



Health Care Reform Coordinating Council

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Final Report and Recommendations

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Table of Contents

Executive Summary	i
Introduction.....	1
Overview of Health Care Reform	2
Interim Report’s Findings on the Impact of Health Reform in Maryland	4
Maryland’s Foundation for Reform	7
Health Care Reform Coordinating Council’s Work and Process	12
Workgroup Process	13
Implementation Issues and Recommendations	13
Exchange and Insurance Markets	14
Entry into Coverage	17
Education and Outreach	20
Public Health, Safety Net, and Special Populations	20
Health Care Workforce	23
Health Care Delivery System.....	25
Reduction of Racial and Ethnic Health Disparities	26
Preservation of Employer-Sponsored Insurance.....	27
Leadership and Oversight of Health Care Reform Implementation	27
Essential Investments.....	28
Conclusion	29
Appendices (available at www.healthreform.maryland.gov)	

- A. Executive order
- B. HCRCC Members
- C. HCRCC Operating Principles
- D. HCRCC Full Council Meeting Agendas
- E. Summary of ACA Provisions in Effect
- F. Summary of Public Input
- G. Workgroup Descriptions
- H. Workgroup White Papers
- I. ACA Funding Received to Date
- J. Glossary of Terms

EXECUTIVE SUMMARY

Passage of the Affordable Care Act (ACA) earlier this year offered states an unprecedented opportunity to change the face of health care. While some states have responded with calls for obstruction, Maryland took bold action to build on the reforms already in place and our renowned health care system to develop a national model for the implementation of health reform. Under the auspices of the Health Care Reform Coordinating Council (HCRCC) established by Governor O'Malley in the immediate aftermath of Congress' enactment of the ACA, the State has spent the last nine months creating the blueprint for a well-planned and inclusive implementation of health care reform that is at once both visionary and realistic.

This final HCRCC report sets forth that blueprint. It provides an overview of the federal health care reform law; describes the already-established foundation for reform in Maryland; summarizes the work and process of the HCRCC; identifies the major challenges and opportunities presented by implementation; identifies the necessary investments to ensure success; and identifies 16 recommended short- and long-term action items on how federal reform can be implemented most effectively. With this roadmap, the State is better positioned than most states to comply with the requirements of the ACA and take full advantage of the once in a generation opportunity to lower costs, expand coverage, and improve health services.

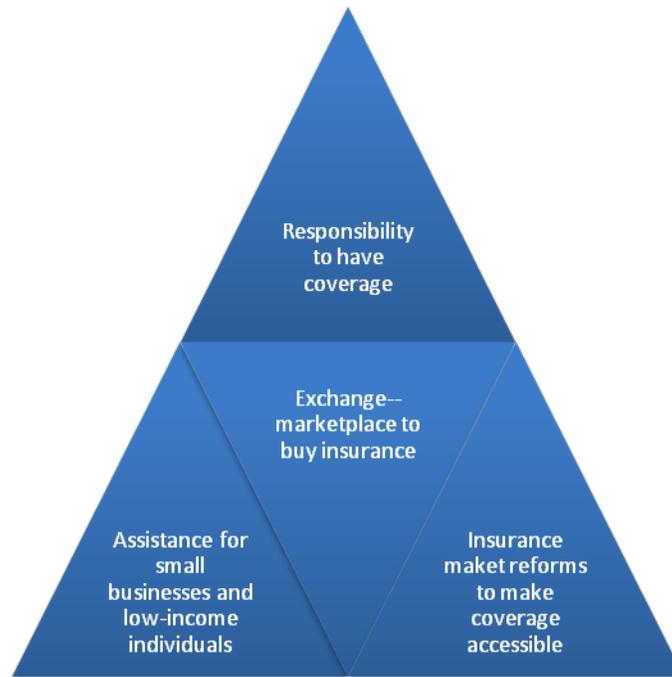
OVERVIEW OF HEALTH CARE REFORM

With comprehensive reforms to hold insurance companies more accountable, expand access to care and coverage, and enhance the quality of care, the ACA sets the stage for the transformation of health care in Maryland and across the country. Despite this broad reach, the law's goals at their core are built on essential and interrelated components:

- A responsibility to have coverage;
- Assistance for small businesses and low-income individuals.
- Market reforms to make coverage accessible; and
- A marketplace to buy coverage;

These building blocks of reform, shown below in Figure ES-1, work together to reduce the number of uninsured and improve health.

Figure ES-1: Essential Components of Health Reform



The first pillar - **the responsibility to have coverage or “individual mandate”** - spreads risk across the spectrum of all individuals, regardless of health status. It promotes affordability and paves the way for insurance market reforms necessary for everyone to be able to access and maintain coverage. The second pillar of reform - **federal subsidies providing assistance for small businesses and low-income individuals** - is necessary to enable those who cannot afford insurance on their own to fulfill their responsibility to purchase it. The third – **new insurance market rules which prohibit industry practices that have often resulted in people losing or being denied coverage just when they need it most** - ensure that no individual can be barred from accessing insurance and complying with the individual mandate. Finally, the ACA facilitates this coverage expansion through the fourth pillar - **a new marketplace or “Exchange”** - through which individuals and businesses can purchase insurance in an open, transparent and competitive environment.

In addition to these fundamental and interdependent building blocks of reform, the ACA includes additional features that will reshape the health care system, including:

- Supporting prevention and public health programs;
- Promoting initiatives designed to reduce racial and ethnic disparities;
- Shoring up primary care infrastructure through workforce development strategies;
- Protecting Medicare;
- Initiating changes in long-term care; and

- Cultivating payment reforms and other innovations designed to improve quality and slow the growth of costs.

HEALTH CARE REFORM COORDINATING COUNCIL'S WORK AND PROCESS

The HCRCC has been committed to conducting an open, transparent process designed to solicit and incorporate as much public input as possible. The Council initially conducted an assessment of the ACA and its potential impact on Maryland, submitting its findings to the Governor in its July 2010 Interim Report. A multi-faceted workgroup process followed in which six groups, open to all stakeholders and interested members of the public, focused on key implementation issues and developed options for consideration by the HCRCC. The Council solicited direct public input on proposed draft recommendations during five hearings held across the State. Finally, incorporating both public testimony and feedback from individual Council members, the HCRCC developed its final recommendations to be presented to the Governor in this report.

INTERIM REPORT'S FINDINGS ON THE IMPACT OF HEALTH REFORM IN MARYLAND

The HCRCC's Interim Report found that full ACA implementation will reduce Maryland's 700,000 uninsured by more than half, to just below 7%.¹ With respect to fiscal impact, Maryland's reform implementation will result in estimated savings of \$829 million over the next ten years.² The HCRCC's financial model can be adapted and updated over time. The current estimate remains unchanged from the Interim Report as assumptions about implementation continue to be explored. That these savings reverse course and begin to decline in 2020, underscores the critical imperative that the State focus immediately on bending the cost curve to rein in spending growth and improve the long-term fiscal outlook.

MARYLAND'S FOUNDATION FOR REFORM

Most of reform's implementation will be left to states. Reforms already in place in Maryland position the state to enact the federal measures more successfully than other states. For example, Maryland has extended coverage to more than 250,000 Marylanders since 2007 by expanding Medicaid eligibility, 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

¹ Health Care Reform Coordinating Council. (2010, July). *Interim report*. Retrieved from <http://healthreform.maryland.gov/interimreport.html>

² Health Care Reform Coordinating Council. (2010, July). *Interim report - Appendix F: Maryland Health Care Reform financial modeling tool: Detailed analysis and methodology*. Retrieved from <http://healthreform.maryland.gov/documents/100726appendixf.pdf>

logical extension of these and other current policy initiatives, while in other cases, federal mandates may require rethinking existing efforts.

Other features of Maryland's existing system and recent reforms will also affect implementation decisions. Examples include medical underwriting in its nongroup market; the Comprehensive Standard Health Benefit Plan and community rating in the small group market; the prominent role played in both markets by independent producers and third party-administrators; the hospital rate setting system used to finance uncompensated care; safety net programs for the State's uninsured and underinsured; and State and local public health infrastructure and systems.

IMPLEMENTATION ISSUES AND RECOMMENDATIONS

The HCRCC has developed 16 recommendations on how Maryland should undertake reform implementation. Public input was central to understanding critical implementation issues and shaping recommendations. The first two recommendations, relating to the health benefit exchange and entry into coverage, address the immediate building blocks of reform necessary to meet federal deadlines. The second group - recommendations 3 through 15 – responds to opportunities presented by reform to advance a sustained effort to strengthen the health care system and improve health. The last recommendation addresses the ongoing leadership and oversight necessary to achieve Maryland's goals for implementing health reform successfully, and for strengthening health and the health care system over the long term.

Recommendation One: Establish the basic structure and governance of Maryland's Health Benefit Exchange. This is a required building block of reform. The HCRCC recommends that Maryland establish the initial structure and governance of a single health benefit exchange during the 2011 legislative session of the General Assembly to meet the March, 2012 federal deadline. The enabling statute should create an independent public entity, establish the Board and governing principles for transparency and accountability, ensure sufficient flexibility with respect to procurement and personnel practices, and confer authority to begin some federally-mandated implementation activities immediately while developing recommendations for the Governor and General Assembly on others.

The success of Maryland's Exchange will depend in large part on its ability to balance transparency, accountability, and the capacity to coordinate with state agencies on the one hand, with the flexibility and independence necessary to respond nimbly to market forces, attract expert personnel, and remain insulated from changing political environments and budgetary cycles on the other. The Exchange's influence over insurance markets, certification of qualified health plans, administration of publicly financed benefits, as well as its mandate to provide recommendations on the design of the Navigator program, selective contracting and a host of other critical functions all demand utmost transparency, stakeholder input, and accountability.

The Exchange will operate in the private sector and must be competitive and nimble in its hiring and procurement practices as well as nonpartisan in its administration and development of policy. In order to be a stable and credible marketplace capable of meeting the myriad challenges of functioning in both the public and private sectors, the Exchange will need some combination of all of these qualities.

The Exchange's start-up functions and wide-ranging influence over both public and private sector entities and markets require, at least initially, the transparency and accountability of an independent public entity. However, the Council recognizes that while the attributes of a public entity will be clear advantages in the early incubator phase of the Exchange, it may evolve into a nonprofit later on. Once the Exchange is established, has a self-sustaining funding stream, and has carved out independent relationships with other government agencies and private sector entities, the balance may shift and the benefits of a nonprofit may begin to outweigh the strengths of a public entity. As such, the HCRCC recommends that the Exchange study and report to the Governor and General Assembly by 2015 its findings and recommendations on whether it should be transformed into a nonprofit or should remain a public entity.

Recommendation Two: Continue development of the State's plan for seamless entry into coverage to meet federal implementation deadlines and to maximize federal funding for information technology systems and infrastructure. This is a required building block of reform. A critical component of expanding insurance coverage and reducing the number of uninsured will be the states' success in enrolling people in new and existing public and private coverage options. To address this challenge, the HCRCC recommends Maryland continue expeditious development of its plan for seamless entry into coverage. The plan should leverage federal funding to the full extent possible and be technically feasible by the 2014 implementation deadline. Under the plan, the new eligibility determination policies and processes should: 1) constitute a dramatic simplification with a new income-based methodology; 2) embrace a "no wrong door" approach, with seamless integration across both health and public assistance programs; 3) reflect a "culture of insurance" in which everyone is expected to have coverage; and 4) be integrated with actual enrollment rather than having two separate processes for eligibility and enrollment administered by distinct systems.

Recommendation Three: Develop a centralized education and outreach strategy. The success of health care reform will depend in large part on whether individuals and organizations understand and utilize its changes in the health care delivery system to improve their health and well-being. To this end, the HCRCC recommends that Maryland develop a centralized education and outreach strategy. Components should include formally establishing a public/private educational coalition and developing templates for

outreach materials. The strategy should also focus on incorporating cultural competence and taking other steps necessary to ensure that its messages connect with racial and ethnic minorities and special populations.

Recommendation Four: Develop State and Local Strategic Plans to achieve improved health outcomes. The HCRCC recommends that Maryland undertake interconnected state and local planning efforts to address opportunities to improve coordination of care for those remaining uninsured even after reform implementation. A State Health Improvement Plan (SHIP) should conduct a health needs assessment with identified priorities and set goals for health status, access, provider capacity, consumer concerns, and health equity. The SHIP should also designate public and private sector partners to work with the State and local health departments on implementation and to monitor performance metrics. Local Implementation Plans should involve collaborations led by local health departments to identify systemic issues which must be addressed to achieve SHIP goals. The Community Health Resources Commission should provide technical assistance in the development of these plans, piloting models and sharing lessons learned.

Recommendation Five: Encourage active participation of safety net providers in health reform and new insurance options. Even with the ACA's substantial coverage expansion, an estimated 400,000 or more Marylanders will remain uninsured. Given the ongoing need for their services, the HCRCC recommends that Maryland provide technical assistance to safety net providers to help them prepare for changes brought about by reform. This effort should assess the administrative infrastructure of small safety net providers, identify partnering opportunities among providers, and develop a roadmap for the sustainability of these efforts. In addition, in order to fully leverage opportunities for public-private partnerships to improve health care delivery, the HCRCC also recommends removing certain statutory and administrative barriers to contracting between local health departments and private entities.

Recommendation Six: Improve coordination of behavioral health and somatic services. Given the high prevalence of behavioral health needs and the ACA's implications for behavioral health, the HCRCC recommends that DHMH examine different strategies to achieve integration of mental health, substance abuse, and somatic services. Potential avenues to be explored include statewide administrative structure and policy, financing strategies designed to encourage coordination of care, and delivery system changes.

Recommendation Seven: Incorporate strategies to promote access to high quality care for special populations. Virtually the entire spectrum of ACA implementation decisions have potential consequences for special populations at high risk of encountering difficulties in accessing affordable, high quality care. The HCRCC recommends that

wherever possible, Maryland should incorporate strategies to promote improved access to high quality care for special populations in making these implementation decisions.

Recommendation Eight: Institute comprehensive workforce development planning.

While more people will have health insurance when reform is fully implemented, coverage will mean little without access to health care providers. The HCRCC recommends that Maryland institute comprehensive workforce development planning to ensure sufficient providers able to meet the needs of the newly insured. Using a grant to the Governor's Workforce Investment Board as a resource, this planning effort should improve data collection to enable more accurate assessment of needs and should enhance coordination of various workforce development efforts throughout the State.

Recommendation Nine: Promote and support education and training to expand Maryland's health care workforce pipeline.

The HCRCC recommends that Maryland expand and maintain a robust workforce pipeline through support for education and training initiatives. Strategies should include renewing efforts to secure federal approval of funding for the Maryland Loan Assistance Repayment Program, facilitating clinical training opportunities in community settings, and promoting non-traditional paths to participation in Maryland's health care workforce, including promotion and expansion of career ladder opportunities for existing allied health care professionals.

Recommendation Ten: Explore improvements in professional licensing and administrative policies and processes.

The HCRCC recommends exploring ways in which licensing and administrative policies and processes could be streamlined and improved to ease entry into the health care workforce. Potential improvements include permitting reciprocity for health occupations licensed in other states, with certain safeguards; incentivizing volunteerism in underserved areas; promoting cultural competency training; and continuing efforts to streamline credentialing.

Recommendation Eleven: Explore changes in Maryland's health care workforce liability policies.

The HCRCC recommends that Maryland explore changes in its approach to health care workforce liability. After federal guidance becomes available, the State should consider participating in the ACA's demonstration program to evaluate alternatives to current medical tort litigation. In addition, Maryland should encourage hospitals and health systems to provide medical malpractice coverage for volunteer providers in community settings.

Recommendation Twelve: Achieve cost savings and quality improvements through payment reform and innovation in health care delivery models.

With current rates of health care spending unsustainable, the long-term success of reform depends on whether

we can transform the delivery system to control costs while also improving health. The HCRCC recommends that Maryland achieve cost savings and quality improvements through multiple payment reform demonstrations and innovations in health care delivery models throughout the health system. The HCRCC specifically encourages continued support of the Maryland Health Care Commission's Patient-Centered Medical Home pilot and encourages coordination with other models to facilitate participation by small practices and to align care coordination strategies. Maryland should also promote evidence-based practices by disseminating findings from comparative effectiveness research.

Recommendation Thirteen: Promote improved access to primary care. The HCRCC recommends that Maryland support improved access to primary care by working towards critical investment in Maryland's network of primary care providers. This investment should be pursued by promoting deployment of some savings achieved through delivery system reform to increase Medicaid's primary care provider reimbursement rates.

Recommendation Fourteen: Achieve reduction and elimination of health disparities through exploration of financial, performance-based incentives and incorporation of other strategies. While coverage expansion is important to reducing disparities, it is only a first step; disparities exist among both the insured and uninsured. Maryland must employ strategies to help translate coverage expansions into improved health outcomes for everyone, across the spectrum of racial and ethnic groups. Given the important role of incentives in driving systemic change, the HCRCC recommends that Maryland explore financial, performance-based incentives to reduce and eliminate health disparities. The State should enhance data collection to facilitate better assessment of both needs and performance metrics, and it should ensure that all reform implementation efforts incorporate and are aligned with the goal of reducing health care disparities.

Specifically, opportunities to address disparities include: 1) Using existing data and knowledge of incentives to craft programs that reward reductions in Maryland's racial and ethnic health disparities; 2) Using the SHIP and Local Implementation Plans to identify and address disparities and to monitor the performance of efforts to mitigate them; 3) Creating a more diverse workforce and strengthening the safety net through comprehensive workforce development planning; 4) Promoting cultural competency training; 5) Helping safety net providers leverage health reform opportunities to improve access and care for the diverse populations they serve; 6) Employing education and outreach efforts that ensure cultural sensitivity and engage community based organizations; and 7) Improving data collection and analysis through SHIP and Local Implementation Plans, as well as the Maryland Health Care Commission's ongoing work to encourage common reporting of race and ethnicity among health plans.

Recommendation Fifteen: Preserve Maryland’s strong base of employer sponsored insurance. Recognizing that employer-sponsored insurance is the backbone and primary source of health coverage in this country and the State, the HCRCC recommends that Maryland seek to preserve its strong base of employer sponsored insurance through strategies that bend the cost curve and hold down the cost of premiums for employers. The State should also work towards simplifying employer enrollment in health coverage, and all reform implementation decisions affecting employers should seek to minimize potential disruption for those currently offering insurance to their employees.

Recommendation Sixteen: Ensure continued leadership and oversight of health care reform implementation by establishing a Governor’s Office of Health Reform. Given the need for ongoing coordination of health reform implementation, the HCRCC recommends that the Council continue to function through 2014 to monitor progress on recommendations and provide input on implementation activities. Additional HCRCC members should be considered, including leadership from the new Health Benefit Exchange and representation from the Governor’s Workforce Investment Board. The HCRCC should be an advisory body to the Governor’s Office of Health Reform, which should be the focus of authority for health reform implementation.

The Office of Health Reform should direct reform policy and issue instructions for implementation, without duplicating the functions of other executive branch agencies involved in reform implementation. To the greatest extent possible, the resource needs for the Office of Health Reform will be addressed through federal and private grant funding and existing general fund resources. It is important to invest a modest level of resources in leadership and oversight in order to realize the full savings potential of reform.

ESSENTIAL INVESTMENTS

While the HCRCC’s financial model estimates that health reform will generate substantial cumulative savings to Maryland over the next ten years, some individual components of health reform involve costs as well as savings. In many areas, the early phases of implementation require initial investments to build infrastructure and support administrative functions that will help the State fully realize potential savings down the road. The federal government will make available, for limited periods of time, financing for significant portions of many of these initial investments if states act early. Thus, Maryland must be vigilant in taking the steps necessary to obtain all available federal funds as soon as possible. For example, federal exchange planning and implementation grants will largely support the creation of Maryland’s exchange if the State complies with federal deadlines. The federal government has also announced recently that it will provide 90% of the funding necessary for the development of the new Medicaid eligibility systems until 2015. In sum, the State must recognize that the investment of some limited

resources upfront will be needed to take full advantage of all the opportunities presented by health reform to achieve both substantial long-term savings and lasting improvements in our health system.

CONCLUSION

Maryland's blueprint for health care reform implementation is ambitious. Realizing its full potential will require sustained and collaborative effort on the part of all public and private stakeholders to preserve the best of Maryland's world-renowned health care system while transforming other areas. If we can rise to this challenge, we can change the face of health care. We can become a state in which everyone has access to high quality care at an affordable cost. Working together towards that day when no Marylander ever faces again the choice between health care and other basic human needs, we can achieve the full promise of reform. We will leave our children a healthier Maryland.

Introduction

Maryland's implementation of the Affordable Care Act (ACA) offers a once in a generation opportunity. If we implement it effectively, we can achieve a transformation of our health care system that will enhance the health and wellbeing of all Marylanders.

Maryland Governor Martin O'Malley created the Health Care Reform Coordinating Council (HCRCC) by executive order³ on March 24, 2010, the day after President Obama signed the ACA into law. The Governor charged the HCRCC to develop a plan to ensure that Maryland implements health care reform as effectively as possible to comply with the ACA's mandates and to take advantage of its opportunities. Through careful deliberation and collaboration across agencies and branches of government, and with meaningful participation from the health care community and other stakeholders, the HCRCC has spent the last year formulating recommendations on the key decisions that are critical to successful implementation of health care reform in Maryland.

The significance of health care reform in Maryland is reflected in the composition of the HCRCC. Led by Lieutenant Governor Anthony G. Brown and Secretary John M. Colmers of the Maryland Department of Health and Mental Hygiene (DHMH), the thirteen-member HCRCC includes leadership from Maryland's executive budget, health, and human services agencies, the Governor's office, the Attorney General, and chairs and leading members of Senate and House health and budget committees.

Realizing the full potential of reform presents an unprecedented challenge. The HCRCC has focused on leading a coordinated and sustained effort to lay the groundwork necessary to meet this challenge and to make health care reform in Maryland a success. Efforts to undermine the ACA in other states and at the national level notwithstanding, Maryland remains committed to its long-standing health care reform goals:

- Leading the nation in tapping the full potential of reform to improve health
- Improving the health of all Marylanders, with particular focus on health equity
- Developing a consumer-centric approach to both coverage and care
- Improving quality and containing costs
- Promoting access to affordable coverage and mitigating risk selection
- Preparing and expanding the health care workforce to meet existing and new demands

This final report builds on the HCRCC's July 2010 Interim Report and constitutes the culmination of nine months of work.⁴ It provides an overview of the federal health care reform law; describes the foundation for reform in Maryland; summarizes the work and process of the HCRCC; identifies the major issues presented by implementation; highlights core investments necessary to ensure success; and makes sixteen recommendations to the Governor on how federal reform can be implemented most effectively in Maryland.

³ See Appendix A.

⁴ Health Care Reform Coordinating Council. (2010, July). *Interim report*. Retrieved from <http://healthreform.maryland.gov/interimreport.html>

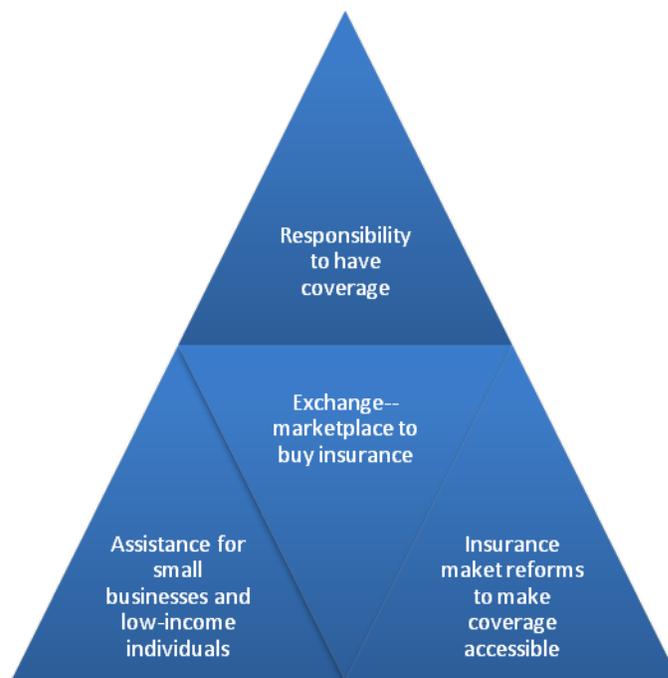
The first two recommendations relating to the health benefit exchange and entry to coverage address the essential building blocks of health care reform. Maryland must make progress in these two areas in order to meet timeframes established by the ACA. Recommendations three through fifteen address foundational components on which progress is needed to make Maryland's health and health care systems as strong as possible. Prior to the passage of national health care reform, Maryland had already taken steps to advance many of these foundational issues, but the ACA provides the opportunity and impetus for renewed attention and continued improvements. The last recommendation highlights the need for ongoing leadership and oversight to ensure the long-term success of Maryland's health care reform implementation and its efforts to strengthen the health care system and improve the health of all Marylanders.

Overview of Health Care Reform

The ACA initiates comprehensive health care reforms that will hold insurance companies more accountable, expand access to care and coverage, and lower costs while enhancing the quality of care. When fully implemented, its projected reduction in insurance premium costs could help as many as 32 million uninsured Americans.⁵

The ACA sets the stage for the transformation of health care in Maryland and the rest of the United States. Yet despite its broad reach, its goals at their core are built on a few essential and interrelated components (see Figure 1). Expanding coverage by making it required, accessible, and affordable, these building blocks of reform work together to reduce the number of uninsured and improve the health of all Americans.

Figure 1: Essential Components of Health Care Reform



⁵ U.S. Department of Health and Human Services. *Understanding the Affordable Care Act: About the law*. Retrieved from <http://www.healthcare.gov/law/about/index.html>

Illustrated in Figure 1, the building blocks of reform are defined as follows:

- *Responsibility to have coverage:* Referred to as the individual mandate, the ACA's requirement that all individuals maintain health care coverage is an essential element of its goal to expand coverage. By spreading risk across the spectrum of all individuals, regardless of health status, this requirement guards against the sharp rise in health care premiums that can occur if healthy individuals wait to buy insurance until they become sick and need health care. It also paves the way for insurance market reforms that require carriers to offer health insurance to everyone, including people with poor health status. Sharing risk in this manner promotes affordability across the system. The ACA also enlarges the risk pool further by requiring large employers to either provide health coverage or pay penalties.
- *Assistance for small businesses and individuals with low incomes to purchase health care coverage:* Even with more affordable insurance products and a requirement to maintain coverage, some individuals still will not have sufficient income to be able to purchase insurance. The ACA helps these individuals with low incomes obtain coverage by both expanding Medicaid and providing subsidies. The ACA extends Medicaid eligibility to all individuals with incomes below 133 percent of the federal poverty level (FPL)—or approximately \$14,000 for an individual or \$24,000 for a family of three—and streamlines eligibility determinations. It also makes federal subsidies available for individuals with annual incomes up to 400 percent of the FPL—or approximately \$43,000 for an individual or \$73,000 for a family of three—to help them purchase insurance through a health benefit exchange. The ACA also provides federal subsidies to certain small businesses offering coverage to their employees.
- *Insurance market reforms to make coverage accessible:* Requiring everyone to have health insurance is only feasible if no individual is barred from accessing insurance because of poor health status. The ACA thus prohibits insurers from discriminating against individuals based on their health. Insurance market reforms also seek to make coverage more reliable by prohibiting long-standing industry practices that have often resulted in people losing coverage just when they need it most. Examples include new prohibitions on annual or lifetime caps, the cancellation of policies just because the insured becomes sick, and exclusions based on pre-existing conditions.
- *Exchange/new marketplace for insurance:* To facilitate the coverage expansion achieved through increased access, affordability, and responsibility, the ACA also creates a new marketplace, known as an exchange, through which individuals and businesses can purchase insurance. Offering a comprehensive array of products ranging from the most basic to the most expansive, the exchange will provide individuals and small businesses a mechanism for purchasing insurance that will be easier and more transparent than ever before. Consumers will be able to compare the costs and benefits of different products available in the market and determine whether they are eligible for Medicaid or federal subsidies.

In addition to these fundamental and interdependent building blocks of reform, the ACA includes many other 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. Some of these additional features include

the following:

- *Prevention and Public Health*: In order to improve health outcomes through population-based prevention strategies, the ACA establishes the Prevention and Public Health Fund. A historic investment in prevention and public health programs, this fund will help reduce health care costs by promoting strategies that prevent illness and injury before they occur. In addition, the Community Transformation Grant Program was established to 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*: The ACA provides opportunity for serious investment in training programs and other strategies 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. 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.
- *Medicare*: The ACA also ensures that Medicare will continue to be protected as a strong and stable insurance program for the elderly. Addressing one prominent gap, for example, it fills the “donut hole” in Medicare Part D prescription drug coverage.
- *Long-Term Care Reform*: The ACA establishes the CLASS Act, the first national long-term care insurance program. Financed through voluntary payroll deductions, the CLASS Act is a program for purchasing community living assistance services and supports. All working adults will be enrolled automatically in the program but will have the ability to opt-out. In addition, the ACA includes new Medicaid long-term care options and incentives for states to help shift from institutional- to community-based long-term care.
- *Payment Reform and Quality Improvement*: The ACA also establishes and promotes initiatives designed to increase health care quality, improve health system performance, and contain health care costs. Spanning Medicare, Medicaid, and the private sector, examples include pilot programs to provide greater incentives for quality and efficiency through payment reforms, as well as programs that place more emphasis on evidence-based practice, primary care, disease prevention, and chronic care management. The ACA also provides a substantial investment to fund research in evidence-based treatments.

Interim Report’s Findings on the Impact of Health Reform in Maryland

The findings of its Interim Report, described below, document some important projections and analyses that have helped inform the HCRCC’s recommendations in this final report.

Projected Cost Savings from Health Care Reform Implementation: The HCRCC’s financial model set forth in the Interim Report projects that health care reform will result in substantial

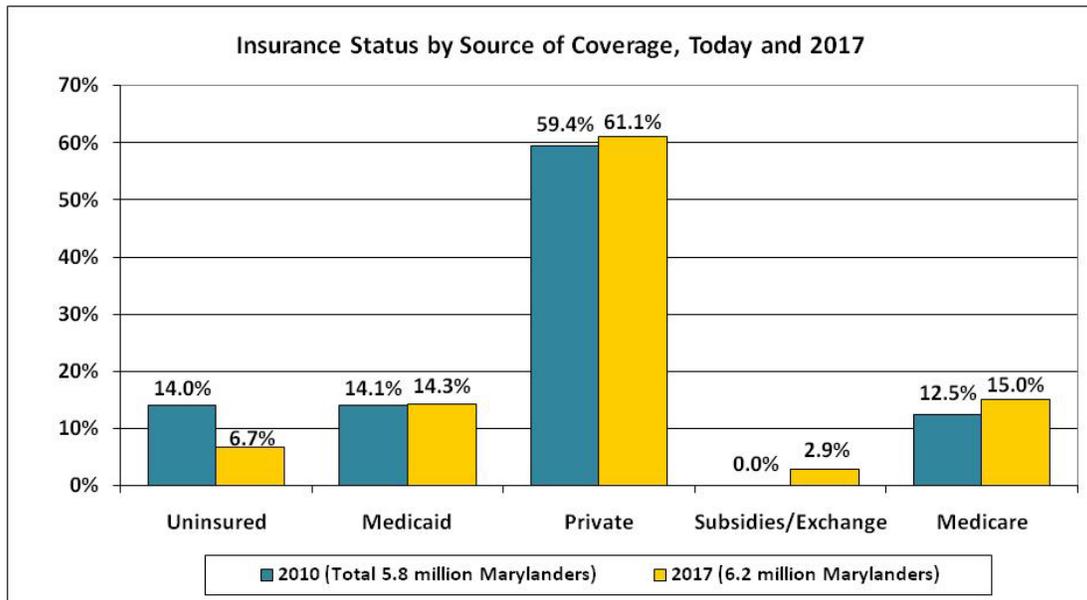
savings to Maryland's budget over the next ten years.⁶ This model is a dynamic tool capable of facilitating projections that can be adapted and updated as data become available, conditions and factors change over time, and decisions are made by policymakers, providers, employers, and consumers. Although exploration of assumptions about implementation is ongoing and must continue, the current estimate remains unchanged from that documented in the Interim Report. The state's projected total cumulative savings for fiscal years (FYs) 2011 to 2020 are \$829 million, the midpoint of a projected range from \$622 million to \$1.036 billion. The cumulative savings increase over time, peak in FY 2019, and begin to decline in FY 2020, when the state is projected to spend \$46 million more in that year than it would have without health care reform. This trajectory underscores how critically important it is for the state to focus on bending the cost curve early in order to improve the fiscal outlook at the end of the decade.

Projected Reductions in the Number of Uninsured Marylanders: Currently over 700,000 Marylanders—or 15 percent of the non-elderly—are without insurance coverage, a rate slightly lower than the national average of 17 percent. When the ACA is fully implemented, Maryland's uninsured rate is estimated to be cut by more than half,⁷ with most of this reduction a direct result of ACA implementation. Many of the currently uninsured will obtain coverage through the new health benefit exchange with the help of federal premium subsidies. Others will receive coverage through Medicaid Expansion. In addition, baby boomers becoming eligible for Medicare will also decrease the number of uninsured. Finally, many people newly uninsured or on Medicaid because of job loss are projected to return to employer-sponsored insurance as the economy recovers and stronger job growth takes hold. A comparison between the health coverage status of Maryland's population today and after full implementation of health care reform is found in Figure 2 below.

⁶ Health Care Reform Coordinating Council. (2010, July). *Interim report - Appendix F: Maryland Health Care Reform financial modeling tool: Detailed analysis and methodology*. Retrieved from <http://healthreform.maryland.gov/documents/100726appendixf.pdf>

⁷ Health Care Reform Coordinating Council. (2010, July). *Interim report*. Retrieved from <http://healthreform.maryland.gov/interimreport.html>

Figure 2: Insurance Status by Source of Coverage, Today and 2017



Federal Implementation Timelines: Some aspects of health care reform are already in effect (see Appendix E), and others have interim deadlines over the next couple of years, but most of the major provisions do not become fully effective until 2014. States must nevertheless begin careful planning now to meet both interim and full implementation timelines. States’ specific responsibilities for meeting deadlines with respect to some components of reform are clear, with APA directives and federal guidance already in place. In other areas, states must await further federal guidance before making implementation decisions.

Essential Health Benefits: A critically important component of reform still awaiting federal guidance is the definition of “essential health benefits.” The ACA requires the federal government to define essential health benefits, which must be included in all individual and small group products offered through health benefit exchanges. The ACA provides that essential health benefits should be equal to the range of benefits offered by a typical employer-sponsored plan and must include certain service categories. The federal government has yet to promulgate guidelines, however, on specific coverage requirements such as the amount, duration, and scope of these service categories.

The federal definition of essential health benefits will be important to states. States may choose to require that exchange products offer benefits in addition to the essential health benefits, but if they opt to do so, states must assume the full cost of the additional benefits for everyone purchasing in the Exchange. Current Maryland law applies 42 mandated benefits to most regulated health insurance products. The cost of these mandated benefits, however, is *not* borne by the state. Thus, should Maryland choose to require any benefits in exchange health plans beyond those defined as essential health benefits, this decision could have a substantial fiscal impact. Until federal guidance on essential health benefits is released, however, the extent to which they differ from Maryland’s current mandates and the cost of imposing any additional

mandates cannot be determined. Similarly, the effect of essential health benefits on Maryland's Comprehensive Standard Health Benefit Plan, discussed below, also remains unclear.

Maryland's Foundation for Reform

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. 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, the state has extended coverage to more than 250,000 Marylanders by expanding Medicaid eligibility, 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; in other cases, federal mandates may require rethinking existing efforts.

Maryland's Insurance Markets: Federal health care reform makes a number of changes to the ways in which states regulate their private 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 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.⁸

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. 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. As discussed above, the CSHBP will be affected by new federal standards for "essential health benefits."

⁸ Maryland Insurance Administration. (2009). *2009 health benefit plan report, market share by earned premium*. U.S. Department of Health and Human Services. (2010). Retrieved from <http://www.healthcare.gov/glossary/e/exchange.html>

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 they are subject to modified community rating. Modified community rating limits the factors that insurance carriers may consider when they price insurance policies, and thus it reduces variation in how much small businesses pay for health insurance. This rating policy helps make purchasing insurance affordable even for small employers who have employees with poor health status because carriers cannot consider the employers' history of health care costs in pricing their plans. Since 2009, however, insurance carriers have been allowed to impose pre-existing condition limitations or exclusions for individuals who are new to the small group market or 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. Once fully implemented, however, the ACA's insurance market reforms will impose greater limitations on the factors insurers may consider in pricing policies.

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 that have not previously offered insurance, the Maryland Partnership will pay up to half of the cost of health insurance. As of December 2010, the Partnership had enrolled 350 businesses and about 1,450 individuals, which is below the initial projection, in part because of the country's economic downturn. The ACA'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 ten 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 constitutes a smaller percentage of the insured population than the individual market comprises in most other states. Unlike in the small group market, insurance carriers in the non-group market 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 altogether in the individual market. Although underwriting practices limit coverage for many seeking insurance in this market, they also serve to keep premium rates down, especially for younger, healthier individuals. Moreover, a relatively large number of high-deductible plans with narrow 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. The ACA's insurance market reforms will significantly alter the non-group market, making changes to carrier pricing practices and benefit requirements for products that will be sold in the exchange.

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 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 country's fastest growing and third largest high-risk pool out of 34 nationwide—MHIP enrolls over 20,000 individuals and is over 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 MHIP risk pool is sicker than the pool of relatively healthier people able to obtain coverage in the individual market. Since 2005, MHIP has also offered an “MHIP +” plan that provides further subsidies to individuals with low and moderate incomes up to 300 percent of the FPL to enable them to buy coverage. MHIP receives the funding to subsidize premiums for both MHIP and MHIP + plans 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, which constitutes about 62 percent of MHIP’s overall funding. With respect to changes brought about by the ACA, it will eliminate the need for high-risk pools when fully implemented, and in the interim it creates a federal temporary high-risk pool.

Large Group Market: About two-thirds of Marylanders with commercial health coverage are enrolled in self-funded plans that fall outside the scope of 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 large group market share.

The ACA will give states the option of expanding access to their exchanges to employers with 50 to 100 employees earlier than the 2016 federal mandate for implementing such expansion. 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.

Health Insurance Sales Force: Insurers rely on licensed producers (including both agents and brokers) to sell and service their products to individuals, employers, and other groups (e.g., associations). Producers play a significant role in the small group market, assisting in nearly 100 percent of all transactions. The exact percentage of individual policies sold by producers is not known. CareFirst, the largest carrier, estimates approximately 25% of their individual products are sold by producers. In order to sell small group or individual policies, producers must be licensed and authorized to sell health insurance in the state and have appointments with the carriers for any policies they sell. Producers may place the business directly with carriers, through registered third-party administrators (TPAs), or through other intermediaries such as wholesalers. Premiums do not vary regardless of whether an insured purchases a policy through a producer or directly from a carrier, or whether the producer places the business directly with a carrier or through an intermediary. Carriers pay producers commissions that vary in amount from carrier to carrier and producer to producer, depending on a number of factors. In the small group market, some carriers also pay TPAs/wholesalers administrative fees to carry out certain functions they perform under contract for the carrier, such as billing employers. Both producers and intermediaries currently perform functions and services that exchanges will be required to provide or facilitate with respect to all products sold in the exchange.

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

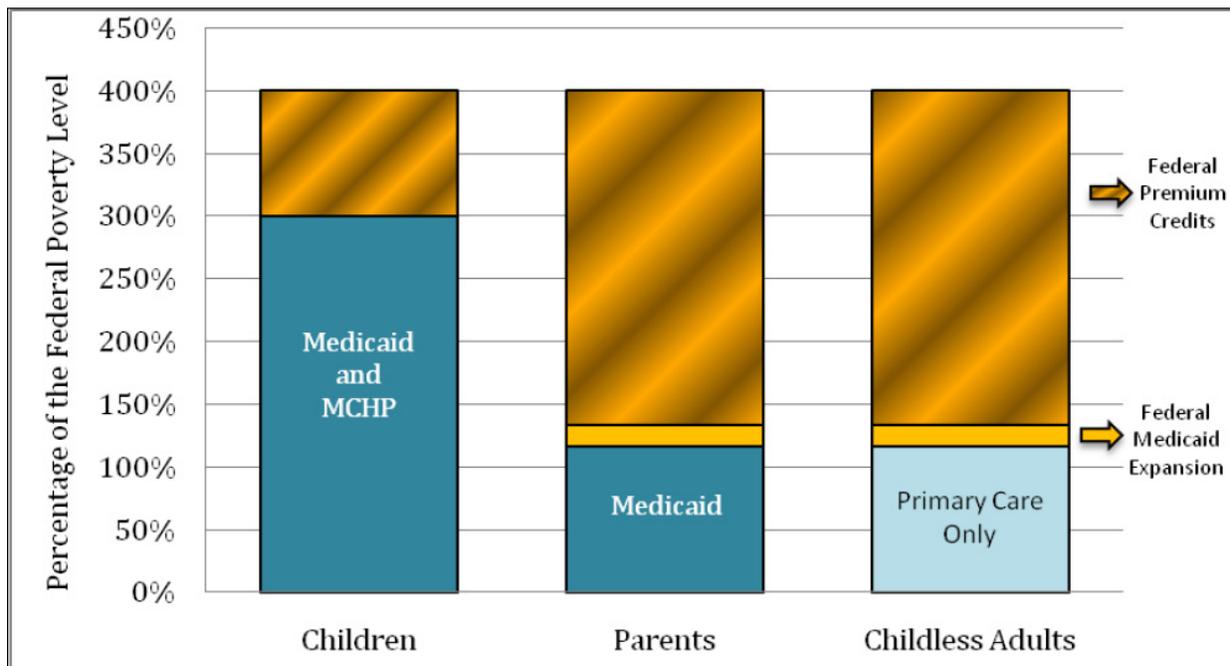
underwriting rules. MHIP will be phased out as a state-run high-risk pool will no longer be needed. Depending on how Maryland chooses to implement other components of reform, the changes in current non-group underwriting practices and the elimination of the high-risk pool may increase premiums for the younger and healthier individuals currently in the individual market as higher-cost individuals from MHIP are included in the risk pool and healthy individuals no longer receive the benefit of medical underwriting.

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 adults with low incomes. First, it extended eligibility to parents with incomes up to 116 percent of the FPL. This expanded coverage to about 70,000 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 parents with low incomes above 100 percent of the FPL (\$18,000 for a family of three). Second, Maryland began a phased-in expansion of coverage to childless adults with low incomes to be implemented over several years by progressively adding benefits to the existing Primary Adult Care (PAC) program. The new comprehensive benefits for adults required by 2014 under the ACA (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 in 1997 of the Maryland Children's Health Program (MCHP), the states' Children's Health Insurance Program (CHIP), Maryland has been a leader in coverage levels for children. 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 changes from current Medicaid eligibility levels and programs to the expanded levels under the ACA, and the new options available for subsidized insurance up to 400 percent of the FPL, are shown in Figure 3.

Figure 3: Public Coverage, Today and 2014



Maryland's Rate Setting System: Maryland has a system unique in the country for financing hospital uncompensated care. Through its hospital rate setting system, it finances over \$1 billion in uncompensated care annually for all Maryland hospitals, spreading the cost of the uninsured among all payers. This rate setting system has also financed policy initiatives that actually reduce the amount of uncompensated care, including the state's high-risk pool and recent Medicaid expansions. Most significantly, the all-payer system has generated substantial savings in hospital costs over its 33-year history.

Maryland's all-payer system is made possible by a waiver granted by the federal government. It will remain in place as long as the system continues to pass the so-called "waiver test," under which it must save money as compared to the rest of the country. The cost containment components of the ACA will increase the difficulty of meeting that test. At the same time, the flexibility afforded through the waiver and the ACA's opportunities for pilots and demonstrations give Maryland tools that will help meet the challenge.

Maryland's Safety Net Programs: Maryland also has many programs and initiatives that provide a safety net for the state's uninsured and underinsured. For example, it has 16 federally qualified health centers (FQHCs) with over 60 sites. The ACA provides new funding for FQHCs, although historically Maryland has not been competitive in obtaining funding for FQHCs because of its relative wealth. The state has almost 70 school-based health centers serving Maryland's uninsured families, and the ACA also offers new funding opportunities for these centers.

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.

These and other safety net providers are an important source of care for individuals both with and without insurance. Because many will still lack sufficient coverage even after health care reform is fully implemented, the functions of these providers must be preserved and adapted to the post-reform environment.

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 also is 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 significant improvements in individual and public health, including high childhood immunization rates and major reductions in smoking, cancer deaths, adolescent pregnancy, and lead poisoning. Yet, due largely to the state's demographics and consistent with national trends, unresolved public health challenges remain, particularly in the areas of infant mortality, obesity, substance abuse, HIV/AIDS, and chronic diseases.

Health Care Reform Coordinating Council's Work and Process

The HCRCC conducted its work in four phases and has remained committed to obtaining widespread public input through an open, transparent process. During Phase I, it conducted an assessment of the ACA and its impact on Maryland and submitted its Interim Report to the Governor on July 26, 2010. The Interim Report sets forth:

- An overview of the ACA and its general implications for reform in Maryland
- The role and mission of the HCRCC
- The opportunities and challenges presented by reform implementation and the principles by which it must be guided
- The state's unique health care landscape and regulatory environment within which implementation decisions must be made
- The projected fiscal impact of reform over the next decade
- The workgroup process through which the HCRCC would formulate its recommendations on the decisions most critical to success
- A timeline for planning and key activities
- A section-by-section review of the ACA

Public testimony at HCRCC meetings and written comments sent to the HCRCC website were central to shaping the Interim Report.

Phase II involved an active public workgroup process, described in more detail below, which focused on key implementation issues. The HCRCC directed the workgroups to develop options for reform implementation to be considered in its recommendations. During this phase, the HCRCC also began coordination with other efforts currently underway in the state that address additional issues critical to the success of reform implementation. This coordination will continue as the HCRCC seeks to promote the goals of reform without duplicating ongoing efforts.

In Phase III, the HCRCC reviewed the options identified by the workgroups and directed development of initial staff recommendations. The HCRCC then solicited public input on the recommendations through a series of five public hearings in different regions of the state, as well as through written comments via its website.

Finally, in Phase IV, incorporating public testimony, public comments, and input from individual members, the HCRCC developed its final recommendations to be presented in its report to the Governor. A summary of oral and written input provided during the public hearing process is attached as Appendix F.

Workgroup Process

The HCRCC created six workgroups to address core issues that are central to the short- and long-term success of Maryland's reform implementation: (1) exchange and insurance markets, (2) entry to coverage, (3) education and outreach, (4) public health, safety net, and special populations, (5) health care workforce, and (6) health care delivery system. Although these topics vary in the specific challenges they pose with respect to ACA timelines and other implementation issues, they all have the potential to significantly affect and transform the health care system.

As such, the HCRCC recognized the need and worked hard to obtain broad public input on these issues. Central to its efforts was the promotion and facilitation of active public participation. To ensure that the process would be as inclusive as possible, the HCRCC opened up workgroup participation to any interested party. Collectively, the workgroups met over twenty times and solicited input from hundreds of Maryland stakeholders during meetings as well as through written comments. This process provided a structured forum for meaningful dialogue on different implementation issues with diverse groups of stakeholders from both the public and private sectors. See Appendix G for a list of each workgroup's charge and co-chairs, and Appendix H for the final workgroup white papers.

Implementation Issues and Recommendations

Through its workgroup process, and informed by substantial written and testimonial public input on the critical implementation issues examined and vetted through that process, the HCRCC has developed 16 recommendations on how Maryland should undertake reform implementation. Divided into three categories, the first two recommendations address the immediate building

blocks necessary to meet federal timeframes. The second group, recommendations 3 through 15, present opportunities to strengthen Maryland’s health care system and improve health. The final recommendation addresses the ongoing leadership and oversight necessary to achieve Maryland’s goals of implementing health care reform successfully and strengthening health and the health care system over the long term. Figure 4 below lists the HCRCC’s recommendations.

Figure 4: Summary of HCRCC Recommendations

Required Building Blocks for Reform	
1	Establish the basic structure and governance of Maryland’s Health Benefit Exchange.
2	Continue development of the state’s plan for seamless entry into coverage to meet federal implementation deadlines and to maximize federal funding for information technology (IT) systems and infrastructure.
Opportunities to Strengthen Maryland’s Health Care System and Improve Health	
3	Develop a centralized education and outreach strategy.
4	Develop state and local strategic plans to achieve improved health outcomes.
5	Encourage active participation of safety net providers in health reform and new insurance options.
6	Improve coordination of behavioral health and somatic services.
7	Incorporate strategies to promote access to high quality care for special populations.
8	Institute comprehensive workforce development planning.
9	Promote and support education and training to expand Maryland’s health care workforce pipeline.
10	Explore improvements in professional licensing and administrative policies and processes.
11	Explore changes in Maryland’s health care workforce liability policies.
12	Achieve cost savings and quality improvements through payment reform and innovation in health care delivery models.
13	Promote improved access to primary care.
14	Achieve reduction and elimination of health disparities through exploration of financial, performance-based incentives and incorporation of other strategies.
15	Preserve Maryland’s strong base of employer-sponsored insurance.
Oversight Necessary to Achieve Goals	
16	Ensure continued leadership and oversight of health care reform implementation, with the locus of authority in a new Governor’s Office of Health Reform.

Exchange and Insurance Markets

The ACA provides that all states must either create their own health benefit exchanges or allow the federal government to do it for them. As a new mechanism for individuals and small employers to purchase coverage, the exchange is to be a transparent and competitive marketplace that will offer a choice of health plans that meet certain benefits and cost standards.⁹ While the competitive choice of plans facilitated through information presented in a standardized format will provide an alternative to existing individual and small group markets for everyone, the

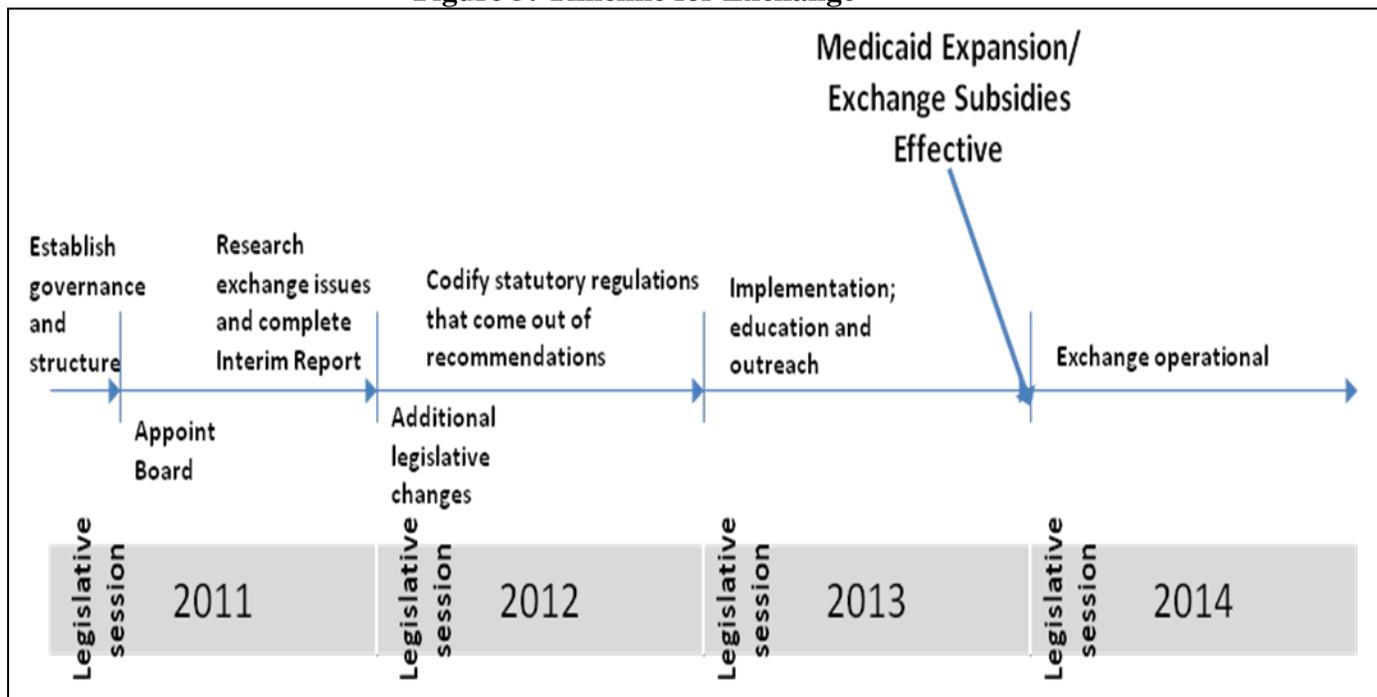
⁹ Definition from [www.healthcare.gov](http://www.healthcare.gov/glossary/e/exchange.html), <http://www.healthcare.gov/glossary/e/exchange.html>

exchange will be the sole mechanism through which individuals and small employers can access and utilize federal subsidies. Although estimates of how many small businesses and individuals will obtain coverage through the exchange are not yet possible, approximately 180,000 Marylanders will likely be eligible for a federal subsidy to purchase an exchange product.¹⁰

The individual and employer premium and cost-sharing subsidies available through the exchange constitute an important component of the ACA’s effort to promote coverage affordability. Premium tax credits will be available to eligible individuals and families with incomes up to 400 percent of the FPL (\$73,000 for a family of three), and cost-sharing subsidies to reduce out-of-pocket costs will be available for eligible individuals and families with incomes up to 250 percent of the FPL. With these federal subsidies available only for products purchased through the exchange, the ACA requires the exchange to determine eligibility for federal assistance and to facilitate eligibility determinations for Medicaid and MCHP.

The ACA allows states flexibility with respect to the structure, governance, and some functions of their exchanges. Exchanges must be created by March 23, 2012, and operational by January 1, 2014. If a state fails to act, then the federal government will step in to establish an exchange by January 1, 2013. Thus, the General Assembly’s calendar dictates that Maryland must act to establish its exchange in 2011 to comply with ACA deadlines. A timeline for exchange and related insurance market reforms is shown below in Figure 5.

Figure 5: Timeline for Exchange



¹⁰ Health Care Reform Coordinating Council. *Exchange and Insurance Markets Workgroup: Overview of the existing insurance market in Maryland*. Retrieved from <http://www.healthreform.maryland.gov/workgroups/documents/100810insurancemarketpp.pdf>

The success of Maryland's exchange will depend in large part on its ability to strike the right balance between transparency, accountability, and the capacity to coordinate with state agencies on one hand, and the flexibility and independence necessary to respond nimbly to market forces, attract personnel with appropriate expertise, and remain insulated from changing political environments and budgetary cycles on the other hand. The exchange's influence over insurance markets, certification of qualified health plans, facilitation of access to publicly financed benefits, procurement of services, and a host of other critical functions all demand transparency, with stakeholder participation in decision-making and public access to information to assure accountability. Yet, at the same time, the exchange will operate in the private sector and must be permitted to be competitive and nimble in its hiring and procurement practices, as well as nonpartisan in its administration and development of policy. Maryland stakeholders were united in the view that the exchange will need some combination of all these qualities to be a stable and credible marketplace and to meet the myriad challenges inherent in its mandate to function in both the public and private sectors.

The appropriate characteristics of the exchange's governance and structure are only the first order of business. Once in place, the exchange must evaluate, and advise policymakers on, multiple policy and operational issues to refine its goals and more clearly delineate its functions beyond those dictated by the ACA. Examples include whether the exchange should engage in selective contracting to reduce health care costs and improve quality of care; what rules should govern inside and outside the exchange to mitigate adverse risk selection; whether any benefits should be required of qualified health plans beyond the federally mandated "essential health benefits;" how the navigator program should be designed; how the Exchange should function for small employers; and through what user fees or other mechanisms the Exchange should become self-sustaining.

Recommendation One: Establish the basic structure and governance of Maryland's Health Benefit Exchange. This is a required building block of reform. Having an exchange in place by March 2012 is a key requirement for compliance with federal reform implementation deadlines. Thus, the HCRCC recommends that Maryland establish the initial structure and governance of a single health benefit exchange during the 2011 Session of the General Assembly. The enabling statute should create an independent public entity and establish guidelines for the constitution of the Board. It should also provide governing principles for transparency and accountability, and should ensure that the Exchange has sufficient flexibility with respect to procurement and personnel practices. Finally, it should afford the Exchange an appropriate mix of authority to begin some federally mandated implementation activities immediately and to develop recommendations for the Governor and General Assembly with respect to other functions and operational policies.

The HCRCC believes that the Exchange's start-up functions and wide-ranging influence over private sector entities and markets, as well as public sector funds and services, require the transparency and accountability of an independent public entity. It also recognizes, however, that while the attributes of a public entity will be clear advantages in the early incubator phase of the Exchange, it may turn out that spinning it off into a nonprofit makes sense later on. Once the Exchange is established, has secured a self-sustaining funding stream, and has carved out its independence and relationships with other state and federal

agencies and private sector entities, the balance may shift and the benefits of a nonprofit may begin to outweigh the strengths of a public entity. As such, the HCRCC recommends that the Exchange study and report to the Governor and General Assembly by 2015 its findings and recommendations on whether it should be transformed into a nonprofit or remain a public entity. In making this recommendation, the HCRCC relies on its conviction that the transformation from public body to nonprofit is more feasible than the other way around.

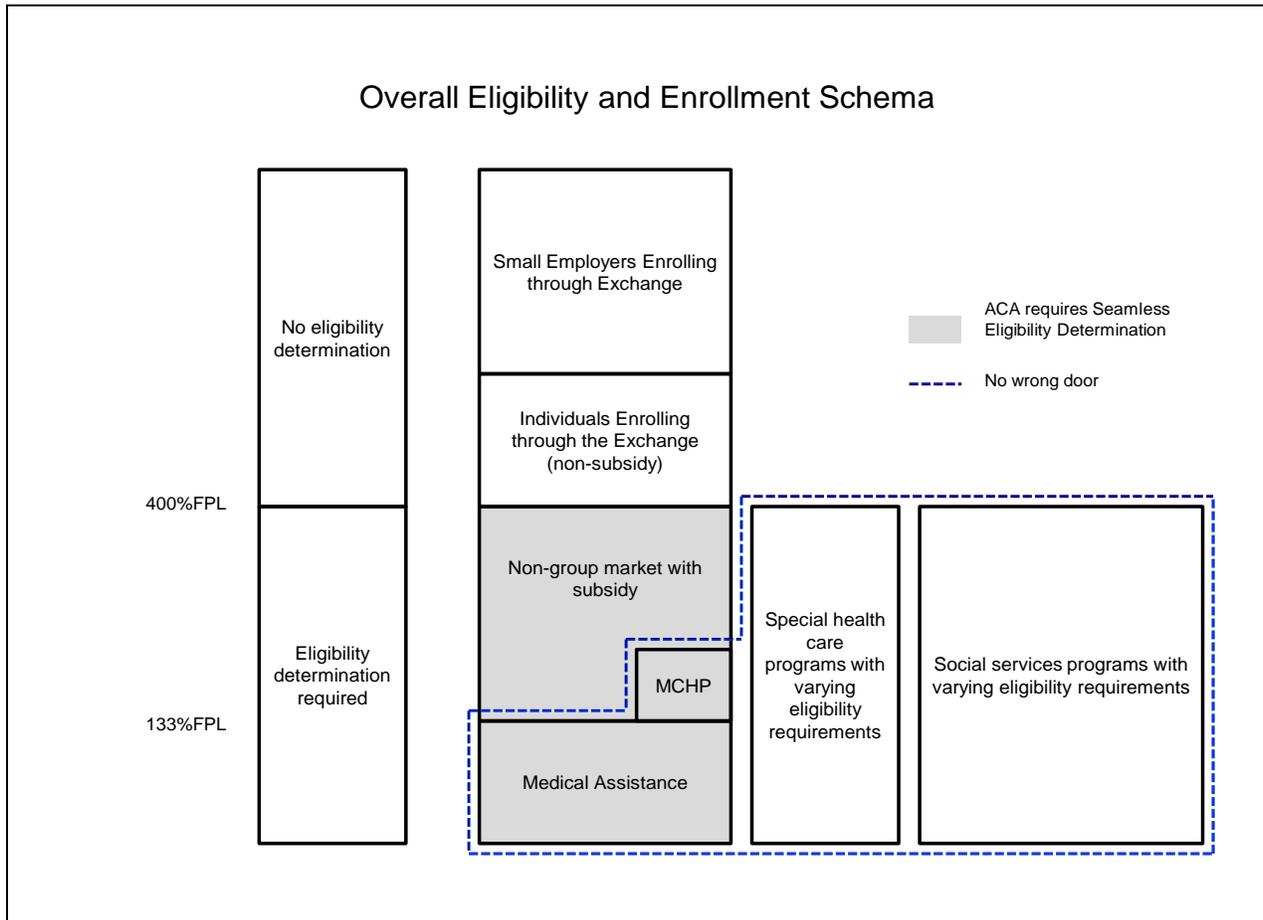
Entry into Coverage

Achieving the ACA's goal of expanding insurance coverage and reducing the number of uninsured depends largely on states' ability to enroll people in new and existing public and private coverage options. Many implementation decisions involved in establishing the requisite eligibility and enrollment functions are left to states. These decisions encompass both eligibility—the structure, process, and policies that should govern eligibility determinations for Medicaid, MCHP, and income-based premium credits offered through an Exchange—and enrollment—the point of access for individuals and small businesses to enroll in health plans offered through an Exchange.

The ACA requires states to facilitate entry to coverage with a “no wrong door” approach, ensuring that the process is more consumer-friendly and coordinated than ever before. Thus, applicants must be screened for all public subsidy programs (Medicaid, MCHP, and federal premium and cost-sharing subsidies) and enrolled in the appropriate program. Eligibility determinations, enrollment, and transitions between programs should be seamless from the perspective of the consumer. To this end, the ACA simplifies eligibility with requirements for uniform income rules and applications and the use of data matching and verification. Technology will also streamline entry into coverage in new ways, through web portals such as www.healthcare.gov, online applications, and the secure exchange of data across programs.

The major challenge for implementation is how to achieve the ACA's mandate to ensure seamless enrollment into health coverage programs across the income scale and coordinate the eligibility determination process for related health and public assistance programs (Figure 6).

Figure 6: Coordination of Eligibility Determinations



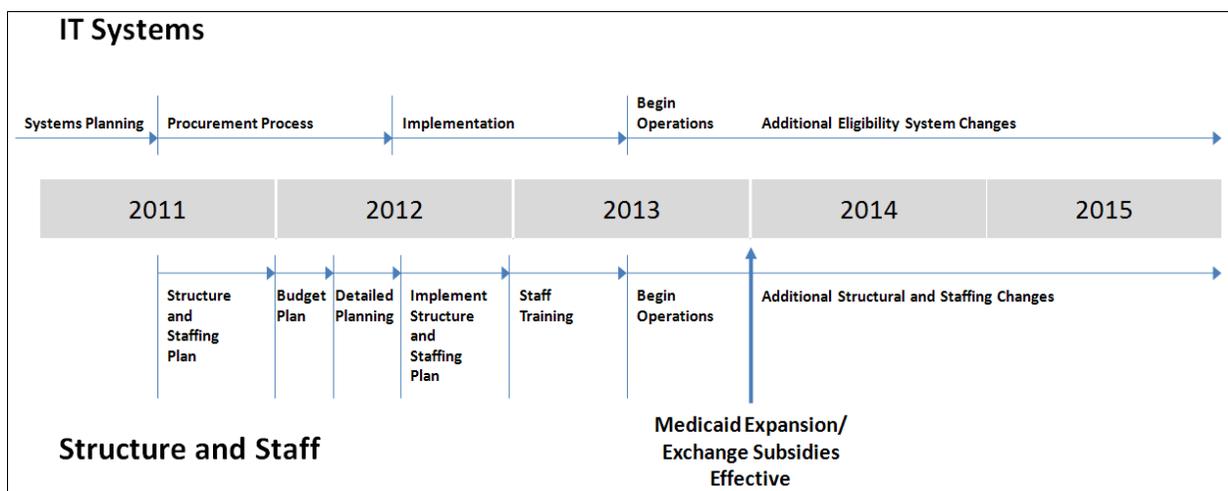
Maryland’s current process for Medicaid eligibility determinations has evolved over a 40-year history of changing public assistance programs and Medicaid Expansion. Today, about 1,600 staff at DHMH, 24 local departments of social services, and 24 local health departments all review and approve applications. The Client Automated Resource and Eligibility System (CARES) facilitates eligibility determinations for the majority of Medicaid and MCHP enrollees and other public assistance programs, although some eligibility determinations still occur outside of CARES.

Recent guidance from the Centers for Medicare and Medicaid Services (CMS) has clarified that enhanced federal matching funds will be available for the changes in eligibility systems necessary for ACA implementation, with the federal government providing 90 percent of the funding through December 31, 2015. For other issues important to entry into coverage implementation efforts, however, states are still awaiting necessary federal guidance. For example, the essential requirements of the new eligibility systems, the standards for data exchange with federal databases, and the extent to which eligibility rules may be streamlined are not yet clear.

In addition, fundamental decisions about how Maryland will achieve the ACA’s required seamless entry into coverage are dependent on or related to other major areas of reform implementation. For example, Maryland’s exchange will have the option of contracting with the Medicaid program to make its eligibility determinations for income-based federal subsidies. In turn, decisions about how to design entry into coverage will drive components of the state’s education and outreach strategy.

Despite these uncertainties, efforts must begin immediately to meet ACA timelines and maximize the use of federal implementation funds. Maryland’s new eligibility and enrollment systems will constitute a major departure from our current systems, requiring a greater need for flexibility, stability, accessibility, and round-the-clock support. The state must make decisions about its IT infrastructure and systems in 2011 because of their impact on procurement and budget decisions in FY 2012 and beyond. In short, the development of such sophisticated eligibility and enrollment systems requires significant time for planning, procurement, and implementation, as illustrated in the timeline below.

Figure 7: Timeline of Entry to Coverage Decisions for IT Systems and Structure



Recommendation Two: Continue development of the state’s plan for seamless entry into coverage to meet federal implementation deadlines and to maximize federal funding for IT systems and infrastructure. This is a required building block of reform. The HCRCC recommends that Maryland continue expeditious development of its plan for seamless entry into coverage. The plan should leverage federal funding to the fullest extent possible and be technically feasible by the 2014 implementation deadline. In addition, it should be consistent with the following goals:

- Current policy and processes for Medicaid and MCHP eligibility determination should be simplified dramatically in transitioning to the new income-based eligibility determination
- Eligibility determinations should embrace a “no wrong door” approach, with seamless integration across both health and public assistance programs
- Eligibility policy and processes should reflect a “culture of insurance” in which

all individuals are expected to have coverage as required by the ACA and endorsed by the HRCCC in its Interim Report

- Eligibility determinations and actual enrollment into health plans should be integrated into a single process rather than separated and administered by distinct systems

Education and Outreach

The success of health care reform will depend in large part on whether individuals and organizations respond favorably to its changes in the health care delivery system and utilize those changes to improve their health and wellbeing. Thus, engaging stakeholders and consumers in health care reform implementation and educating the public about its impact are essential. The state's education campaign must reach a broad range of groups, from consumers and employers to providers, insurers, brokers, and others. Yet the volume, complexity, and delayed effective dates of the reforms required by the ACA create communication challenges. Continuing uncertainties about aspects of implementation still awaiting federal guidance and clarification also exacerbate these difficulties. Finally, the education and outreach campaign must incorporate principles of cultural competence to ensure that its message also connects with racial and ethnic minorities and special populations.

Part of the challenge will be to channel and coordinate multiple and disparate education efforts already underway. The public has already begun receiving information about health care reform from different sources, including friends and family, media, health care providers, insurers, brokers, and employers. The federal government also provides a clearinghouse of factual information on health care reform through www.healthcare.gov, and Maryland's state and local governments have launched multiple efforts to begin educating consumers, businesses, health care providers, and others. In addition, private foundations and community-based organizations are producing materials on health care reform and/or actively conducting outreach at national, state, and local levels. Maryland must determine how best to leverage these federal, state, local, and private resources to achieve a coordinated and effective education and outreach campaign.

Recommendation Three: Develop a centralized education and outreach strategy.

The HCRCC recommends that Maryland develop a centralized education and outreach strategy as part of its ongoing oversight and implementation of health care reform. Development of this centralized strategy should consider and respond to the needs identified by the education and outreach workgroup. Components should include formally establishing a public/private coalition and supporting that coalition by developing templates for outreach materials. In addition, federal exchange planning grant funding designated for the development of a comprehensive communications plan will support the more general education and outreach campaign.

Public Health, Safety Net, and Special Populations

As discussed, the ACA will expand coverage and mandate changes in benefits offered by qualified health plans. In addition, it creates new funding opportunities and demonstration projects to effect changes in the health care delivery system and improve health outcomes by promoting wellness, prevention, and health equity. These changes will affect the traditional role

and functions of safety net programs and the public health infrastructure that serve the uninsured, underinsured, and special populations. Thus, proactive planning to shape the future of the health care safety net and services for special populations is critical. In addition, the multiple issues related to public health, safety net, behavioral health, racial and ethnic disparities, and special populations infuse almost all other aspects of health care reform. They must be considered across the board as implementation moves forward.

The workgroup developed ten points of consensus that underlie its goals for reshaping the public health infrastructure and safety net in the post-reform environment:

1. Health insurance coverage is a necessary but insufficient prerequisite to improving health outcomes. Thus, Maryland must seize the opportunity presented by health care reform to embrace a “culture of care” where individuals have not only health insurance, but also meaningful access to health care services. In its implementation efforts, the state must recognize the many reasons some individuals cannot access health care, which include racial or ethnic disparities, geographic, cultural, or linguistic barriers and provider shortages. Achieving a culture of care will ensure that these barriers are addressed.
2. Maryland should maintain support for safety net programs because some individuals will remain uninsured or have needs that are not met by their health insurance.
3. Continuity of care is particularly important for special populations. Some individuals will likely transition in and out of Medicaid and commercial coverage offered in the exchange, and they may be uninsured for periods of time. Assuring continuity of care necessitates maintaining a robust safety net and ensuring its integration and coordination with Medicaid and exchange plans.
4. Health care reform offers the opportunity to improve the coordination and delivery of care for the uninsured.
5. Some safety net providers may need to change their business models and operating practices to take full advantage of opportunities presented by reform.
6. Maryland should improve collaboration between public and safety net providers to compete for new funds more effectively and to use current resources more efficiently.
7. The federal government’s definition of essential health benefits will be critically important. Some populations, like those covered by Medicaid, will be affected more than others by how comprehensive the federal government decides to make these benefits. Maryland may need to maintain funding for services excluded from this definition.
8. Behavioral and somatic health services should be integrated and coordinated to improve patient care.
9. The public health infrastructure, including local health departments and population-based health programs, perform unique functions that should be maintained in the post-reform environment.
10. Health care reform implementation should address the barriers to care experienced by some special populations.

Public health, in service to the community as a whole, is the science and practice of protecting, promoting, and improving the health and wellbeing of the public through the control of communicable diseases, application of sanitary measures, monitoring of environmental hazards, promotion of health education and prevention, reduction of health disparities, and development of policies designed to achieve these goals. The ACA establishes some initiatives to strengthen

public health and safety net programs. Yet, because the public health infrastructure performs some unique functions that will not be replaced by the ACA's coverage expansion or other changes in health insurance, Maryland must ensure that it be retained as a vital component of the state's health care system.

Recommendation Four: Develop state and local strategic plans to achieve improved health outcomes. The HCRCC recommends that Maryland undertake interconnected state and local planning efforts that address opportunities to improve coordination of care for those remaining uninsured even after reform is fully implemented. The State Health Improvement Plan (SHIP) should conduct a state health needs assessment, identify health priorities, and set goals for health status, access, provider capacity, consumer concerns, and health equity. The SHIP should also designate public and private sector partners to work with the state and local health departments on implementation and monitor performance metrics. Local implementation plans should involve collaborations, led by local health departments, to identify systemic issues for inclusion in the SHIP. These collaborations should also help work towards SHIP goals. The Community Health Resources Commission should provide technical assistance in the development of the SHIP and local implementation plans, piloting models in a few jurisdictions and sharing lessons learned with others.

While full implementation of the ACA will expand coverage substantially, an estimated 400,000 or more Marylanders will remain uninsured either by choice or circumstance. These uninsured will continue to need and rely on the safety net. Moreover, even some insured individuals will likely have unmet health care needs and will rely on the safety net for special services not covered by traditional insurance products. Federal decisions about essential health benefits will affect the scope of this unmet need.

Maryland is fortunate to have a broad network of safety net providers who currently provide care for both insured and uninsured individuals, and the demand for their services will continue. With the changing landscape, however, many safety net providers may have to adjust their business models and operational practices. For example, they will need to participate in both Medicaid and the Exchange in order to assure continuity of care as individuals move between Medicaid and Exchange products. As more individuals obtain coverage and uncompensated or undercompensated services become reimbursable, providers may also need to make other adjustments, like billing insurance carriers for the first time.

Recommendation Five: Encourage active participation of safety net providers in health care reform and new insurance options. Given the ongoing need for the services of safety net providers, the HCRCC recommends that Maryland provide technical assistance to help the providers develop a plan to prepare for the changes brought about by reform. The Maryland Community Health Resources Commission is capable and well-positioned to provide this assistance. The plan should assess the administrative infrastructure of small safety net providers, identify partnering opportunities to enable more efficient support of these activities, and develop a roadmap for the sustainability of these efforts. Finally, to fully leverage opportunities for public/private partnerships that will improve health care delivery, the HCRCC also

recommends the removal of certain statutory and administrative barriers that prevent local health departments from contracting with private entities.

The ACA will also affect the delivery of behavioral health services. With the high prevalence of behavioral health needs and the larger role to be played by Medicaid and commercial insurance in financing mental health and substance abuse treatment, the state should take advantage of the ACA's implications for behavioral health.

Recommendation Six: Improve coordination of behavioral health and somatic services. The HCRCC recommends that DHMH examine different strategies to achieve integration of mental health, substance abuse, and somatic services. Potential avenues to be explored include statewide administrative structure and policy, financing strategies designed to encourage coordination of care, and delivery system changes.

Recommendation Seven: Incorporate strategies to promote access to high-quality care for special populations. Special populations are defined as groups with characteristics that render individuals at high risk of encountering difficulties in accessing affordable, high-quality care. Virtually the entire spectrum of ACA implementation decisions has potential consequences for special populations. The HCRCC recommends that, wherever possible, Maryland incorporate strategies to promote improved access to high-quality care for special populations in making these implementation decisions.

Health Care Workforce

While more people 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. Health care workforce shortages exist nationally and in Maryland. These shortfalls will soon be exacerbated by the increased demand for services resulting from the ACA's coverage expansion, coupled with the rise in health services made necessary by an aging population. Changing demands on the workforce, however, will flow not only from the increased need for all services, but also from trends and shifts in emphasis in the health delivery system. Examples include the gradual move from acute to primary care and prevention, and from institutional to community-based settings.

Multiple public entities address workforce issues in Maryland and have examined health care workforce capacity. From these disparate studies, some common themes have emerged. Primary care, emergency medicine, and obstetrics are critical areas of concern. Urban areas have a more adequate supply of physicians overall, but certain populations with limited access require special attention. Rural and outer suburban areas give rise to particular concerns about primary care and specialty care capacity. Issues that, if addressed, could potentially alleviate shortages, include the adequacy of reimbursements, the need for simplification of administrative functions, improvements in medical management, and new care delivery models, such as patient-centered medical homes. All studies agree on the need for obtaining better data on workforce supply and improving coordination of existing resources.

Maryland has implemented multiple initiatives involving health care workforce development in recent years. New laws have addressed scope of practice and reimbursement, and an

administration bill in 2010 created a patient-centered medical home pilot. Other examples include financial support for education and training and physician reimbursement rate increases in the Medicaid program.

Existing shortages and upcoming changes require examining Maryland's health care workforce as a whole. Efforts to strengthen it should cover the broad spectrum of providers, including physicians and physician assistants; advanced practice nurses, registered nurses, and others in the nursing profession; dentists and dental hygienists; behavioral health providers; pharmacists; social workers; occupational, physical, and respiratory therapists; and others in the allied health professions. In addition, Maryland's health care workforce lacks sufficient diversity. Black/African American, Native American, and Hispanic/Latino populations are under-represented in the health professions, and this disparity must be ameliorated.

Recommendation Eight: Institute comprehensive workforce development planning.

The HCRCC recommends that Maryland institute comprehensive workforce development planning. This planning effort should improve data collection to enable more accurate assessment of needs and should enhance coordination of workforce efforts throughout the state. The Health Care Workforce Development Planning Grant of the Governor's Workforce Investment Board should be used as a resource for this effort.

Recommendation Nine: Promote and support education and training to expand Maryland's health care workforce pipeline. The HCRCC recommends that Maryland expand and maintain a robust workforce pipeline through support for education and training initiatives. Strategies include renewing efforts to secure federal approval of funding for the Maryland Loan Assistance Repayment Program, facilitating clinical training opportunities in community settings, and promoting non-traditional paths to participation in Maryland's health care workforce, including promotion and expansion of career ladder opportunities for existing allied health care professionals.

Recommendation Ten: Explore improvements in professional licensing and administrative policies and processes. The HCRCC recommends exploring ways in which licensing and administrative policies and processes could be streamlined and improved to ease entry into the health care workforce. Potential improvements include permitting reciprocity for health occupations licensed in other states with certain safeguards; incentivizing volunteerism in underserved areas; promoting cultural competency training; and continuing efforts to streamline credentialing.

Recommendation Eleven: Explore changes in Maryland's health care workforce liability policies. The HCRCC recommends that Maryland explore changes in its approach to health care workforce liability policies. After federal guidance becomes available, the state should consider participating in the ACA's demonstration program to evaluate alternatives to current medical tort litigation. In addition, Maryland should encourage hospitals and health systems to provide medical malpractice coverage for volunteer providers in community settings.

Health Care Delivery System

In 2009, the United States was estimated to spend \$2.5 trillion, or 17.3 percent of gross domestic product (GDP), on health care. This amount will likely increase to 19.6 percent of GDP by 2019.¹¹ These alarmingly high spending levels cause grave concern among policymakers, health care economists and other experts, and those in the private sector. Virtually everyone agrees this rate of growth in spending is unsustainable. Thus, the long-term positive impact of health care reform depends on whether we succeed in transforming the health care delivery system to control costs while also improving health. As more people obtain insurance coverage, delivery system reforms could reduce the growth in costs, improve the quality and efficiency of care, and keep health insurance affordable. The ACA offers tools to achieve these goals, 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 to have already initiated several efforts in this regard. It established the Maryland Health Quality and Cost Council several years ago, is engaging in an effort to assure continuation of the Medicare waiver, and is working to expand the use of health IT. It has also created a patient-centered medical home program, is working to reduce hospital-acquired infections, and is focusing on health promotion in the workplace. The workgroup addressed these and other initiatives, providing additional input on primary care reimbursement and access; patient-centered medical homes; payment reform; electronic health records/health IT; evidence-based practices; behavioral health; controlling health care costs; regulated insurance products; health care professional schools; and grants, demonstrations, and pilot programs in Maryland.

Recommendation Twelve: Achieve cost savings and quality improvements through payment reform and innovation in health care delivery models. The HCRCC recommends that Maryland achieve cost savings and quality improvements through multiple payment reform demonstrations throughout the health system and innovation in health care delivery models. Maryland should also promote evidence-based practice by disseminating findings from comparative effectiveness research. The HCRCC encourages continued support of the Maryland Health Care Commission's pilot of Patient-Centered Medical Homes and supports coordination between MHCC's pilot and other models to facilitate easier participation by providers in all models. Such coordination will facilitate participation by small practices and align care coordination strategies.

Recommendation Thirteen: Promote improved access to primary care. The HCRCC recommends that Maryland promote improved access to primary care by working toward critical investment in Maryland's network of primary care providers. This investment should be pursued by promoting deployment of some savings achieved through delivery system reform to increase Medicaid's primary care provider reimbursement rates.

¹¹ Sisko, A. et al. (2010, September). National health spending projections: The estimated impact of reform through 2019. *Health Affairs*. Bethesda, MD. Retrieved from <http://content.healthaffairs.org/content/early/2010/09/09/hlthaff.2010.0788.full.pdf+html>

Reduction of Racial and Ethnic Health Disparities

Maryland is a state enriched by a diverse population, with more than 42 percent of Marylanders belonging to racial and ethnic minority groups. These groups constitute key target populations for health care reform. Most (62 percent) of Maryland's uninsured are from racial and ethnic minority groups, and this percentage has increased as the percentage of minorities in Maryland's overall population has increased. As the first significant coverage expansion in a generation, the ACA will dramatically reduce the ranks of the uninsured. Accordingly, the ACA will have a profound effect on efforts to increase rates of coverage among racial and ethnic minority groups.

Maryland data reveal striking health disparities that break down along racial and ethnic lines. In 2008, for example, the age-adjusted death rate from all causes was 1.25 times higher for Blacks or African Americans than for whites. In 2009, death rates were higher among African Americans than whites for six of the ten leading causes of death.¹²

While health insurance coverage is important for reducing disparities, it is only a first step. Health disparities exist among uninsured and insured populations alike. Multiple, complex factors contribute to health disparities, so reducing them will require a multi-faceted approach. Maryland must employ strategies to help translate coverage expansions into improved health outcomes for everyone, across the spectrum of racial and ethnic groups. To this end, the state should take full advantage of the ACA's investments in the safety net, workforce, coverage expansion, public health, disease prevention, and other areas fundamentally linked to reducing disparities and improving access and health outcomes for individuals from racial and ethnic minority groups.

Recommendation Fourteen: Achieve reduction and elimination of health disparities through exploration of financial, performance-based incentives and incorporation of other strategies. Given the important role of incentives in driving systemic change, the HCRCC recommends that Maryland explore financial, performance-based incentives to reduce and eliminate health disparities. The state's first step should be to enhance data collection to facilitate assessment of both needs and performance metrics. Having adequate data is fundamental to understanding current and future gaps and disparities, targeting efforts to address them, and evaluating the success of different strategies. Second, Maryland should ensure that all reform implementation efforts incorporate and are aligned with the goal of reducing health care disparities, including using financial incentives where appropriate. Specifically, the HCRCC's recommendations and other activities that provide opportunity to address disparities include:

- Using existing data and knowledge of incentives, craft programs that reward reductions in Maryland's racial and ethnic health disparities;
- Using the SHIP and local implementation plans to identify disparities, implement strategies to address them, and monitor performance;
- Creating a more diverse workforce and strengthening the safety net through strategic and comprehensive workforce development planning;

¹² Maryland Department of Health and Mental Hygiene Vital Statistics Administration. (2009). *Maryland vital statistics annual report: 2009*. Retrieved from <http://vsa.maryland.gov/doc/09annual.pdf>

- Promoting cultural competency training for health occupations;
- Providing technical assistance to help safety net providers leverage health care reform opportunities to improve access and care for the diverse populations they serve;
- Employing education and outreach efforts that ensure cultural sensitivity and engage community-based organizations; and
- Improving data collection and analysis through the SHIP and local implementation plans, as well as building on MHCC's ongoing work to encourage common reporting of race and ethnicity among health plans.

Preservation of Employer-Sponsored Insurance

Employer-sponsored insurance is the primary source of health coverage in this country. A relatively wealthy state, Maryland has 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 more than half (58 percent) of all private sector employers in Maryland offer health insurance, again a figure slightly higher than the national average.

In recent years, employers nationally and in Maryland have struggled to continue offering coverage as insurance costs have escalated. Between 2003 and 2009, employer premiums in Maryland increased 50 percent for families, from approximately \$9,200 in 2003 to approximately \$13,800 in 2009. Premiums for individuals increased 42 percent, from approximately \$3,420 in 2003 to \$4,900 in 2009. Maryland's employer premiums were ninth highest among those in all 50 states.¹³

The rising cost of insurance inflicts particular hardship on small businesses. The small group market cannot share its risk over large populations and has less purchasing power to negotiate rates with insurers. In addition, small businesses incur proportionately higher administrative costs in managing health insurance plans than do larger businesses.

Recommendation Fifteen: Preserve Maryland's strong base of employer-sponsored insurance. The HCRCC recommends that Maryland seek to preserve its strong base of employer-sponsored insurance through strategies that bend the cost curve and hold down the cost of premiums for employers. The state should also work toward simplifying employer enrollment in health coverage. Finally, all reform implementation decisions affecting employers should seek to minimize potential disruption for those employers currently offering insurance to their employees.

Leadership and Oversight of Health Care Reform Implementation

Pursuant to the Governor's Executive Order, the HCRCC has functioned as the primary body coordinating the state government's implementation of the ACA. As directed, it has created a process through which it has identified and made recommendations with respect to the fundamental decisions critical to the successful implementation of health care reform in

¹³ Schoen, C., Stremikis, K., How, S. K. H., & Collins, S.R. (2010, December). *State trends in premiums and deductibles, 2003–2009: How building on the Affordable Care Act will help stem the tide of rising costs and eroding benefits*. The Commonwealth Fund.

Maryland. Although under the Executive Order the HCRCC commences in January 2011, ongoing leadership and coordination of health care reform remains necessary. In many respects, the work of reform implementation has just begun and will continue over the next several years. Indeed, implementation of some aspects of reform awaiting federal guidance or funding cannot even begin until well into 2011 and beyond.

Recommendation Sixteen: Ensure continued leadership and oversight of health care reform implementation by establishing a Governor’s Office of Health Reform. Given the need for ongoing coordination of health reform implementation, the HCRCC recommends that the Council continue to function through 2014 to monitor progress on recommendations and provide input on implementation activities. Additional HCRCC members should be considered, including leadership from the new Health Benefit Exchange and representation from the Governor’s Workforce Investment Board. The HCRCC should be an advisory body to the Governor’s Office of Health Reform, which should be the focus of authority for health reform implementation.

The Office of Health Reform should direct reform policy and issue instructions for implementation, without duplicating the functions of other executive branch agencies involved in reform implementation. To the greatest extent possible, the resource needs for the Office of Health Reform will be addressed through federal and private grant funding and existing general fund resources. It is important to invest a modest level of resources in leadership and oversight in order to realize the full savings potential of reform.

Essential Investments

As described above, the HCRCC’s financial model estimates that health care reform will generate substantial cumulative savings to Maryland over the next decade. Yet, across its individual components and during different time frames, some aspects of health care reform involve costs as well as savings. Costs in the early phases of implementation will support administrative functions and building infrastructure, including the development of new eligibility systems and the health benefit exchange. Early savings will result from changes to pharmacy rebates and enhanced federal funding for state employees’ and retirees’ health benefits.

Because establishing the exchange will be one of Maryland’s first and most significant steps in its reform implementation, this effort must begin immediately to meet federal timeframes. Federal grants will, to a large extent, fund development of the exchange. Maryland has already received a nearly \$1 million planning grant, and another round of federal exchange implementation grants will be announced in February 2011 and likely awarded before the end of federal fiscal year 2011 (September 30, 2011).¹⁴ Maryland may also attempt to secure support for the exchange through a federal innovator cooperative agreement, which could be awarded as early as February 2011. Given potential pressures on health care reform funding in Congress, Maryland should do everything possible to obtain all available federal funds as quickly as possible.

¹⁴ Federal officials have asserted that because these grant funds have already been appropriated, their expectation is that the grants will be awarded regardless of whatever congressional delays in future ACA-related appropriations may occur.

Compliance with the ACA's entry into coverage requirements constitutes another essential and significant building block of health care reform. Maryland must undertake a wholesale modernization of its eligibility and enrollment IT systems to satisfy these ACA mandates. The federal government's recent announcement that it will provide 90 percent of the funding necessary for the development of new Medicaid eligibility systems presents an unprecedented opportunity to advance Maryland's long-term modernization goals at a substantially reduced cost. Because this 90 percent federal match rate is available only through December 31, 2015, Maryland will need to make the investments necessary to take advantage of this significant federal funding opportunity.

The ACA also offers numerable opportunities to improve Maryland's health and health care system through a wide array of federal pilots, demonstrations, and initiatives, many of which are funded fully or partially with federal resources. Maryland has already pursued many of these opportunities (see Appendix I) and should continue to expedite administrative approvals and take other steps necessary to bring as many of these dollars into the state as possible.

In sum, the state must recognize that, despite the substantial projected savings to be realized from health care reform, the investment of some limited resources will be needed to leverage and take full advantage of all the opportunities presented by health care reform to achieve both long-term savings and lasting improvements in our health system.

Conclusion

Health care reform holds the promise of transforming our health care system to improve the health and wellbeing of all Marylanders. We can enhance quality while reducing costs and expand coverage while maintaining affordability. We can achieve our long-sought goal of ensuring all Marylanders access to the care they need. With help and collaboration from public and private sector leaders, providers, carriers, employers, producers, and consumers, we can realize the full promise of reform: a healthier Maryland.