementation process.

4. Public Health, Safety Net, and Special Populations

When reform is fully implemented, more individuals will have health insurance. However, some segments of the population will remain uninsured or have some health care needs not covered by insurance. These shifts in coverage status and other changes will affect the traditional role and functions of safety net programs and the public health infrastructure. The HCRCC must engage in proactive planning to shape the future of the health care safety net and services for special populations in the wake of these changes.

5. Health Care Workforce

While more individuals will have health insurance when reform is fully implemented, their coverage will only be meaningful if they have access to health care providers able to meet their needs. PPACA creates new funding opportunities to support efforts to expand the health care workforce, and the HCRCC will fully consider how to leverage these opportunities and develop other strategies to prepare the workforce for the future. This workgroup will also partner closely with the Governor's Workforce Investment Board to identify areas best addressed through collaboration with its existing programs and initiatives.

6. Health Care Delivery System

The success of health care reform, at its most fundamental core, will depend on whether (and if so, how) the health care delivery system is transformed. It will be judged ultimately on the extent to (and the ways in) which health care delivery is altered to improve health and control costs. Maximizing the likelihood of this fundamental transformation will require focus on the key drivers of health care costs. Health care reform offers tools to achieve this goal, providing opportunities for pilots, demonstration projects, and other mechanisms to test and evaluate delivery system changes designed to improve quality and rein in costs. Maryland has already initiated several such efforts with the creation of the Maryland Health Quality and Cost Council, the effort to renew the Medicare waiver, and the ongoing development of health information technology. This delivery system workgroup will need to coordinate and work in concert with these existing efforts, identifying new opportunities and maintaining the HCRCC's focus on delivery system changes that result in improved health and reduced costs.

A number of issues integral to implementation, like long-term care reform and the promotion of health information technology, are currently being addressed by other efforts. Rather than duplicate these activities, the HCRCC intends to leverage its efforts and ensure coordination with reform. Other implementation objectives cut across all aspects of reform. These cross-cutting issues, which must be addressed in the context of each workgroup's efforts, include: considering the potential cost and savings of all options; preserving and strengthening employer-sponsored insurance; identifying sufficient data and planning resources to support efforts; developing strategies to reduce racial and ethnic disparities; integrating behavioral health and services for individuals with disabilities; creating systems to ensure accountability and compliance; considering the balance of state and local needs for infrastructure, technology, and human resources; and setting priorities and providing input with respect to grants and demonstration projects.

In some areas, the states' implementation efforts are largely dependent on federal guidance that is not yet available. A prominent example is benefit design, which must await federal regulations before it can be addressed effectively. In other areas, such as mental health parity, the HCRCC may be able to draw upon current efforts to identify consensus with which to inform and guide federal rule-making.

Timeline for Planning and Key Implementation Activities

The major elements of PPACA, including the exchanges, Medicaid Expansion, and premium credits, become effective in 2014. Meeting this deadline for most aspects of reform will require planning well before 2014, and planning efforts must begin immediately. Thus, successful implementation will require Maryland to focus on both the elements calling for immediate attention and the longer-term, transformative opportunities presented by reform.

Conclusion

The task of implementing health care reform is formidable and the stakes are high. Riding on the success of this task are the sustainability of our health care system and the well-being of all Marylanders. Yet, with the help and positive collaboration of all who care about the results (public and private sector leaders, providers, carriers, employers, producers, and consumers), we can make this happen. We can do more with less, improve quality while reducing costs, and expand access while maintaining affordability. We can finally achieve our long-awaited goal of ensuring that all Marylanders have access to the care that they need. We can realize the full promise of reform: a healthier Maryland.

Background

Overview of Health Care Reform

The Patient Protection and Affordable Care Act (PPACA) sets the stage for transformation of health care in Maryland and the rest of the United States. For the first time, access to affordable coverage will be within reach for Marylanders.

For the first time, Americans who already have insurance will be able to count on it when they become ill—no more annual caps, lifetime limits, or insurance carrier decisions to rescind individuals' existing policies. For the first time, purchasing insurance will be easier and more transparent, due to the creation of a new marketplace known as an exchange, in which both individuals and small employers will have the opportunity to shop among different policies offered by different insurance carriers. For the first time, all low-income childless adults will have access to comprehensive coverage through Medicaid. For the first time, discrimination against individuals with pre-existing conditions will be prohibited—a person's poor health status will not be considered when pricing an insurance policy. For the first time, many small businesses and Americans with modest incomes will be eligible to receive substantial tax credits to assist them in the purchase of health insurance. In short, no longer will restrictive eligibility rules, modest income, or poor health status pose an insurmountable barrier to obtaining coverage, and no longer will people wonder about the reliability of the insurance they have.

PPACA includes many other transformative features that will reshape public health and the health care delivery system, payment methods, long-term care, access to community-based supportive services, and the quality of care delivered across products, programs, and populations. Summarized below, the primary components of PPACA's reform provisions are closely intertwined, with most becoming effective in January 2014:

- *Medicaid Expansion:* All non-elderly U.S. citizens at or below 133 percent of the federal poverty level (FPL) will be eligible for Medicaid.
- *Health Insurance Exchange:* Individuals and small businesses will be able to purchase insurance through an exchange. Non-elderly citizens above 133 percent of the FPL who lack access to employer-sponsored insurance will be able to purchase coverage through the new health insurance exchange. The exchange will offer a comprehensive array of products that range from basic insurance to more expensive policies with more expansive benefits.
- *Federal Subsidies:* Individuals without access to employer sponsored insurance between 100 and 400 percent of the FPL will receive a federal subsidy on a sliding scale to buy their coverage through the exchange.
- *Small Employers:* Small employer groups will also be able to buy coverage through the exchange, and many will be eligible for federal subsidies to assist in the purchase of coverage.

- *Insurance Market Reforms*: The insurance market will operate under new rules, with guaranteed issue of coverage, no annual or lifetime caps, and no exclusions based on pre-existing conditions. Adjusted community rating rules will be utilized for both individual and small group purchasers. This means that health care premiums will be based on the average experience of a broad range of individuals, making the cost of premiums higher for some individuals and lower for others.
- *Individual Insurance Mandate*: In order to ensure that premiums are affordable, PPACA requires all individuals to either secure coverage or pay a penalty. Under health care reform, insurance market rules will change so that individuals with poor health status can now access health insurance. The individual mandate guards against the impact on health care premiums if individuals wait to buy insurance until they need health care. By encouraging personal responsibility and the participation in the insured pool of both relatively healthy and more vulnerable people, this requirement will spread the risks and costs of insurance across all individuals, as well as promote affordability.
- *Large Employer Responsibility*: PPACA also promotes large group employer-sponsored insurance by requiring that large employers either offer coverage or pay a fine.
- *Medicare*: Medicare will continue to be protected as a strong and stable insurance program for the elderly.
- *Prevention and Public Health*: In order to improve health outcomes through population-based prevention strategies, PPACA established the Prevention and Public Health Fund. This fund is a historic investment in prevention and public health programs that prevent illness and injury before they occur, resulting in lower health care costs. In addition, the Community Transformation Grant Program will provide competitive grants to reduce chronic disease rates, address health disparities, and develop a stronger evidence base of effective prevention programming.
- *Racial and Ethnic Health Equity*: Focused, data-driven federal requirements, aimed at eliminating health disparities, will provide the basis for significant improvement in efforts to reduce and eliminate the persistent racial/ethnic gap in infant mortality, chronic diseases, and infectious diseases.
- *Primary Care Infrastructure*: PPACA also provides the opportunity for serious investment in training programs to increase the number of primary care doctors, nurses, and other public health care professionals in an effort to improve access to affordable health care. Other funding opportunities include the establishment of a public health workforce loan repayment program, training for mid-career professionals in public health or allied health, expanded public health fellowship training opportunities, and training for general, pediatric, and public health dentistry.

Making all of this work to realize the full potential of reform poses significant challenges for Maryland. We must ensure coordination of access to coverage. We must also expand and maintain a robust health care workforce with provider capacity sufficient enough to serve the population and meet increasing demands. The exchange must be well-designed, with governance

rules and a structure that are suited to competition, choice, flexibility, and adaptability as the health insurance market evolves. We must also ensure that the cost of insurance is kept within a reasonable and affordable rate of growth over time. Although challenging, all of these goals are achievable, and Maryland is well-positioned to be a national leader in making them happen. Yet to assure optimal implementation, we will need a coordinated and sustained effort across all levels of government and the private sector. The Health Care Reform Coordinating Council (HCRCC) is focused on leading this effort to make health care reform in Maryland a success.

The Role of HCRCC

PPACA was signed into law by President Obama on March 23, 2010. The next day, Maryland Governor Martin O'Malley signed Executive Order 01.01.02010.07, creating the HCRCC¹ to coordinate Maryland's response to PPACA. The objective of the Executive Order and the HCRCC is to ensure that the state implements federal health care reform thoughtfully and thoroughly, with careful deliberation and collaboration across agencies and all branches of government, and with meaningful participation of the health care community and other private sector stakeholders.

The significance and breadth of health care reform in Maryland is reflected in the composition of the HCRCC. Led by Lt. Governor Anthony Brown and Secretary John Colmers of the Maryland Department of Health and Mental Hygiene (DHMH), the twelve-member HCRCC includes leadership from all of Maryland's executive health agencies, budget and management, and the Governor's office; chairs and leading members of the health committees in both the Senate and House; and the Attorney General.

The Executive Order created the HCRCC as the primary body in Maryland charged with coordinating state government activity in implementing PPACA. The HCRCC is directed to identify and present a series of recommendations on the issues and decisions that are critical to the successful implementation of health care reform in Maryland. To fulfill this mandate, the HCRCC must submit both this interim report and a final report by January 1, 2011. This interim report includes a presentation of the key milestones and a timeline for reform; the critical decisions that will require recommendations in the final report; a financial model for an ongoing estimate of the state's projected costs and savings through 2020; and a section-by-section summary of PPACA.

The HCRCC's mission is to implement health care reform effectively to improve access, quality, and affordability of health care for all Marylanders. Thus, its focus includes the people seeking insurance, the companies offering coverage, the producers/third-party administrators facilitating its purchase, the providers delivering services, and the businesses securing insurance on behalf of their employees. The HCRCC must also seek to build capacity in the workforce, protect the state's safety net, and represent the interests of public and private sector stakeholders who are

¹ The Executive Order is Appendix A to this report.

essential to the state's long-term health. As such, the HCRCC recognizes the need to be transparent and inclusive in its work and welcome assistance and input from all stakeholders.

In conducting all of this work, the HCRCC will factor the potential costs and savings to the state into its recommendations. While fiscal impact is not the only factor to consider in making choices among various options, it is an important one that figures prominently in the HCRCC members' cognizance of their obligations to the state and its residents.

Opportunity for Reform Implementation and Challenges in Maryland

Health care reform presents a historic opportunity in Maryland. The state's implementation of PPACA has the potential to enhance public health, reduce racial and ethnic health disparities, promote parity and increased access to behavioral health care, and improve Maryland's overall health care delivery system.

To ensure that this window of opportunity is not wasted, implementation cannot focus simply on those tasks minimally necessary to comply with the new federal law. Rather, efforts must embrace the full possibility of what reform can bring to Maryland. Policymakers must examine and think creatively about how the federal law can best be harnessed to preserve what has worked well for its residents and redesign and rebuild what has not. Recommendations should resist being bound by historic regulatory frameworks and should instead consider new paradigms for those components of our health care delivery system that have fallen short.

Meaningful reform of any system, let alone one as complex and multi-faceted as the health care delivery system, is not easy. Realizing the tremendous opportunities offered by national reform will require, in some instances, that individuals and organizations in both the public and private sectors embrace significant change. Yet, as HCRCC members are acutely aware, individual and institutional change is complicated and difficult, and it may be resisted or delayed for quite legitimate reasons. Thus, in formulating its recommendations, the HCRCC must be particularly careful to consider all viewpoints on the pace, nature, and scope of change that should characterize Maryland's implementation of health care reform.

Achieving meaningful reform will require significant technical resources from individuals in state government and in the private sector. There are realistic limitations in the amount of change that happen simultaneously, and effective implementation requires a focus on the major issues that lay the groundwork for Maryland's long-term success.

To achieve all of these goals, the HCRCC has adopted, as an operating principle,² that its recommendations be guided by the following: critical objectives of promoting positive health outcomes; expanding access; improving quality, equity, and administrative efficiency; fostering workforce development; and containing the rate of growth in public and private sector health financing.

² Appendix C contains a complete list of the HCRCC's Operating Principles.

Thus, the HCRCC's approach to implementation must:

- **Serve the overarching goal of improving the health of all Marylanders, with particular focus on health equity.** Efforts to institute delivery system changes and payment reforms, increase access to coverage, and ensure that coverage assures access to care will mean little if they do not result in actual improvements in the health status of all Maryland residents.
- **Develop a consumer-centric approach to both coverage and care.** Reform provides an opportunity to break down the silos that have long existed between commercial and public coverage and between different programs and systems of care. For example, providing access to coverage through the exchange will not succeed unless individuals moving between its commercial products and the publicly financed products in Medicaid experience a seamless transition between enrollment and eligibility determinations, insurance carriers, and health care providers.
- **Use the tools provided by reform to improve quality and contain costs.** Our health care system will soon be unsustainable unless we succeed in improving quality and containing costs. Health care reform provides opportunities to test new ideas and approaches to achieve these goals. Maryland is well-positioned to be a national leader in these innovations because of initiatives already underway in the public and private sectors, the state's unique rate setting system, and the state's longstanding commitment to building data and analytic resources and relying on them for decision making. Maryland can and should build on these efforts by identifying and maximizing opportunities for consumers, providers, payers, and government to adopt evidence-based prevention and wellness practices to reduce costs, improve health outcomes, manage chronic and infectious diseases, and attenuate health conditions that represent significant cost drivers.
- **Think broadly and creatively about strategies to promote access to affordable coverage and mitigate risk selection.** PPACA will both require and provide opportunity for changes in the health insurance marketplace that will bring coverage to individuals. The viability of the market and how well it adapts to these changes will depend on the availability of affordable products for all consumers—from the relatively healthy to those with greater health care needs. PPACA's mandate that all individuals obtain and maintain coverage and the federal penalties for failure to do so will not be effective if premiums are not affordable.
- **Prepare and expand the health care workforce to meet new demands.** The benefits of reform and the expansion of coverage require a health care workforce adequate to meet the needs of the population. Efforts to expand and maintain a robust workforce must therefore be a central focus of implementation.
- **Lead the nation in tapping the full potential of reform to improve health.** Maryland is fortunate enough to have a number of strengths in our health care system that position us well to maximize the opportunities that this reform presents. Maryland should aspire to test new approaches and share the experiences and lessons from our implementation efforts to improve health nationally.

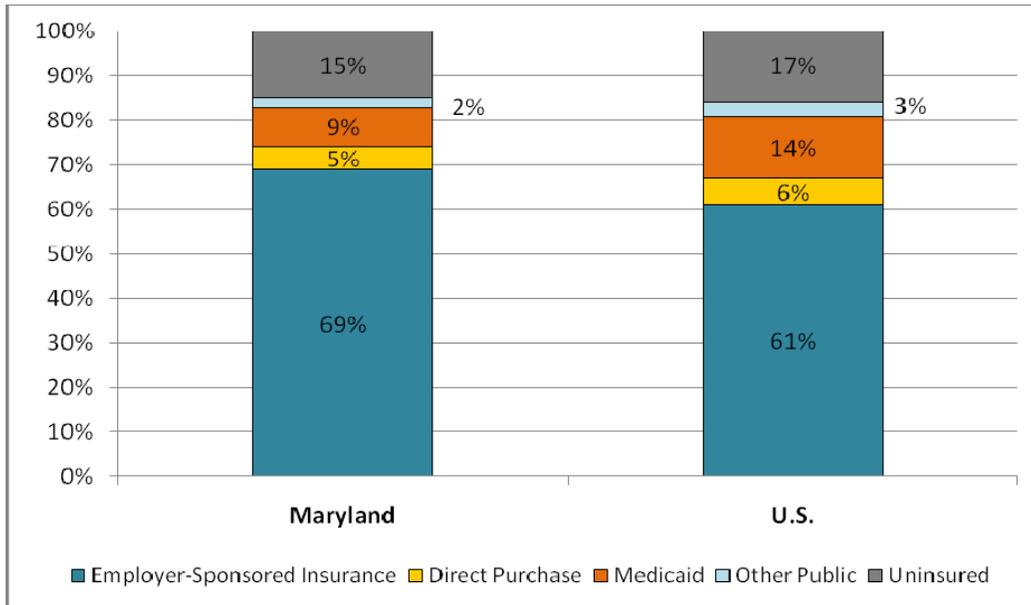
Realizing the full potential of health care reform will not be easy. With significant technical and operational challenges ahead, it will be daunting to 1) bring together and balance the wide range of perspectives and interests at stake and 2) effectively communicate changes to the general public. However, with the help of all its public and private sector partners, Maryland is poised to achieve historic reforms that will create a vastly better health system for future generations.

Foundation for Reform Implementation in Maryland

Federal health care reform leaves numerous implementation decisions to states. Accordingly, Maryland policymakers have the flexibility and obligation to consider the state's unique health care landscape and regulatory environment when evaluating choices about how to implement reform in a way that best serves Marylanders. In doing so, they are not starting from scratch. Rather, current reform efforts will build on the state's long and unique history of coverage expansion and financing and delivery system innovations. For example, in recent years, Maryland has extended coverage to 200,000 or more Marylanders by expanding Medicaid eligibility for adults with low income, helping small employers offer coverage, creating a high-risk pool for individuals unable to secure insurance because of their health conditions, and improving access to commercial insurance for young adults. In some areas, federal health care reform presents a logical extension of these and other current policy initiatives, while in other cases, federal mandates may require rethinking the existing efforts. In any event, policymakers will need to determine how best to implement federal health care reform in the context of Maryland's unique health care and regulatory environment.

Status of Coverage and the Uninsured in Maryland: Over 700,000 people in the state remain uninsured, representing 15 percent of non-elderly Marylanders. The state's uninsured rate is in the mid-range, slightly lower than the national average of 17 percent. See Figure 1, below. Maryland is a relatively wealthy state with a higher percentage of individuals covered through their employers than the national average; only four states have higher rates of employer-sponsored coverage. A little over half (58 percent) of all private sector employers in Maryland offer health insurance, which is slightly higher than the national average. Offer rates vary significantly by firm size, but with less than 40 percent of firms with fewer than 10 employees now offering insurance, the offer rate among the smallest employers is down from prior years.

Figure 1. Health Insurance Coverage of Non-Elderly, 2006-2007



Source: MHCC, *Health Insurance Coverage in Maryland through 2007*, January 2009.

Maryland’s Insurance Market: Federal health care reform makes a number of changes to the ways in which states regulate their health insurance markets. These changes, however, will affect only about one-third of the private health insurance market that is actually subject to state regulation. The remaining two-thirds is covered by large self-insured plans exempt from state regulation by the federal law known as the Employee Retirement Income Security Act of 1974 (ERISA).

Maryland’s regulated health insurance sector is divided into the large, small and non-group markets, all of which are highly concentrated and dominated by one carrier. Although seven insurance carriers operate in the non-group market, CareFirst has over 80 percent of the market. Similarly, eight insurance carriers offer coverage in the small group market, but CareFirst accounts for over 75 percent of that market.³

Maryland’s Small Group Market Reforms: In 1993, Maryland sought to improve small employers’ access to insurance by enacting certain reforms to the small group market, which is composed of employer groups of 2 to 50 employees. It created a minimum level of coverage, the Comprehensive Standard Health Benefit Plan (CSHBP), which requires all insurance carriers to offer the same benefits to all small employers. It also established standardized cost sharing for different products. The Maryland Health Care Commission (MHCC) may annually update and modify the CSHBP so that the average cost does not exceed 10 percent of Maryland’s average annual wage. Employers can add benefits by purchasing riders, but they may not reduce benefits.

³ Maryland Insurance Administration. (2009). *2009 health benefit plan report*.

The vast majority of small employers choose to purchase riders, which results in a wide variety of cost-sharing arrangements across employer-sponsored plans, despite the uniformity of the basic CSHBP rules.

Another key characteristic of Maryland's small group market is that all plans must be offered on a guaranteed issue and guaranteed renewal basis and are subject to modified community rating. Modified community rating limits the factors that insurance carriers may consider when they price insurance policies; thus, it reduces variation in how much small businesses pay for health insurance. This provision makes it possible for a small employer with a sick employee, or a group of sick employees, to nevertheless purchase insurance because insurance carriers cannot price policies based on a given small employer's history of health care costs. Since 2009, though, insurance carriers have been allowed to impose pre-existing condition limitations or exclusions for individuals who are new to the small group market or who had previously been uninsured. As of July 2010, insurance carriers are also able to adjust premiums based on health status for new small businesses purchasing coverage.

Premium Assistance for Small Businesses: In 2007, Maryland created the Maryland Health Insurance Partnership to help very small low-wage businesses offer health insurance to their employees. For qualifying businesses who have not previously offered insurance, the Maryland Partnership will pay up to half the cost of health insurance. As of June 2010, the Partnership had enrolled 250 businesses and about 1,200 individuals, which is below the initial projection in part because of the country's economic downturn. The federal health care reform's small business tax credit shares many features of the Partnership but is available to more small employers, including those currently offering insurance and those with more than 10 employees.

Maryland's Non-Group Market: Maryland's non-group (or individual) market is very different from the small group market and covers about 160,000 individuals. This is a smaller percentage of the insured population than the individual market comprises in most other states. Unlike in the small group market, insurance carriers are allowed to medically underwrite products sold in the individual market (i.e., base the price on a person's health status or exclude sick people altogether). Thus, applicants may be charged higher premiums based on age or health status, have limitations placed on their coverage, or be denied coverage in the individual market. Although underwriting practices limit coverage to many, they also serve to keep premium rates down in this market, especially for younger, healthier individuals. Moreover, a relatively large number of high-deductible plans with skinny benefit designs are offered and purchased in the individual market (as compared to the group market), which also helps keep premiums down. Finally, although a number of coverage mandates apply in the non-group market, insurance carriers are not required to offer any standard plan like the CSHBP.

Maryland's High-Risk Pool: For individuals denied coverage in the non-group market on the basis of health status, Maryland has operated a high-risk pool since 2003 called the Maryland Health Insurance Plan (MHIP). Through MHIP, individuals can access subsidized coverage even if they are "uninsurable" (unable to secure coverage based on health status) in the individual market. Administered on behalf of MHIP by CareFirst, and now the third largest high-risk pool in the country (out of 34 nationwide) and the country's fastest growing, MHIP enrolls over 18,000 individuals and is about 10 percent of Maryland's individual commercial market.

MHIP enrollees typically pay a higher premium to purchase insurance through MHIP than the “average” premium in the individual market (which is medically underwritten, as described above). The higher MHIP premium partially reflects the fact that the composition of the MHIP risk pool is sicker than the pool of generally healthier people able to obtain coverage in the individual market. Since 2005, MHIP has also offered an “MHIP +” plan that provides further subsidies to low- and moderate-income individuals to enable them to buy coverage. Eligibility for subsidies in MHIP Plus is available to people up to 300 percent of the FPL. MHIP receives the funding to subsidize premiums for all MHIP plans (MHIP and MHIP Plus) through an assessment applied to all hospital rates in the state. The hospital assessment generated approximately \$114 million for MHIP in the most recent year; this constitutes about 62 percent of MHIP’s overall funding.

Large Group Market: About two-thirds of Marylanders with commercial health coverage are enrolled with self-funded plans that fall outside state insurance regulatory oversight. Some businesses choose to self-insure even though they are relatively small. About 943,000 individuals are covered through insured products in the large group market, and they are served by six carriers. In 2009, CareFirst had about half of the market share.

PPACA will give states the option of expanding access to their exchanges to groups of 50 to 100 employees earlier than the federal implementation deadline for this expansion in 2016. States will also need to decide whether to allow large employers (more than 100 employees) to purchase coverage through the exchange in future years. These options and enhanced federal oversight of self-insured plans may have implications in health care reform implementation.

Market Implications for Reform: The characteristics of Maryland’s small and non-group markets and high-risk pool have potential implications for federal health care reform. Effective January 2014, insurance carriers that sell products within the exchange will be required to enroll all individuals seeking coverage in at least a basic benefit package, without application of underwriting rules. MHIP will be phased out, as a state-run high-risk pool is no longer needed. Depending on how Maryland chooses to implement other components of reform, the changes in current non-group underwriting practices and the elimination of the high-risk pool may increase premiums for the younger and healthier individuals presently covered in the individual market. Policymakers must assess strategies to address this potential disruption.

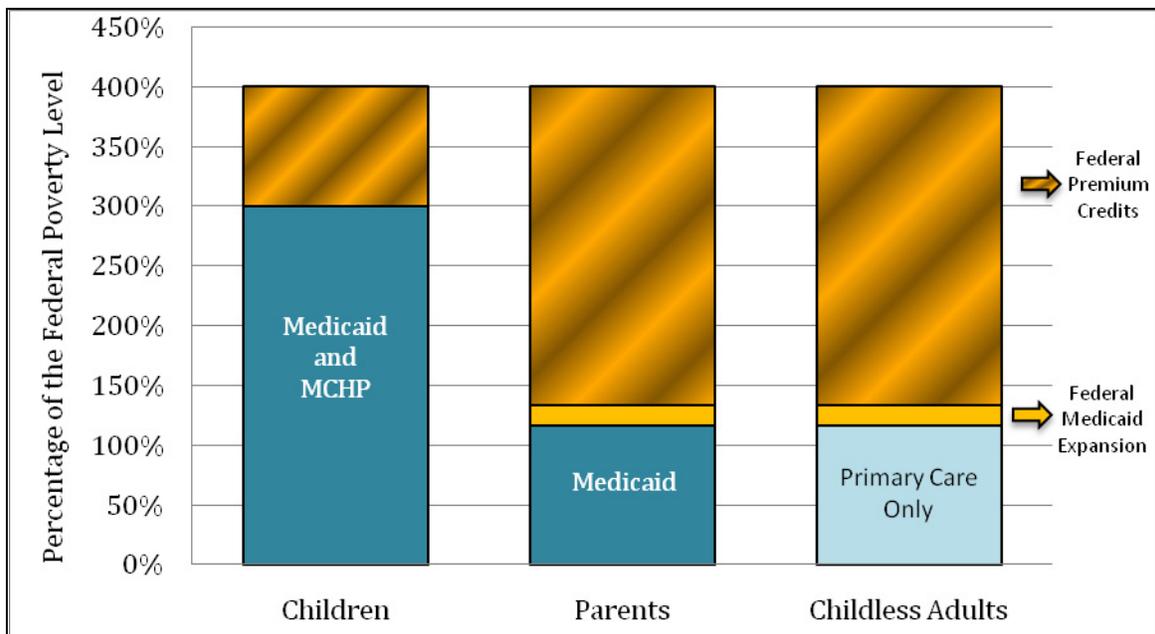
Coverage for Young Adults: In 2008, Maryland became one of several states to help young adults maintain health insurance. The new state law expanded the definition of dependents to include adults up to age 25, allowing young adults to remain on their parents’ insurance policies as dependents. Federal health care reform expands the definition of dependents by one year—to age 26—and makes other changes that increase the number of young adults who may benefit from this change.

Public Coverage—Medicaid, Maryland Children’s Health Insurance Program, and Primary Adult Care: No later than January 2014, federal health care reform requires states to expand coverage to more adults with low incomes. This expansion will end the categorical nature of Medicaid. Historically, Medicaid coverage has been limited to specific categories of people, such as children, pregnant women, parents of minor or dependent children (below certain poverty

levels), individuals with permanent disabilities, and the elderly. In 2007, Maryland began its own effort to implement a phased-in expansion of Medicaid coverage to all low-income adults. First, it extended eligibility to parents with incomes up to 116 percent of the FPL. This expanded coverage to over 65,000 adults in two years, and moved Maryland from one of the most restrictive eligibility states to one of 17 states that provide Medicaid coverage to low-income parents above 100 percent of the FPL (\$18,000 for a family of three). Second, Maryland began a phased-in expansion of coverage to low-income childless adults to be implemented over several years by progressively adding benefits to the existing Primary Adult Care (PAC) program. The new coverage levels for adults required under federal health care reform (i.e., coverage up to 133 percent of the FPL) are similar to those targeted by a full phase-in of the state’s 2007 expansion.

From the onset of the states’ Children’s Health Insurance Program (CHIP) in 1997, Maryland has been a leader in coverage levels for children. Maryland’s program, MCHP, provides comprehensive health insurance coverage to children in families with incomes up to 300 percent of the FPL (or \$55,000 for a family of three). Maryland is one of only five states with comprehensive coverage at this level. In recent years, a few states have expanded CHIP eligibility to all income levels, essentially allowing higher-income families to buy into the program at full cost. Federal health care reform will require states to maintain their current coverage levels for children for which they will receive enhanced matching funds. The full depiction of the change from current eligibility levels and programs to the new Medicaid eligibility levels, and the new options available for subsidized insurance up to 400 percent of the FPL, is found in Figure 2.

Figure 2: Public Coverage, Today and 2014



Maryland’s Rate Setting System: In addition to many health insurance coverage initiatives, Maryland has a unique system for financing hospital uncompensated care. The hospital rate setting system finances over \$1 billion in uncompensated care annually to Maryland hospitals,

spreading the cost of the uninsured among all payers. The rate setting system has also been used to finance policy initiatives that reduce the amount of uncompensated care, including Maryland's high-risk pool and recent Medicaid expansions. Most significantly, the all-payer system has generated significant savings in hospital costs over its 33-year history.

Maryland's Safety Net Programs: A number of programs and initiatives also provide a safety net of coverage for the state's uninsured and underinsured. For example, Maryland has 16 Federally Qualified Health Centers (FQHCs) with over 60 sites. PPACA provides new funding for FQHCs, although, historically, Maryland has not been competitive in obtaining funding for FQHCs because of its relative wealth. The state also has almost 70 school-based health centers serving Maryland's uninsured families, and health care reform also offers new funding opportunities for these centers. These safety net providers are an important source of care for individuals both with and without insurance.

In some jurisdictions, local health departments provide direct care services or arrange for clinical safety net services such as primary, prenatal, dental, and home health care. All local health departments provide or facilitate immunizations, family planning, cancer screening, screening and treatment for certain infectious diseases, and outbreak investigation and control. Networks of other programs also contribute to the safety net, including Maryland's public mental health system, substance abuse treatment services provided through local jurisdictions, the Breast and Cervical Cancer Program, the Ryan White-funded HIV service delivery system, and the Kidney Disease Program.

Maryland's Public Health System: In addition to the safety net providers that address gaps in services to meet the needs of special and underserved groups, Maryland has a strong state and local public health infrastructure that focuses on delivering population-based public health services and health promotion programs. The system not only has essential surveillance and laboratory capacities, but is also strengthened by effective linkages with academic resources (such as Johns Hopkins University, Morgan State University, and the University of Maryland) and by its organizational co-location within DHMH along with the behavioral health and Medicaid units.

These structural public health assets have produced numerous health gains, including notably high childhood immunization rates and major reductions in smoking, cancer deaths, adolescent pregnancy, and lead poisoning. Yet, largely due to the state's demographics, and consistent with national trends, there remain unresolved public health challenges in Maryland—notably, infant mortality, obesity, substance abuse, HIV/AIDS, and chronic diseases.

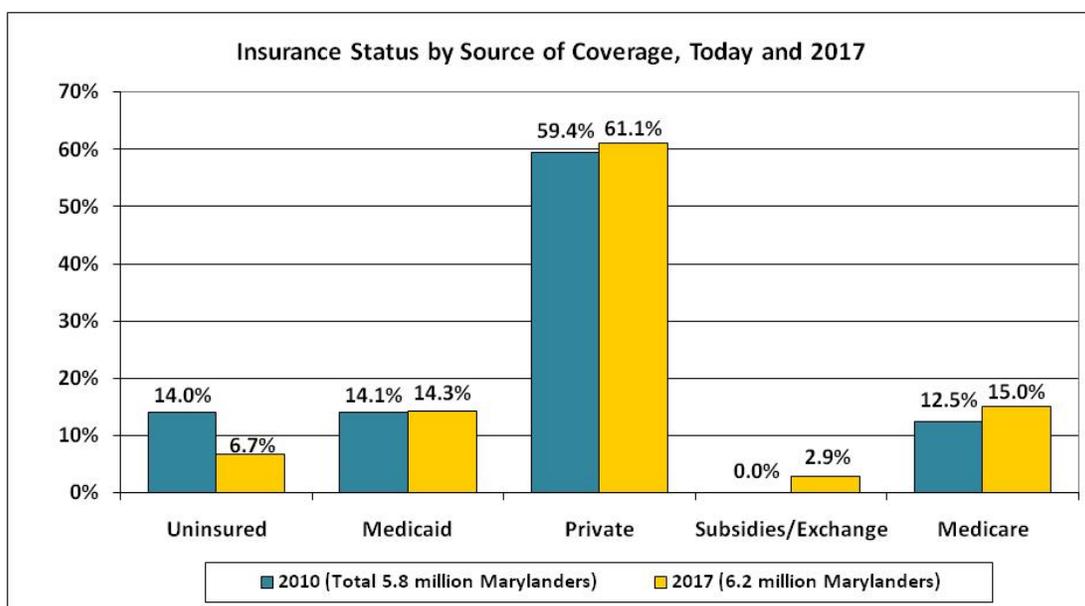
Fiscal Implications of Health Care Reform in Maryland

Federal health care reform and states' implementation of its mandates will have an enormous fiscal impact on health care costs and savings in both the public and private sectors. For that reason, the Executive Order directed the HCRCC to develop a financial modeling tool to estimate the impact of health care reform on the state budget. Any current and future projections about relative costs and savings necessarily will be fluid and dependent on the various choices and decisions states make in implementing reform, as well as how various components of the

delivery system—from the insurance markets to providers and consumers—respond to the reforms as they evolve. The goal of the financial modeling tool, therefore, is to be dynamic in order to make projections that can be adapted and updated as data become available, as conditions and factors change over time, and as decisions are made by policymakers, employers, and consumers.

Health care reform will result in more Marylanders with health insurance. Currently, about 14.0 percent of Marylanders are uninsured; by 2017, this rate is expected to decline to about 6.7 percent. As Figure 3 illustrates, by 2017, currently uninsured individuals will be covered with the help of premium subsidies, through Medicaid, through Medicare as more baby boomers hit age 65, and through employer-sponsored insurance as strong job growth continues through 2017. Estimates of these changes underlie many assumptions in the financial modeling tool.

Figure 3. Insurance Status by Coverage



The financial modeling tool focuses on the new costs, savings, and revenues that are related to health care reform. As a result, the financial modeling tool compares the new costs, savings, and revenues to a baseline assumption of what those costs, savings, and revenues would have been, in the absence of health care reform. It is important to keep this in mind, because the tool does not attempt to address the state’s overall budget picture related to the health programs described in the financial modeling tool, but rather to identify how health care reform might change the financial picture for the state.

With that in mind, estimates of the savings Maryland can expect in its budget from health care reform between fiscal year (FY) 2011 and FY 2020 range from \$622 million - \$1.036 billion. The midpoint estimate of savings in that period is \$829 million.⁴ Underlying this estimate are

⁴ The detailed Financial Model is found as Appendix F to this report.

several components—some that will increase the state’s costs and others that are projected to generate substantial savings and new revenues.

Health care reform will affect many other state-funded programs and funding streams. The full details underlying the financial model are found in Appendix F, along with a detailed description of the data sources and methods utilized to generate the projections. When using this model, it is important to keep in mind the following cautionary notes:

- The model is a living tool that will be updated over time as actual data replace projections.
- The model is also subject to modification in another crucial respect: many decisions have yet to be made. Once these decisions are made, the financial forecast will need to be adjusted to reflect and conform to these decisions. Thus, the model must be understood as a dynamic tool rather than as a static and fixed guarantee.
- The financial modeling tool deliberately was designed to conservatively estimate savings. For example, the financial modeling tool does not include projected savings to Medicaid (as a payer) as the portion of uncompensated care built into hospital rates declines once more people have coverage. As another example of a conservative assumption, the tool does not include potential federal grants that might address certain infrastructure-building needs (e.g. the preparation for the exchange); these start-up infrastructure costs are included in the financial modeling tool as state costs.
- While health care reform is expected to generate substantial savings to Maryland over the next ten years, the overall savings decline toward the end of the decade, as the federal law shifts more of the financial burden for Medicaid Expansion to the states, including Maryland. Thus, even though the forecast is favorable, the state must not lose—but rather reaffirm and strengthen—its commitment to reduce the cost of health care.
- The financial modeling tool does not address the ongoing short-term challenges in Maryland’s budget related to the growth in Medicaid enrollment and other factors. Because these factors are independent of health care reform, and are not an implication of health care reform itself, they are omitted from the modeling tool. Nevertheless, the short-term budget challenges are real, and should not be overlooked by the longer-term savings projected in this analysis.

Areas of expected cost increases include:

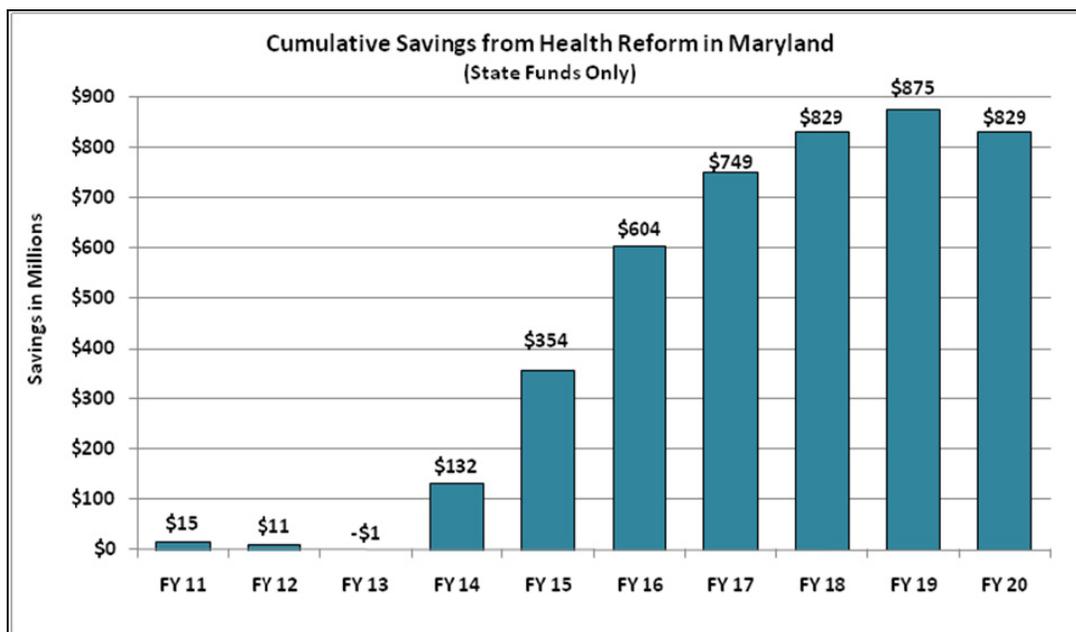
- Medicaid, due to the significant expansion in coverage, especially for low-income childless adults.
- State employee/retiree health insurance, as the state, in its capacity as employer, extends the new consumer protections in the insurance market to its employees and retirees.
- Administrative functions and infrastructure costs dependent on implementation, including development and administration of new eligibility systems, the expanded Medicaid program, and the new insurance exchange.

Areas of expected savings and new revenue include:

- MCHP, in which the federal government will bear a greater share of the cost.
- Newly available hospital assessment revenue, which will no longer be needed to subsidize MHIP after it is phased out in 2014 when the exchange and coverage expansions go into effect.
- Increased revenue from existing premium assessments on insurance products, as coverage expands and more products in Medicaid and the exchange become subject to this assessment.
- A partial reduction in direct state funding for safety net programs. Once the number of insured Marylanders increases, with people who formerly relied on the public safety net instead having access to coverage, the safety net programs are expected to experience reduced demand for direct state subsidies. However, even though the demands on the public safety net are expected to decline, the financial model retains significant financing for these programs.

As depicted in Figure 4, the financial model projects a decline in the rate of savings after FY 2016 and a net cost increase in FY 2020.

Figure 4. Cumulative Savings



Because of the declining savings at the end of the decade, it is essential to immediately begin serious and sustained efforts to bend the cost curve and align incentives toward quality, safety, and efficiency. Everyone—consumers, employers, providers, insurers, and taxpayers—has a stake in promoting quality and access while improving efficiencies and incentives to reduce costs. Even modest reductions in the rate of growth if sustained over a long period of time can

have a substantial impact on affordability. Capitalizing on these opportunities will result in even greater savings than the financial model currently projects and will protect Maryland from declining surpluses at the end of the decade.

Workgroups, Critical Decisions, and the Process for the Development of Recommendations

PPACA, with its new federal statute spanning access, quality, and costs, affects virtually every aspect of our health system. It addresses changes for the commercial insurance market, public programs, the public health infrastructure, safety net programs, and workforce development. Implementing this far-reaching reform in Maryland will involve the work and leadership of many state and local agencies, the General Assembly, leaders from private sector institutions and organizations, and the general public. The HCRCC's challenge is to coordinate these efforts under a shared vision of realizing the full potential of reform.

The importance of implementing health care reform as effectively as possible invites the temptation to address all of the innumerable and detailed aspects of PPACA at once. However, the enormity of health care reform and its aggressive timelines require the opposite. To be effective, states must set priorities and pursue implementation in appropriate stages. Thus, the HCRCC's role must be to focus initially on the major aspects of reform that are critical to laying the foundation for Maryland's long-term success. We must first address the core issues that are imperative to get reform right.

This interim report outlines the HCRCC's work plan over the next six months, but the effort necessary to complete reform implementation will go well beyond the timeframe and scope of this mandate. In the coming months, the HCRCC will need to consider long-term strategies for coordinating and providing leadership for this ongoing work. Maryland's implementation of reform will not reach its full potential without robust oversight, leadership, and systems that hold accountable all the public and private individuals and institutions who have a stake in this effort.

Workgroup Process

As directed by the Executive Order, the HCRCC will create workgroups to allow for comprehensive work on the most important, core issues that will be central to the short- and long-term success of Maryland's reform implementation. These workgroups will address the full scope and complexity of these major aspects of reform—many of which will require further research. In these meetings, various options will be analyzed and reviewed, detailed deliberations will be encouraged, and common areas of agreement will be identified. HCRCC members or state government designees will lead the workgroups and promote active participation from members of the public. The workgroup process will provide a structured forum for meaningful dialogue on specific implementation issues, with a diverse group of stakeholders from both the public and private sectors.

Through focused and detailed research, analysis, discussion, and evaluation of options, the workgroups will provide a summary of different perspectives on the core issues and will seek to identify and establish common areas in which to offer suggestions to the HCRCC. The HCRCC

will then have the benefit of this comprehensive analysis and input when it formulates its recommendations to Governor O'Malley. Many decisions ultimately will require consideration and action by the Maryland General Assembly. The workgroups, therefore, will constitute the beginning of a deliberative process to craft Maryland's approach to the major issues of reform implementation.

Although the workgroups will be broadly charged to address high-level implementation issues because their efforts must focus initially on the big picture of reform, a number of more detailed implementation decisions will naturally evolve from the process and should also be considered by the workgroups. Indeed, the work plans of these groups are expected to evolve as they are informed by the activities of other workgroups and by other developments that could support their efforts.

The HCRCC has identified six areas that require the focus of a workgroup because of their central importance to reform and the need to meet implementation timeframes. These subject matter areas involve complex issues with significant and transformative potential that are best discussed and vetted through the workgroup process. They go beyond any reform initiatives already underway, and they also affect other cross-cutting implementation issues that will require input and collaboration among different agencies and branches of government. These focus areas are:

1. Health Insurance Exchange and Insurance Markets

Maryland has never before attempted to create a state-based health insurance exchange. This workgroup must begin with a comprehensive conceptual analysis of how such an exchange could and should be developed in order to advance our goal of expanding access and affordability and to function in concert with the state's existing insurance markets. Many of the issues related to the health insurance exchange are fundamentally linked to how these insurance markets currently operate, and they also raise questions as to whether the structure and function of our markets should be altered in any way.

Critical questions this group should address include: What are the state's goals for an exchange and what will its functions be? How should the exchange be structured to achieve its goals? To what extent will the establishment of an exchange either necessitate or provide opportunity for transforming the current health insurance market? What policy changes should be considered to promote affordability and mitigate risk selection? How can we ensure that an exchange will facilitate seamless transitions between commercial and public insurance coverage?

2. Entry to Coverage

Achieving the goal of reducing the number of Maryland's uninsured ultimately depends on whether individuals actually enroll in the health coverage options available, which include private insurance, public coverage programs, and subsidized products offered through the exchange. Fundamental to the goal of reducing Maryland's uninsured, therefore, is facilitating simple and seamless entry to coverage and transition between types of coverage. This workgroup will address the technology and human resources needed to establish and

maintain a system that accomplishes these objectives. The group will also need to partner with the other agencies over issues related to funding and technology procurement.

Critical questions this group should address include: How should Maryland design its approach to facilitating consumers' entry into coverage? How should Maryland simplify and integrate enrollment practices to promote coverage to the fullest extent possible? What policies, operating practices, and system changes should be adopted to maximize access to coverage? To what extent does Maryland want to transition from long-standing enrollment practices designed for income-related coverage to embrace a new paradigm that would help minimize barriers to entry into coverage?

3. Outreach and Education

Both the enactment of PPACA itself and the states' implementation of its mandates have and will continue to create some uncertainties on the part of all stakeholders about the future of health care. In addition, much of the success of health care reform will depend on how individuals and organizations respond to and utilize the new health care delivery system. The HCRCC believes, therefore, that engaging the public in health care reform implementation is essential. A critical component of its role must be to provide information about how reform may affect different individuals and stakeholders, and how they may participate in the implementation process.

Critical questions this group should address include: How should the state communicate to various constituencies the significant changes that will occur as health care reform unfolds at both the federal and state level? What type of plan for a coordinated and comprehensive outreach and education strategy should be developed to meet the needs of different groups, including consumers, providers, insurers, employers, and others? How will Maryland assure that efforts are effective and culturally and linguistically appropriate? How should the state address current needs for information on reform implementation and its implications, as well as develop a long-term strategy for ongoing effective communication about the new health care system?

4. Public Health, Safety Net, and Special Populations

When reform is fully implemented, more individuals will have health insurance. However, there will still be people who remain uninsured or have some health care needs not covered by insurance. These shifts in coverage status and other aspects of reform will affect the traditional role and functions of safety net providers, programs, and the public health infrastructure. The HCRCC must engage in a proactive approach to planning for these changes and the future of the health care safety net and services for special populations.

Critical questions this group should address include: How will Maryland ensure that populations that remain without adequate insurance coverage obtain the health care they need? How will the safety net prepare for the likely changes in benefits that are covered by commercial or public insurers? How should the public health infrastructure leverage the demonstration projects, grant opportunities, and other features of reform to augment its resources, increase its effectiveness, and enhance its impact? What changes should occur in

how behavioral health services are provided and how will these changes interface with new mental health parity rules and other changes in insured benefits? How will Maryland facilitate the coordination of safety net services in the reformed health care system while identifying both persistent and new unmet needs and coordinating safety net care delivery? What should be expected of traditional safety net providers in an environment in which more people have insurance coverage, and how can the capacity of these providers be leveraged and fostered?

5. Health Care Workforce

While more individuals will have health insurance when federal reform is fully implemented, their coverage will be meaningful only if they have access to health care providers able to meet their needs. The federal law creates new funding opportunities to support efforts to expand the health care workforce; the HCRCC will fully consider how to leverage these opportunities and develop other strategies to prepare the workforce for the future. This workgroup will also be directed to partner closely with the Governor's Workforce Investment Board to identify areas best addressed through collaboration with its existing programs and initiatives.

Critical questions this group should address include: What steps should Maryland take to ensure sufficient capacity in the health care delivery system to meet increased demand? To what extent should Maryland use a broad range of tools to increase capacity and assure an adequate workforce, including fostering educational and training programs designed for the workforce of the future, changing licensing policies, supporting recruitment and retention strategies, and changing liability laws and regulations? How can Maryland effectively compete for new federal resources to support underserved areas?

6. Health Care Delivery System

The success of health care reform, at its most fundamental core, will depend on whether (and if so, how) the health care delivery system is transformed. It will be judged ultimately on the extent to (and the ways in) which health care delivery is altered to improve health and control costs. Maximizing the likelihood of this fundamental transformation will require us to focus on the key drivers of health care costs. Health care reform offers tools to achieve this goal, providing opportunities for pilots, demonstration projects, and other mechanisms to test and evaluate delivery system changes designed to improve quality and control costs. Maryland is fortunate enough to have already initiated several efforts in this regard. It established the Maryland Health Quality and Cost Council several years ago, is launching an effort to renew the Medicare waiver, and has harnessed multiple opportunities to fully embrace the potential of health information technology. This delivery system workgroup will need to coordinate and work in concert with these existing efforts, identifying new opportunities and maintaining the HCRCC's focus on delivery system changes that result in improved health and reduced costs.

Critical questions this group should address include: How will Maryland use the new tools and opportunities available through reform to improve quality and contain costs? How will

Maryland promote the use of evidence-based practices? How will Maryland address the fundamental cost drivers in health care?

Issues Addressed by Other Efforts

A number of issues critical to the success of reform implementation are currently being addressed by other efforts. The HCRCC does not seek to duplicate these activities; rather, it intends to leverage its efforts and ensure coordination with reform. As mentioned above, the Health Care Delivery System Workgroup will need to coordinate with current efforts to promote health information technology, payment reform related to the Medicare waiver, and the Maryland Health Quality and Cost Council's development of a medical home pilot. Other workgroups will likely need to ensure similar coordination in other areas. In addition, PPACA creates new opportunities related to long-term care services, including new options for home and community-based care and long-term care insurance. The HCRCC's leveraging of these opportunities should be coordinated with the process instituted legislatively in 2009 and now underway, which is addressing long-term care reforms.

Cross-Cutting Issues

Many implementation issues span multiple workgroups. These cross-cutting issues need to be addressed in the context of each workgroup's identification, analysis, and evaluation of options for consideration by the HCRCC. These issues include:

- Considering the cost of options, as well as the potential savings
- Preserving and strengthening employer-sponsored insurance
- Identifying sufficient data and planning resources to support efforts
- Developing strategies to reduce racial and ethnic disparities
- Integrating behavioral health and services for individuals with disabilities
- Creating systems to ensure accountability and compliance
- Considering infrastructure needs, including the balance of local and state infrastructures, technology, and human resources
- Prioritizing and providing input related to grant and demonstration opportunities

Immediate Next Steps

The workgroups identified above will be active in the short term, from July through December 2010. A final report, to be issued by January 1, 2011, will summarize the HCRCC's recommendations on the critical issues of health care reform implementation. The work of the federal reform will continue beyond this timeframe, and the HCRCC will need to address how to manage implementation after it completes its work. Indeed, some issues that are critical to the implementation of reform cannot even be taken up effectively until after the end of the year.

An important example of an issue central to reform but not yet ready for consideration is that of benefit design. State implementation of benefit design mandates largely depends on federal guidance that has yet to be provided. Thus, the multiple benefit design issues that the HCRCC anticipates will be integral to health care reform implementation will need to await resolution until federal guidance becomes available.

Some of these benefit design issues include: How should Maryland conceptualize the ground rules for selling regulated products? To what extent should the state allow or encourage variation in products offered? Should Maryland continue its current benefit mandates above and beyond minimum standards established by the federal government? To what extent will Maryland use its implementation efforts to drive policy objectives to assure mental health parity, foster wellness and prevention, or encourage certain cost-sharing arrangements? How will implementation of benefit design changes interact with the delivery system to ensure that coverage is meaningful?

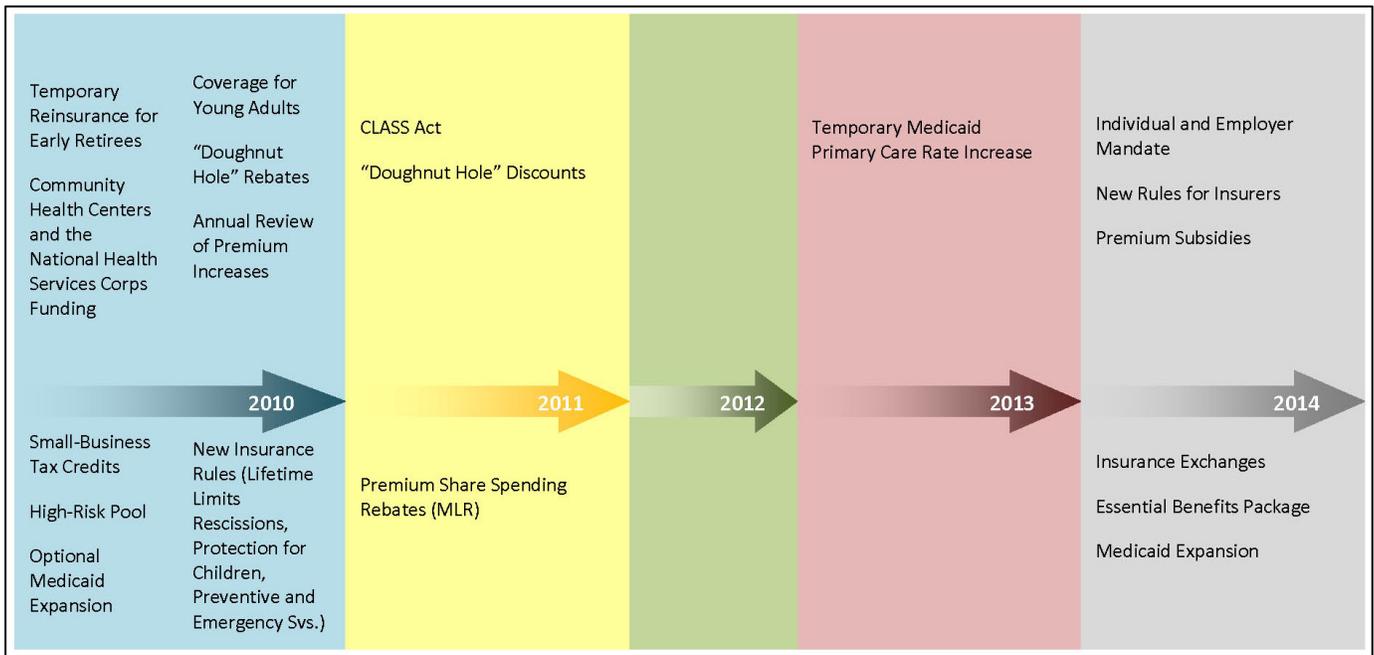
In many areas of benefit design, Maryland is—or has the potential to become—a national leader. Thus, the state’s current objective should be to draw upon its own experience and expertise to inform the federal rule-making process. The HCRCC will rely on existing efforts to identify how Maryland will speak with a single voice on these critical benefit design issues. For example, prior advisory efforts on behavioral health could be reconvened to address the implementation of mental health parity.

Timeline for Implementation of Key Activities

The major elements of health care reform become effective in 2014. A number of components become effective earlier, however, and many changes require planning and other implementation activities to begin immediately. In any event, successful implementation will require Maryland to focus on both the elements calling for immediate attention and the longer-term, transformative opportunities presented by reform.

A comprehensive timeline of Maryland health care reform implementation issues, highlighting areas that potentially require state action, is shown in Appendix E. A summary of the highlights can be found in Figure 5 on the following page.

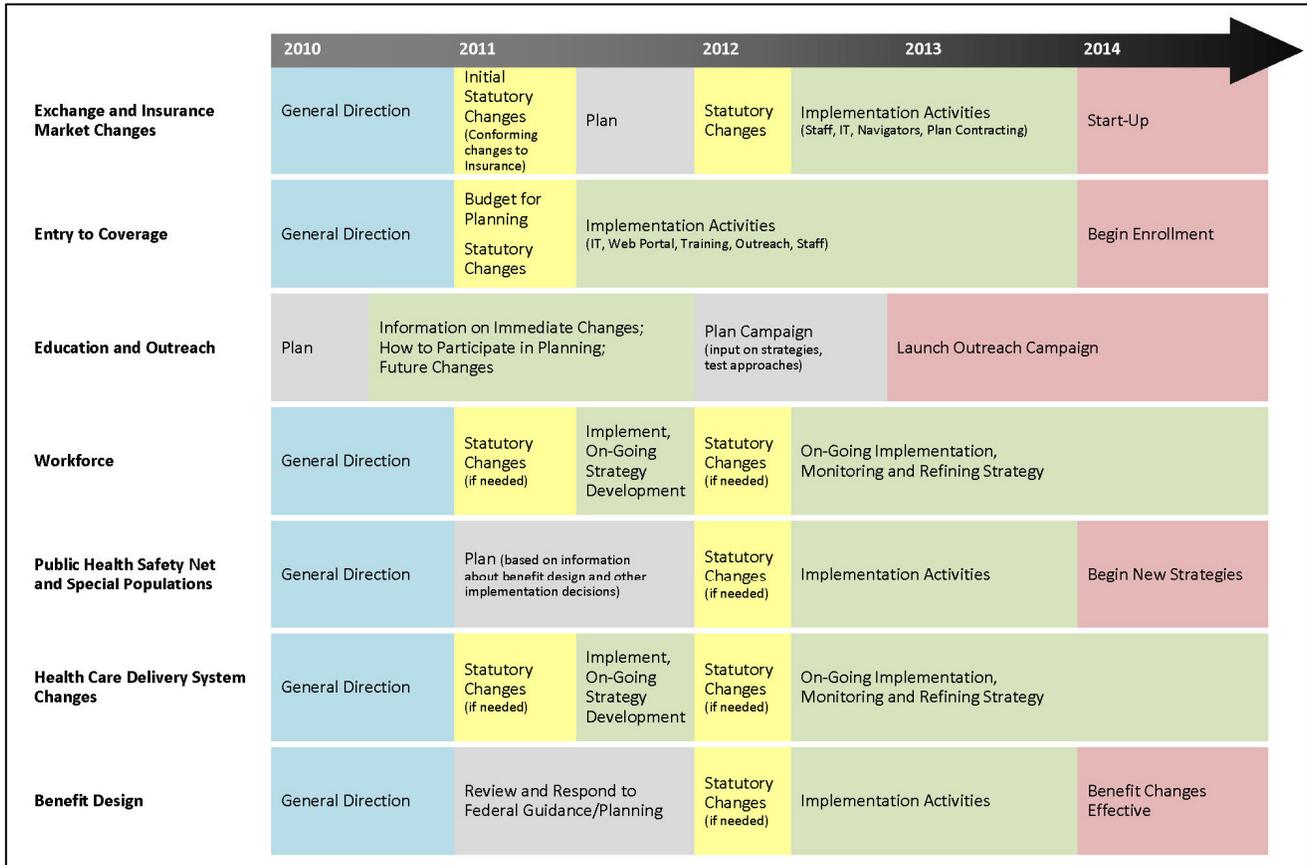
Figure 5. Effective Dates for Major Health Care Reform Initiative



From Maryland’s perspective, the establishment of a new federal high-risk pool to operate alongside the MHIP program is one of the components of reform requiring most immediate implementation activity. Also in the short term, the federal government is issuing guidance on several insurance market changes. Maryland’s task will be largely to conform to these federal mandates and to conduct oversight to ensure that the new rules are enforced. In addition, some opportunities for optional initiatives, grants, and demonstration projects become available immediately.

The major elements of reform that require significant implementation by the states, including the exchanges, Medicaid Expansion, and premium credits, will become effective in 2014. The planning and implementation activities required to implement these components, however, need to begin immediately. As illustrated by the timeline in Figure 6 on the following page, changes in both infrastructure and delivery systems will be significant. Sufficient implementation timeframes are essential to meet even the basic requirements of reform. Workgroup recommendations and policy decisions will affect this initial timeline. See Appendix E for a more comprehensive timeline of overall health care reform implementation.

Figure 6. Major State Activities: Illustration of Potential Implementation Timeline



Note: The timeline will be significantly affected by the input of workgroups and the recommendations of the HCRCC.

Conclusion

The implementation of health care reform is a significant undertaking. Health care reform holds the promise of transforming our health care system to improve the health and well-being of Marylanders. We can save money, improve quality while reducing costs, and expand access to insurance while maintaining affordability. We can achieve our long-sought goal of ensuring that all Marylanders have access to the care that they need. We can realize the full promise of reform: a healthier Maryland. With help and collaboration from all the key stakeholders (public and private sector leaders, providers, carriers, employers, producers, and consumers), we can make this happen.

Meaningful reform will likely mean that both individuals and institutions will be called upon to make changes that may be difficult. The HCRCC will carefully consider all perspectives on the pace, nature, and scope of change that should characterize Maryland’s implementation. The enormity of health care reform and the task of implementation require that we focus initially on the major aspects of reform that are critical to laying the foundation for Maryland’s long-term success. This report reflects the end of the beginning. Now we must turn our attention to the work of realizing the opportunities presented to Maryland by health care reform.