MARYLAND HEALTH CARE COMMISSION

REQUIRED UNDER SB 131 and HB 845 (2004)

Interim Report on the Study of the Affordability of Health Insurance in Maryland

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INTERIM REPORT ON THE STUDY OF THE AFFORDABILITY OF HEALTH INSURANCE IN MARYLAND

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Executive Summary

During the 2004 session, the Maryland General Assembly passed Senate Bill 131 and House Bill 845 which requires the Maryland Insurance Administration (MIA) and the Maryland Health Care Commission (MHCC) to study issues related to the affordability of private health insurance in Maryland. A preliminary report is due to the legislature in January 2005 and a final report in January 2006.

The bills require the MIA, in consultation with the MHCC, to study: (1) the number of, and the regulatory requirements, including the rating of health status, related to health insurance carriers in Delaware, the District of Columbia, Pennsylvania, Virginia, and West Virginia; and (2) the role of tax-deferred health savings accounts and other models of offering health insurance designed to increase consumer awareness of the cost of health care services. The MHCC is required, on its own, to study: (1) the factors that contribute to increases in health care costs in Maryland, including utilization of health care services; (2) ways to educate consumers about health care issues and promote personal accountability in health care; (3) ways in which disease management programs can promote the appropriate management of chronic diseases; (4) ways to encourage strategies to purchase health care that focus on quality, patient safety, and wellness; (5) ways to facilitate a more effective and efficient health care delivery system, including improved information technology and evidence-based medicine; (6) innovative programs in other states designed to encourage the appropriate use of health care services; and (7) ways to make health insurance more understandable to both employers and consumers.

This preliminary report defines and explains the drivers in health care spending, and addresses the issues laid out in Senate Bill 131 and House Bill 845 through a literature review. By addressing each of these issues, we attempt to define and assess how the State of Maryland, businesses, and the residents may attempt to curb the growth of spending in health care costs, increase access to health care, and improve quality of care. This report provides preliminary recommendations and puts forth issues to further consider for the final report.

The analysis presented in this document includes data from the MHCC annual state health expenditure analysis, as well as a literature review of current articles relating to the cost of health care and strategies and programs undertaken by public or private organizations and states to curtail the growth in medical spending. During the forthcoming year, staff from the Maryland Health Care Commission will conduct a more detailed analysis of the cost drivers and issues put forth in the legislation. Staff will

attempt to replicate detailed cost analysis conducted by other states, such as Maine and Indiana.

While the recent figures for health care premiums did not surpass last year's numbers, it marked the fourth straight year of double digit increases and outpaced the rate of inflation. In order to develop recommendations on ways to make private health insurance more affordable for Maryland residents, due to the Maryland General Assembly in January 2006, the MHCC will explore several issues over the next twelve months. Based on the MHCC's analysis of current literature, including legislation and activities undertaken by other states and health insurance carriers to stem the rising cost of medical care and health insurance, it is recommended that the Maryland General Assembly consider the following preliminary recommendations as attempts to control health care spending in Maryland –

- Transparency of full cost information to the consumer – Similar to the Florida legislation which requires the Agency for Health Care Administration (ACHA) to post pricing information on procedures performed in Florida hospitals, the MHCC should consider adding cost data to its Maryland Hospital Performance Guide for each high volume medical procedure. Information describing the all-payer rate setting system as administered by the Health Services Cost Review Commission should be presented. Cost data may be presented in the Maryland Ambulatory Surgical Facility Consumer Guide as it is developed as well.

- Emergency Department Diversion Plans - Another part of the Florida legislation which Maryland could replicate is the encouragement of hospitals and health insurance carriers to have emergency department diversion plans, such as a hospital 'emergency hotline' whereby consumers may call to help them determine if the emergency department is the appropriate setting for their medical condition. The Florida legislation also encourages the development of a hospital 'fast track' program which would refer non-emergency patients to alternative sites, and the increased on-call availability of health care providers to carriers' enrollees after hours. Maryland, as in other states, is seeing an increase in the number of patients seeking care in the emergency department setting, and many of these individuals have non-emergent medical conditions. To alleviate some of the burden faced by the hospitals in treating patients, it is worth educating patients on the appropriate setting for treating medical conditions.

- Financial Incentives to Providers - In order to encourage health care providers to provide cost-effective quality care, health insurance carriers should be encouraged to provide incentives to physicians. Blue Cross Blue Shield (BCBS) of Michigan recently paid $5 million in incentives to providers who directed patients to disease management programs in congestive heart failure, heart disease, asthma and diabetes. As the first BCBS organization to provide incentives to physicians in its traditional and preferred provider organization plans, ten physician groups with 2,900 physicians participated in the program, paying the physicians with money allocated towards increased physician fees. Through an education process with nurses affiliated with the BCBS program, patients are taught ways to manage their chronic illness, which in turn reduces trips to the emergency room and hospital

stays. Also, the Health Services Cost Review Commission (HSCRC) is currently developing a pay-for-performance program that will provide financial support and incentives to hospitals that meet or exceed established performance measures consistent with evidence-based health services research.

In addition to health insurance carriers, incentives should be explored through which hospitals, health systems, and private providers can be encouraged to improve chronic disease management.

- Redesign of the Small Employer Website - Similar to the California Healthcare Foundation's Health Coverage Guide, the MHCC should redesign their small employer website to include additional educational material that will assist small employers in understanding the intricacies of health insurance (especially the cost and options to reduce spending), and help them when purchasing coverage. In addition, information on individual insurance market products currently available on the Maryland Insurance Administration website should be more prominently featured to facilitate access by consumers. The MIA website should also include general information on health insurance to educate consumers on the costs associated with the plans, as well as basic information describing health insurance.

- Listing of Additional Prescription Drugs on Maryland OAG Website - Consumers may use the Maryland Office of the Attorney General website to locate the least expensive price for the drug they are taking according to their area of residence. It would be more beneficial, however, to include additional prescription drugs so that a greater share of the Maryland population would benefit from this cost comparison tool. On the Maryland Office of the Attorney General website, prices for the 25 most commonly prescribed prescription drugs are available by county. A consumer can compare the prices for these drugs by county or by city or zip code. The name and address of pharmacies are presented along with the 'usual and customary' price of the drugs.

In addition, the Maryland Health Care Commission will conduct a more detailed analysis of the cost drivers, including issues related to the health care status of Maryland residents (such as the prevalence of obesity and smoking in Maryland) and issues put forth in the legislation. MHCC staff will take into consideration the cost analysis undertaken by other states (e.g., Maine and Indiana). Staff will also explore the effectiveness of other state and carrier initiatives and programs, such as the use of evidence-based medicine, wellness programs coupled with health insurance premium rebates, provider pay-for-performance programs, and provider 'tiering' as possible methods to control health care spending and reduce health insurance premiums.

STUDY OF THE AFFORDABILITY OF HEALTH INSURANCE IN MARYLAND

I. Introduction

During the 2004 session, the Maryland General Assembly passed Senate Bill 131 and House Bill 845[1] which requires the Maryland Insurance Administration (MIA) and the Maryland Health Care Commission (MHCC) to study issues related to the affordability of private health insurance in Maryland. A preliminary report is due to the legislature in January 2005 and a final report in January 2006.

The bills require the MIA, in consultation with the MHCC, to study: (1) the number of, and the regulatory requirements, including the rating of health status, related to health insurance carriers in Delaware, the District of Columbia, Pennsylvania, Virginia, and West Virginia; and (2) the role of tax-deferred health savings accounts and other models of offering health insurance designed to increase consumer awareness of the cost of health care services. The MHCC is required, on its own, to study: (1) the factors that contribute to increases in health care costs in Maryland, including utilization of health care services; (2) ways to educate consumers about health care issues and promote personal accountability in health care; (3) ways in which disease management programs can promote the appropriate management of chronic diseases; (4) ways to encourage strategies to purchase health care that focus on quality, patient safety, and wellness; (5) ways to facilitate a more effective and efficient health care delivery system, including improved information technology and evidence-based medicine; (6) innovative programs in other states designed to encourage the appropriate use of health care services; and (7) ways to make health insurance more understandable to both employers and consumers.

The purpose of this preliminary report is to define and explain the drivers in health care spending, and address the issues laid out in Senate Bill 131 and House Bill 845 through a literature review. By addressing each of these issues, we attempt to define and assess how the State of Maryland, businesses, residents, and other stakeholders in the health care system may attempt to curb the growth of spending in health care costs, increase access to health care, and improve quality of care. This report provides preliminary recommendations and puts forth issues to further consider for the final report.

The analysis presented in this document includes data from the MHCC annual state health expenditure analysis, as well as a literature review of current articles relating to the cost of health care and strategies and programs undertaken by public or private organizations and states to curtail the growth in medical spending. During the forthcoming

[1] Chapter 93 of 2004 (Senate Bill 131) and Chapter 94 of 2004 (House Bill 845), *Maryland Health Care Commission and Maryland Insurance Administration – Affordability of Health Insurance in Maryland – Study and Recommendations, 2004.*

year, staff from the Maryland Health Care Commission will conduct a more detailed analysis of the cost drivers and issues put forth in the legislation. Staff will attempt to replicate detailed cost analysis conducted by other states, such as Maine and Indiana. As part of their interim State Health Plan, Maine examined the amount of spending on hospital services (inpatient cost and utilization, outpatient costs and utilization), and spending on physician/health care professionals' services. The cost analysis for Indiana included a review of its current economy and the effect of the health care sector on it, as well as the health insurance market, employer-sponsored coverage and factors that drive health care costs.

II. Background on Increasing Health Care Costs

This section will cover -

- National Trends in Health Care Spending
- State Trends in Health Care Spending
- Maryland Demographics and Marketplace
- Health Care Cost Drivers

National Trends

In 2002, national health care expenditures were approximately $1.6 trillion, rising 9.3 percent from 2001, and accounting for 14.9 percent of the gross domestic product (GDP).[2] The 2002 increase in national health care expenditures is the largest in eleven years, and outpaced overall economic growth (3.6 percent).[3] Per person expenditures were on average $5,440, an increase of $419 from 2001.

Private health insurance accounted for the largest share of spending at approximately $550 billion or 35 percent, with private payers accounting for over half of the spending. Out-of-pocket payments were 14 percent of expenditures. Medicare comprised 17 percent of spending, Medicaid and SCHIP accounted for 16 percent and other public services accounted for 13 percent of spending.[4] Hospital spending growth grew to $486.5 billion in 2002, an increase of 9.5 percent from 2001. Since 1999, the growth in hospital spending nationwide has increased, and 2002 was the first year "hospital spending outpaced overall spending since 1991."[5] According to the CMS, "recent [hospital] spending trends reflect growing demands for services, rising compensation and other input costs, and the increased ability of hospitals to negotiate higher prices from private payers." In addition, increases in the number of admissions, the length of stay in hospitals, and the cost of malpractice insurance have led to increased hospital spending growth.[6]

Prescription drug spending was down slightly in 2002 to 15.3 percent, possibly attributable to the slow down in growth in private health insurance spending. As more of

[2] National Health Expenditure Highlights, 2002, Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov
[3] Robert Pear, "Health Spending Rises to Record 15% of Economy," *The New York Times*, January 9, 2004, and the Centers for Medicare and Medicaid Services.
[4] 'Other public services' includes programs such as worker's compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, State and local health subsidies, and school health.
[5] National Health Expenditure Highlights, 2002, Centers for Medicare and Medicaid Services.
[6] Robert Pear, "Health Spending Rises to Record 15% of Economy," *The New York Times*, January 9, 2004.

the cost of prescription drugs is shifted to the consumer through tiered drug formularies, out-of-pocket spending increased in 2002 (14.4 percent). Spending for physician services grew at a slower rate in 2002 than in 2001 (7.7 percent vs. 8.6 percent) as a result of the reduction in the Medicare payment update for physician services.[7]

Compared to the national health care expenditures, spending per privately insured U.S. resident increased 9.2 percent in 2002; slightly down from the 10 percent increase between 2000 and 2001.[8] According to a study reported by the Center for Studying Health System Change, data from the Milliman USA Health Cost Index show that hospital outpatient spending, per privately insured person, accounted for 37 percent in health care spending growth in 2002, and hospital inpatient spending made up 14 percent of health care spending growth; collectively accounting for over half of the overall increase in spending in 2002.[9] Prescription drugs and physician services each accounted for 22 percent and 27 percent, respectively, in the growth of health care spending.

Recent data reported by the Center for Studying Health System Change and The Employee Benefit Research Institute show that medical spending for those services typically covered by health insurance (hospital and physician services and pharmaceuticals) for the first half of 2004 grew at a faster rate than the gross domestic product (GDP).[10] For the period January through June 2004, health care costs per privately insured individual rose at 7.5 percent; almost the same rate as in 2003 and more than the growth in the U.S. economy (5.9 percent). The primary driver in the increased costs is hospital spending with the growth in hospital prices comprising a larger proportion of the growth than hospital utilization (7.7 percent compared to 0.8 percent, respectively). The growth in prices is attributable to the large growth in wage rates for hospital workers (4.5 percent). Another factor that may be reflected in the growth in hospital prices is the decline in hospital profit margins for Medicare patients. More hospitals are shifting costs to other patients (insured and private pay) to help compensate for the Medicare payment decrease.

Unlike other states, Maryland hospitals are subject to the all-payor rate setting system– all payors pay the same rate for a particular service at a hospital and cost-shifting is not permitted. Factors that influence hospital prices in Maryland, as well as nationwide, are considered in the hospital rates during the annual review. A percentage of the annual increase is allocated to cost inflation which is a 'market basket' of various costs, such as labor and facility malpractice rates.[11] For Fiscal Year 2005, a one percentage increase in rates was provided to hospitals for the improvements in facilities' property, plant and equipment. In addition, the Health Services Cost Review Commission (HSCRC) offers the 'Nursing Support Program,' whereby hospitals may apply for funding to support their nursing recruitment and retention programs to increase the number of registered nurses in

[7] Ibid.
[8] Center for Studying Health System Change, "Tracking Health Care Costs: Trends Stabilize but Remain High in 2002," Data Bulletin, Results from HSC Research, Number 25, June 2003.
[9] Ibid.
[10] Bradley C. Strunk and Paul B. Ginsburg, "Tracking Health Care Costs: Spending Growth Slowdown Stalls in First Half of 2004," The Center for Health System Change, Issue Brief No. 91, December 2004.
[11] Health Services Cost Review Commission, Final Staff Recommendations for the Annual Update to Inpatient and Outpatient Rates for the Rate Year FY 2005, May 5, 2004. The 'base factor cost inflation (DRI) percentage represents the 'market basket'.

Maryland. To date, the HSCRC has funded approximately $27 million to hospitals through this program.[12]

Over the past four years, the national increase in health care premiums for employer-sponsored health insurance has risen in the double digits, with premiums increasing between 11 percent and 12 percent between 2003 and 2004, slightly down from 13.9 percent in 2003, marking the fourth year of double-digit inflation.[13] Per capita spending for the privately insured increased 39 percent between 1999 and 2003, and worker's average hourly earnings increased only 14 percent.[14] This increase has led many employers, individuals and families to either spend more to purchase or maintain health insurance coverage, accept greater out-of-pocket costs or scaled back benefits in exchange for lower or constant premiums or, in the worst extreme, forgo it. Recent information shows these increases moderating somewhat with many U.S. large employers anticipating an increase of only 8 percent in health care premiums for 2005, down from 12 percent in 2004 (a separate study cited a 11.3 percent increase in 2005).[15] Even with the slight increase in costs, employers anticipate the average increase per employee to be approximately $582, down from $781 in 2004.

The level of health insurance premiums determines the affordability of health coverage. Premiums are comprised of heath care costs as well as administrative costs and costs associated with profit and risk charges. Changes in premiums mirror changes in health care costs over the long run. If health care costs rise rapidly, insurance premiums will follow. In the short run, however, health care costs and health insurance premiums may not change in concert. Premium trends can differ from cost trends if coverage becomes more or less comprehensive, if consumer cost sharing rises or falls, or if the proportion of the premium allocated to administrative expenses and profits changes.

Changes in health premiums have long followed what is called an underwriting cycle. This cycle describes insurers' characteristic pattern of underwriting gains and losses which is largely explained by competition. In periods of underwriting gains, some insurers may seek to build market share by reducing premiums. Other insurers will follow suit to

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[12] Health Services Cost Review Commission, Nurse Support Program Awards, Staff Recommendations, December 1, 2004 cites an increase if 11.2 percent in premiums for family employer-sponsored coverage between spring 2003 and spring 2004. Hewitt Associates cites an increase in premiums of 12.3 percent (Hewitt Associates, "Health Care Costs Show Signs of Moderating, but Still Outpace Inflation," October 11, 2004.

[13] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2004 Annual Survey*. The Kaiser and HRET study cites an increase if 11.2 percent in premiums for family employer-sponsored coverage between spring 2003 and spring 2004. Hewitt Associates cites an increase in premiums of 12.3 percent in 2004 (Hewitt Associates, "Health Care Costs Show Signs of Moderating, but Still Outpace Inflation," October 11, 2004). And a Mercer Human Resource Consulting survey cites and increase in average employer cost for health benefits at 7.5 percent per employee in 2004 (Reed Abelson, "Growth Rate in Health Cost to Employers Slowed in '04," *The New York Times*, November 22, 2004.)

[14] Paul B. Ginsburg, (Commentary) "Controlling Health Care Costs," *New England Journal of Medicine*, 351(16), October 14, 2004.

[15] Vanessa Fuhrmans, "Health-Care Cost Surge Set to Ease," *The Wall Street Journal*, October 6, 2004. Survey of 200 large U.S. employers, covering over 4.5 million workers, retirees, and dependents. Survey conducted by Towers Perrin. Another study conducted by Hewitt Associates of 300 employers with 2,000 health plans covering 18 million members indicates that employer health care costs are expected to increase 11.3percent in 2005 (Hewitt Associates, "Health Care Costs Show Signs of Moderating, but Still Outpace Inflation," October 11, 2004).

protect their market share, causing a general reduction in premiums relative to health care costs across the industry, leading to reduced profitability for the industry as many insurers generate underwriting losses. Premiums will continue to decline relative to medical costs until a lead insurer with market power raises premiums to restore at least "break even" revenues. As other insurers follow suit, premiums will rise relative to medical costs as insurers take underwriting gains to offset the "bad years." Eventually, the cycle will repeat as one or more insurers attempt to gain market share at the top of the cycle. If health care costs are rising during the period of the underwriting cycle when insurers are raising premiums to offset "bad years", consumers will experience the cycle as an additional increase in average premium growth.

During the years 1965 to 1991, health insurance carriers underwriting cycles were characterized by a six-year cycle with three years of gains followed by three years of losses. During the advent of managed care in the 1990s, the underwriting cycle became more stable, with less fluctuation. The years 1999 to 2003 were marked by an increase then decrease in health care cost trends, with many plans missing the downturn in the cost trend and not adjusting their prices accordingly. For 2003, many health plans posted high profit margins (between three and over four percent).[16] The prediction of the underwriting cycle for 2004 and upcoming years is to be even more stable with fewer swings in losses or gains; however, the introduction of a new product (e.g., consumer driven health plans) could cause carriers to price their products in direct competition to new plans. The effect of increasing stability in pricing of health plans, while possibly leading to additional people taking up health insurance and fewer people dropping coverage, consequentially may lead to people paying higher premiums for an extended period of time (i.e., carriers have no reason to lower prices), as well as less incentives for carriers to reduce costs.[17]

State Trends

Despite short-term fluctuations in the underwriting cycle, long-term increases in health insurance premiums mirror long-term increases in health care expenditures. Premium levels cannot be reduced unless health care cost escalation is curbed. Therefore, it is important to understand what is happening to health care spending in Maryland. The following information is based on the MHCC's forthcoming *State Health Care Expenditures: Experience from 2003*.

About one-third of Maryland's health care dollars were spent on hospital care. In 2003, inpatient hospital care accounted for 24 percent of total health care spending; outpatient hospital care accounted for an additional 8 percent. Physician services accounted for 18 percent of total spending, while other professional services accounted for 14 percent. In total, Marylanders spent over $8.6 billion for inpatient and outpatient hospital care, $4.9 billion for physician services, and $3.6 billion for other professional services during 2003.

Spending for prescription drugs in Maryland totaled $3.4 billion in 2003, 13 percent of total health care spending, about the same as was reported for other professional

[16] Joy M. Grossman and Paul B. Ginsburg, "As the Health Insurance Underwriting Cycle Turns: What Next?" *Health Affairs*, 23(6), November/December 2004.
[17] Ibid.

spending and almost $1.4 billion more than total spending for outpatient hospital care. Administrative costs, including the net cost of private health insurance[18], accounted for 8 percent of total health care spending in 2003.

Per capita spending was $4,811 in 2003, an increase of 7.2 percent from 2002. The lower rate of per capita spending relative to total spending is attributable to the one percent increase in the population between 2002 and 2003.

Maryland Characteristics and Marketplace

Maryland Demographics, Health Status, and Industry

There are approximately five and one-half million people residing in Maryland, with the largest proportion of individuals between the ages of 19 to 64 (62 percent). Thirteen percent of residents live below the federal poverty level (FPL), while 73 percent have incomes in excess of 200 percent of the FPL. The median household income in Maryland is $55,213 compared to $43,257 for the U.S. Seventy-seven percent of Maryland households have at least one full-time worker, while six percent of households have part-time workers and 17 percent have no workers. The unemployment rate as of August 2004 is 4.3 percent, down slightly from one year ago at 4.5 percent.[19]

The publication *America's Health: State Health Ranking - 2004 Edition*[20] lists Maryland as 34th in the ranking of healthiest states – down from 29 last year. As noted in the publication, the challenges Maryland faces include a high infant mortality rate (8.2 deaths per 1,000 live births), and a high incidence of infectious disease (43.9 cases per 100,000 population). In addition, the prevalence of obesity in Maryland rose to 21.9 percent of the population compared to 19.4 percent last year. The prevalence of smoking among Maryland residents is 20.1 percent, slightly down from 21.9 percent last year, and deaths attributable to cardiovascular disease and cancer slightly decreased from 2003 (328.6 and 208.4 per 100,000 population, respectively).

The HMO penetration rate in 2003 was 33 percent in Maryland (nine HMOs representing six corporate entities sell in the state[21]) for the privately insured, compared to 25 percent for the U.S. Almost 1.3 million privately insured individuals are enrolled in HMOs in Maryland. [22] The average annual cost for employment-based health insurance coverage for individuals in Maryland was $3,164 in 2002, slightly less than the U.S. of $3,189. Comparatively, the cost of family coverage in the employer setting averaged $8,809 in Maryland versus $8,469 in the U.S. While the cost of family coverage in Maryland compared to the U.S. average is higher in real dollars, it is lower when

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[18] Administrative costs and net cost of insurance are the marketing costs, broker expenses, claims processing costs, and underwriting gains.

[19] The Henry J. Kaiser Family Foundation, Maryland data from statehealthfacts.org, Source is 2002 and 2003 Current Population Survey, http://www.statehealthfacts.org.

[20] *America's Health: State Health Ranking – 2004 Editions*, United Health Foundation, American Public Health Association, and Partnership for Prevention, 2004 edition.

[21] The MHCC *2004 Consumer Guide to HMOs and POS Plans in Maryland* includes seven HMOs. PHN and UnitedHealthCare of the Mid-Atlantic are not included as they received waivers from reporting under permissible circumstances.

[22] MHCC internal analysis of Interstudy county-level HMO enrollment data and the Henry J. Kaiser Family Foundation, Maryland data, Kaiser's source of data is the Interstudy Competitive Edge 13.2, Part II: HMO Industry Report, October 2003.

considered as a percent of income (13.2 percent in Maryland vs. 14.6 percent in the U.S.).[23] Family premium as a percent of income in Maryland is also the second lowest compared to surrounding states.[24] The percentage employees contribute towards employment-based family coverage is higher in Maryland compared to the U.S average (29.3 percent vs. 23.5 percent); for single coverage the rates are 21.2 percent and 17.7 percent for Maryland and the U.S., respectively.[25]

Three industry sectors dominate the Maryland economy. They are the public sector (federal, state, and local employment); professional services and technical services; and retail trade and other services. While approximately 650,000 workers are employed by retail companies and other service organizations, such as restaurants, office and residential services companies, this group contains the largest segment of the uninsured in Maryland at 43 percent (2002-2003 CPS data). While the uninsured rate in this industry is relatively high at 30 percent, those individuals employed in agricultural, fishing, and construction businesses have a higher rate of uninsurance at 37 percent.[26]

Table 1: Rate and Distribution of Uninsured Non-elderly Adult Workers by Industry, 2002-2003

Industry	Number of Workers	Percent of Uninsured	Uninsured Rate
Public Sector	610,000	6%	4%
Manufacturing, Mining	180,000	6%	14%
Professional Services	730,000	11%	7%
Agriculture, Fishing, Construction	230,000	19%	37%
Retail Trade, Other Services	650,000	43%	30%
All Others	410,000	15%	17%

Data on the Uninsured

Data from the Current Population Survey (2002 and 2003) indicate that 13.6 percent of the Maryland population was uninsured, or approximately 740,000 people (at 15.3 percent of the non-elderly population). This figure increased from 12.8 percent in 2001-2002, although the increase is not statistically significant. The decrease in the employment-based coverage rate - from 75 percent during 2000-2002 to 72 percent in 2002-2003 – is most notable. Based on analysis of the 2002-2003 data, the largest proportion of uninsured individuals by age is young adults between the ages of 19-24, 25-

[23] The use of premium as a percent of income is a method by which the true cost of premium to a family is standardized across states – it accounts for differences in wage rates and the cost of medical care across geographic regions.
[24] For companies with less than 50 employees, family premium as a percent of income in the U.S. is 14.6 percent, 12.8 percent in Virginia, 13.2 percent in Maryland, 13.8 percent in Pennsylvania, 16.2 percent in Delaware, and 17.5 percent in West Virginia. Source: 2002 Medical Expenditure Panel Survey (MEPS) Insurance Component, analysis by the Maryland Health Care Commission, September, 2004.
[25] Ibid. Source for data is the Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2002 Medical Expenditure Panel Survey – Insurance Component, Tables II.D.1, II.D.2, and II.D.3.
[26] Maryland Health Care Commission, *Health Insurance Coverage in Maryland Through 2003*, November 2004.

29 and 30-34. These age groups account for approximately 40 percent of uninsured persons in Maryland; 18 percent of the uninsured are between the ages of 19 and 24. By income level, individuals with family incomes of more than 300 percent FPL ($54,732 for a family of four) account for a large proportion of the uninsured. These individuals make up 34 percent of the uninsured in Maryland, with 23 percent of the uninsured with incomes above 400 percent FPL or $72, 976 per year for a family of four.[27]

Maryland's All-Payor Rate System

In 1971, the Health Services Cost Review Commission (HSCRC) was created to set rates which hospitals are allowed to charge. Currently, Maryland is the only state granted federal permission to set hospital rates. The all-payer system requires all payers which reimburse hospitals – Medicare, Medicaid, commercial insurers, and self-paying consumers – to pay the same rate for the same service at a particular hospital. The rates are established based on several factors and are updated on an annual basis. Maryland is exempt from national Medicare reimbursement requirements by meeting a 'waiver test,' which mandates that federal payments per case for Medicare in Maryland cannot exceed the rest of the country.[28]

Uncompensated care, which includes charity care and bad debt, are factored into the rates. In addition, each hospital pays a specified amount of gross revenues into an uncompensated care fund managed by the HSCRC to compensate those hospitals which deliver a large percentage of uncompensated care. The benefit of the all-payer rate setting system is that all hospitals must treat patients regardless of the patient's ability to pay, which reduces hospital 'patient dumping' and cost shifting that other states experience.[29]

Certificate-of-Need

The Maryland Certificate of Need (CON) program is designed to ensure that new health care services and facilities are developed only as needed, based on the publicly-developed measures of cost effectiveness, quality of care, and geographic and financial access to care.[30] CON review of proposed projects implements the policy goals and service-specific standards articulated in the State Health Plan, and allows the Maryland Health Care Commission (MHCC) to oversee, monitor, and respond to the effects of changes in the system influenced by the marketplace. This public participation enables the Commission to determine whether proposed health care projects address the community's health care priorities and are in the public interest. More specifically, the CON program is intended to:

- **Protect against overbuilding**, particularly in services based in facilities;
- **Protect against over-utilization**, which could be generated by excessive supply of a service and profit motive of providers competing for a finite number of patients;

[27] Ibid.
[28] Hugh Waters, Laura Steinhardt, Thomas Oliver, et. al., "The Costs of Not Having Health Insurance in the State of Maryland," Maryland HRSA State Planning Grant, December 22, 2003.
[29] Ibid.
[30] Maryland Health Care Commission, *An Analysis and Evaluation of Certificate of Need Regulation in Maryland*: Phase I, Final Report to the Maryland General Assembly, January 1, 2001.

- **Protect the Medicaid budget, and other public funds**, where they become a prime source of reimbursement (such as with nursing homes, where nearly 70 percent of residents are paid for by Medicaid by the end of their first year in a facility);
- **Ensure a rational, planned growth in capacity**, tied to population, demographics, and changes in medical practice and technology, through policies, standards, and statistical projections of need adopted as part of the State Health Plan;
- **Limit the number of programs providing some highly-specialized services, where a sufficient number of cases or procedures is crucial to guaranteeing good quality and outcomes of care;**
- **Ensure access to needed health care services** by promoting the development of capacity in appropriate geographic areas and discouraging growth in areas already adequately served;
- **Guarantee public notice of and participation in decisions affecting its health care delivery and availability** through local health planning, public notice, public informational hearings;
- **Guarantee legal due process** in contested reviews for new services, where there are many applicants to fill a limited projected need; and
- **Foster competition among these applicants**, encouraging improvements and greater cost effectiveness in proposed service, to help ensure that providers improve their services and citizens receive even higher quality and availability of care than they would without that competition.

CON is maintained by 36 states and the District of Columbia as a method not only to control costs, but to improve the quality of care delivered in health care facilities. Most recently, it has been stated that CON programs are ineffective in controlling aggregate capital spending and are anti-competitive in that they pose barriers to entry for providers.[31] The Department of Justice and the Federal Trade Commission Report recommend that state CON programs should be reconsidered, and that the risks posed by CON outweigh their economic benefits. The report discusses the effect of "market incumbents" on CON programs as impeding a competitor's ability to enter into the market, and states that evidence is available that "CON programs can actually increase prices by fostering anticompetitive barriers to entry."[32] Other methods of cost control are recommended.

Another report, however, states that CON programs are utilized to improve health care access and reduce medical costs.[33] The authors claim that there is "convincing and credible "real-life" evidence that demonstrates the value and success of CON programs."[34] They cite studies which demonstrate improved quality of care, lower health care costs, and increased access to quality care in those states with CON programs. One recent study found higher mortality rates for Medicare patients undergoing coronary artery bypass graft (CABG) surgery in states without CON programs. A substantially higher proportion of

[31] Paul B. Ginsburg and Len M. Nichols, "The Health Care Cost-Coverage Conundrum: The Care We Want vs. The Care We Can Afford," Center for Health System Change, Fall 2003, and *Improving Health Care: A Dose of Competition*, A Report by the Federal Trade Commission and the Department of Justice, July 2004.
[32] *Improving Health Care: A Dose of Competition*, A Report by the Federal Trade Commission and the Department of Justice, July 2004.
[33] Hilary K. Schneider and Joseph P. Dirtre, "When Where and How Much: Improving Maine's Certificate of Need Program," Consumers for Affordable Health Care Foundation, June 2004.
[34] Ibid.

patients in states without CON regulation underwent CABG surgery in low volume hospitals.[35] While many states are currently reviewing their CON programs, no state has repealed their CON program since 1999.[36]

Small Group Reform

In 1993, the Maryland General Assembly enacted House Bill 1359, which, among other duties, charged the Maryland Health Care Commission (the Health Care Access and Cost Commission at the time) with implementing reforms in the small group health insurance market. The reforms apply to all contracts issued or renewed after July 1, 1994, and include guaranteed issue and renewal, adjusted community rating with rating bands, and elimination of pre-existing condition limitations. Further, the insurance law requires carriers in the small group market to sell only the Comprehensive Standard Health Benefit Plan (CSHBP). Carriers may sell additional benefits through riders but these enhancements must be offered and priced separately. The MIA and the MHCC have joint responsibility for administering these reforms. The MIA must approve contracts, rates, and forms, as well as monitor carrier marketing. MHCC is responsible for the design and annual review of the CSHBP.

Legislation enacted in 2003 altered the premium cap, or ceiling, of the standard plan, so that the cost of the CSHBP may not exceed 10 percent of the state's average annual wage. Carriers pool the risk of all small groups they insure: the rate charged to any particular employer group cannot vary by more than ±40 percent from the average rate based on adjustments for only age and geography.

While the State's small group market reform effort, now in its eleventh year, has increased access to employer-based coverage for residents, it has not solved the problem of the uninsured among small group employers: 46 percent of uninsured workers ages 19-64 in Maryland work for companies with 25 or fewer employees.[37] The annual average cost of the CSHBP per employee in 2003 was $4,021 (or $5,188 with riders).[38] This average cost represents a blended figure of the premium of employee-only and family plans. The average cost per employee increased by only 5.45 percent between 2002 and 2003. In 2004, the number of covered lives in the small group market increased less than one (1) percent from 2003, while the number of employer groups decreased slightly by less than three (3) percent.

States generally define a small employer as a firm employing 50 or fewer workers. Every state, with the exception of Maryland, offers more than one health plan option to small employers. Although one standard plan must be offered by all carriers selling in the small group market in Maryland, that plan can be enhanced by riders that add benefits to enrich the coverage available in the CSHBP or that lower deductibles and copayments.

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[35] Mary S. Vaughan-Sarrazin, et. al., "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation," *JAMA*, 288(15), October 16, 2002.
[36] Hilary K. Schneider, et. al.; and Thomas R. Piper, "Certificate of Need: Protecting Consumer Interests," presentation as part of planning panel on "Federal Trade Commission / Department of Justice Hearings on Health Care Competition Quality and Consumer Protection: Market Entry," Washington, DC, June 10, 2003.
[37] Maryland Health Care Commission, *Health Insurance Coverage Through 2003*, November 2004.
[38] *Maryland's Small Group Health Insurance Market, Summary of Carrier Experience for CY2003*, MHCC 5/13/2004.

These options can lead to numerous variations on the standard plan. Ninety-nine percent of employers are buying riders, at a higher premium, to enhance the standard plan.

Health Care Cost Drivers

It is not an easy task to untangle the underlying causes of health care cost escalation. Most observers of the health care system believe that recent increases have been fueled by the retreat from managed care.[39] In the mid-1990s—when many large employers were turning to managed care as a way of reducing their costs—the rate of increase of health care costs and insurance premiums fell well below previous levels. However, as consumers and providers (physicians and hospitals) expressed increasing dissatisfaction with the attempts of managed care to constrain utilization of medical services, changes to the managed care industry, either through legislation or self-imposed changes, caused a retreat from these strict utilization controls. In addition, as employers were forced to compete vigorously for scarce labor resources at the peak of the economic boom, employers began to turn away from the more stringent forms of managed care to satisfy their employees. The result was that utilization rates increased and premiums rose.

Several years ago, prescription drug costs were also rising much more rapidly than overall health care costs. There is evidence that this was in part a consequence of pharmaceutical companies' aggressive advertising campaigns directed to consumers.[40] The development of new, more effective, but also more expensive, drugs played a part as well. In the last couple of years, drug costs have been advancing less rapidly, perhaps partly in response to efforts by insurers and employers to impose sophisticated forms of consumer cost sharing on high-cost brand-name drugs leading to an increase in the use of generic drugs.

Most observers of the health care system agree that the ever-more-rapid pace of technological change in medicine is responsible for a large portion of health care cost escalation. As a general rule, new technologies are more expensive than the ones they supplant, and technologies that were originally developed for certain limited purposes often become used on a relatively routine basis to diagnose or treat less critical medical conditions. While the result may be improved health status, less intrusive kinds of medical intervention, and more comfort and convenience for patients, costs rise as a result. There is no reason to expect the pace of technological change to diminish and, as long as the health care financing system gives well-insured people almost unlimited access to these new technologies, the cost-escalating consequences will be reflected in higher insurance premiums.

A recent article cites all three reported sources of cost increases – pharmaceutical drugs, expensive technology, and increased utilization – as significant contributors to premium increases. The article states that "the increase in health

[39] Cara S. Lesser and Paul B. Ginsburg, "Health Care Costs and Access Problems Intensity," Center for Studying Health System Change, Issue Brief No. 36, May 2003.
[40] Jeffrey M. Drazen, M.D., "The Consumer and the Learned Intermediary in Health Care," *New England Journal of Medicine,* 346 (7), February 14, 2002, and Sidney M. Wolfe, M.D., "Direct-to-Consumer Advertising – Education or Emotion Promotion?" *New England Journal of Medicine*, 346 (7), February 14, 2002.

insurance premiums reflects the rising cost of health care, which is being driven by expensive new drugs, many of them heavily advertised to consumers; medical advances including diagnostic tests that require costly new machines; and a reaction to past restrictions in managed care health plans that sought to reign in costs."[41] In addition to the aforementioned cost drivers, other factors contributing to rising health care costs have been cited – the growing number of uninsured and cost to care for them, the increasing costs of malpractice insurance leading providers to practice defensive medicine, inefficient administrative practices, and increasing hospital prices.[42]

Other factors that are mentioned as a source of rising health care costs are regulations and mandated benefits.[43] In the most recent analysis of Maryland's mandated benefits, it was found that the full cost of all the current mandates is about 12.6 percent of premium, although the marginal cost is only 1.5 percent meaning that most policies cover these services but not quite to the same extent as the mandates require.[44]

Federal and State health care regulation, such as the regulation of facilities, health care professionals (licensing), and mandated benefits, as well as other regulations, accounts for $169 billion in net costs, or over $1,500 annually per household according to one analysis examining the costs of regulation to the health care system.[45] The author of this study claims that the medical tort system (e.g., litigation costs, court expenses and the practicing of defensive medicine), the regulation of the U.S. Food and Drug Administration (FDA), and health facilities comprise the largest share of costs. In addition, the author argues that regulatory costs contribute to unaffordable health insurance for millions of people and premature death for thousands of U.S. citizens.

Those in support of regulations contend that they result in improved care and reduced costs, and that savings resulting from fewer regulations would not benefit the public through reduced health insurance premiums or increased quality of care, but instead would shift the monetary savings to health care providers, health insurance carriers and pharmaceutical providers.[46]

Also, the structure of third party payments (i.e., payments made by someone other than the health insurance enrollee, such as an employer) may not expose the consumer to the full cost of health insurance, and thus, encourage consumers to spend and utilize more health care services than if they were required to spend a greater portion of their own

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[41] Eduardo Porter, "Rising Cost of Health Benefits Cited as Factor in Slump of Jobs," *The New York Times*, August 19, 2004.
[42] Vanessa Fuhrmans, "Health-Care Cost Surge Set to Ease," *The Wall Street Journal*, October 6, 2004; Victoria Colliver, "In Critical Condition: Health Care in America – How the Health Care System is Failing – and Why it's Hard to Fix," *San Francisco Chronicle*, October 1,, 2004; and, Raymond J. Keating, "Less Government Needed to Stem Rising Health Costs," *Silicon Valley/San Jose Business Journal*, October 1, 2004.
[43] Ibid.
[44] Maryland Health Care Commission, Annual Mandated Health Insurance Services Evaluation, December 2004.
[45] Christopher J. Conover, "Health Care Regulation: A $169 Billion Hidden Tax," CATO Institute Policy Analysis, No. 527, October 4, 2004.
[46] …"Cost of Health Care Regulation May Outweigh Social Benefits, According to Research Presented to JEC," Kaisernetwork.org, May 14, 2004. U.S. Congress, Joint Economic Committee Hearing, May 13, 2004.

money.[47] Furthermore, the current structure of federal and state tax code allows employers to exempt employees' health insurance premiums from federal income and Social Security payroll taxes, and thus, serves as a form of compensation. Also, the tax exemption provides an incentive to offer health insurance benefiting most likely the higher income population (since they are more likely to have health care coverage). According to an article published in Health Affairs, "these tax preferences are widely believed to have encouraged employers to provide more comprehensive coverage than they otherwise would have done, resulting in higher levels of health care spending."[48]

It is estimated that total spending for employer-sponsored coverage will be $576 billion in 2004. Of that amount, approximately $520 billion will be spent on employees and their dependents, and about $56 billion for retirees. Employers' expected contribution towards this expense will be the greatest at 77 percent ($443 billion) compared to the amount employees and retirees are expected to pay (23 percent or $132 billion). The average tax savings from employer-sponsored health insurance is estimated to be about $1,482 per family in 2004, with high-income groups receiving a greater tax benefit due to the fact that they are more likely to have employer-sponsored insurance and are in a higher tax bracket (a tax savings of $2,780 for a family income of $100,000 or more compared to $102 for a family income of less than $10,000).[49] The issue of equity regarding the distribution of tax benefits has been considered by researchers regarding the tax savings allocated to employer-sponsored insurance and not to non-group insurance, and also the greater tax benefit obtained from higher income groups compared to the low income population.[50] Also, the issue of the overuse of the health care system because of the tax savings, as well as the generally sizable contribution by the employer to the total premium has been a cause for concern since most employees are not aware of the total cost of their health insurance since they are not responsible for the full payment, and also a belief that employer-sponsored insurance "reduces incentives for workers and their employers to seek out the most cost-effective health insurance options."[51]

Many individuals believe that one source of high costs can be addressed—namely, the waste and inefficiencies that are by-products of failing to deliver quality care. There is well-documented evidence that accepted standards for best medical practice are often not met. What needs to be done is often not done (underutilization), and what is done is too often not necessary (overutilization). Several studies show that people in different areas of the country and even within different areas in a state receive very different treatment for identical medical conditions is strong evidence of the problem.[52] Not all the changes to

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[47] Raymond J. Keating, "Less Government Needed to Stem Rising Health Costs," *Silicon Valley/San Jose Business Journal*, October 1, 2004.
[48] John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs*, February 25, 2004.
[49] Ibid.
[50] Ibid and Mark Pauly, et. al., "Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons," Health Affairs, 18(6), November/December 1999. Non-group insurance is paid for in after-tax dollars for those who are not self-employed, and is fully deductible for the self-employed.
[51] Congressional Budget Office Testimony by Rosemary D. Marcuss, Assistant Director for Tax Analysis, Congressional Budget Office, to the Committee on Finance, U.S. Senate, April 26, 1994.
[52] Eve A. Kerr, Elizabeth A. McGlynn, John Adams, Joan Keesey, and Steven M. Asch, "Profiling the Quality of Care in Twelve Communities: Results from the CQI Study", *Health Affairs*, 23(3), May/June 2004; and Elizabeth A. McGlynn, Steven M. Asch, John Adams, Joan Keesey, Jennifer Hicks, Alison

improve quality would reduce costs because some people receiving treatment do not get services that they need. However, quality improvements in many instances would involve less expensive treatments and, in other instances, would make treatment for later more expensive episodes of illness unnecessary.

Finally, it is critical to realize that a small proportion of the population is responsible for the vast majority of health care costs. Two separate analyses make clear that health care costs are severely skewed across the population. One study shows that only 10 percent of the entire population accounts for 69 percent of health expenditures in the U.S.[53] A more recent estimate of Medical Expenditures Panel Survey data by the Employee Benefit Research Institute shows that 25 percent of the nonelderly account for 80 percent of the costs while, at the other end of the spectrum, the healthiest 50 percent of the nonelderly account for only 6 percent of costs.[54] Both these studies conclude that utilization attributed to high-cost users must be better managed or else costs will not decrease.

Some point out that the increase in medical spending is not detrimental to society and that it is affordable to most consumers. Some researchers have viewed the growth as value-added, in that both purchasers (consumers) and providers are benefiting from the rise in medical spending.[55] Certain providers, such as registered nurses and radiology specialists who provide highly technical services, benefit from the increased demand for their services, resulting in a growth in health care sector employment (through higher wages). [56] The growth in spending is believed by many to be a result of the utilization of costly medical services and technology, which has resulted in better health care outcomes, longer life expectancy, lower disability rates, fewer hospitalized days, as well as lower death rates for conditions related to heart attacks, strokes and breast cancer.[57] One study estimates that "each additional dollar spent on health care services has produced health gains valued at $2.40 to $3.00" over the past 20 years.[58]

For employers, higher medical costs are often passed along to the employee through lower monetary bonuses or raises, and most recently through higher cost sharing arrangements or higher premiums. The question of whether or not the U.S. population can afford and are willing to pay the continued increase in higher medical costs and rising premiums continues to be debated among health care policy makers, researchers, employers, and consumers. The increase in the number of uninsured Maryland residents and U.S. citizens leads to the speculation that health care insurance is not affordable for a

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DeCristofaro, and Eve A. Kerr, "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine*, 348(26), June 26, 2003.

[53] A.C. Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences." Medical Care 41 (July 2003 Suppl.): 11153-11164.

[54]Paul Fronstin. "Health Savings Accounts and Other Account-Based Health Plans." EBRI Issue Brief No. 273, September 2004.

[55] Michael E. Chernew, Richard A. Hirth, and David M. Cutler., "Increased Spending on Health Care: How Much Can the United Sates Afford?" *Health Affairs*, 22(4), July/August 2003.

[56] Mark V. Pauly, "Should We Be Worried About High Real Medical Spending Growth in the United States?" *Health Affairs*, January 8, 2003.

[57] Ibid; Joseph P. Newhouse, "An Iconoclastic View of Health Cost Containment," *Health Affairs*, 12, 1993; and MEDTAP International, Inc. *The Value of Investment in Health Care*. Bethesda, MD: 2004. Available at http://www.medtap.com/Products/HP_ExecutiveSummary.pdf

[58] MEDTAP International, Inc. *The Value of Investment in Health Care*. Bethesda, MD: 2004.

growing number of people; however, some research indicates that as a person's income increases (real income), a greater share of income is spent on health care, meaning that more services are utilized.[59] The issue may be how to reduce the waste and inefficiencies in the health care system, and to educate consumers, so that health care is more affordable to a greater population. The following sections of the report address these issues.

[59] Chernew, et. al.

III. Regulatory Requirements in Maryland Compared to Surrounding States

(The following section was prepared by Maryland Insurance Administration staff).

Currently, states reported the following numbers of individual and small group carriers to be actively writing in their state:

State	Number of Individual Carriers	Number of Small Group Carriers
Maryland	10	15[60]
Delaware	Not available[61]	18
District of Columbia	Not available	Not available
Pennsylvania	Not available	Not available
Virginia	25	44
West Virginia	34	31

There are many regulatory requirements put upon companies by states throughout the United States. The ultimate goal of the regulation of insurance carriers is the protection of consumers. Regulatory requirements address contracts, rates, financial solvency and market conduct. In large part, there is a great deal of consistency in what is required from state to state. Certain regulatory requirements have a more significant role on the impact of affordability of health care. For purposes of this interim report, this survey will focus on two areas that have the greatest impact on cost variation.

Mandated Benefits

Health insurance can be looked at as existing in three markets: individual, small group and large group. In Maryland, statutory law dictates that certain benefits must be offered in the individual and large group markets. These benefits are often referred to as mandated benefits. Delaware, the District of Columbia, Pennsylvania, Virginia and West Virginia all require some mandated benefits under their law. The following chart summarizes the offerings in each state.

[60] This number is based on the number of carriers who report to the Maryland Insurance Administration that are actively writing and have covered lives as of December 31, 2004.

[61] In order to obtain the number of carriers actively writing in the individual and small group markets, each state department of insurance was contacted. Delaware, Pennsylvania and the District of Columbia were unable to provide the Maryland Insurance Administration with numbers for their respective state.

Benefit	Maryland	Delaware	District of Columbia	Pennsylvania	Virginia	West Virginia
Alzheimer's disease and care of elderly individuals	✔					
Treatment of mental illnesses, emotional disorders, and drug and alcohol abuse	✔	✔	✔	✔	✔	✔
Payments for blood products	✔				✔	
Coverage for off-label use of drugs	✔				✔	
Reimbursement for pharmaceutical products	✔	✔				
Choice of pharmacy for filling prescriptions	✔	✔				
Coverage for medical foods and modified food products	✔			✔		
Home health care	✔			✔		✔
Hospice care	✔				✔	
In vitro fertilization (IVF)	✔					✔ [62]
Hospitalization benefits for childbirth	✔					
Inpatient hospitalization coverage for mothers and newborn children	✔	✔	✔	✔	✔	✔
Disability caused by pregnancy or childbirth	✔					
Mammograms	✔	✔	✔	✔	✔	✔
Reconstructive breast surgery	✔	✔	✔	✔	✔	✔
Routine gynecological care	✔		✔	✔		✔
Child wellness services	✔	✔	✔	✔	✔	✔
Cleft lip and cleft palate	✔	✔		✔	✔	
Outpatient services and second opinions	✔					
Prosthetic devices and orthopedic braces.	✔					
Diagnostic and surgical procedures for bones of face, neck, and head	✔				✔	
Diabetes equipment, supplies, and self-management training	✔	✔	✔	✔	✔	✔

[62] Requires basic HMO coverage of infertility services.

Benefit	Maryland	Delaware	District of Columbia	Pennsylvania	Virginia	West Virginia
Osteoporosis prevention and treatment	✔					
Coverage for maintenance drugs	✔					
Detection of prostate cancer	✔	✔	✔		✔	✔
Coverage for contraceptive drugs and devices	✔	✔			✔	
Clinical trials	✔	✔			✔	
General anesthesia for dental care under specified conditions	✔				✔	
Detection of chlamydia	✔					
Referrals to specialists	✔	✔		✔	✔	
Non-formulary drugs or devices	✔			✔	✔	
Mastectomies	✔			✔	✔	
Extension of benefits	✔					
Prostheses after mastectomy	✔	✔	✔	✔	✔	
Habilitative services for children under 19 years of age	✔					
Hair prosthesis	✔					
Colorectal cancer screening coverage	✔	✔	✔		✔	✔
Hearing aid coverage for a minor child	✔					
Treatment of morbid obesity	✔				✔	
Medically necessary residential crisis services	✔					

As required by §15-1502 of the Insurance Article, the Maryland Health Care Commission issued a report (January 14, 2004) on the cost of the existing mandated benefits in Maryland.[63] In the report, the full cost of the mandates and the marginal cost of the mandates were examined. The marginal cost is the full cost less the cost of any benefit that would be offered absent a mandate. For instance, the report's researchers believed that hospitalization after mastectomy would have been a covered benefit even without the mandate. As a result, the marginal cost of providing the benefit would be 0.[64]

[63] Study of Mandated Health Insurance Services: A Comparative Evaluation, Maryland Health Care Commission, January 15, 2004. This report excludes the Comprehensive Standard Health Benefit Plan in the analysis. It is available on the MHCC website at www.mhcc.state.md.us.

[64] The researchers determined the likelihood a benefit would be offered absent a mandate and to what extent the benefit would be offered by reviewing offer rates of mandated services in self-funded plans that are not required to offer the state's mandated benefits.

The report found that the full cost of offering the Maryland mandates to be 15 percent of premium costs, which translates to 3.3 percent of the Maryland average wage for individual contracts and 2.4 percent of the Maryland average wage for group contracts.[65] The report found the marginal cost of the Maryland mandates to be 1.6 percent of premium costs, which translates to 0.3 percent of the Maryland average wage for individual contracts and 0.2 percent of the Maryland average wage for group contracts.[66]

When compared to other jurisdictions, Maryland has a more extensive list of mandated benefits. **Of the 40 Maryland mandates:**

16 are required in Delaware;
11 are required in the District of Columbia;
15 are required in Pennsylvania;
22 are required in Virginia; and
11 are required in West Virginia.

These variations in requirements will ultimately impact premium.

In the report, comparisons were made with Delaware, the District of Columbia, Pennsylvania and Virginia. West Virginia was not included in the analysis. The researchers found that "[o]n a full cost basis for these 40 Maryland mandates, the other states have a lower financial burden. Based on a percentage of premium, the difference ranges from 4.1 percent of premium lower in Delaware to 6.5 percent lower in Pennsylvania."[67] On a marginal basis, the financial burden was also found to be lower in the surrounding states. "Based on a percentage of premium, the difference ranges from 0.9 percent of premium lower in Delaware to 1.2 percent lower in Pennsylvania."[68] The Maryland mandates found to make the greatest contribution to this financial difference are Mental Illness and Substance Abuse, Pharmaceutical Products, In Vitro-Fertilization and Morbid Obesity Treatment.[69]

Ultimately, the report concludes that some cost savings could occur if Maryland were to eliminate coverage for mandates not offered in other states and reduce coverage under the remaining mandates to the minimum required in other states. The report warns, however, that the existence of many of these benefits in self-funded plans may prevent the full predicted savings from being realized. As employers use benefits as a means of attracting employees, the presence of these benefits in self-funded plans indicates that competing companies with fully-insured benefits may choose to

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[65] The average annual wage used in the report is Maryland's 2002 annual wage of $39,360, as reported by the Maryland Department of Labor, Licensing and Regulation (DLLR).
[66] In the most recent analysis of Maryland's mandated benefits, it was found that the full cost of all the current mandates is about 12.6 percent of premium, although the marginal cost is only 1.5 percent of premium meaning that most policies cover these services but not quite to the same extent as the mandates require. Maryland Health Care Commission, Annual Mandated Health Insurance Services Evaluation, December 2004.
[67] Page 13, Study of Mandated Health Insurance Services: A Comparative Evaluation, Maryland Health Care Commission, January 15, 2004.
[68] Ibid.
[69] Ibid.

offer them even without the mandate.[70] It is not clear, however, whether or not self-funded plans include these benefits in order to compete with fully-funded plans that are required to include them. If there is no mandate requirement for any plan to include a particular benefit, there is a chance that the self-funded plan would cease to offer it as well. Additional data regarding the reasons self-funded plans choose to include certain benefits (demand from employees, desire to make benefit package comprehensive, need to compete with fully-funded plans) would be needed in order to draw a sound conclusion about the likely impact of removing a mandated benefit from Maryland law.

Small Group Rating

In the 1990's many states across the country implemented small group reforms. Maryland enacted reforms to its small group law in 1993. One of the key features of the reform effort was the desire to control rates charged to small employers. As a result, three main rating restrictions emerged: pure community rating, modified community rating and rate banding. Pure community rating required carriers to charge the same rate to all small businesses of the same size purchasing the same coverage and may vary only for geography and family size. Modified community rating prohibited the use of health status to determine rates but would allow use of factors such as geography and age. Lastly, rate banding places the least restriction on factors to be considered but limits the impact each factor may exert on the premium charged as a relative percentage, i.e variation for the type of industry may only be plus or minus 15%. **In 2003, the Government Accountability Office (GAO – formally known as the General Accounting Office) reported that of 47 states that enacted some form of restriction on how rates were set, 2 used pure community rating, 10 used modified community rating, and 35 used rate banding.[71]** Maryland is part of the 21% that uses modified community rating.

Currently, Maryland's rating model is a modified community rating structure that does not allow the use of health status in small group rating. The following chart reflects the structure of the surrounding states:

[70] Ibid, page 5.
[71] GAO-03-1133 Private Health Insurance- Federal and State Requirements Affecting Coverage Offered by Small businesses, General Accounting Office, September 2003.

States	Type of rating structure	Limits on premium setting for renewals	Statutory reference
Maryland	Modified Community Rating	Yes	§15-1205 of the Insurance Article, Md. Ann. Code
Delaware	Rate banding	Yes	§18-7205 Delaware Insurance Code
District of Columbia	No restrictions	No	None
Pennsylvania	No restrictions	No	None
Virginia	Rate banding	Yes	§38.2-3433 Virginia Code
West Virginia	Rate banding	Yes	§33-16D-5 West Virginia Code

Limits on how rates are set coupled with other reforms in the small group market force carriers to pool their risks across some groups. This should ultimately create less risk segmentation. "Less pooling and more risk segmentation is typically more profitable for insurers, but the consequences of unfettered segmentation are potentially volatile premiums for many and some groups or individuals will be unable to purchase insurance from any insurer."[72] As a result, there is a natural tension between the desire for carriers to adequately assess risk and small employers' need for reasonable premium costs.

While there are many factors that contribute to a carrier's decision to participate in a particular state's small employer market, the ability to use health status and other lifestyle factors is often cited as an important consideration. In October 2003, the National Association of Health Underwriters (NAHU) asserted that "[o]ne of the most important characteristics of a successful state health insurance market is the ability for health insurers to accurately assess risk for policies sold to both individuals and small businesses."[73] Medical underwriting, or reviewing the health status of the applicant, is one of the ways in which risk is assessed.

> NAHU has observed that in all states with the community rating and modified community rating mechanisms, younger healthier individuals and workers are penalized since carriers cannot account accurately for these healthy risks. This leads to much higher overall health insurance rates than in the states that allow for the use of medical underwriting in the individual and small-group markets. In addition, since these laws make it much more difficult for health insurers to rate their products accurately, doing business in states with these requirements is much more costly. As such, fewer health insurers may offer plan options in these states, which in turn limits consumer choice, reduces competition and leads to overall price increases.

Although younger employees will experience higher rates, it should be noted that older, less healthy employees will experience lower rates under community rating and modified community rating. Ultimately, the challenge is to balance the needs of employers

[72] Variation in the Uninsured: State and County and Level Analysis, Jill A Marsteller, et al., The Urban Institute June 11, 1998.
[73] "Analysis of State-Level Health Insurance Market Reforms," National Association of Health Underwriters, October 2004.

and their employees (representing various ages and health status conditions) with the state's desire for a healthy competitive insurance market.

NAHU goes on in their paper to consider Virginia to be an example of a market that is performing relatively well. Virginia does permit the use of health status within limits. "As a result, for the size of the state, there are a large number of carriers competing in the market place, rates are relatively low for individuals and businesses, and only 12 percent of the state's population goes without health insurance, compared with the 14.7 percent national average."[74]

Statutory requirements

The statutory limits on rating are as follows for each jurisdiction:

Maryland

In Maryland, the following factors may be used in establishing the community rate for a small employer plan:

(1) age;
(2) geography; and

Rates for a health benefit plan may vary based on family composition as approved by the Commissioner.

The rate may vary by 40% above or below the community rate and may not take into consideration health status or occupation or any other factor not specifically authorized by law.[75]

Delaware

In Delaware, the following factors may be used in establishing the community rate for a small employer plan:

(1) The index rate for any class of business shall not exceed the index rate for similar coverage for any other class of business by more than 20 percent in any rating period;

(2) The premium rates for similar health benefit plans within a class of business shall not vary from the index rate by more than 35 percent, with:

(a) An additional combined variation of no more than 10 percent for gender and geography; and

(b) The actuarially justified adjustment for age and family composition.

[74] Ibid. It should be noted that the data of rates of insurance is based on a two year average covering the period 2001-2002. Based on 2002-2003 data, Virginia's uninsured rate was 13.3% and the National rate was 15.4%. Maryland's rate for 2002-2003 was 13.6%, better than the national average.
[75] Section 15-1205 of the Insurance Code, Md. Ann. Code.

Delaware law imposes limits on the increases that may be experienced at renewal to the sum of:

(1) The percentage change in the new business premium rate calculated using premium rates on the first day of the prior rating period and the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;
(2) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and
(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

Delaware law prohibits adjustments in rates for claim experience, health status and duration of coverage from being charged to individual employees or dependents. This type of adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer. Additionally, a small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification does not exceed the lowest rate factor associated with any industry classification by more than 15 percent.[76]

Virginia

In Virginia, two plans are defined by statute for offering in the small employer market: the Essential Plan and the Standard Plan. These plans have benefits defined in law and regulation. The following factors may be used in establishing the community rate for the Essential and the Standard plans:

(1) A health insurance issuer may use the following risk classification factors in rating small groups: demographic rating, including age and gender; and geographic area rating;
(2) The premium rates charged by a health insurance issuer may deviate from the community rate filed by the health insurance issuer by not more than twenty percent above or twenty percent below such rate for claim experience, health status and duration only during a rating period for such groups within a similar demographic risk classification for the same or similar coverage. Rates for a health benefit plan may vary based on the number of the eligible employee's enrolled dependents.

Virginia small employer carriers are required to "apply rating factors consistently with respect to all small employers in a similar demographic risk classification. Adjustments in rates for claims experience, health status and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the small employer".[77]

[76] Delaware Insurance Code, §18-7205.
[77] Virginia Insurance Code §38.2-3433

West Virginia

In West Virginia, the law imposes limits on the premium that may be charged to a small employer to the sum of:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;
(2) An adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and
(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

Under West Virginia law, the limits imposed are not intended to affect the use by a small employer carrier of legitimate rating factors other than claims experience, health status or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

West Virginia law prohibits adjustments in rates for claim experience, health status and duration of coverage from being charged to individual employees or dependents. This type of adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer. Additionally, a small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification does not exceed the lowest rate factor associated with any industry classification by more than 15 percent.[78]

Each of the surrounding states that permit the use of health status under a rate banding formula applies limits to the impact the permitted factors may exert on the premium. These data imply that a rating system that permits health status rating may impact competition or affordability in the Maryland market; however, there is no guarantee. This is an area for consideration and further study so that more definitive conclusions can be included in the final report.

[78] West Virginia Insurance Code §33-16D-5

IV. The Role of Tax-Deferred Health Savings Accounts and Other Models of Offering Health Insurance Designed to Increase Consumer Awareness of Health Care Costs

(The following section was prepared by Maryland Insurance Administration staff).

In recent years, there has been a move toward greater consumer directed health care models. Since the late 1970's, with the creation of Flexible Spending Accounts, the federal government has created various models of tax deferred accounts. Currently, health consumers can choose between Flexible Savings Accounts, Health Reimbursement Arrangements, and the newest creation, Health Savings Accounts.

A. Types of Accounts

Flexible Savings Accounts[79]

Originally created in the 1970's, Flexible Savings Accounts are the accounts most frequently offered by employers at this time. A study conducted by Mercer Human Resource Consulting found that 80% of employers with 500 or more employees offered a Flexible Savings Account in 2003.[80] Of the employees whose employers offered Flexible Savings Accounts, a reported 19% of employees took advantage of a Flexible Spending Account in 2003.[81]

Flexible Savings Accounts are accounts offered by employers and funded by employees. The employee designates a certain amount of money to be deducted from each paycheck throughout the year to fund the account. Although deductions from the employee are made throughout the year, the employer must make the funds available immediately. This puts the employer at risk. Should an employee use all of the funds in the account early in the year and quit before they have repaid the employer, the employer may not recoup the funds from the employee and will take a loss. This potential loss is one of the least attractive features of Flexible Savings Accounts for employers, especially small businesses. Amounts deducted from the employee are pre-tax dollars.

Typically, a Flexible Savings Account is offered along with other health care coverage. The funds in the Flexible Savings Account are then used to cover deductibles, co-payments or co-insurance as well as other medical expenses that may not be covered under the other health coverage. The additional coverage offered in conjunction with a Flexible Savings Account does not have to be a high deductible plan, but may be one if the employer so chooses.

[79] *See* § 125 Revenue Act of 1078
[80] Issue Brief No. 273, Employee Benefit Research Institute, September 2004
[81] Ibid.

Distributions from the account can be made at any time. As long as the funds are used for a qualified health expense, the funds are tax-exempt. There is no limit in the federal law on how much may be contributed to the account, but employers have the ability to impose a limit if they choose.

Funds in a Flexible Savings Account are "use or lose." In other words, at the end of the year, any money not spent in the account reverts to the employer and may not be redistributed to employees. The funds cannot rollover and cannot be made available to the employee in the following year.

Health Reimbursement Arrangements[82]

A more recent type of consumer directed account is the Health Reimbursement Arrangement or Health Reimbursement Account (HRA). HRAs are authorized by the U.S. Treasury Department and were announced on June 26, 2002. Most of the information regarding HRAs can be found in Internal Revenue Service and Treasury Department guidance, rules and notices. A study by Mercer Human Resources Consulting found that while only 1% of employers offered HRAs, 99% of those with 20,000 or more employees offered these accounts.[83]

HRAs are accounts offered by employers and funded by employers. Unlike a Flexible Savings Account, there is no contribution made by the employee. Although the employer funds the HRA, the funds belong to the employee and cannot be recouped by the employer. If an employee leaves, the funds contributed belong to the employee.

Typically, a HRA is offered along with other health care coverage, although it is not required. One of the advantages of the HRA is the array of choices an employer can make. The account can be offered with comprehensive health coverage, a high deductible plan or with no plan. When offered with no plan, the funds in the account can be used to purchase insurance coverage.

Distributions from the account can be made at any time. As long as the funds are used for a qualified health expense, the funds are tax-exempt. Contributions to a HRA are tax-deductible for an employer. Funds in a HRA can rollover from year to year at the employer's discretion. The greater flexibility for the employer is one of the most attractive features of a HRA.

Health Savings Accounts[84]

The newest tax-deferred accounts are Health Savings Accounts (HSAs). HSAs could be sold beginning January 1, 2004. They have not been on the market long enough to gauge how they will be received by employers. Guidance from the Internal Revenue

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[82] *See* IRS Revenue Ruling 2002-41 and Notice 2002-45 (Internal Revenue Bulletin 2002-28, July 15, 2002)
[83] Issue Brief No. 273, Employee Benefit Research Institute, September 2004
[84] See Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, P.L. 108-173), "Issue Brief: Health Savings Accounts: Issues and Implementation Decisions for States", Mila Kaufman, J.D. (AcademyHealth, September 2004)

Service answering questions about these accounts has been published and many expect to see greater use of these accounts in 2005 and 2006.

HSAs can be either a tax-exempt trust or a custodial account. The Internal Revenue Service must approve the bank, trustee or administrator responsible for the account. In order to have a HSA, the employee must not be a Medicare recipient or listed as a dependent on someone else's tax return. Employers or employees can make contributions. Employee contributions are tax deductible to the employee, even if they do not itemize their tax returns. There are maximum contribution limits that apply. The limits are $2,600 for an individual and $5,150 for a family. Individuals over age 55 can make "make up" contributions of up to $500 above these limits. These limits are set to increase over time. The contribution made to the account cannot exceed the deducible of the accompanying health insurance coverage.

HSAs must be coupled with a high deductible health coverage plan. The plan must have a deducible of no less that $1,000 for an individual and $2,000 for a family as well as an out of pocket maximum of $5,000 for an individual and $10,000 for a family. The money in the HSA can be used to pay medical expenses while meeting the deductible. Certain preventative services provided in the plan may be covered in full before the deductible is met. The plan may be set up with in-network and out-of-network provisions where out-of-network deductibles and out-of-pocket maximums are higher.

The HSA is owned by the individual and is portable. The portability of a HSA is a significant feature distinguishing it from other tax-deferred accounts. An employee who leaves one employer will be able to keep their account. HSAs replaced Medical Savings Accounts, which were created for small employers in 1996 as part of the Health Insurance Portability and Accountability Act. Individuals with Medical Savings Accounts can roll them over to HSAs.

Distributions from the account can be made at any time, even when not covered by a high deductible health plan. Distributions are tax exempt when used for qualified medical expenses as well as the purchase of coverage under COBRA, long term care insurance, individual health insurance coverage when receiving unemployment benefits, and insurance other than Medigap while receiving Medicare. Funds in the account can rollover from year to year. The spending choices and ability to maintain ownership of the account are likely to be some of the more attractive features to employees.

Proponents of consumer driven care argue that when people are forced to shoulder the cost of care they will make more responsible and cost efficient decisions. Critics fear that these plans will not alter the utilization patterns of consumers significantly, but will result in cost shifting to the employee. There is a fear that consumer driven plans will create adverse selection by attracting healthier individuals to the high deductible plan while leaving the sicker population to the more traditional plans. Some preliminary studies have been conducted to determine the impact of these accounts on cost, utilization patterns and employee satisfaction. The data at this time are preliminary and not substantial enough to

lead to clear conclusions. The specific impact of consumer driven health care and tax deferred accounts will be explored in greater detail in the final report.[85]

[85] Health Services Research (HSR) has published articles and commentary in a Special Supplement entitled "Consumer Driven Heath Care: Beyond Rhetoric with Research and Experience." The reviewers followed health plans at large employers who introduced tax-deferred accounts and consumer driven options into their array of offerings. Most articles concluded that there were some emerging trends but at least another year of data was needed to see what the true impact would be.

V. Factors That Contribute to Increases in Health Care Costs in Maryland, Including Utilization of Health Care Services

Throughout this section, we refer to four separate, although not mutually exclusive, primary drivers of health care costs in Maryland:

- Utilization of services and inefficiencies in the delivery of services
- Populations with chronic conditions
- The cost of pharmaceuticals
- Populations who are uninsured

These drivers factor into the rise of health care expenditures in Maryland, some more so than others. The retreat of consumers from managed care plans to plans that allow greater access to providers has led to a greater usage of hospital and professional services. The increased use by consumers of hospital emergency departments along with health care professional staffing shortages has led to inefficiencies in the delivery of health care services. In addition, those living with chronic conditions, such as diabetes and obesity, are increasing, creating a significant impact on Maryland's health care system, as well as the delivery of health care throughout the U.S. The rising cost and utilization of pharmaceutical drugs is also discussed along with the implications of the uninsured and the cost to treat them.

A. Utilization of Services and Inefficiencies in Delivery of Services

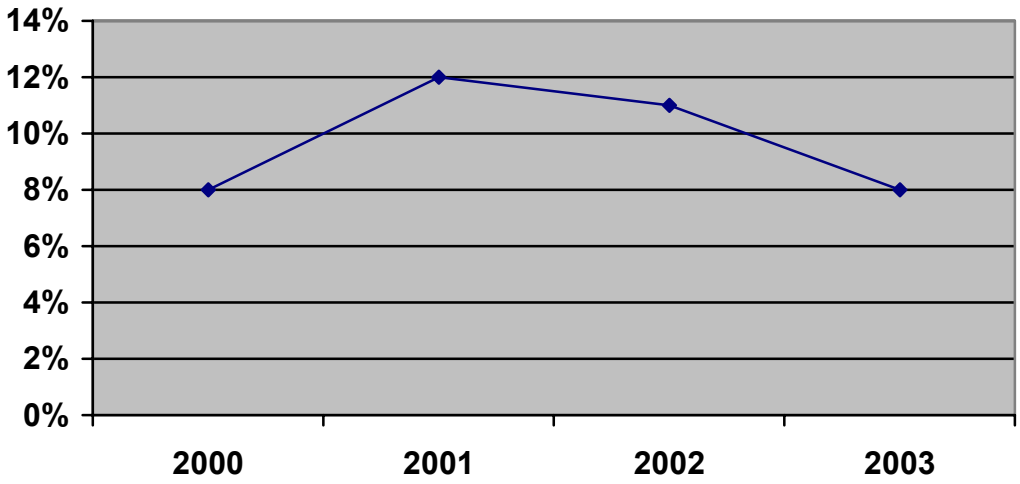
Maryland Data, 2003

Despite short-term fluctuations in the underwriting cycle, long-term increases in health insurance premiums mirror long-term increases in medical costs. Premium levels cannot be reduced unless health care cost escalation is curbed. The recent trend for medical costs including payers' administrative expenses and the net cost of insurance is shown in Figure 1.

The latest year for which health care expenditures estimates are available is 2003.[86] In that year, total health care spending was $26.5 billion in Maryland, an increase of 8.4 percent.

[86] Maryland Health Care Commission, "State Health Care Expenditures – Experience from 2003", January 2005 (Forthcoming).

Figure I: Rate of Growth of Maryland Health Care Spending – 2000 to 2003



The smaller growth rate in health care spending in 2003 suggests that the rapid escalation in spending that began in 1999 may have peaked in 2001. During that period, growth in spending in Maryland outpaced growth in the US. Over that period, health care costs in Maryland and the United States grew more rapidly than the economy as whole. Given the magnitude of the increases, it is not surprising that many purchasers, including individuals and employers, find that coverage is no longer affordable.

Table 2 below compares how the various components of spending increased between 2002 and 2003.

Table 2: Total Expenditures and Rate of Growth by Type of Service, 2002-2003 ($ millions)

EXPENDITURE COMPONENTS	2002	2003	PERCENT CHANGE
Total Health Expenditures	**$24,452,462**	**$26,502,580**	**8.4 %**
Hospital Services			
Inpatient	6,024,621	6,400,602	6.2 %
Outpatient	2,079,308	2,245,448	8.0 %
Physician Services	4,487,519	4,904,020	9.3 %
Other Professional Services	3,442,075	3,603,075	4.7 %
Prescription Drugs	3,178,378	3,471,601	9.2 %
Nursing Home Care	1,777,850	1,879,029	5.7 %
Home Health Care	825,401	994,297	20.5 %
Other Services	856,326	948,668	10.8 %
Administration and Net Cost of Insurance	1,780,985	2,055,840	15.4 %

Source: Maryland Health Care Commission, "State Health Care Expenditures – Experience from 2003," January 2005 (Forthcoming).

About one-third of Maryland's health care dollars were spent on hospital care. In 2003, inpatient hospital care accounted for 24 percent of total health care spending; outpatient hospital care accounted for an additional 8 percent. Physician services accounted for 18 percent of total spending, while other professional services accounted for 14 percent. In total, Marylanders spent over $8.6 billion for inpatient and outpatient hospital care, $4.9 billion for physician services, and $3.6 billion for other professional services during 2003.

Spending for prescription drugs in Maryland totaled $3.4 billion in 2003, 13 percent of total health care spending, about the same as was reported for other professional services and almost $1.2 billion more than total spending for outpatient hospital care. Administrative costs, including the net cost of private health insurance[87], accounted for 8 percent of total health care spending in 2003.

Per capita spending was $4,811 in 2003, an increase of 7.2 percent from 2002. The lower rate of growth in per capita spending relative to total spending is attributable to the one percent increase in the population between 2002 and 2003.

How Does Maryland Compare to the US?

While spending per capita for all health care services in Maryland is near the national average ($4,811 versus $4,826), Maryland's pattern of spending by service type differs. Specifically, Marylanders spend much less per capita for physician care and for home health care (19 percent and 35 percent less, respectively). Marylanders also pay less for hospital and nursing home care, although the difference is relatively small (both about 4 percent).

However, for some types of services Marylanders pay much more per capita. In particular, per capita spending for other professional services is much greater in Maryland (65 percent) than the U.S. average. Although these are relatively small categories of expenditure relative to hospital and physician care, both entail relatively large proportions of consumer spending out of pocket.

Per capita spending for prescription drugs in Maryland is about the same as the national average, as is spending for insurance administrative and net costs.

Retreat from Tightly Managed Care

The expansion of health maintenance organizations (HMOs) took place during the latter part of the 20th century as a result of increasing costs borne by the consumer and strong support for the concept of the 'corporate practice of medicine' in certain states. The popularity of HMOs, however, markedly increased after the passage of the HMO Act in 1973.[88] Initially, HMOs were one form of managed care that managed patient care through

[87] Administrative costs and net cost of insurance are the marketing costs, broker expenses, claims processing costs, and underwriting gains.

[88] Peter Kongstvedt, Essentials of Managed Health Care, 1995, The HMO Act of 1973 "enabled managed care plans to increase in numbers and expand enrollments through health care programs financed by grants, contracts, and loans" (2).

limited provider networks and stricter utilization control. Another form of managed care is the Preferred Provider Organization (PPO). PPOs allow greater flexibility with choice of providers.

Consumer backlash against HMOs, peaking around 2000, has led to less restrictive management practices by these organizations and greater utilization of services by enrollees. One example is emergency department services. In the past, some HMOs have denied coverage on the basis that some care rendered in the emergency department was not truly 'emergency' care. Currently, over 40 states, including Maryland[89], have passed legislation allowing the enrollee to use a "prudent layperson" standard to decide a medical emergency,[90] requiring the HMO to pay for the service if a prudent layperson would consider it to be an emergency.

HMO enrollment in Maryland declined, on average, 6.7 percent between 2001 and 2002.[91] The rising costs of HMO plans, along with the desire by the public to have the ability to obtain care without the gatekeeper approach, has led to a slowing of growth in HMO market share and the loosening of the restrictions governing managed care plans. Rising medical costs and health insurance premiums, however, are leading to more individuals and employers to consider and/or choose managed care plans to stem the premium increases. A survey commissioned by the California HealthCare Foundation found that individuals favor those managed care practices that control costs, such as the use of a primary care gatekeeper.[92] The survey reported that slightly over half (52 percent) of the respondents support the requirement for specialist referrals, and 54 percent support the use of generics or less-expensive prescription drugs.[93]

Declining HMO enrollment may be nearing an end in Maryland. In 2003, 1.8 million people were enrolled in Maryland HMOs – up slightly from 1.7 million in 2002. Total enrollment in Maryland HMOs increased by 5 percent in 2003. The highest growth in HMO enrollment occurred among the privately insured -- about 65,000 lives.[94]

Some of the managed care plans that are currently available on the market do not offer the similar tight restrictions that were available in HMO plans in the 1990s. These 'revised' plans are comparable to point-of-service plans in that they allow the enrollee to obtain out-of-network care by paying a greater proportion of the cost-sharing arrangement. Employers may offer a choice between these types of plans or the less restrictive preferred provider organization (PPO) plans, and a traditional HMO plan. According to an article in

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[89] Maryland Annotated Code, Health General Article, § 19-701 (d) " 'Emergency services' means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) Placing the patient's health in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part."

[90] Linda R. Brewster, Liza Rudell, Cara S. Lesser, Center for Studying Health Systems Change, *Emergency Room Diversions: A Symptom of Hospitals Under Distress*, Issue Brief Number 38, May 2001.

[91] Maryland-specific data provided to MHCC by InterStudy.

[92] "Surveys Show U.S. Public Concerned with Health Costs," kaisernetwork.org, November 11, 2004, Claudia l. Schur, Marc L. Berk, and Jill M. Yegian, "Public Perceptions of Cost Containment Strategies: Mixed Signals for Managed Care," *Health Affairs*, November 10, 2004.

[93] Ibid.

[94] Maryland-specific data provided to MHCC by InterStudy.

Health Affairs, "consumers' resistance to managed care was based at least in part on lack of choice; it is well established that consumers are more satisfied with their health plan when they choose it."[95]

The authors of the aforementioned article give two reasons why consumers are becoming more responsive to managed care. The first is that rising medical costs and health insurance premiums are significantly affecting employers' ability to afford offering health insurance, and employees' ability to afford to purchase it. Health care spending as a percentage of gross domestic product rose to approximately 15 percent between 2000 and 2002 after remaining relatively stagnant since 1993. In addition, more employers are shifting additional cost-sharing requirements to employees as premiums rise while trying to maintain the availability of plans with broad networks and choice. By providing a choice of plans, one with lower premiums and more restrictions, compared to a plan with higher premiums and less restrictions, employees are able to choose which plan fits their budget and health care needs.[96]

Provider Capacity Constraints (Emergency Department Overflow/Diversion; Nursing Shortages)

Hospital Emergency Departments

A source of rising health care costs is the inappropriate use of hospital emergency departments by those who are uninsured and also the insured. A study published in the *Annals of Emergency Medicine* (October 2004) reported that approximately 85 percent of those who sought treatment in emergency rooms have health insurance, and 83 percent of them have a regular source of health care other than the emergency department, such as a primary care physician.[97] Also, those who are uninsured were not more likely to seek treatment in an emergency department than those who have health insurance. Emergency room visits were associated with "poor physical health, poor mental health, and five or more outpatient visits of care during the year…"[98] The authors recommend improving outpatient care, especially for those in poor health and whose regular care is interrupted.

An analysis of Maryland hospital emergency department utilization conducted by the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) in 2002 found that in Maryland, and across the United States, there have been substantial increases in the utilization of acute care hospital emergency department services over the past twelve years.[99] In fiscal year 2001, there were 1.9 million visits to the emergency department services operated by Maryland's acute care hospitals. Between 1990 and 2001, the emergency department utilization increased by 454,000 visits

[95] Claudia l. Schur, Marc L. Berk, and Jill M. Yegian, "Public Perceptions of Cost Containment Strategies: Mixed Signals for Managed Care," *Health Affairs*, November 10, 2004.
[96] Ibid.
[97] Ellen J. Weber, MD, Jonathan A. Showstack, PhD, MPH, Kelly A. Hunt, MPP, David C. Colby, PhD, and Michael L. Callaham, MD, "Does Lack of a Usual Source of Care or Health Insurance Increase the Liklihood of an Emergency Department Visit? Results of a National Population –Based Study," *Annals of Emergency Medicine*, October 2004.
[98] Ibid.
[99] *Trends in Maryland Hospital Emergency Department Utilization: An Analysis of Issues and Recommended Strategies to Address Crowding*, Report of the Joint Work Group on Emergency Department Utilization, Maryland Health Care Commission and the Health Services Cost Review Commission, April 2002.

or 30.6 percent. Over this same time period, Maryland's total population increased by about 11.6 percent.

Because emergency department services are a vital component of the health care system, the MHCC and the HSCRC convened a Joint Work Group to examine the underlying causes of the recent increases in utilization, assess the impact of future trends on the provision of these services, and ensure that public policy is coordinated in developing effective strategies to address emergency department crowding. A large number of interrelated factors influence how hospital emergency department services are utilized and the frequency of diversions and crowding. These factors can be broadly categorized as follows: (1) increased demand for emergency department services; (2) changes in the management of emergency department patients; and, (3) the capacity of hospital and community health care system resources to address treatment and other needs following discharge from the emergency department.

Appendix A lists the results and recommendations of the MHCC and HSCRC analysis.

Nurse Staffing Shortage

The shortage of nurses has been a focus of national attention as the issue of staffing and its effect on hospital costs and patient safety is debated. The American Hospital Association cites 126,000 vacant nursing positions in hospitals nationwide, and the aging of the nurse workforce is expected to create an additional shortage of 400,000 nurses by 2020. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has analyzed data reported from their sentinel event database, noting that, in 24 percent of more than 1600 reported events, nurse staffing levels played a factor in the adverse event. The JCAHO Roundtable on the Nursing Shortage issued recommendations to reverse the trend in the nursing shortage: (1) create organizational cultures of retention; (2) bolster the nursing educational infrastructure; (3) establish financial incentives for investing in nursing; (4) establish "staffing levels based on nurse competency and skill mix relative to patient mix and acuity;" and (5) increase funding for nurse education and the allocation of federal funds to health care organizations designated for nursing services.[100]

A U.S. Department of Health and Human Services study found a correlation between nurse staffing and increased rates of five adverse outcomes in medical patients - urinary tract infection, pneumonia, shock, upper gastrointestinal bleeding, and length of stay. A relationship was found between failure-to-rescue (a concept which refers to recognizing the potential for an adverse outcome and preventing it) and nurse staffing for major surgery patients. The study also found that increased staffing of patient care units with registered nurses was associated with a 3 to 12 percent reduction in the rates of the aforementioned outcomes. A 2 to 25 percent reduction in these outcome rates was found with an increase in staffing with all types of nurses.[101]

[100] The Joint Commission on Accreditation of Healthcare Organizations. Healthcare at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis. November 2002.
[101] Jack Needleman, Peter I. Buerhaus, et al., Nurse Staffing and Patient Outcomes in Hospitals, Final Report, U.S. Dept. of Health and Human Services, HRSA, February 28, 2001

In early 2002, the GAO was commissioned to study the possibility of a relationship between nurse staffing levels, quality of care, and expenditures. Data from three states (Mississippi, Ohio, and Washington) were analyzed and the results indicated that facilities which provided a higher number of nursing hours per resident day were "less likely to have repeated serious or potentially life-threatening quality problems, as measured by deficiencies detected during state surveys" than facilities with lower levels of nursing hours.[102] The effect seemed to be related specifically to the nursing hours since no relationship was found between spending per resident day and the number of deficiencies received by a facility.[103]

Another study analyzed the relationship between nursing staffing and patient outcomes in hospitals. [104] For the study, a cross-section of nurses was surveyed regarding their demographics, work history, job satisfaction, and degree of job "burnout." This information was then compared to patient outcomes data. It was determined that patients in hospitals with high patient to nurse ratios (fewer nurses per patient) experienced higher risk-adjusted 30-day mortality and failure-to-rescue rates.

In California, a mandatory patient-nurse ratio for hospitals was signed into law in 1999. It requires "licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit for inpatient units in acute care hospitals."[105] This law follows similar legislation enacted in 1977 that requires a nurse-patient ratio of 1:2 in intensive care and coronary care units, and also a requirement that at least half of the licensed nurses working in these units are registered nurses.[106] Proponents contend that more nurses per patient (or fewer patients per nurse) improve quality of care and patient safety, and also improve the working conditions for nurses. Opponents of the legislation argue that mandating a set ratio of nurses to patients increases costs associated with nurses' salaries and may unintentionally cause those facilities that currently have ratios above the mandated minimum ratios to reduce their nursing staff, possibly because of the subsequent salary increases or due to a reduced supply of nurses. A study analyzing the costs of implementing the staffing mandate in California hospitals found that the increase in nursing expenditures range from approximately $20,000 to over $300,000 per hospital.[107] Recently, the California Department of Health Services proposed emergency regulations easing the requirements of the nurse staffing legislation in order to alleviate the financial burden placed on hospitals. The emergency regulations delay the implementation of the nurse-to-patient ratio in medical-surgical units and emergency departments, as well as other changes.[108] Numerous hospitals have asked for waivers from the ratios (68 hospitals), while "11 hospitals cited the staffing requirements as contributing to facility closures or service reductions."

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[102] General Accounting Office, Nursing Homes: Quality of Care More Related to Staffing than Spending, June 13, 2002.
[103] Ibid.
[104] Linda H. Aiken, Sean P. Clarke, Douglas M. Sloane, Julie Sochalski, Jeffrey H. Silber, "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," *JAMA* (288), October 2002.
[105] California Assembly Bill 394 of 1999. Janet M. Coffman, Jean Ann Seago, and Joanne Spetz, "Minimum Nurse-to-Patient Ratios in Acute Care Hospitals in California," *Health Affairs*, 21(5) 53-63: 2002.
[106] Ibid.
[107] Ibid.
[108] "California Proposes Easing Nurse Staffing Rules to Reduce Financial Burden on Hospitals," kaisernetwork.org, November 5, 2004.(Chong, *Los Angeles Times*, November 5, 2004).

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of the Department of Health and Human Services (HHS) to contract for a study to assess whether minimum-staffing ratios in nursing homes should be established. Although staffing thresholds were determined, the Secretary recommended at that time, that it was inappropriate to mandate staffing standards. As a result, the HHS found that that staffing standards "are insufficient for determining the appropriateness of staffing ratios…".[109] These uncertainties over the reliability of staffing data and "feasibility of establishing staffing ratios" were cited as reasons that HHS would not recommend minimum staffing ratios for nursing homes. Because the studies do not address certain issues, such as the current nursing shortage and the importance of management and training of staff on the quality of care, the HHS found that it would be impractical to implement the recommended staffing thresholds.[110]

According to a study recently published in *Health Affairs*, the number of registered nurses (RNs) in hospital and non-hospital settings increased about 205,000 between 2001 and 2003.[111] Factors cited as leading to the increase are wage increases (4.9 percent increase in real RN earnings for 2002 and about 1.5 percent in 2003); the national unemployment rate (six percent in 2003 and 5.8 percent in 2002); and private-sector initiatives to encourage people to enter the nursing profession. In 2002, the growth in the number of RNs came from the reentry of 'older' RNs ages 50 to 64 years into the workforce and the entry of foreign-born RNs. A sizable number of 'younger' RNs ages 21 to 34 years old entered the nursing workforce in 2003. The implications of increasing wages to attract nurses to work in health care facilities will lead to higher overhead costs, which are then passed on to the consumer either directly or through a third-party payor.

Inpatient Hospital Services and Costs

The national BlueCross BlueShield Association (BCBSA) commissioned several studies analyzing health care expenditures and their associated causes. One of the studies examined the rising health care spending associated with inpatient hospital expenditures. The study examined five factors that largely contribute to inpatient costs. They are: workforce shortages and costs; new technology costs (including prescription drugs) and the consumer demand for them; retreat from managed care; legislation changes related to public and private health care spending; and changes in hospital business strategies/plans (e.g., mergers, greater negotiation power with health plans).[112] The authors conducted a literature review and reported the following findings:

Workforce shortages and costs – Fifty percent of hospitals' operating expenses are workforce costs with a growing proportion of costs going towards nurse staffing. The current nurse staffing shortage affecting hospitals not only affects its costs to provide care

[109] Centers for Medicare and Medicaid Services, Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II Final Report. Letter to The Honorable Richard B. Cheney, President of the Senate, from Tommy G. Thompson, Secretary of the Department of Health and Human Services.
[110] Ibid.
[111] Peter I. Buerhaus, Douglas O. Staiger, and David I. Auerbach, "New Signs of a Strengthening U.S. Nurse Labor Market?" *Health Affairs*, November 17, 2004.
[112] Sharon Forest, Mireille Goetghebeur, and Joel Hay, "Forces Influencing Inpatient Hospital Costs in the United States," Prepared for the Blue Cross Blue Shield Association by BioMedCom Consultants Inc. and the University of Southern California, October 16, 2002.

but also has a direct impact on quality of care and patient safety. According to the report, "nurse cost center direct costs represent approximately 44 [percent] of the direct costs of inpatient care with payroll representing 80 [percent] of these costs."[113] To fill the vacant slots, hospitals have increased salaries for full-time nurses (up to 10 percent), and are using agency and traveling nurses. The average age of a registered nurse has increased, leading to a greater demand for nurses in the years to come.

Technology – The costs of new technology and the population it will be used to treat, as well as the demand for the technology from patients, increases hospital spending. New technology comes at a high cost to hospitals, with highly advanced imaging machines averaging $1 million to $2 million. While a greater proportion of people may benefit from the technology, increased utilization comes at a cost to the hospital which is then passed on to payers of these services.

Changes in hospital business strategies/plans – Nationally, hospital consolidation and cost shifting are major factors influencing costs for hospitals. According to the report, 40 hospitals closed each year between 1994 and 1998, and in 1997, 184 mergers between hospitals occurred. As a result, hospitals have increased their negotiating leverage with health insurance carriers leading to increased reimbursement rates. In addition, hospitals (including those in Maryland) are facing a construction boom with the Maryland Health Care Commission currently reviewing over $2 billion in hospital certificate-of-need requests.

Physician Services and Costs

In 2002, the Lewin Group released a study on physician services and the associated health care costs. Based on the analysis, physician costs nationwide for the year 2002 comprised 22 percent of national health care expenditures with a strong correlation to the growth in total national health expenditures.[114] Data from the Blue Cross Blue Shield national database indicate that physician costs per beneficiary increased 7 percent between 2000 and 2001.

The results of this study indicate that four factors greatly influence the rising cost of physician services – general economic variables and demographics; general price inflation; physician and specialist supply; and technology and treatment patterns.

General Economic Variables, including general price inflation – Economic variables account for the amount of disposable income available to people. High per capita income is positively associated with health care expenditures (the higher the personal income, the higher the average annual health care expenditure), whereas individuals with lower per-capita income have lower average annual health care expenditures. However, individuals with lower per-capita income spend a greater proportion of their personal income on health care services.

[113] Ibid.
[114] Keith Hearle, Lane Koenig, Allen Dobson, et. al., "Drivers of Healthcare Costs Associated with Physician Services," Prepared for the Blue Cross Blue Shield Association by The Lewin Group, Inc., October 16, 2002.

Demographics – In 2000, those age 65 and older made up 12.4 percent of the U.S. population and accounted for one-third of all health care spending. According to the report, "…on average, people in the 65 and older cohort use six times the healthcare resources of people in the under 18 cohort…"[115] In addition, racial and ethnic disparities in health care services is a significant problem as studies indicate that racial and ethnic minorities face significant barriers accessing health care services. The non-white U.S. population is expected to increase to one-third by 2010.

Physician and Specialist Supply – In 1999, the average number of physicians per 1,000 people in the U.S. was 1.71. The Council on Graduate Medical Education predicts a shortage of primary care physicians in the near future, along with a surplus of specialists. According to the study, specialists use more expensive technology and perform more intensive procedures.

Medical Technology – While new technologies are proven to provide a benefit in terms of prevention, diagnostic treatment and rehabilitation, the cost of new technology, as well as the use of existing technology "account for one-half to two-thirds of the annual increase in U.S. healthcare spending that is not attributable to inflation in the economy as a whole."[116]

Other variables studied by the Lewin Group for the effect on costs include physician operating costs and health status (which had a moderate effect on costs) and health regulation, health insurance product and benefit design and provider payment (which had the least influence on physician costs).

Technology Growth - Use of Newer, Costly Procedures and Refinements in Existing Technology

New technology growth over the past thirty years has enabled more people to obtain costly interventions at a questionable benefit. According to a report released by the BlueCross BlueShield Association (BCBSA), 20 to 40 percent of the annual increase in medical spending during the late 1990s is attributable to changes in medical technology.[117] The study cites three causes of technology as a major cost driver –

1. New technology offers improved services and quality;
2. Less invasive and oftentimes safer technology encourages more people to use them, leading to a higher volume of procedures performed; and
3. The use of technology that is not proven clinically effective (providers who do not consider evidence-based medicine when recommending high technology procedures).[118]

Patient's desire to use the technology also is a major contributor to the overuse of technology. While many of the diagnostic imaging services used provide greater insight into existing or unforeseen medical conditions, some technology is used when it is not

[115] Ibid.
[116] Ibid.
[117] BlueCross BlueShield Association, "Medical Technology as a Driver of Healthcare Costs: Diagnostic Imaging," http://bcbshealthissues.com/relatives/20865.pdf.
[118] Ibid.

clinically advisable. In 2000, technology accounted for $65 to $75 billion in expenditures. The expected amount of growth between 2000 and 2005 for increasing technology is $18 to $21 billion.[119]

A recent article in the Wall Street Journal approximated the cost of diagnostic scans at $100 billion per year with magnetic resonance imaging (MRI) as one of the "fastest growing costs in U.S. health care."[120] The BCBSA analysis also cites the use of MRIs, as well as computed tomography (CT) scans, as the fastest growing health care costs. To curb the growing expenses associated with medical technology, the BCBSA article recommends that: (1) technology should be used when clinically appropriate and consumers should be educated that the "newest, most expensive technology is not always necessary" and may not "improve the quality or results of their care";[121] (2) physicians should take an active role in the reduction of the inappropriate use of technology and use evidence-based medicine when prescribing diagnostic testing; (3) hospitals should not compete with one another by purchasing and offering expensive technology; and (4) health plans should share information with providers on those areas where medical costs and utilization are increasing.

Many believe that technology is the preeminent cause behind the growth in health care spending, and that the use of managed care or other forms of cost control cannot limit the demand for technology. The results of a study published in the health policy journal *Health Affairs* show that external factors outside of a health plan contributed to the demand for innovative, yet expensive technology. Demand for technology is fueled by physicians who perceive greater clinical benefits as well as factors related to "competition among physicians, consumer demand, and manufacturers' marketing strategies."[122] Also, internal factors, such as a plan's coverage policy, were limited in terms of curbing the use of high-technology services. A main finding from the study is that health plans highly value their relationship with physicians, employees, and consumers, and are therefore, highly unlikely to alienate these groups. As stated in the article "maintaining a high level of these stakeholders' satisfaction is central to a plan's success, and administrators considered it important for plans to avoid conflict with physician groups or being perceived by consumers as denying care."[123]

The study also found that health plans generally do not use coverage contracts to limit services, and patients and physicians are not amenable to other types of cost containment. Plans are more likely to provide 'appropriate care' that is supported by clinical data that use cost containment efforts. The study concludes by stating that "managed care, as historically practiced, will not dramatically slow health care cost growth." [124] The authors recommend that physicians' ability to adopt and use new services as applicable to evidence-based medicine may be fundamental to constraining cost growth aside from health plans' efforts.

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[119] Ibid.
[120] Vanessa Fuhrmans, "Big Health Insurer to Target Scan Tests as Way to Cut Costs," *The Wall Street Journal*, August 19, 2004.
[121] Blue Cross Blue Shield Association.
[122] Michael E. Chernew, Peter D. Jacobson, Timothy P. Hofer, Keith D. Aaronson, and A. Mark Fendrick, "Barriers to Constraining Health Care Cost Growth," *Health Affairs*, 23(6), November/December 2004.
[123] Ibid.
[124] Ibid.

Aging of the Population

The aging of the population is often cited as contributing to the growth in medical spending since traditionally more health care services are utilized later in a person's life and these services are generally more expensive. Uwe Reinhardt examines the effect of the aging U.S. population on the future demand for health care, and challenged conventional thinking "that the aging of the population by itself is a major contributor to the annual increase in demand for health care and, thus, to total national health spending."[125] The author reviews recent literature addressing the issue of aging and health care spending on the demand side (use of health care services), and also the results of an analysis using data from the Medical Expenditure Panel Survey (MEPS).[126] Most research indicates that the aging of the population by itself is not a major factor in the increase in the use of healthcare services, and the MEPS analysis shows that with the aging of the population over time, the average increase in annual spending per capita is minimal. Another article claims that "the increase in the elderly population could account for a 7 percent rise in medical spending – a trivial part of the total increase."[127] While there is a real increase in spending attributable to aging, its effect on overall medical spending is negligible.[128]

B. Populations with Chronic Conditions

The substantive rise in the number of Americans with chronic health conditions is increasing each year, and the cost associated with treating these patients is exorbitant. An article in the September 2004 journal *Hospitals and Health Networks*, reported that 23 percent of the U.S. population 18 years and older suffer from high blood pressure, 10.3 percent have heart disease, asthma affects 9.1 percent of individuals and diabetes affects 6.1 percent of the population.[129] The article states that the cost of treating patients with chronic conditions is extremely expensive, with "nearly 80 percent of all health care dollars spent in the nation [going] towards chronic care."[130] A Wall Street Journal article states that "people with chronic diseases account for more than two-thirds of the nation's $1.6 trillion medical bill."[131] And, as the number of chronic conditions per patient increases, so does the average per capita spending.[132]

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[125] Uwe E. Reinhardt, "Does the Aging of the Population Really Drive the Demand for Health Care?", *Health Affairs*, 22(6), November/December 2003.
[126] The Medical Expenditure Panel Survey conducted by the federal Agency for Healthcare Research and Quality.
[127] Joseph Newhouse, "An Iconoclastic View of Health Cost Containment," *Health Affairs*, 12, 1993
[128] Ibid. The Center for Health System Change also examined the relationship between aging and rising health care costs and found that aging contributes a very small amount to per capita health care spending for people under age 65. (Bradley C. Strunk and Paul B. Ginsburg, "Aging Plays a Limited Role in Health Care Cost Trends," Center for Health System Change, Number 23, September 2002).
[129] Matthew Weinstock, "Chronic Care: An Acute Problem," *Hospital and Health Networks*, September 2004. The source of the data is the Medical Expenditure Panel Survey, 2000.
[130] Ibid. In the September 1, 2004 edition of the JAMA, chronic disease is labeled as the "principle cause of disability and use of health care services…". Halsted Holman, MD, "Chronic Disease – The Need for a New Clinical Education," *JAMA*, Vol. 292, No. 9, September 1, 2004.
[131] Laura Landro, "Does Disease Management Pay Off?" *The Wall Street Journal*, October 20, 2004.
[132] Weinstock. The average per capita spending for one medical condition is $2,000 and rises to almost $12,000 for five or more chronic conditions.

Chronic conditions are generally defined as lasting longer than three months and frequently recurring. By 2010, 141 million Americans are expected to suffer from a chronic condition with more than 70 million people affected by multiple conditions. The number is expected to climb to approximately 171 million by 2030. "[A]bout 4 percent of people with no chronic condition have an inpatient stay during a given year verses 33 percent of people with five or more conditions" (according to the federal Medical Expenditure Panel Survey).[133]

A recently published study examines those illnesses that significantly contribute to high medical expenditures.[134] The study found that 15 illnesses "accounted for 56 percent of the $200 billion rise in health spending between 1987 and 2000." Of the fifteen, five conditions accounted for one-third of the increase. Heart disease, followed by pulmonary conditions, mental disorders, cancer and hypertension topped the list. Some of the services used to treat conditions, however costly, provide benefits that far outweigh the costs (such as treating low-birthweight babies and heart attacks).[135] The article states that "Americans spent about $1.6 trillion on health care last year, or about 15 percent of the gross domestic product (GDP), compared with 11 percent of GDP 15 years ago. In the past three years, health insurance costs have increased an average of 12.5 percent annually, and that increase is the most commonly cited reason for why nearly 44 million people do not have insurance."[136] Americans spend more per capita than citizens of other industrialized nations.

The study found that the growth in medical spending on chronic conditions has increased due to three reasons: (1) additional people suffer from asthma and diabetes, possibly as a result of air pollution and obesity (rise in treated prevalence); (2) an increase in the cost of treating certain medical conditions, especially heart disease, over time (rise in cost in per-treated case): and (3) the number of individuals diagnosed with certain illnesses, such as depression, have increased substantially (increase population per medical condition).[137]

Another recent article states that "at least 57 million, or one-third of [the] U.S. working-age adults, deal with some kind of long-term illness, such as diabetes, heart disease, or depression," and "more than one in five are in families with problems paying their medical bills."[138] A recent Institute of Medicine (IOM) report notes that 9 million school-age children are obese, with an estimated 30 percent of boys and 40 percent of girls in the U.S. at risk to develop Type 2 diabetes.[139] The recommendations from the IOM committee include: nutritional standards for all food and beverages served in school; programs to teach health education; more physical activity for students; and creation of a federal interagency task force to coordinate activities.[140]

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[133] Ibid.
[134] Kenneth E. Thorpe, Curtis S. Florence, and Peter Joski, "Which Medical Conditions Account for the Rise in Health Care Spending?" *Health Affairs*, August 25, 2004.
[135] Ceci Connolly, "15 Illnesses Drive Up Costs," *The Washington Post*, August 25, 2004.
[136] Connolly and Thorpe, et. al.
[137] Ceci Connolly, "15 Illnesses Drive Up Costs," *The Washington Post*, August 25, 2004.
[138] Vanessa Fuhrmans, "When the Insured Struggle to Pay for Health Care," *The Wall Street Journal*, September 22, 2004; Institute of Medicine of the National Academies, *Preventing Childhood Obesity: Health in the Balance*, Jeffrey P. Koplan, Catharyn T. Liverman, and Vivica I .Kraak, editors, September 30, 2004.
[139] Catherine Arnst, "The Kids Are Not All Right" (Commentary) *Business Week*, October 11, 2004.
[140] Marian Burros, "New Approach to Childhood Obesity Urged," *The New York Times*, October 1, 2004.

Nationwide, approximately 64 percent of the US population is overweight or obese, and, as previously mentioned, the rate of obesity in children is escalating.[141] A study on spending growth attributable to changes in obesity and per capita spending among the obese found that the prevalence of obesity among the non-institutionalized and civilian U.S. population rose 10.3 percent between 1987 and 2001, with "the rising prevalence of obesity and higher relative per capita spending among obese Americans account[ing] for 27 percent of the growth in real per capita spending…"[142] The results of the study also indicated that "costs incurred by the obese were 37 percent higher than costs for those with normal weight in 2001."[143] Because of the increase in the prevalence of obesity (accounting for 24 percent of the population), the prevalence of secondary medical conditions has also increased. Large spending increases occurred in three of the medical conditions examined – diabetes, high cholesterol, and heart disease.[144]

Health Affairs recommended that effective interventions be developed promoting weight loss for those who are considered obese.[145] Approaches used to assist patients in losing weight include diet and exercise programs, drug therapy, and usually as a last resort, bariatric surgery. Several strategies have been proposed to assist the federal government, the food industry, the health industry, and other interest groups in an effort to curb the rising obesity rate, such as reducing or eliminating food advertising aimed at young children and shifting the federal corn subsidy to fruits and vegetables.[146]

C. Pharmaceuticals

Costs of Prescription Drugs

According to a survey published in the American Journal of Health-System Pharmacy (October 1, 2004), nine prescription drugs that are in short supply nationwide "are resulting in hospitals prolonging patient stays, canceling certain medical procedures and paying tens of thousands of extra dollars annually.[147] As a result, hospitals are being forced to alter patient care, and at worst, the shortages have resulted in adverse events (such as a serious medication error, death or disability). The study found that some pharmacists have purchased the medications at higher prices or used a substitute which is priced higher.

For the first half of 2004, national prescription drug spending per privately insured person increased 8.8 percent, lower than the 9.6 percent increase in the second half of 2003 and significantly lower than the 19.5 percent increase in the second half of 1999. The growth of prescription drug prices and utilization also slowed (to 3.1 percent and 5.5 percent, respectively). The increase in drug prices peaked in late 2001 at 6 percent and drug utilization per person increased 12.9 percent in the second half of 1999. The reduced

[141] Susan J. Landers, "Policy-makers Take Aim at Obesity Rates," American Medical News, July 19, 2004
[142] Kenneth E. Thorpe, Curtis S. Florence, David H. Howard, and Peter Joski, "The Impact of Obesity on Rising Medical Spending," Health *Affairs*, October 20, 2004.
[143] Ibid.
[144] Ibid.
[145] Ibid.
[146] Corn syrup is a type of sugar that is a primary ingredient in many processed foods.
[147] Kaiser Daily Health Policy Report, "Drug Shortages Adversely Impacting Patient Care, Survey Finds", September 30, 2004.

rate of growth may be attributable to an attempt by employers and individuals to control spending by using generic drugs instead of brand-name prescriptions, a tiered pharmacy benefit structure, and larger copayments or shifting to coinsurance.[148]

Direct to Consumer Marketing

In 2000, the pharmaceutical industry spent over $2 billion marketing pharmaceutical products to the public. There has also been an increase in direct-to-consumer advertising of diagnostic services (i.e. high technology medical screening test, such as chest imaging and body scanning). The costs to treat those conditions that are discovered from these tests which are not life-threatening add costs to the medical system.[149] An article in the New England Journal of Medicine cites that over $15 billion was spent by pharmaceutical companies promoting pharmaceutical drugs in 2000 (to both the medical population and general public), compared to $11 billion in 1997.[150] This article cites evidences which states that "[t]here is evidence that many drug advertisements are not balanced or accurate."[151] Another article in the New England Journal of Medicine countering this argument advocates that both the provider and patient benefit from pharmaceutical advertisements in that advertising "encourage[s] patients to talk to their physicians about their medical conditions and treatment options."[152] The author of this article explains because of pharmaceutical advertisements to the public, the rate of use of drugs has increased among those who had untreated conditions, and compliance among those with known conditions has improved.[153] The author states that "the proper use of prescription drugs is often the most effective and least expensive form of health care."[154]

[148] Bradley C. Strunk and Paul B. Ginsburg, "Tracking Health Care Costs: Spending Growth Slowdown Stalls in First Half of 2004", The Center for Health System Change and The Employee Benefit Research Institute, Issue Brief No. 91, December 2004.
[149] Jeffrey M. Drazen, M.D., "The Consumer and the Learned Intermediary in Health Care," New England Journal of Medicine, 346 (7), February 14, 2002.
[150] Sidney M. Wolfe, M.D., "Direct-to-Consumer Advertising – Education or Emotion Promotion?" New England Journal of Medicine, 346 (7), February 14, 2002.
[151] Ibid.
[152] Alan F. Holmer, J.D., "Direct-to-Consumer Advertising- Strengthening our Health Care System," New England Journal of Medicine, 346 (7), February 14, 2002.
[153] Ibid.
[154] Ibid.

D. Populations who are Uninsured

Data from the Current Population Survey (2002 and 2003) indicate that 13.6 percent of the Maryland population was uninsured, or approximately 740,000 people (at 15.3 percent of the non-elderly population). This figure increased from 12.8 percent in 2001-2002. The employment-based coverage rate declined from 75 percent during 2000-2002 to 72 percent in 2002-2003. Based on analysis of the 2002-2003 data, the largest proportion of uninsured individuals by age is young adults between the ages of 19-24, 25-29 and 29-34. These age groups account for approximately 40 percent of uninsured persons in Maryland; 18 percent of the uninsured are between the ages of 19 and 24. By income level, individuals with family incomes of more than 300 percent FPL ($54,732 for a family of four) account for a large proportion of the uninsured. These individuals make up 34 percent of the uninsured in Maryland, with 23 percent of the uninsured with incomes above 400 percent FPL or $72,976 per year for a family of four.[155]

The data also show that fewer employers are offering health benefits, probably as a result of the growing cost of health insurance. Recent surveys indicate that health care costs are rising at a faster rate than wages and other costs which employers usually cover.[156] In 2003, there were 20.6 million uninsured U.S. full-time workers – an increase of 1.6 million between 2002 and 2003.[157] The rising costs associated with employee health insurance are suggested to have contributed to a decrease in employment-based coverage as five million fewer jobs included health insurance in 2004 compared to 2001.[158] As reported in *The New York Times*, health benefits costs increased at a 12-month rate of 8.1 percent for the second quarter of 2004 – "more than three times the inflation rate and the rate of increases in wages and salaries."[159]

In a survey conducted by Mercer Human Resource Consulting, many employers report they are planning to cut benefits and shift some of the cost to the employees. The effect of the projected increase in premiums will probably cause some small employers to discontinue offering coverage or to shift the costs to employees through increased premiums, or higher deductibles and copayments.[160]

Description of the Uninsured in Maryland

Approximately 740,000 people in Maryland have neither public nor private health insurance.[161] During 2002-2003, the rate of uninsurance in Maryland rose from 12.8 percent of the total population to 13.6 percent. Among the non-elderly, the rate rose from 14.4 percent to 15.3 percent. Historically, the proportion of uninsured people in Maryland

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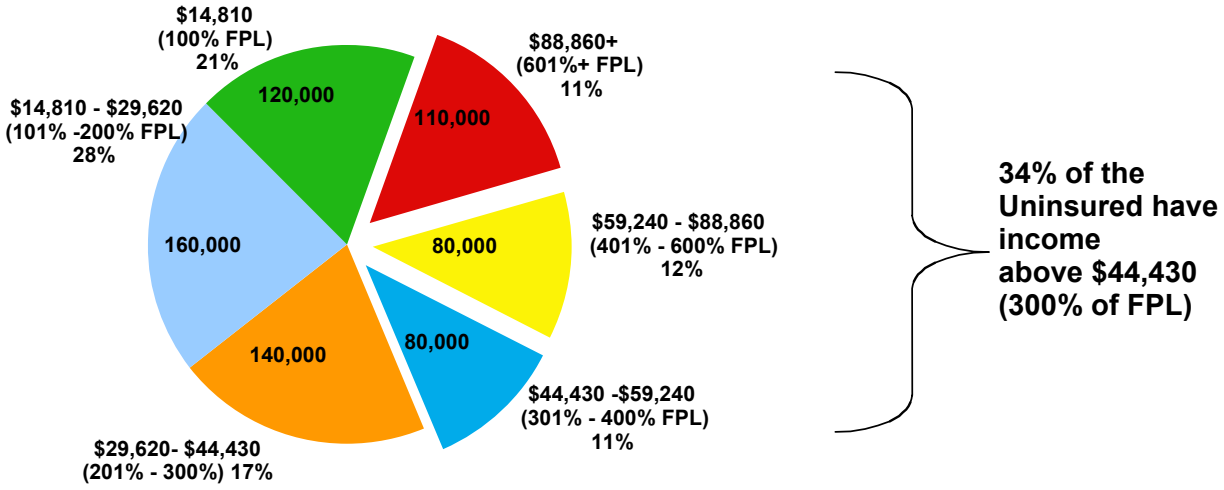
[155] Maryland Health Care Commission, *Health Insurance Coverage in Maryland Through 2003*, November 2004.
[156] Eduardo Porter, "Rising Cost of Health Benefits Cited as Factor in Slump of Jobs," *The New York Times*, August 19, 2004.
[157] Milt Freudenheim, "Record Level of Americans Not Insured on Health," *The New York Times*, August 27, 2004.
[158] __ "Health-Care Costs Climb, As Premiums Rise 11%," *The Wall Street Journal/Associated Press*, September 9, 2004.
[159] Eduardo Porter.
[160] Milt Freudenheim.
[161] The Maryland Health Care Commission, *Health Insurance Coverage in Maryland Through 2003,* November 2004.

is lower than for the nation as whole (the uninsured rate for the U.S. is 17 percent) due to Maryland's higher employment rate among adults. The growth in the number of uninsured in Maryland is attributable primarily to a reduction in the number of people with employment-based coverage. Between 2000 and 2003, the rate of employer-based coverage declined from 77 percent to 72 percent.

Contrary to many people's expectations, only 13 percent of the uninsured live in families (including single individuals) in which there are no working adults. Since small firms are less likely than larger firms to offer coverage, it is not surprising that 33 percent of the working uninsured are employed by companies with fewer than 10 employees. Another 27 percent work for medium-sized firms, those with 25 to 499 employees. Even though nearly all large firms offer health coverage, 21 percent of the working uninsured are employed at firms with more than 500 workers. About 6 percent of the working uninsured are government employees. An individual's income is a better predictor than firm size of whether he or she will be insured (i.e., a highly-paid attorney working in a small firm is more likely to be have insurance than a low-paid sales clerk at a large retail establishment with many employees).

There are substantial numbers of uninsured people at every income level, as shown in the figure below. The largest proportion, 49 percent, falls into the low-income category, having a household income of less than 200 percent of the federal poverty level. Another 17 percent are families of modest means, with incomes between 201 percent and 300 percent of the poverty level. About 34 percent of all uninsured individuals live in households with incomes above 300 percent of the poverty level ($44,430 for a family of three), and 11 percent live in households with incomes above 600 percent of the poverty level ($88,860 for a family of three).

Figure 2: The Nonelderly Uninsured by Poverty Level (Family of 3), 2003



While workers employed during an entire year (or full year) on a full-time basis are more likely to have health insurance, this group includes more than two-thirds of uninsured workers. As expected, those individuals employed part-time or who are part-year workers (less than 50 weeks) are less likely to have health insurance.

Certain populations with historically high uninsured rates continue to be less likely to have health care coverage. Young adults ages 19 to 34 are less likely to have health insurance than children or older adults. They make up 41 percent of all of the uninsured. Single adults are more likely to be uninsured than married adults. The uninsured rate for single female adults for 2002 and 2003 was 20 percent, and the uninsured rate for single male adults was 34 percent; this compares with 13 percent for married adults. The difference in uninsured rates between single males and single females is not income related; it may be a reflection of different attitudes towards health insurance and/or job choices.

Non-U.S. citizens in Maryland are significantly less likely than citizens to have health insurance, regardless of family income. Non-U.S. citizens comprise about 30 percent of Maryland's uninsured, even though they are only 9 percent of the non-elderly population. In addition, minority racial/ethnic groups, regardless of income, are less likely to have insurance than non-Hispanic Whites.

A person's level of education is also a predictor for having health insurance. Individuals with a college degree or some college education are less likely to be uninsured (10 percent and 16 percent, respectively). The uninsured rate among Maryland residents with only a high school diploma or no diploma is 28 percent and 58 percent, respectively.

The growth of the uninsured population in Maryland between years 2002 and 2003 reflects a worsening social problem. The 740,000 Maryland residents who go without a stable source of health care are at greater risk of not obtaining health care services for needed care, including preventative care, and of facing financial ruin as a result of incurring large medical expenses.

Costs of Non-Insurance

The Institute of Medicine released a report in 2002 estimating that nearly 18,000 people die each year in the U.S. because they lack health insurance, and that when these people seek medical care, it is oftentimes poorer care compared to those individuals with health insurance.[162] Under the auspices of the Health Resources Services Administration (HRSA) State Planning Grant, a report detailing the costs of being uninsured in Maryland was prepared.[163] In the report, several studies are mentioned that attempt to analyze and quantify the cost of not having health insurance (the State of Texas, the Kaiser Family Foundation, and the Institute of Medicine).

The IOM study, titled *Hidden Costs, Value Lost – Uninsurance in America*, focuses on the individual and societal costs of non-insurance. The report first addresses current

[162] The Institute of Medicine, *Care Without Coverage: Too Little, Too Late*, 2002.
[163] Hugh Waters, Laura Steinhardt, Thomas Oliver, et. al., "The Costs of Not Having Health Insurance in the State of Maryland," Maryland HRSA State Planning Grant, December 22, 2003.

expenditures on medical services for the uninsured totaling $98.9 billion for part- and full-year uninsured, and then quantifies other 'hidden costs' resulting from uninsurance (such as health status loses – value of averted risk expressed by expected number of lives saved – and financial risk). In addition, the costs of care the uninsured would use if they had health insurance were calculated, and ranges from $34 billion to $69 billion (in 2001 dollars).

In determining the costs of non-insurance in Maryland, the authors examined several factors, including amount of uncompensated care, public subsidies for the uninsured, physician ambulatory services, philanthropic spending, uninsured individuals' costs, and lost health status and added risk. The total expenditures and costs related to non-insurance in Maryland for fiscal year 2002 were calculated ranging from $ 2.4 billion to $3.7 billion. Health status losses (i.e., decreased health status) are considered to have the largest cost, estimated between $1.1 to $2.3 billion for 2002, followed by statewide programs ($409 million), and individuals' out-of-pocket spending at $318 million.

While some of the cost of treating the uninsured is paid for out-of-pocket by those without insurance and/or considered bad debt or charity care by the health care provider, the costs of non-insurance are generally paid by all Maryland residents in the form of higher premiums or health care bills.

VI. Ways to Educate Consumers About Health Care Issues and Promote Personal Accountability in Health Care

A. Information about the Health Care System

Performance Guides

Available on the Maryland Health Care Commission (MHCC) website are performance guides for hospitals and nursing homes, as well as a consumer guide on ambulatory surgery facilities. The Maryland Hospital Performance Evaluation Guide was first released in January 2002 and features information on several facility characteristics, such as the location of the hospital, number of beds, and accreditation status. Thirty-three high volume conditions and procedures are featured. For each hospital, consumers are able to compare the volume, risk adjusted length-of-stay, and risk adjusted readmission rate for each condition. Quality of care information specific to the treatment and prevention of congestive heart failure and community acquired pneumonia for each hospital are featured. General information on patient rights and how hospitals are regulated in Maryland, as well as a checklist to help consumers select a hospital, and guidance on what to expect in the hospital setting is also included in the Guide.

The combination of quality data for physicians and hospitals, along with cost data, will provide the consumer with additional information that can be used to select providers. The addition of cost data to the Guide or another public document may assist consumers with comparing hospitals in a certain region for a particular procedure or quality measure. Quality information on individual physicians is not available at this time, but should be considered as a source of information for which consumers can use to make decisions about their medical care. However, standardizing and collecting cost and quality information on individual physicians entails substantial administrative and technical difficulties.

Role of Health Care Provider

Aside from formal programs, health care providers have historically taken a lead role in assessing a patient's health and targeting specific medical interventions based on the patient's medical condition. All of this, however, is predicated on a patient receiving preventive care. Oftentimes, a patient's health care condition worsens to the point that expensive emergency care is required, and the health care costs associated with that treatment are significantly higher than if the patient's medical condition was treated earlier.

Providers should take an active role in their patient's health care, and carriers should institute programs targeted to those enrollees who exhibit signs of a chronic illness. Methods that providers and carriers could use to educate patients on treating certain chronic conditions and the costs associated with them are listed below.

1. Educate providers on identifying and treating patients who exhibit chronic conditions;
2. Educate patients on the short and long term implications from the disease, as well as the costs associated with it;
3. Educate patients on how to improve their health through a better diet and exercise (if recommended), and routine medical care; and
4. Educate patients that they should be accountable for their health, and that they can take control of their condition with the assistance of their provider.

All of these steps can also be taken in conjunction with formal disease management programs as outlined in Section VII below.

Small Employers

Maryland State Planning Grant - Qualitative Research: In an effort to study ways to identify ways to increase coverage for the uninsured, the Maryland Department of Health and Mental Hygiene, in partnership with the Maryland Health Care Commission and the Johns Hopkins University Bloomberg School of Public Health, applied for a federal Department of Health and Human Services' Health Resources Services Administration (HRSA) grant. In 2002, Maryland was one of twelve states to receive a State Planning Grant from HRSA which allowed Maryland the opportunity to build on its longstanding commitment to developing innovative private and public sector programs that make health insurance coverage more accessible and affordable for Marylanders.

As part of the grant, focus groups were conducted with small employers and insurance brokers. Feedback received from the focus group research with firms not providing coverage indicates that many of these businesses are operating on extraordinarily thin margins and health insurance is not the only benefit these firms perceive as unaffordable: most do not offer retirement plans, paid vacation, etc. At virtually any price, premiums are perceived as unaffordable, given these firms thin profit margins, the cyclical or seasonal nature of many of these businesses and the effects of the economic slow-down.

In addition to being cost prohibitive, there are a host of administrative reasons these employers cite as to why they do not offer coverage. Many of the proprietors themselves lack coverage and know little about how to purchase insurance or select a plan. The process is perceived as complex, highly confusing, time consuming, burdensome and thankless. These owners perceive that once they offer coverage, they will not be able to rescind it. Thus, coverage with its concomitant, highly variable and unpredictable premium costs becomes a fixed cost over which they have virtually no control. Moreover, administering the health benefit is perceived as a time consuming burden for which there is little appreciation on the part of employees. Finally, many of these firm's proprietors have a very negative perception of the health insurance industry. Many employers believe that if they provide coverage and the insurer denies care, or if an employee faces a problem with their coverage or care, they will be blamed. Simply put, unless the premium is very highly subsidized, these firms will not voluntarily offer coverage.

The focus group research found that familiarity with the Comprehensive Standard Health Benefit Plan (CSHBP), required to be offered by carriers to Maryland small

employers, is poor. Virtually none of the focus group participants were familiar with 1993 small group market reforms, although some were aware of some of the protections associated with the reform. None of the participants were aware of the Standard Plan (CSHBP). However, some employers vaguely recalled their brokers presenting them with a "minimum plan" option.

Recommendations presented by Shugoll Associates include:

- Determine the feasibility of launching an employer education program to educate small employers about health benefits. This includes providing consumer-friendly educational material on its website since small employers and brokers use the Internet to gather information on health benefits. Further research is needed to determine the viability of providing marketing information through the MHCC's website.

- Broader distribution of Maryland's CSHBP brochure for small business is needed. The MHCC should evaluate the feasibility of mailing the brochure to small employers, possibly along with other State forms, and should make it available through local Chambers of Commerce, other local business associations and brokers.

- Once the MHCC re-evaluates the benefits in the CSHBP, it should work with brokers to gain their cooperation in presenting and promoting the standard plan to small employers. The State should also inform brokers about some of its other programs (e.g., Maryland Health Insurance Plan), since brokers are a major source of information for small employers.

- If possible, the MHCC should work with brokers and carriers to address their concerns about the high cost of servicing the small employer market since this issue is likely to drive more and more brokers away from presenting health benefit plans to small employers.

California Healthcare Foundation (CHCF): The CHCF maintains a website designed to assist the small employer in purchasing and evaluating health insurance plans. The site, www.HealthCoverageGuide.org, provides general information on health insurance, along with more specific information to assist employers with purchasing health plans. For example, small employers are encouraged to consider health plans' scope of coverage, choice of providers, and cost sharing arrangements. Examples of situations in which business owners decide how much the employees should pay towards their health insurance is provided. The site also provides information on the role of brokers, how to communicate the plan's benefits to employees, and the 'rights and rules' affecting small employers.

Information on the Cost of Services

The actual, or true, cost of health care services is generally not known to the average consumer. Many times, only if an Explanation of Benefits (EOB) is provided does a consumer know that cost of the service. However, the EOB may only show the contractual rate between the provider and the health plan and not the actual rate charged for the service. If the individual has no insurance, a bill for full charges is generally provided.

Minnesota features information on costs and quality on a website (MinnesotaHealthInformation.org). The site serves as a clearinghouse for information on hospitals, physicians and medical groups, health plans, and nursing homes. Links are provided to assist consumers with determining annual health care costs, costs of health plans, and general state hospitals costs. Specific costs for certain procedures performed in the inpatient and outpatient settings are not provided.

In 2004, the Florida legislature voted to make the health care system more "transparent" by requiring licensed facilities to provide prospective patients with an estimate of charges for services. This information may be obtained by those who do not have insurance or those who are insured but whose carrier does not maintain a contract with the hospital. The estimate of charges is only available to those qualifying individuals if the hospital determines that the individual's medical condition is not an emergency or if the services would not be covered under the person's insurance contract. In addition, the Florida Agency for Health Care Administration must "make available [on its website] information regarding patient charges, volume, length of stay, and performance outcome data for medical conditions…"[164] The Agency's purpose is to ensure accessible, affordable, quality health care for all Floridians. The Agency administers the state's Medicaid program, and conducts the licensing and certification of health care facilities. It also operates the State Center for Health Statistics and develops health care policies and proposals.

A recent article describes several methods health insurers are using to educate their enrollees on the cost of health care services, and well as provide services that steer the consumer away from costly medical care (e.g., emergency departments) to less expensive treatment, if warranted. [165] Aetna provides cost data for common procedures by zip code. By entering the zip code of their residence or provider location, an enrollee will be able to obtain the average charge for procedures such as a breast biopsy and knee or shoulder arthroscopy. The enrollee is also able to compare the cost of a procedure in-network and out-of-network. In addition, other insurers encourage patients to call nurses if they have questions regarding their care and their health condition. The nurses are available 24 hours a day and, often times, divert patients from costly care received at hospital emergency rooms.[166]

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[164] Florida House of Representatives Staff Analysis of HB 1629 (Chapter 297), http://www.flsenate.gov/data/session/2004/House/bills/analysis/pdf/h1629e.ap.pdf
[165] Tom Graham, "Your Health, Your Money," *The Washington Post*, October 5, 2004.
[166] Ibid.

Pharmaceuticals

The public display of prescription drug costs for the most commonly prescribed drugs is one tool used to educate consumers on the costs of health care. Several states, including Maryland, and the federal Medicare program provide cost data on the most commonly prescribed medications. On the Maryland Office of the Attorney General website,[167] prices for the 25 most commonly prescribed prescription drugs are available. A consumer can compare the prices for these drugs by county, by city or by zip code. The name and address of pharmacies are presented along with the 'usual and customary' price of the drugs. New Hampshire recently included cost data on prescription drugs on their state website. Consumers are able to compare prices for prescription drugs sold in-state and in state-approved Canadian pharmacies.[168] New York recently made available the prices of the 25 most commonly prescribed medications in the state. Four hundred and forty pharmacies, including major chains, were surveyed. Information on the prescription drugs is available for the 62 New York counties.[169] And in Florida, legislation passed in 2004 requires the posting of the retail prices of the 50 most frequently prescribed pharmaceutical medicines.[170]

Consumers may use the Maryland Office of the Attorney General website to locate the least expensive price for the drug they are taking according to their area of residence. It would be more beneficial, however, to include additional prescription drugs so that a greater share of the Maryland population would benefit from this cost comparison tool.

Another way to educate consumers on the price of pharmaceutical drugs and to encourage personal accountability of costs is through coinsurance. As opposed to copayments, coinsurance is a certain percentage of the cost of the drug whereas copayments are fixed payments (e.g., $5.00). Many employers have increased prescription drug copayments, however, higher copayments are not popular among employers and employees.[171] By requiring health plan enrollees to pay a certain percentage of the price of prescription drugs, individuals are less inclined to purchase brand name drugs and instead buy generic prescriptions. On the other hand, individuals may choose not to take a required medicine because of the cost.[172]

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[167] http://www.oag.state.md.us/Drugprices/index.htm

[168] KaiserNetwork.org, *State Watch | New Hampshire Adds Prescription Drug Price Comparison Link to State Web Site*, September 20, 2004.

[169] KaiserNetwork.org, Daily Health Policy Report, Prescription Drugs/ "New York Attorney General's Prescription Drug Price Web Site Attracts Half Million Hits in First Day," August 20, 2004; www.NYAGRx.org

[170] [170] Florida House of Representatives Staff Analysis of HB 1629, "2004 Affordable Health Care for Floridians Act, Chapter 2004-297.

[171] Scott Hensley, "Employers Use Co-Payments to Keep Drug Costs in Line," *The Wall Street Journal*, May 10, 2004.

[172] Dana P. Goldman, et. al., "Pharmacy Benefits and the Use of Drugs by the Chronically Ill," *JAMA*, 291 (19), May 19, 2004.

B. Consumer-Directed Health Care Plans

Consumer-directed health care plans provide consumers with greater financial control over their health care. These types of arrangements generally include a lower-cost, high-deductible insurance plan, coupled with some sort of tax free investment account. They use greater patient cost-sharing, through the use of a high deductible, in order to lower the premiums of the plan, and encourage the patient to use money set aside in the tax-free account by the employer and/or the employee or individual for health care expenses. The overarching goal of consumer-directed plans is to reduce utilization and thus, reduce health care costs associated with the plan by exposing the enrollee to greater financial risk. This is based on the assumption that there is overutilization or inappropriate utilization in the current system.

The recent push for consumer directed health plans, resulting from the rising costs of health care and spending, has led to the demand for information that can be used by consumers when selecting health plans, determining which health care practitioners or hospitals will best serve their needs, and engaging the consumer in a direct dialogue with their provider on efficient and effective care and the associated costs. Coupled with quality information, cost data can enable individuals with health insurance coverage to have a better understanding of the intrinsic value of health services and what their premiums, copayments, and deductibles are paying for.

See a more detailed discussion of tax-deferred Health Savings Accounts and other consumer directed health care in Section IV above.

VII. Ways in Which Disease Management Programs Can Promote the Appropriate Management of Chronic Diseases

Disease Management Programs

The rising cost of medical care associated with chronic conditions has led medical experts, health insurance carriers and employers to search for ways that will improve the overall health and well-being of those affected by long-term illnesses, as well as attempt to reign in health care costs.

A disease management program involves a provider, usually a nurse, contacting the patient on a daily, weekly, or monthly basis depending on the severity of the illness. The provider recommends that the patient follow a set treatment plan, while encouraging the patient to lead a healthy lifestyle.

Currently, approximately 160 private companies across the US operate disease management programs.[173] Disease management programs are less than a decade old, and while they may educate the patient, thus leading to healthier lifestyles, the proof that the programs lead to large cost savings is currently not available.[174] Other methods used by health care providers are 'best practices,' or evidence-based medicine. These practices are demonstrated to improve the health condition of individuals suffering from certain medical conditions, such as diabetes.[175] "[H]ealth plans and employers have stepped up efforts to get providers to follow so-called "best practices" intended to lead to the optimal use and amount of care."[176]

Disease management programs are increasingly used by employer-sponsored health plans to educate patients about their chronic condition and to provide ways to manage their symptoms, while improving the person's quality of care.[177] These programs are also designed to fend off complications that may lead to the use of expensive treatment.

Fifty-eight percent of employer-sponsored health plans offered disease management programs last year; 17 percent more than in 2002.[178] Several hospitals around the country have implemented a chronic care program aimed at reducing a large part of uncompensated care delivered each year.[179] The Joint Commission on the Accreditation of

[173] Laura Landro, "Does Disease Management Pay Off?" *The Wall Street Journal*, October 20, 2004.
[174] An article by Bruce Fireman, Joan Bartlett, and Joe Selby, "Can Disease Management Reduce Health Care Costs by Improving Quality?" Health Affairs, 23 (6), November/December, 2004, finds that lower costs from disease management programs have not yet been realized; however, quality of care does improve.
[175] Ceci Connolly, "15 Illnesses Drive Up Costs," *The Washington Post*, August 25, 2004.
[176] Chen May Yee, "HealthPartners to Withhold Payment for Errors," *Star Tribune (Minnesota)*, October 6, 2004.
[177] Laura Landro.
[178] Ibid.
[179] Matthew Weinstock, "Chronic Care: An Acute Problem," *Hospital and Health Networks*, September 2004. Truman Medical Center, Kansas City, MO, Northeast Health, Troy, NY, and Sutter Health, Northern California have programs aimed at chronic health care conditions.

Health Care Organizations maintains a certification program for disease management and chronic care. Currently, over 100 organizations are certified, many of which are affiliated with accredited hospitals or home health agencies. Providers who are certified are required to meet certain conditions, such as following clinical guidelines and measuring outcomes of care.

Payments to providers under the current acute care management system are generally on a per-episode basis; under a disease management program, caring for an individual is on a long term basis and in concert with other caregivers. One report states that "moving from an acute care model to one that emphasizes care management will not be an easy task. It requires a fundamental shift in the way providers are paid and how they think about patients."[180]

Programs Instituted by Insurance Carriers

Several national carriers, such as Anthem Blue Cross Blue Shield (New England) and Health Partners in Minnesota, are introducing disease management into their benefit plans in an effort to control spending.[181] Jenny Craig, a nationwide weight loss organization, is partnering with health insurance carriers and employers and offering weight loss programs. Anthem Blue Cross and Blue Shield, BlueCross BlueShield of South Carolina, and BlueCross BlueShield of Vermont are offering these programs at a reduced cost.[182]

Kaiser Permanente, the largest private-sector, non-profit provider of health care in the U.S., emphasizes management of chronic diseases, and claims to save money on its members due to the avoidance of costly hospital care. Kaiser spends $55 million a year on chronic care programs in Northern California. Approximately 70 percent of Kaiser members reside in California. Kaiser Permanente of the Mid-Atlantic claims that its disease management program is one reason that it received fifteen Star Performer designations in the most recent MHCC HMO Consumer Guide.[183]

The following examples of disease management programs were provided by local representatives of Aetna, Kaiser Permanente, CareFirst BlueCross BlueShield, and MAMSI/UnitedHealthcare:

<u>Aetna</u>

Aetna's approach to disease management employs a combination of evidence-based clinical design, ongoing program evaluation and enhancement, and a commitment to improving health care outcomes. Their disease management programs presently support nearly 885,000 members nationwide with asthma, congestive heart failure, coronary artery disease, diabetes, low back pain and end-stage renal disease.

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[180] Ibid.
[181] Ibid.
[182] American Health Line, "Weight Management: Jenny Craig Partners with Health Insurers," October 6, 2004 (Cheddar Berk, Dow Jones/Wall Street Journal, 10/6/04).
[183] Star Performer status is awarded for each measure for which a plan has performed above average for three consecutive years.

Members who can benefit the most from their disease management programs are identified in a number of ways. In addition to accepting physician, member, and employer referrals, Aetna uses sophisticated analytic tools and support to appropriately target members for inclusion in their programs. Their predictive modeling and risk stratification tools help them identify members based on the severity of their condition so they can tailor their activities to the member's individual educational and clinical needs.

Aetna's focus on continuous quality improvement to enhance the value that these programs deliver and improve health outcomes has won awards like the Disease Management Association of America's (DMAA) 2003 Best Disease Management Award, which Aetna's Chronic Heart Failure program won last year and the 2004 DMAA Leaders Award for their work to address racial and ethnic disparities in health care, in part through their enhanced clinical program.[184]

Kaiser Permanente

Kaiser's Asthma Initiative focuses on people who use "too much" reliever medication and not enough prevention medication. Kaiser reaches out to these patients in an attempt to prevent asthma flares, hospitalizations and missed days from work. Kaiser's hospital days over the past several years have trended down as a result of this outreach program.

Kaiser also offers a Cardiac Risk Reduction Program which targets people with either known coronary artery disease (CAD) or diabetes (who have a very high risk for developing heart disease), and reaches out to them to encourage use of aspirin, blood pressure and cholesterol medications to reduce their risk of a future heart attack. Even taking the cost of the drugs into account, by significantly decreasing the risk of a heart attack and/or stroke, Kaiser expects to realize cost savings. They will spend more on medications up front in order to produce savings by avoiding complications in the future.[185]

CareFirst BlueCross BlueShield

CareFirst offers disease management programs to their members who have asthma, chronic obstructive pulmonary disease, diabetes, heart failure, and heart disease. Participants are identified through claims and pharmacy data, physician referrals, nurse referrals and self-referrals, and then are provided information based on a predictive modeling and risk stratification methodology. Participants are educated on how to self-manage their condition and receive information targeted to their specific condition. CareFirst reports that of those participants with diabetes, coronary heart disease, and congestive heart failure, 55 percent of participants reported improved physical status, and 69 percent of participants reported improved mental status.[186]

Mid-Atlantic Medical Services, LLC (MAMSI)/UnitedHealthcare

[184] Email correspondence with Lee Ann Bailey, Aetna Small Group Product Development, Mid-Atlantic.
[185] Email correspondence with Gail M. Thompson, Director, Government Relations, Kaiser Foundation Health Plan of the Mid-Atlantic States.
[186] Correspondence with Patty Ciotta, Government Affairs, CareFirst BlueCross Blue Shield. Information also obtained from CareFirst marketing materials.

On the MAMSI/UnitedHealthcare website, consumers may obtain information on resources and strategies to deal with chronic conditions, such as asthma, cardiovascular disease and diabetes. MAMSI/UnitedHealthcare offers disease management programs.[187]

Research

The issue of cost savings of these programs is debatable. Several groups, such as Cigna and disease management organizations, point to cost savings associated with the alleviation of catastrophic illnesses and patients' improved quality of care. For employers, research conducted on Cigna employees enrolled in disease management programs showed that the overall cost of care for treating these patients was less than treating those chronic care patients not enrolled in the programs.[188] According to Cigna, "these programs have a profound impact on the quality of care and costs on a short- to intermediate-term basis."[189]

A recent report released by the Congressional Budget Office (CBO), however, questions the ability of disease management programs to save money in the long-run (because of a lack of evidence), while proposing that these programs may, in fact, raise costs because of increased medical spending on the chronically ill patients. The longer a patient lives, the more it costs to treat that person and the more likely that that person will die of more serious illnesses.[190] A report published in *Health Affairs* also cites a lack of evidence of cost savings from disease management programs.[191] An analysis conducted by Mercer Human Resource Consulting found some limitations in the CBO study, including: (1) the population analyzed (CBO assumed disease management was made equally available to all beneficiaries rather than concentrated on those for whom it was likely to be cost-saving); (2) an assumption that no incentives were offered to individuals to encourage participation in the programs; and (3) the analysis of disease management studies conducted in the early to mid 1990s that were hospital or provider-based interventions that targeted local populations. Most of the disease management programs offered today are implemented by large disease management vendors and health plans that have national books of business across a broader population base.[192]

Home and Community-Care Services: House Calls and Related Programs

At least one million seniors ages 65 years and older are permanently homebound, and millions more individuals are so disabled they cannot easily access physician offices. Many of these persons are Medicare's "high cost" users, with five or more chronic

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[187] Email correspondence with Elizabeth Sammis, Vice President of Communications, MAMSI/UnitedHealthcare, and http://www.mamsi.com/index.jsp.

[188] Laura Landro, "Does Disease Management Pay Off?" *The Wall Street Journal*, October 20, 2004.

[189] Ibid. Quote from Allen Woolf, National Medical Director, Cigna Corp.,
Victor C. Villagra and Tamim Ahmed, "Effectiveness of a Disease Management Program for Patients with Diabetes, *Health Affairs*, 23 (4), July/August 2004.

[190] Laura Landro.
Congressional Budget Office, "An Analysis of the Literature of Disease Management Programs," October 13, 2004.

[191] Bruce Fireman, Joan Bartlett, and Joe Selby, "Can Disease Management Reduce Health Care Costs by Improving Quality?" Health Affairs, 23 (6), November/December, 2004.

[192] Email correspondence with Bruce Kangisser, Mercer Human Resource Consulting.

conditions consuming two-thirds of the Medicare program's expenditures.[193] Home and community-care services programs serve the medical needs of the Medicare-eligible population with multiple chronic conditions through such methods as house calls for the elderly who are bed bound. The focus of these programs is on chronic care models that address the care needs of individuals over age 65 with multiple chronic conditions, not just a single chronic disease, and in turn, reduce medical spending through less inpatient, acute-care treatment. Because the most costly care is generally given to individuals who are elderly, these programs serve to significantly reduce medical spending.

Medical house call programs are one example of programs aimed at reducing high health care spending for this population. Through these programs, physicians, often in association with nurse practitioners and/or physician assistants, provide primary care in the home of the patient. In Maryland, there are currently four functioning "house call" programs that serve only Medicare patients (in Baltimore City, Anne Arundel, Howard and Harford counties). Through Medicare, approximately 1.5 million house calls are made per year (with many shut-in patients never seeing a physician), compared to an average of eight to nine annual medical visits to nursing home patients, and 11 to 12 annual physician office visits by ambulatory patients with chronic illnesses.[194] While house calls typically cost payors more per visit, they can prevent unnecessary, expensive emergency department visits and hospitalizations. The cost-effectiveness of treating patients with chronic conditions in a home care setting is proven in several studies.[195]

In addition, some health care systems have demonstrated savings by improving the way chronic disease patients are treated. For example, North East Health System (New York) redesigned their care processes for heart failure patients through a coordinated care management program. This system reported reducing length of stay by nearly one day, and reducing rates of hospitalizations for home care and residential care patients by up to 67%.[196]

'Partnership for Solutions' is an initiative led by the Johns Hopkins University and the Robert Wood Johnson Foundation to improve the lives of millions of Americans who suffer from chronic conditions.[197] The focus of the initiative is research into the chronic care problems; communicating the research to policymakers, researchers, and others; and identifying solutions to the problems faced by those suffering from chronic conditions. Several programs have been identified though this initiative as offering a promising solution to chronic care, including a federal demonstration project titled 'Cash and Counseling' which is currently offered in three states, and 'Improving Chronic Illness

[193] "Chronic Conditions: Making the Case for Ongoing Care,: Partnership for Solutions, A Project of The Johns Hopkins University and The Robert Wood Johnson Foundation, http://www.partnershipforsolutions.com/partnership/index.cfm
[194] S Levine, J. Boal, P. Boling, "Home Care", *JAMA*, 290(9), September 3, 2003.
[195] Mary D. Naylor, et. al., "Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders: A Randomized Clinical Trial," *JAMA* 281, February 1999; Steven L. Phillips, et. al., "Chronic Home Care: A Health Plan's Experience." *Annals of Long Term Care*, 12(4), April 2004; Susan S. Jackson, et. al., "Impact of a Medical House Call Program on Use of Acute Hospital and Emergency Department Services in an Urban VA Medical Center," poster 34121, AGS 2002..
[196] American College of Healthcare Executives, "The CEO Perspective: How Changing Chronic Care Needs Affects Hospitals," December 9, 2004.
[197] 'Partnership for Solutions', http://www.partnershipforsolutions.com/partnership/index.cfm

Care,' a Robert Wood Johnson Foundation national program aimed at improving preventive care and education of individuals with certain chronic conditions.

Medicare Modernization Act

The Medicare Prescription Drug Improvement and Modernization Act of 2003 authorized federal officials to conduct a disease management program for Medicare recipients titled the 'Chronic Care Improvement Act.' The goal is to "produce better medical outcomes for chronically ill patients, while, at the same time, reducing the cost of caring for them."[198] A main component of the program is to monitor patients with chronic diseases, with such methods as phone calls from nurses, and educate the patients to spend less time seeking treatment in costly settings such as in the emergency department. Eventually, it is anticipated that the program will lead to lower health care expenditures. Medicare has begun disease management programs in 10 regions (as required in the Medicare Modernization Act) with the plan to expand the programs nationwide.

[198] Glenn Ruffenach, "Miracle Cure?" *The Wall Street Journal*, August 9, 2004.

VIII. Ways to Encourage Strategies to Purchase Health Care that Focus on Quality, Patient Safety, and Wellness

A. Purchasing to Improve Quality

Pay For Performance

Several states, the federal government and some national organizations are instituting pay-for-performance programs to encourage physicians and hospitals to provide high-quality evidence-based medical care that is cost-effective.

A recent article describes programs in California and Hawaii that reward physicians for adherence to basic guidelines for efficient and effective medical care.[199] In California, the Integrated HealthCare Association, a group of 35 health plans, will grant bonuses next year totaling $40 million to $60 million to 215 medical groups, with 24,000 primary care doctors receiving the bulk of the bonuses. In Hawaii, a physician bonus program encouraging the use of evidence-based medicine has led to a higher percentage of care being delivered using these practices. Other programs include the federal Centers for Medicare and Medicaid Services (CMS) pilot programs that "reward physicians for providing quality care and investing in new technology to better track patients," Wellpoint Health Networks Inc. (a California-based Blue Cross Blue Shield health plan), and the "Bridges to Excellence" program devised by General Electric Co., Ford Motor Co., and other organizations which "pay doctors bonuses for treating diabetes and heart patients correctly."[200]

Some physicians have countered this effort with their concern that the measures are not risk-adjusted (i.e., they do not take into account specific risks of certain patients) and that the claims data used to measure a physician's performance are flawed. Others say that providers cannot be responsible for patients who do not follow-up with recommended procedures and also that their offices are not equipped with technology that would assist them with tracking a patient's care. Still others contend that some providers will deny care to the sicker patients or tend to care for those who are healthier in order to receive favorable ratings.[201]

Several initiatives are currently underway that attempt to influence health care providers to reduce utilization of health care services by patients while not jeopardizing quality of care. A recent article describes two companies that have established new programs that aim to lower health insurance costs.[202] Financial incentives are used to encourage hospitals and health care practitioners to provide data on their performance

[199] Laura Landro, "To Get Doctors to Do Better, Health Plans Try Cash Bonuses," *The Wall Street Journal*, September 17, 2004.
[200] Ibid.
[201] Ibid.
[202] Vicki Kemper, "Maverick Health Plan Ups Quality to Cut Cost," *The Los Angeles Times*, August 23, 2004.

which are then used to identify the highest quality health care providers. The companies have designated 'centers of excellence,' and encourage their employees to seek treatment from these facilities. In turn, the companies pay a higher percentage of premiums (from 80 percent to 90 percent) and waive the employee's deductible. The companies reimburse employees for some food, travel and lodging costs. Since implementing this program, health care costs among the companies have decreased by approximately 2.5 percent.[203]

By focusing on improving quality of care, companies like the ones mentioned above are attempting to reduce overutilization, as well as complications and medical mistakes that lead to longer hospital stays and recovery times. These programs, in turn, result in reduced medical spending.

The Center for Studying Health Systems Change (HSC)[204] conducts an annual study of 12 communities each year to gain a better understanding of changing health care markets. Of the 12 communities visited, seven communities currently have 'health plan-based quality incentive programs.' The HSC report notes that each program contains three key design features – quality measurement, incentive payment structure, and incentive size – with variations in each feature.[205] According to the report, health insurance "plans…perceive a business case for paying for quality. A few argue that the business case for paying for quality hinges on its potential to reduce unnecessary follow-up care and improve efficiency, thereby generating cost savings that can be passed on to purchasers through lower premium increases. However, there is little empirical evidence to date to support such claims. Other plans use quality incentives because they believe they can promote better performance for a given level of cost or payment rate increase—and that purchasers will see the value added through gains in provider performance. In other words, these plans view quality incentives as a way to assure purchasers they are getting more for what they pay for in terms of health benefits."[206]

The Centers for Medicare and Medicaid Services (CMS) is increasing payments to hospitals that report quality data on ten measures under the following categories: heart failure, heart attack, and pneumonia care. For fiscal year 2005, hospitals that did not report data on the ten measures received a 0.4 percent lower payment. A majority of U.S. hospitals are reporting the data, and all hospitals in Maryland reported data on heart failure and community acquired pneumonia.[207] The use of quality data to financially reward, or penalize, hospitals is one method that is increasingly recommended to improve the delivery of quality care and improve patient safety. It has been suggested that the federal government should "purchase health care from only those providers that track and publish

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[203] Ibid.

[204] The mission of the Center for Health System Change is "to inform health care decision makers about changes in the health care system at both the local and national levels and the effects of such changes on people. HSC seeks to provide objective, incisive analyses that lead to sound policy and management decisions, with the ultimate goal of improving the health of the American public." http://www.hschange.com/index.cgi?file=about

[205] Bradley C. Strunk, Robert E. Hurley, Paying for Quality: "Health Plans Use Carrots Instead of Sticks", Center for Studying Health System Change, Issue Brief No. 82, May 2004

[206] Ibid.

[207] Kaiser Daily Health Policy Report, "Hospitals, Including Facilities Reporting Quality Information, To Receive Medicare Payment Increase, Officials Announce," August 3, 2004, and CMS, Reporting Hospital Quality Data for Annual Payment Update, Fact Sheet, http://www.cms.hhs.gov/quality/hospital/FactSheetAP.pdf

information on health care quality, such as the rate of infections acquired in the hospital or the number of unanticipated complications a doctor confronts."[208]

HealthPartners, a Minnesota health plan, has announced that effective January 1, 2005, it will no longer pay providers for certain health care procedures that are considered 'never events,' such as wrong site surgery or leaving a foreign object in a patient's body after surgery. While the health plan does not expect to save a substantial amount of money from this new policy (since these events rarely occur), it hopes to set a precedent by paying for high quality medical care while not paying for care that results in a serious medical error.[209]

Another method to reduce overutilization and improve the safety and wellness of patients is to encourage providers to adopt uniform technologies, such as electronic medical records and billing practices. The Leapfrog Group, a consortium of approximately 80 Fortune 500 companies and other large private and public health care purchasers, initiated a national effort in 2000 to recognize and reward providers for advances in patient safety and to educate employees, retirees, and families about the importance of hospitals' efforts in this area. The Group's current focus on improving patient safety is focused on three areas: computerized physician order entry (CPOE); referral of patients with certain complex conditions to hospitals proven to provide better care (evidence-based hospital referral); and staffing of intensive care units with intensivists (i.e., physicians who specialize in the care of critically ill patients). A national access initiative announced in May 2004 entitled "Regional Health Care Quality Reform Initiatives" would use the Leapfrog Group patient safety proposals to purchase higher quality care at a lower cost. This initiative would require regional groups to "form a purchasing coalition committed to using its collective clout to buy higher quality, lower priced care by strategies such as structuring their benefits programs to encourage workers to use providers who match up well against patient-safety standards promulgated by the Leapfrog Group…"[210]

The use of information technology to improve systems has proven successful in many health care organizations; however, the cost to implement these systems has posed a barrier to many facilities. In New York, a coalition of large businesses has agreed to award bonuses to those providers that have instituted CPOE systems.[211] The bonuses, in effect, act as a subsidy for the implementation of the system; however, the initial cost of implementing the system is assumed by the health care facility. While many organizations are very interested in this type of system, the expense of implementation is often financially prohibitive. Some facilities, including hospitals in Maryland, have sought to reduce costs by implementing CPOE incrementally.

Maryland HSCRC Quality Initiative

The Health Services Cost Review Commission (HSCRC) has initiated a pay-for-performance *Quality Initiative* for all Maryland hospitals. Maryland's all-payor rate setting

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[208] Jonathan Weisman, "Sick About Health Care," *The Washington Post*, May 26, 2004.
[209] Chen May Yee, "HealthPartners to Withhold Payment for Errors," *Star Tribune*, October 6, 2004.
[210] … "Employer Sponsored Coverage – Employers Plan Unified Effort on Quality, Access," Medicine & Health, Published by the Health Care Information Center, Vol. 58, No. 20, May 17, 2004.
[211] Milt Freudenheim. "Companies Start Fund to Reward Hospitals for Better Care." The New York Times. October 18, 2001.

structure provides a unique opportunity to utilize the State's authority over hospital rates and revenue to improve the quality of patient care and the efficiency and effectiveness of services provided at Maryland hospitals.

One of the primary goals of the *Quality Initiative* is to work with Maryland hospitals to enhance the quality of patient care by providing financial support and incentives to hospitals that meet or exceed established performance measures consistent with evidence-based health services research. This would be achieved through several programs:

- Reward Program - Provide additional funding to those hospitals that perform the best during each scoring period.
- Incentive Program – Encourage hospitals to continue to improve over time.
- Financial Support – Provide infrastructure support funding to hospitals that demonstrate that they are efficient but do not have the infrastructure and resources to provide a reasonable level of quality health care.

This initiative is still in its formative stages with the report of the Steering Committee on the HSCRC Quality Initiative recommending that two Workgroups be convened. The Initiation Workgroup would examine the various process, patient and performer safety, outcome, and patient satisfaction and experience measures available and make recommendations on an initial set of measures for the HSCRC Initiative. The Examination Workgroup would establish a process for the evaluation of any adopted process and system related measures to determine whether they are meeting the desired health care outcomes.

Tiered Networks

Tiered networks are increasingly being used by employers and insurers nationwide as a cost containment strategy for health care services, and also as a negotiation tool with hospitals and medical groups.[212] Most people are familiar with prescription drug cost-sharing tiering, in which no copayment or a small copayment is applied to generic drugs, followed by a higher copayment for preferred (brand name) drugs, and an even higher copayment for non-preferred drugs.

Tiered provider networks require health plan enrollees to pay "different cost sharing rates for different tiers of providers," essentially exposing the individual to differences in the cost of health care.[213] All or most hospitals and physicians in a general area may be included in a health plan with tiered networks, with the lower cost and higher quality hospitals and physicians in a smaller network with the lowest copayment, coinsurance and/or deductible. Those hospitals and providers that provide lesser quality at a higher cost will require a higher out-of-pocket payment by the health plan enrollee. Essentially, the patient decides on the provider and the associated costs, rather than the carrier or employer.[214]

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[212] Glen Mays, Gary Claxton, and Bradley Strunk, "Tiered-Provider Networks: Patients Face Cost-Choice Trade-Offs" (Issue Brief), Center for Studying Health System Change, No. 71, November 2003.
[213] EBRI – Employee Benefit Research Institute, EBRI Issue Brief – Tiered Networks for Hospital and Physician Health Care Services, August 2003.
[214] Mays, Claxton, and Strunk.

In addition to controlling health care costs, tiering enables the health plan enrollee to become more familiar and knowledgeable with their health plan, and health care in general, and can be used with consumer-directed plans. Tiering encourages enrollees to "have more of an incentive to become engaged in the process of provider and treatment selection,"[215] and in turn, may persuade hospitals or physicians to improve their quality of care while reducing costs.

Several private companies operate tiered networks throughout the country. Patient Choice Healthcare, based in Minneapolis, Minnesota, has a tiered program in three states, and "offers 15 care systems, including primary care physicians, specialists and hospitals."[216] CompcareBlue, based in Milwaukee, Wisconsin, manages the 'Tiered Copayment Option.' The three-tiered hospital network is offered with a point-of-service (POS) product. In this option, in-network hospitals, emergency rooms, and outpatient surgery centers are placed in one of the first two tiers based on cost of care provided at each facility, with the lowest charge available through the first tier. Out-of-network facilities are placed in the third tier, requiring the consumer to pay the highest out-of-pocket costs.[217] HealthPartners (Minneapolis, MN) offers a two-tiered plan called 'Distinctions' for primary-care only. Blue Shield of California's tiered plan, 'Network Choice,' promotes the use of 'Choice' hospitals with a 80/20 cost sharing arrangement, and a 70/30 arrangement for the 57 'Affiliate' hospitals. In addition to cost data, Blue Shield also uses quality measures (e.g., the Leapfrog Organization's patient safety initiatives), the accreditation status of hospitals from the Joint Committee on the Accreditation of Health Care Facilities (JCAHO), and information from a consumer questionnaire, the Patients' Evaluation of Performance in California (PEP-C).[218]

The Center for Studying Health Systems Change (HSC) analysis of 12 nationally representative communities indicates that some health plans are offering tiered networks; however, they are being met with resistance from hospitals and physicians.[219] From their analysis, they found that "health plans vary considerably in the methodologies used to develop network tiers and in the benefit designs used to steer employers and consumers to preferred providers."[220] One plan based in California established hospital tiers based on negotiated payment rates, while other plans developed tiers "using hospital and physician claims data to estimate the average cost of an entire episode of care, controlling for the differences in the severity of patients' conditions."[221] In the latter example, providers may be placed in a preferred tier by reducing unnecessary services and complications, even if their costs are higher than other providers.

Some of the problems associated with tiered networks found by the HSC study are: hospital networks not willing to participate; too few providers in a geographical area; technical difficulties, such as data limitations and methodological problems; and low-cost physicians who admit to high-cost hospitals. In addition, the examples studied by HSC indicate that most providers are included in the tiers, thereby resulting in lower than

[215] EBRI Issue Brief, August 2003.
[216] Mari Edlin, "Tiers Keep Costs in Tow," *Managed Healthcare Executive*, May 2004.
[217] Ibid.
[218] Ibid.
[219] Mays, Claxton, and Strunk.
[220] Ibid.
[221] Ibid.

expected premium savings. According to several plans, however, "some high-cost hospitals and medical groups [are] accepting lower payment rates in exchange for preferred tiered status."[222]

Another issue to consider is the quality of care. There is a concern that those providers that offer high quality care may be the highest cost providers, thereby discouraging health plan enrollees from seeking treatment from them, or requiring the patient to pay more for services. Another concern is the possibility that hospitals which have higher costs because they are teaching facilities or provide a greater share of charity care will be placed in the non-preferred tiers.[223]

B. Purchasing to Improve Patient Safety

The Leapfrog Group

The Leapfrog Group is a consortium of approximately 80 Fortune 500 companies and other large private and public health care purchasers. In November 2000, the Leapfrog Group initiated a national effort to recognize and reward providers for advances in patient safety and to educate employees, retirees, and families about the importance of hospitals' efforts in this area. The Group's current focus on improving patient safety is tailored to three areas: computerized physician order entry (CPOE); referral of patients with certain complex conditions to hospitals proven to provide better care (evidence-based hospital referral); and staffing of intensive care units with intensivists (physicians who specialize in the care of critically ill patients).

Participation in the Leapfrog Group is on a voluntary basis; however, members must agree to certain purchasing principles:[224]

- Inform and educate employees on selecting and evaluating the performance of a provider;
- Develop comparative value ratings to evaluate providers using sources such as NCQA, JCAHO, and state information;
- Use substantial incentives to influence and reward delivery systems that have 'higher value ratings' by encouraging consumers to receive treatment at high-performing facilities (directing patient volume), varying payment (such as bonuses) for superior care based on comparative ratings, and through recognition of facilities that exhibit superior performance;
- Focus on discrete forward leaps in patient safety that yield improvements in health care delivery (CPOE, evidence-based hospital referral, and ICU physician staffing);
- Hold health plans accountable for Leapfrog implementation of the aforementioned principles; and
- Encourage the support of consultants and brokers through incentives to use the purchasing principles.

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[222] Ibid.
[223] Ibid.
[224] The Leapfrog Group, LeapfrogPurchasers, Purchasing Principles, http://www.leapfroggroup.org/purchase1.htm

In addition, the Leapfrog Group has certain requirements for each of the three safety measures that hospitals must meet.[225] They are as follows:

- CPOE – Hospital computer systems must link to software which prevents prescribing errors. Physicians are required to enter medication orders directly into this system. Hospitals must demonstrate that, through their system, at least 50 percent of serious prescribing errors are identified (or intercepted), and that those physicians who become aware of a prescribing error must provide documentation acknowledging it.

- Evidence-based Hospital Referral – Participating members in the Leapfrog Group are recommended to encourage their employees, retirees and family members who will undergo elective treatment to obtain their care at hospitals that have high volume procedures for which scientific evidence exists of a positive relationship between volume and outcome for certain specific high-risk conditions.[226]

- Intensive Care Unit (ICU) Physician Staffing – Leapfrog defines intensivists as physicians certified (or eligible for certification) in critical care medicine. The requirements for this standard are that patients in adult general medical and surgical ICUs are managed or co-managed by physicians who are certified in critical care medicine and (1) are present in the ICU during daytime hours (minimum 8 hours per day, 7 days per week) and provide care exclusively in the ICU; or (2) are able to return pages (95 percent of the time) within five minutes and can rely on in-hospital physicians or Fundamental Critical Care Support (FCCS)-certified physician extenders for immediate care.

C. Wellness

The use of employer wellness programs as a means of controlling health care costs associated with certain medical conditions has become increasingly popular and is used to educate employees on how to prevent, as well as treat, conditions such as obesity and diabetes.

Wellness programs take a myriad of forms, from company newsletters to participation in health plans that include exercise programs and health assessments. A wellness program coordinator cited in an article states that employee participation should be at least 70 percent in order to achieve cost savings in health care spending.[227] In order to encourage employees to sign up for the wellness programs, financial incentives such as reductions in premiums, bonuses, or gift certificates are used. In a wellness program associated with a health plan, employees initially complete a health assessment form. Based on the information supplied by the employee, a targeted intervention may be

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[225] The Leapfrog Group. Patient Safety. http://www.leapfroggroup.org/safety1.htm

[226] The procedures are: Coronary artery bypass; coronary angioplasty; abdominal aortic aneurysm repair; carotid endarterectomy; esophageal cancer surgery; delivery with expected birthweight <1500 grams or gestational age < 32 weeks; and delivery with pre-natal diagnosis of major congenital anomalies. The Leapfrog Group Factsheet: Evidence-based Hospital Referral (EHR), November 2000, http://www.leapfroggroup.org/FactSheets/EHR_FactSheet.PDF.

[227] Joe Manning, "Wellness Works Out for Employers," *Milwaukee Journal Sentinel*, August 18, 2004.

recommended. It is noted that in order for the program to be successful, employees must be assured that information on their health status is not released to their employer.

A recent newspaper article states that approximately 95 percent of large employers and one-third of small employers offer programs aimed to improve the health of the employees and reduce medical costs.[228] Benefits and programs can range from the availability of an in-house employee fitness gym to risk assessments, discounts at area fitness centers, flu shots, and contests. Data on the success of the wellness benefits or programs are lacking due to shortcomings in existing research.[229] The federal Centers for Disease Control and Prevention has allocated $14 million to study workplace wellness programs.[230]

Many companies and individuals, however, believe that wellness programs improve the health of employees and reduce health care costs. Secretary Thompson of the U.S. Department of Health and Human Services (HHS) has indicated his support for the programs. "Employer spending on prevention is a wise investment that pays off…It pays off in lower health care expenses. It pays off in lower absenteeism and higher productivity. And we encourage all employers to make this investment so that they may reap big returns for a long time."[231] A goal of Healthy People 2010 is "to have 75 percent of U.S. work sites offering "comprehensive health promotion programs" by 2010."[232]

Several states have considered or enacted legislation creating wellness programs for state employees, communities or other groups. Kentucky Governor Fletcher recently announced plans to move from an "illness model to a wellness model" for the 2005 State Employee Health Insurance Plan.[233] Under this plan, wellness initiatives and healthy lifestyle choices will feature:

- Discounts for non-smokers on their share of the premium;
- No-charge health risk assessments for employees and retirees; and
- Health education programs.[234]

The 'Healthy North Carolina Initiative' was announced by the North Carolina Governor in 2003 as a means to control health care spending and improve the health and wellness of North Carolina residents.[235] Some of the features of the initiative include:

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[228] Rita Zeidner, "Fitness on the Job," *The Washington Post*, August, 17, 2004.
[229] Ibid. The article notes that most studies are short in duration, are not randomized, do not have a control group, and are researcher bias.
[230] Ibid.
[231] Ibid. Remarks made by Secretary Thompson at an obesity conference in June 2004.
[232] Ibid. Healthy People 2010 is the Department of Health and Human Services blueprint for disease prevention and health promotion.
[233] National Governor's Association (NGA), "Kentucky Governor Focuses Health Plan on Wellness," September 23, 2004; Commonwealth of Kentucky Governor Ernie Fletcher's Communication Office, 'New Health Insurance Plans Place Focus on Wellness," September 7, 2004.
[234] Ibid.
[235] National Governor's Association (NGA), "Governor Announces Healthy North Carolina Initiative," May 1, 2003; State of North Carolina, Office of the Governor, Press Release, "Gov. Easley Announces Plans to Improve Health Care, Control Rising Costs. Healthy North Carolina Initiative to Promote Wellness, March 3, 2003. North Carolina state employees are allocated a certain dollar amount in their health insurance to use for wellness activities, such as physicals and immunizations.

- Promoting wellness programs targeted to all residents. The programs will target asthma, diabetes, and heart disease;
- Increasing the amount of the wellness benefit available to State employees by one-third;
- Developing model programs in conjunction with local communities and faith-based organizations aimed at closing the gap in receipt of healthcare services that exist between white and male populations versus minority and female populations.

In Florida, legislation created the "Healthy Communities, Healthy People Program, a comprehensive and community-based health promotion and wellness program…designed to reduce major behavioral risk factors associated with chronic diseases by enhancing the knowledge, skills, motivation and opportunities for individuals, organizations and communities to develop and maintain healthy lifestyles."[236]

Illinois has the Employee Wellness Program Grant Act, which requires the Department of Public Health to "make grants to employees to assist them in providing health promotion or wellness services to reduce the prevalence of health risk factors."[237] Hawaii and New Mexico considered bills that would allow tax credits for employee worksite wellness programs.[238] New Jersey law mandates the "Health Wellness Promotion Act, which aims to encourage participation in healthy lifestyles by requiring that health insurance benefits and health care services be provided for wellness health examinations and counseling."[239] Massachusetts, Mississippi, Oklahoma, and West Virginia have enacted wellness programs geared to state employees. In addition, California, New Hampshire, and Vermont have passed legislation recently creating some form of wellness programs.

During the 2004 Maryland legislative session, a bill was introduced that would permit health insurance carriers to offer discounted rates for small employer groups that participate in wellness programs to improve health status and reduce health care costs.[240] The definition of 'wellness activity' was to be defined by the Maryland Health Care Commission and could have included smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education. Another bill, Health Insurance-Child Wellness Services-Obesity (HB 340), was introduced that would have required carriers to cover services related to the prevention and treatment of, and counseling for, obesity in children under 18 years of age. This proposed requirement would have been required under the mandated benefit 'child wellness services.' Neither of these bills passed out of committee.

Five states, Florida, Massachusetts, New Hampshire, Rhode Island, and Washington, have legislation coupled with premium reduction for participation that allows

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[236] National Conference of State Legislature (NCSL), Health Promotion Database – State Legislation and Statutes, http://www.ncsl.org/programs/health/pp/healthpromo_srch.cfm. Fla. Stat. Ann. § 381.734

[237][237] Ibid. Ill. Ann. Stat. ch. 30, § 770/

[238] Ibid. Hawaii State Legislature, 2004 session, HB 1733. New Mexico State Legislature, 2003 session, SB 305.

[239] Ibid. N.J. Stat. Ann. 26:1A-36.11

[240] Maryland General Assembly, 2004 Legislative Session, House Bill 312, Health Insurance-Small Group Market-Wellness Activities-Discount.

health insurance carriers to offer wellness programs in the commercial market. Florida passed legislation this year that authorizes carriers to provide a premium rebate of up to 10 percent when the majority of members of an employer's covered group have enrolled and maintained participation in a health wellness, maintenance, or improvement program offered by an employer. Employers must provide evidence of maintenance or improvement of enrollees' health status as determined by assessments of agreed-upon health status indicators between the employer and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation.[241] Regulations for insurers and HMOs were recently drafted.

Rhode Island also allows carriers to offer wellness programs to employers. This program is relatively new (began about a year ago), and does not have legislative language or regulations that define it. A carrier's actuary must show the Rhode Island Department of Insurance Regulations how the wellness program is going to be factored into the premium, or how the discounts will work. At present, there is no information about the success of the program, or the experience of the carriers and employers.

All states must follow federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which specifies that group health plans may establish premium discount or rebate programs that are health promotion or disease prevention programs. These 'bona fide wellness programs' must meet certain regulatory requirements, such as "the reward must be available to all similarly situated individuals, and a reasonable alternative standard must be made available for any individual for whom, due to a health factor, it would be unreasonably difficult to meet the initial standard," and "the program must be reasonably designed to promote good health or prevent disease for the individuals in the program, and must give eligible individuals the opportunity to qualify for the reward at least once per year."[242]

Negative incentives are another way health insurance carriers and employers are attempting to control health care spending associated with certain chronic diseases. Union Pacific Corp. and General Mills Inc. are two large employers that have instituted programs aimed at significantly reducing rising health insurance costs. As a pilot program, Union Pacific Corp. is not hiring smokers in seven states where it operates, and General Mills Inc. requires smokers to pay a $20.00 per month 'surcharge' on health insurance premiums.[243] One managed care company estimated that 11.5 percent of their large employer population accounts for 80 percent of costs, with the bulk of the spending by the chronically ill.[244]

This type of 'carrot and stick' approach to control health care spending of obese individuals, smokers and individuals with chronic diseases is not without concerns – some feel that positive incentives work better than those that essentially punish individuals.[245] And, individuals with chronic diseases are paying more out-of-pocket for care as an

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[241] The 2004 Florida Statutes, 627.65626 and 627.6402. Florida regulations Rule Number 690-191.0545 and 690-149.0055.
[242] United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy, Appendix F – Incentives for Healthy Behavior.
[243] Bernard Wysocki, Jr., "Companies Get Tough With Smokers, Obese to Trim Costs," *The Wall Street Journal*, October 12, 2004.
[244] Ibid.
[245] Ibid.

increasing number of employers shift the costs of health care coverage to their employees. Low-income individuals with chronic conditions are paying a greater proportion of their income for medical care (over 5 percent of their 2003 income was spent on medical bills).[246]

Examples of Health Insurance Carriers That Offer Wellness Programs

The following examples of wellness programs were provided by local representatives of Aetna, Kaiser Permanente, CareFirst BlueCross BlueShield and MAMSI/UnitedHealthcare.

Aetna

In addition to a host of special programs geared to improving the health and well-being of their members, Aetna offers 'Wellness and Prevention Programs.' Health education reminders are sent to participating members to encourage use of available services to prevent, detect and monitor health problems at early stages when they are most treatable. They send annual mammogram and Pap smear reminders at proper intervals, as well as childhood and adolescent immunization reminders.[247]

Kaiser Permanente

Kaiser offers wellness programs via the Internet called 'HealthMedia Programs,' which are designed to keep people healthy through good nutrition, smoking cessation, weight loss, and stress management. The HealthMedia Balance® program, a weight management program, recently was awarded an Honorable Mention in the 2004 C. Everett Koop Award competition. This program offers a customized strategy based on a member profile. The goal of the program is to improve the members' health and also reduce long-term health care spending.[248]

[246] Vanessa Fuhrmans, "When the Insured Struggle to Pay for Health Care," *The Wall Street Journal*, September 23, 2004.
[247] Email correspondence with Lee Ann Bailey, Aetna Small Group Product Development, Mid-Atlantic.
[248] Email correspondence with Gail M. Thompson, Director, Government Relations, Kaiser Foundation Health Plan for the Mid-Atlantic; and Kaiser Permanente, Health Media Press Release, "Kaiser Permanente and HealthMedia, Inc., Win Prestigious C. Everett Koop National Health Award for 2004."

CareFirst BlueCross BlueShield

Members of CareFirst can obtain information on over 300 health and wellness topics through the CareFirst website. In addition, members receive a quarterly newsletter containing health-related articles, as well as immunization and screening reminders in the mail. CareFirst also offers an 'Options Discount' program to its members, which offers discounts on wellness services.[249]

MAMSI/UnitedHealthcare

MAMSI/UnitedHealthcare offers preventive health care guidelines, immunization schedules and programs for healthy children, adolescents and adults, as well as guidelines for a routine pregnancy.[250]

D. Purchasing Strategies to Reduce Costs

Pharmaceuticals

Several states have joined forces to obtain cost savings on prescription drugs for their Medicaid recipients and/or state employees and retirees. The prescription drug purchasing pools use the same pharmaceutical benefit manager to obtain reduced drug prices through bulk purchasing. A purchasing pool for Medicaid prescription drugs was formed in April 2004 including Michigan, Vermont, New Hampshire, Alaska, and Nevada. Recently, Minnesota and Hawaii received federal permission to join the purchasing pool.[251] The Maryland Department of Health and Mental Hygiene is currently considering joining a multi-state Medicaid drug purchasing pool.

West Virginia and four other states participate in a drug purchasing pool for state employees and retirees. In addition, the West Virginia legislature recently held a special session to "consider legislation that authorizes a single state coordinator to negotiate deep discounts on drugs purchased for virtually all the state's insurance and health care programs."[252] The legislation, which passed unanimously, would cover more than 600,000 West Virginia residents, including state employees, disabled workers, veterans and prisoners. Private employers and individuals may join the program in the future.[253]

Another method frequently used to assist in reducing health care spending is to promote the use of lower cost generic drugs. This is accomplished by pricing generic prescriptions at an affordable copayment, while offering brand name prescriptions at higher prices. In the Maryland small group market, the price of a generic drug is $15.00, the cost of a preferred brand name drug is $25.00 and the cost of a non-preferred brand

[249] Correspondence with Patty Ciotta, Government Affairs, CareFirst BlueCross Blue Shield. Information also obtained from CareFirst marketing materials.
[250] Email correspondence with Elizabeth Sammis, Vice President of Communications, MAMSI/UnitedHealthcare, and http://www.mamsi.com/index.jsp.
[251] Kaiser Daily Health Policy Report, "Minnesota, Hawaii Receive Permission to Join Prescription Drug Purchasing Pool, September 13, 2004.
[252] Robert Pear and James Dao, "States' Tactics Aim to Reduce Drug Spending," *The New York Times*, November 21, 2004.
[253] Ibid.

name drug is $50.00. In addition, when a generic drug is available and the brand name drug is prescribed and selected, the covered person pays the copayment plus the difference between the price of the brand name and the generic drug.

Formularies and 90-day supplies of maintenance drugs are often touted as means to control costs. A formulary is a list of preferred prescription drugs that the employer or carrier covers; all other drugs are not covered under the plan and require the patient to pay either a higher copayment or the full retail price. Ninety-day supplies of maintenance drugs encourage individuals to purchase prescriptions for chronic conditions at a lesser cost than that of a single month's supply. In Maryland, the Department of Health and Mental Hygiene has developed a 'preferred drug list' for Medicaid patients. It is expected that the state will save $31 million per year. Providers are encouraged to prescribe only those drugs on the preferred drug list, in return for discounts from insurers. Doctors may get approval to prescribe a drug by contacting First Health Services Corp., the organization that administers the program.[254] Over 30 states have preferred drug lists for Medicaid recipients.[255]

[254] M. William Salganik, "Md. Uses Buying Power to Save Millions on Drugs," *The Baltimore Sun*, October 1, 2004.
[255] Pear and Dao.

IX. Ways to Facilitate a More Effective and Efficient Health Care Delivery System, Including Improved Information Technology and Evidence-Based Medicine

A. Improved Information Technology

Several national public and private initiatives to promote the adoption and use of information technology in the health care sector have emerged over the past few years. One of the federal initiatives is the President's Information Technology Advisory Committee (PITAC), chartered by Congress in the 1990's to "provide independent expert advice on maintaining America's preeminence in advance information technology."[256] The June 2004 PITAC report discusses the importance that quality and cost-effectiveness of the U.S health care system place on three national priorities - national, homeland, and economic security, and also the barriers to implementation of information technology.[257]

With the passage of the 2003 Medicare Prescription Drug Improvement and Modernization Act (MMA), the Centers for Medicare and Medicaid Services (CMS) is required to develop standards for electronic prescribing, which is anticipated to lead to the adoption of electronic medical records. The MMA also included language mandating the creation of the Commission on Systemic Interoperability. The role of the Commission is to provide guidance on interoperability standards.[258]

In April 2004, President Bush signed an executive order creating the position of National Health Information Technology Coordinator. The following month, Secretary Thompson of the Department of Health and Human Services announced that David J. Brailer, MD, PhD., will serve as the National Coordinator. The National Coordinator is required to "produce a report within 90 days of operation on the development and implementation of a strategic plan to guide the nationwide implementation of interoperable [health information technology] in both the public and private sectors."[259] Also, through this executive order, the President requested widespread adoption of interoperable electronic medical records within the next ten years.

The report prepared by Secretary Thompson and Dr. Brailer (*Framework for Strategic Action*) provides guidance for the national strategic plan for the adoption of information technology nationwide. The report addresses four goals to achieving improved health care through information technology. They are to: (1) inform clinical practice; (2)

[256] President's Information Technology Advisory Committee, Report to the President, Revolutionizing Health Care Through Information Technology, June 2004.
[257] Ibid.
[258] Tommy G. Thompson, Secretary of Health and Human Services, and David J. Brailer, M.D., Ph.D., National Coordinator for Health Information Technology, "The Decade of Health Information Technology: Delivering Consumer-centric and Information-rich Health Care," *Framework for Strategic Action*. Progress Report, July 21, 2004.
[259] Ibid.

interconnect clinicians; (3) personalize care; and (4) improve population health. For each goal, strategies and specific actions are listed that guide the future efforts of the federal strategy to improve quality of care and patient safety and focus on the consumer.

Kaiser Permanente has invested in information technology, spending $3 billion on a multi-year program titled "KP HealthConnect." The goal of the program is to "improve and integrate its clinical and administrative systems and Web-based services for members,"[260] that will eventually signal harmful drug combinations and note effective treatments for certain individuals. Kaiser currently has electronic medical records which include electronic prescribing. The HealthConnect program, as well as Kaiser's current electronic network, are being examined by the federal government as it attempts to develop a nationwide interoperable health information infrastructure.[261]

One report suggests that managed care providers can save up to 16 percent in overhead costs by implementing information technology as it relates to consumer driven healthcare and disease management plans. The savings would come from reduced filing costs, less paperwork, reduced patient visits (through disease management programs).[262] Another study conducted by the U.S. General Accounting Office (now know as the Government Accountability Office) found that among those health care organizations which have implemented information technology, most have realized cost savings from a reduction in "medication errors, communication and documentation of clinical care and test results, staffing and paper storage, and processing of information," as well as "improved quality of care, more accurate and complete medical documentation, more accurate capture of codes and charges, and improved communications among providers that enabled them to respond more quickly to patients' needs."[263]

B. Evidence-Based Medicine

According to a study conducted by Rand Health and published in *Health Affairs* and *The New England Journal of Medicine*,[264] recommended care for certain conditions is given about half the time. This study researched a sample of adults from 12 communities that had previously participated in a national study. The authors of the study found that participants overall received recommended care for preventive, acute and chronic care approximately 55 percent of the time. The recommended care received by the participants ranged from 78.7 percent for individuals with senile cataracts to 10.5 percent of recommended care for those with alcohol dependence. The results were regardless of a person's income level, where they live, or the medical institutions in their community.[265]

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[260] Laura Landro, "Does Disease Management Pay Off?" *The Wall Street Journal*, October 20, 2004.
[261] Ibid.
[262] Bradley Worell, **"**IT-focused, consumer-driven health care offers potential for big savings," *Health Care Strategic Management*, 21(5), May 2003.
[263] United States General Accounting Office, "Information Technology: Benefits Realized for Selected Health Functions," October, 2003.
[264] Eve A. Kerr, Elizabeth A. McGlynn, John Adams, Joan Keesey, and Steven M. Asch, "Profiling the Quality of Care in Twelve Communities: Results from the CQI Study", *Health Affairs*, 23(3), May/June 2004; and Elizabeth A. McGlynn, Steven M. Asch, John Adams, Joan Keesey, Jennifer Hicks, Alison DeCristofaro, and Eve A. Kerr, "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine*, 348(26), June 26, 2003.
[265] Ceci Connolly, "U.S. Patients Spend More but Don't Get More, Study Finds," *The Washington Post*, May 5, 2004.

Another study conducted by the Commonwealth Fund[266] found disparities among the U.S. and four other countries on certain measures such as breast cancer and leukemia deaths, asthma deaths, suicide rates and cancer screening. Despite the fact that Americans spend more per capita on health care than citizens of other countries, the Rand and Commonwealth Studies reaffirm the finding that the health of the U.S. population is not better than that of other countries.

The studies found that "systems to help doctors consistently administer the most effective treatments" are lacking.[267] "Antiquated record-keeping, duplication, cultural biases toward pricey technology and a reimbursement system that rewards intervention rather than prevention are major contributors to the problem…"[268]

A study previously mentioned in Section V which examined the factors that influence medical technology in managed care plans and cost growth, found that health plans generally do not use the coverage policy to limit services and patients and physicians were not amenable to other types of cost containment.[269] Plans are more likely to provide 'appropriate care' that is supported by clinical data than use cost containment efforts. The study concludes by stating that "managed care, as historically practiced, will not dramatically slow health care cost growth."[270] The authors recommend that physicians' ability to adopt and use new services as applicable to evidence-based medicine may be fundamental to constraining cost growth aside from health plans' efforts.

In addition, the Agency for Healthcare Research and Quality (AHRQ) has released an expansive list of evidence-based practices to the public.[271] At the request of the federal government, the National Quality Forum (NQF) has studied this list and has issued a compendium of evidence-based safe practices which providers may adopt.[272]

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[266] Peter S. Hussey, et. al., "How Does The Quality of Care Compare in Five Countries?" *Health Affairs*, 23 (3), May/June 2004.
[267] Ceci Connolly.
[268] Ibid.
[269] Michael E. Chernew, Peter D. Jacobson, Timothy P. Hofer, Keith D. Aaronson, and A. Mark Fendrick, "Barriers to Constraining Health Care Cost Growth," *Health Affairs*, 23(6), November/December 2004.
[270] Ibid.
[271] The Agency for Healthcare Research and Quality (AHRQ) in July 2001, published a report, Making Health Care Safer: A Critical Analysis of Patient Safety Practices, in collaboration with the University of California San Francisco/Stanford University. The publication includes 79 specific practices that contribute to safer patient care and validates each one according to current research. Out of 79 practices, 11 practices with the strongest evidence were rated as the most significant in terms of the strength of the evidence and received the authors' support for more widespread implementation.
[272] National Quality Forum (NQF), "Safe Practices" in Hospital Care." NQF Project Summary, http://www.qualityforum.org.

C. Health Care Delivery System Efficiency

According to a study conducted by Urgent Matters, a program affiliated with the George Washington University, Washington, D.C., "hospital emergency departments are being overburdened with uninsured patients partly because these patients are unaware of primary care services available in their communities."[273] The study found that many of the patients use the emergency room as their only source of care, and a sole option for timely care. The researchers found that "patients perceive the emergency departments as providing the highest-quality care available," even at times when primary care services are available. The study found that community safety-net providers who were better able to coordinate and integrate their services, improved the use of their primary care services.[274]

One article provides several examples of problems in the health care cost structure, citing "that hospitals have less borrowing capacity than they need to invest in the latest technology, including information systems," and the shortage of health care professionals (such as nurses and pharmacists) has impacted health systems operational costs. The reasons for the problems faced by health care facilities are "medical technology advances, population growth and aging, more demanding consumers, and the waning of prominence of managed care plans with their strict controls on treatment." Numerous suggestions were offered to restructure the current system to improve efficiency and reduce costs, including: adopt a payment system where consumers pay a greater percent of the cost of care, develop more dependable payment sources for the uninsured, phase out experience rating and self-insurance, re-establish state oversight of major capital expenditures, offer financial incentives for investment in IT, pay primary care physicians proportionately more, continuously monitor the supply and demand of health care professionals, assure prescription drug coverage for needy Americans covered by public programs, enact tort reform, develop new types of health plans and payment arrangements, simplify administrative requirements and reduce medical errors and improve quality."[275]

[273] Joel B. Finkelstein, American Medical News, amednews.com, June 21, 2004.
[274] Ibid.
[275] Keith Moore and Dean Coddington, "Planning for the Future in an Increasingly Stressed Health Care System," *Health Care Strategic Management*, 22(2), February 1, 2004.

X. Innovative programs in other states designed to encourage the appropriate use of health care services

A. State Initiatives

Pennsylvania: The Pennsylvania House of Delegates recently passed legislation which encourages employers to enroll employees in a "disease management insurance policy" or a health insurance policy that includes a disease management program. The bill would allocate a $100 tax credit to employers for each employee covered by a state-certified disease management insurance policy. The policy could include identifying patients and matching them with an intervention, implementing evidence-based medicine guidelines, management of individual treatment plans (including patient education), and routine reporting and feedback loops. The credit would be available for tax years before January 1, 2007, and employers would need to apply for the certification and for the credit by September 15th following the year for which they claim the credit.[276]

Maine: Signed into law in June 2003, the Dirigo Health Reform Act is a comprehensive program designed to control the growth of healthcare costs, improve and ensure quality of care, and obtain universal access to coverage in Maine by 2009. The Dirigo Health Plan, 'DirigoChoice,' has been created to assist certain groups and individuals in purchasing affordable health coverage. Anthem Blue Cross Blue Shield of Maine will administer the Plan.[277] Small businesses with 50 or fewer employees, the self-employed, and individuals who do not have access to employer coverage are eligible to participate. Funding for the Plan will come from employers, employees, and state and federal funding sources. After the first year, the state will no longer provide supplemental funds, and instead an assessment on insurers' gross premium revenues will be levied if health care cost savings occur. The Plan will provide comprehensive benefits, with sliding scale premiums based upon the employee's or individual's income level.

The cost containment strategies proposed by the Act include hospital planning through certificate-of-need, public price disclosure, simplification of administrative functions and reductions of paperwork, enhanced public purchasing, oversight of insurance costs, reduction in cost shifting, and voluntary limits on the growth of insurance premiums and health care costs. A State Health Plan is currently in development and will include revision of the certificate-of-need program.

In addition, the Maine Quality Forum will be created to "promote quality of care initiatives and educate providers and consumers about best medical practices and other quality of care indicators. The Forum will collect and disseminate research, adopt quality

[276] Pennsylvania General Assembly, 2003 – 2004 Session, House Bill 2501, *Disease Management Tax Credit*.
[277] Kaiser Daily Health Policy Report, "Maine Signs Contract with Anthem Blue Cross and Blue Shield of Maine to Administer DirigoChoice," August 26, 2004.

and performance measures to compare provider performance, issue quality reports, promote evidence-based medicine and best practices, conduct technology assessment reviews to guide the diffusion of new technologies, conduct consumer education campaigns, and make recommendations to the state health plan and Certificate-of-Need program."[278]

Florida: In 2003, the 'Select Committee on Affordable Health Care for Floridians' was formed to address the issue of affordable and accessible employment-based insurance. The Committee recommended several initiatives to control costs, including system transparency, whereby the full costs of health care services or procedures are available to the consumer. The Committee came to the conclusion that most consumers are not aware of the cost of health care because of employer subsidies, and advocates for the proposal believe that by making the costs apparent and transparent to the consumer, the consumer will "make better choices and reduce overall costs."[279]

Based on the recommendations of the Committee, the state recently enacted legislation that attempts to control the growth in health insurance premiums by restraining the growth in health care spending. The "2004 Affordable Health Care for Floridians Act" (HB 1629) makes several significant changes to the Florida health insurance market. For example, the Agency for Health Care Administration (AHCA or Agency) is required to post pricing information on procedures performed in Florida hospitals, and health carriers are required to have a link on their website to the performance outcome and financial data on the AHCA website. The legislation also authorizes premium rebates for employers and employees who maintain healthy lifestyles (i.e., employer wellness programs) and requires hospitals, insurers, and federally qualified health centers to create emergency room diversion programs.[280]

According to the Florida House of Representatives staff analysis of HB 1629, the law includes the following features:

- Licensed facilities not operated by the state are required to provide "an estimate of charges for the proposed service upon request of a prospective patient who does not have insurance coverage or whose insurer or HMO does not have a contract with the hospital and an emergency medical condition does not exist or the service is not a covered service."
- The Agency shall make available on its website and in hard-copy upon request "patient charge, length of stay, and performance outcome indicators collected from health care facilities…for specific medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities as determined by the agency." Licensed facilities are required to provide a link on their website to the Agency website. Their website must also include a description of the patient charge and outcome data.
- Health carriers must link from their websites to the Agency's website on performance outcome and financial data.

[278] Jill Rosenthal and Cynthia Pernice. "Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine," National Academy for Health Care Policy, June 2004.
[279] Ibid.
[280] Florida House of Representatives Staff Analysis of HB 1629, "2004 Affordable Health Care for Floridians Act, Chapter 2004-297.

- A $500 penalty will be assessed for facilities that do not provide requested information to consumers.
- "The Agency must develop and implement a strategy for the adoption and use of electronic health records."

Other aspects of the Florida legislation include:

- An emergency department diversion plan. Hospitals are encouraged to develop emergency department diversion programs, including an "emergency hotline" whereby consumers may call to help determine if the emergency room is the appropriate setting for their malady, and a "fast track" program which would refer non-emergency patients to an alternative site. And, health insurance carriers are required to develop community emergency department diversion programs that may include increased on-call availability of health care providers to carriers' enrollees after hours, and incentives to providers for case management.[281]

- The 'Small Employers Access Program.' This provision will allow small businesses with up to 25 employees the ability to provide health benefits at an affordable cost through purchasing pools. Rural hospitals, municipalities, counties, school districts, and nursing home employers may participate in the pool. Approved health insurance carriers will be required to offer the standard, basic, high deductible, and limited benefit plans in defined geographical areas as well as an 'alternative' plan approved by the Office of Insurance Regulation of the Department of Financial Services.[282]

- Expansion of the 'Healthy Communities, Healthy People Program' to include health care providers, small businesses, and health insurers. The bill requires the Department of Health to make available on its website a listing of age-specific, disease specific, and community-specific health promotion, preventive care, and wellness programs offered under this program. The bill also allows insurance rebates for healthy lifestyles. It authorizes carriers to provide a premium rebate of up to 10 percent when the majority of members of a health plan have enrolled and maintained participation in a health wellness, maintenance, or improvement program offered by an employer. Employers must provide evidence of maintenance or improvement of enrollees' health status as determined by assessments of agreed-upon health status indicators between the employer and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation.[283]

The bill also removed the pilot status of the Health Flex plans, opening the creation and availability of the plans statewide. The Health Flex Pilot Program was created in 2002, and allowed "health insurers, HMOs, health care provider sponsored organizations, local governments, health care districts and other public or private community-sponsored organizations to develop alternative approaches to traditional health insurance which

[281] Florida House of Representatives, 2004 Legislature, HB 1629. Alternative sites could be health care programs funded with local tax revenue and federally funded community health centers, county health departments, or other non-hospital providers of health care services.
[282] Ibid.
[283] Ibid.

emphasize coverage for basic and preventive health services."[284] The Program was developed for low-income, uninsured Florida residents emphasizing basic and preventive services. According to the State Coverage Initiatives, the Health Flex Program had only four approved applications as of June 2004 - "three are private organizations—a physician group and two licensed HMOs based in Dade and Broward counties—which do not receive any public money to fund the program. Enrollment in the Dade and Broward county programs began in May and September 2003, respectively, enrolling just 146 members—far below expectations. The most recent approved HMO plan (May 2004), the Jackson Memorial Hospital Plan, is planning to transfer all the enrollees currently in TrustCare, an indigent health benefit program, into their Health Flex plan."[285] JaxCare Inc. Health Flex Plan in Duval County, Florida, is targeted primarily to small business and has local and community financial support. Developed with the assistance of a Robert Wood Johnson Foundation grant, "JaxCare is funded by the city of Jacksonville, grants, corporate donations, hospital contributions, and employee and employer contributions."[286] The benefits offered through JaxCare, Inc., are more comprehensive than the other two Health Flex plans.

B. Carrier Initiatives

Obesity Coverage

Health insurance carriers across the country are searching for ways to reduce the costs associated with chronic illnesses and encouraging their enrollees to better manage their health. One insurer, Blue Cross and Blue Shield of North Carolina recently expanded coverage to treat its more than 1 million members who are considered overweight or obese.[287] The new benefits package, "Health Lifestyle Choices," will offer the following benefits:

- Four physician's office visits each year and related tests. The carrier will pay for this benefit effective April 1, 2005;
- Two prescription weight-loss drugs. The carrier will pay for the drugs Meridia and Xenical beginning October 1, 2005;
- Counseling by licensed dieticians beginning on October 1, 2005; and
- Stomach stapling surgery performed by physicians in North Carolina "who have demonstrated excellence in performing stomach surgery for obese patients, and continuing to pay for the operations." Twelve physicians in seven practices will be selected. The surgery is elective.

The North Carolina plan is the first in the country to offer comprehensive benefits aimed at offering coverage for weight management. It is expected that several carriers in other states will offer similar benefits in the future. Several large Washington, D.C.-area

[284] Ibid.
[285] Isabel Friedenzohn, "Limited Benefit Policies: Public and Private-Sector Experiences," State Coverage Initiatives (SCI) Issue Brief, Vol. V., No. 1: July 2004.
[286] Ibid.
[287] Rob Stein, "N.C. Health Insurer to Offer Coverage for Weight Problem," *The Washington Post*, October 13, 2004.

health insurers are cited in the article as covering "many of the same kinds of care, but that they have no immediate plans to match the North Carolina package."[288]

In addition, this past summer, Medicare reversed a policy that did not recognize obesity as a disease.

Disease Management

Another method touted by health insurance carriers is the use of disease management programs targeted to patients with high risk/ high cost medical conditions. The goal is to improve the health of the enrollee and eventually lower medical spending, improve productivity, and reduce absenteeism among workers.[289] Blue Cross and Blue Shield of Minnesota has introduced "BluePrint for Health," a disease management program that "assesses and tracks the health of all members…and rewards those who take recommended measures to improve their health."[290] The program will provide "online health assessment[s], individual reports for each participant, customized follow-up health programs, performance-tracking and financial incentives."[291] Other carriers in the market offer similar programs.

Aetna Integrated Informatics (AetInfo) forecasts future health care use and costs among members. This forecasting is called "predictive modeling," a process that examines data and enables Aetna to predict member use of health care services over the upcoming twelve months to identify people who are most likely to generate the highest medical costs. This process then enables Aetna to steer identified members into appropriate care programs and services before a condition becomes a chronic or complex illness, thus improving the quality of care the enrollee receives and possibly reducing the costs in the long-term.[292]

Physician Incentives

Incentivizing physicians to provide cost-effective quality care is another initiative health insurance carriers are pursuing to reduce inefficient care and spending. Blue Cross Blue Shield (BCBS) of Michigan recently paid $5 million in incentives to providers who directed patients to disease management programs in congestive heart failure, heart disease, asthma and diabetes. As the first BCBS organization to provide incentives to physicians in its traditional and preferred provider organization plans, ten physician groups with 2,900 physicians participated in the program, paying the physicians with money allocated towards increased physician fees. Through an education process with nurses affiliated with the BCBS program, patients are taught how to manage their chronic illness, which in turn reduces visits to the emergency department and hospital stays.[293]

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[288] Ibid.
[289] Jim McCartney, "Blue Cross and Blue Shield to Offer New Health Program," *Duluth News Tribune*, September 21, 2004.
[290] Ibid.
[291] Ibid.
[292] Email communication with Lee Ann Bailey, Aetna Small Group Product Development, Mid-Atlantic.
[293] Shantell M. Kirkendoll, "Blue Cross Pays Incentives to Doctors," *The Flint Journal*, September 30, 2004.

Tiered Provider Panels

Increasingly, insurers are developing programs to help reduce health care utilization and costs by encouraging enrollees to select physicians that are deemed to offer better quality care at a lesser cost. For example, Aetna, a major health insurance carrier in the U.S., is currently offering a plan called 'Aexcel' in three markets that encourages enrollees to select physician specialists that have been rated as being cost-effective and providing high quality care. The specialists are rated based on their claims and certain clinical performance measures.[294]

Aetna's focus is on controlling costs associated with specialty care, not primary care. The company believes that much of the recent increase in utilization and associated costs stems from specialists. Aetna subscribers who choose providers from the Aexcel network may receive lower deductibles and/or copayments, higher coverage levels, or a combination. Aetna plans to expand this plan in 2005 to employers in Connecticut, Atlanta, Houston, Los Angeles, the Washington, D.C. area, and metropolitan New York.

Diagnostic Imaging

The rising costs of expensive technology have caused states and health insurance carriers to examine methods to reign in use while not jeopardizing quality of care. Diagnostic scans cost upwards of $100 billion per year nationwide with magnetic resonance imaging (MRI) as one of health care's fastest growing expenses.[295] A recent article states that "…as health plans squeeze payments for other physician services, imaging has appealed to doctors as another source of revenue."[296]

In response to the growing demand and associated costs of medical imaging tests, Highmark, the Pittsburgh, Pennsylvania based Blue Cross Blue Shield plan, recently instituted a new policy regarding reimbursement for diagnostic scans. Highmark has stated that "it would pay for imaging services only in its managed care network, where staff and equipment meet new, rigorous quality standards."[297] In addition, providers will be required to obtain authorization for advanced imaging procedures (e.g., MRIs, CTs, and PET scans). Highmark will reimburse providers for "CT or MRI tests only at locations that make the testing available at least 40 hours a week, plus some Saturdays, and have at least one accredited radiologist on site during normal business hours."[298]

Other insurers are attempting to control costs associated with medical imaging. Harvard Pilgrim Health Care Inc. (Massachusetts) now requires patients to have a consultation for most "non-emergency" imaging tests other than basic X-rays and ultrasounds. Blue Shield of California has staffing requirements for radiologists.[299]

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[294] Robert Kazel, American Medical News, amednews.com, July 26, 2004. The article states that "clinical performance measures are based on rates of hospital readmissions, rates of unexpected adverse events, and total cost of care in and out of the hospital." This plan is currently offered to employers in Dallas-Fort Worth, northern Florida, and Western Washington State.
[295] Vanessa Fuhrmans, "Big Health Insurer to Target Scan Tests as Way to Cut Costs," *The Wall Street Journal*, August 19, 2004.
[296] Ibid.
[297] Ibid.
[298] Ibid.
[299] Ibid.

Consumer Driven Health Care

Insurers are also offering health plans that require enrollees to manage their health care spending. Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs), paired with high deductible plans are what is commonly referred to as 'consumer-driven' health plans. See Section IV for a full discussion of this issue.

C. Employer Initiatives

Retail Health Care: Several large retail chains have recently leased space to clinics in an effort to treat patients with non-chronic illnesses, as well as secure a new source of revenue. These store-based clinics are catering to people who do not want to wait weeks for an appointment or wait hours to see a physician in an emergency setting. A majority of the people treated in the retail store have health insurance. In the Baltimore area, MinuteClinic has plans to open eight clinics in Target stores.

These clinics are staffed by physician extenders (e.g., physician assistants and nurse practitioners) who treat non-chronic illnesses such as sore throats and ear infections. The physician extender uses physician-designed decision-making software to diagnose minor ailments or to assist in determining if a patient should see a physician.

While the concept of the retail clinics is one of quick service, some are skeptical about the quality of care delivered. Primary care physicians believe that some patients may do without a more thorough check-up or possibly suffer a misdiagnosis, and postpone needed care for a condition not diagnosed by the physician extender.[300]

While these clinics cater primarily to the insured, those who lack health insurance may find it economically attractive and easy to fit into their schedule as the retail stores are usually open during the evening and on weekends.

Group Purchasing: In May 2004, a group of approximately 50 large employers announced an initiative to provide health care coverage to those individuals who are affiliated with their companies and not eligible for group coverage from the companies. This includes part-time employees; independent agents, consultants and vendors; those who are not yet 65 years of age who do not have group coverage; employees in a waiting period before group coverage begins; former employees who have exhausted COBRA benefits; and students not eligible for their parents' group coverage. With an estimated four million participants qualified to participate in the initiative, the companies hope to contract with a single national carrier who will offer coverage at a discount.[301]

D. Programs Related to Pharmaceutical Costs

Some states are using tiered formularies which place drugs in 'tiers' based on cost to encourage the use of less expensive medications. Tiered formularies create a financial incentive whereby generic drugs are priced lower than preferred brand and non-preferred

[300] Robert Kazel, American Medical News, amednews.com, September 13, 2004

[301] … "Employer-Sponsored Coverage – Employers Plan Unified Effort on Quality, Access," Medicine & Health, Published by the Health Care Information Center, Vol. 58, No. 20, May 17, 2004.

brand drugs to encourage consumers to purchase them. Tiered formularies "also give health plans more leverage to negotiate lower prices for a higher volume with drug manufacturers" and are currently the most popular model used to control prescription drug spending.[302]

There is concern, however, regarding the impact of a tiered structure on utilization and spending. Individuals who have spent a low dollar fixed amount for prescription drugs (regardless of drug type) may forgo certain prescription drugs because of cost. A positive effect has been the slowing of prescription drug spending. With the increased availability of generic drugs and a reduction in new drugs, prescription drug spending in 2002 increased at a slower pace.[303]

Other methods being used to control prescription drug costs and to promote personal accountability in pharmaceutical spending are drug discount cards. Montgomery County, Maryland recently became a jurisdiction to make a drug discount card available to all county residents and offer up to a 20 percent discount at 130 participating pharmacies. The 80,000 residents who do not have prescription drug coverage are expected to use the discount card.[304]

States and local jurisdictions are exploring drug reimportation. This issue is especially contentious as the Food and Drug Administration (FDA), the federal agency that regulates prescription drugs, does not approve of drug imports from other countries. Montgomery County, Maryland, and the District of Columbia are two local jurisdictions that have recently approved Canadian drug imports. The Montgomery County plan will allow as many as 85,000 county employees, retirees and their dependents to purchase maintenance drugs from a Canadian vendor. The program is expected to begin in February 2005.[305] Minnesota, New Hampshire, North Dakota, and Wisconsin have state-sponsored websites that assist residents with purchasing prescription drugs from Canada.[306] Rhode Island has a link on its state's website to Wisconsin's website, and Illinois recently announced a program allowing state residents to purchase prescription drugs from Canada, the United Kingdom, and Ireland.[307] Vermont officials requested that the FDA approve a pilot program allowing residents to purchase prescription drugs through a Canadian company, and were denied. Vermont has filed a lawsuit against the FDA for rejecting the plan.[308]

A recent study conducted by the Pew Internet and American Life Project found that "only 4% of Americans have ever used the Internet to buy prescription drugs – and even fewer do so through foreign pharmacies – despite websites maintained by a handful of

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[302] AcademyHealth, Changes in Health Care Financing and Organization – Findings Brief – *Pharmaceutical Formularies: The Right Formula for Cost and Utilization?* Vol. VII, No. 5, August 2004.
[303] Center for Studying Health System Change, Data Bulletin, Results from HSC Research, *Tracking Health Care Costs: Trends Stabilize but Remain High in 2002*, Number 25, June 2003.
[304] Tim Craig, "Montgomery to Issue Drug Discount Cards," *The Washington Post*, September 21, 2004.
[305] Cameron W. Barr and Tim Craig, "Montgomery Passes Drug Import Plan," *The Washington Post*, September 22, 2004.
[306] KaiserNetwork.org, "Illinois to Launch Program to Reimport Prescription Drugs from Canada, England and Ireland, Despite Warning from FDA," August 17, 2004.
[307] Ibid.
[308] Pam Belluck, "Vermont Will Sue U.S. for the Right to Import Drugs," *The New York Times*, August 11, 2004.

states to help citizens import medications more cheaply from Canada…"[309] The majority of survey respondents (62 percent) do not purchase pharmaceutical drugs online because they do not think that the drugs are safe. Of those individuals who do buy drugs online, the study also revealed that these people are more likely to "live in a higher-income household and have six or more years of online experience."[310] Most of the Canadian pharmaceutical orders are processed via a toll-free telephone number.

Another recent study notes that drug importation policies may have unintended consequences on drug prices in other countries, undermining intellectual property rights of drug manufacturers and "undermining the incentive to invest in future research and development."[311]

[309] "Few Americans Buy Drugs Online, Let Alone from Canadian Sites," *The Wall Street Journal*, October 11, 2004.
[310] Ibid.
[311] Nina Owcharenko, "Debunking the Myths of Drug Importation," WebMemo #542, The Heritage Foundation, July 20, 2004.

XI. Ways to Make Health Insurance More Understandable to Both Employers and Consumers

A. Health Literacy

According to an article in the *Journal of the American Medical Association*, "nearly half of the adults in the United States have trouble interpreting medical information."[312] Many individuals find it difficult to follow instructions for taking prescription drugs and completing consent forms or are missing appointments. The effects of not complying with "doctor's orders" may result in harm to the patient's health and also higher medical costs for medical treatments needed as a result of the patient not understanding the prescribed treatment. The federal Agency for Healthcare Quality and Research (AHRQ) conducted research examining individuals with poor reading and comprehensive skills. These individuals were more likely to be hospitalized and have a higher use of emergency services, compared to those individuals with a higher literacy level who were more likely to use preventive services. The article recommends that providers communicate more effectively with patients by not using medical jargon and verifying that their patient understands what the doctor is recommending.[313]

With a greater number of consumers becoming knowledgeable about consumer-driven health plans and many employers and individuals choosing these plans and managing their own care, the focus on health literacy is growing. The concern over the public's level of understanding medical treatments and services began with managed care which requires that patients spend less time being cared for by medical professionals and more time on their own to care for themselves.[314] Consumer-directed care allows individuals to select providers and choose medical treatments using money allocated by their employer, the individual, or both. An Institute of Medicine study states that even those individuals with high comprehension levels may face difficulties interpreting medical information. The report brief states that "[h]ealth literacy comes from a convergence of education, cultural and social factors, and health services."[315] The report defines health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."

The Robert Wood Johnson Foundation (RWJF) is involved in several programs aimed at encouraging patients to take an active role in their health care. The National Diabetes Initiative, a $6.3 million program, provides funding, training, and consultation to 14 primary care providers and community coalitions serving diverse populations throughout the U.S.[316] This program involves the patient in setting the plan and encourages the use of non-primary care providers (or lay health workers) to educate the patients. By

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[312] Brian Vastqag, "Low Health Literacy Called a Major Problem," *Journal of American Medical Association*, 291 (18), May 12, 2004.
[313] Ibid.
[314] "Health Literacy: How Many Patients are Left Behind," Medicine and Health, 58 (16), April 19, 2004.
[315] Lynn Nielsen-Bohlman, Allison M. Panzer, David A Kindig, Editors, Institute of Medicine of the National Academies, *Health Literacy: A Prescription to End Confusion*, Report Brief, April 2004.
[316] Lee Green, "Help Health Thyself: Engaging Patients in Their Health Care," Advances - The Robert Wood Johnson Foundation Quarterly Newsletter, Issue 2, 2004.

relying less on expensive interventions, it is expected that this program will not increase costs but possibly lead to a reduction in spending on services for the population served.[317]

Several public and private initiatives are underway to help educate consumers on specific programs, health care services and providers, or about health care in general. Examples of public and private education efforts include:

- 1-800-Medicare
- National Diabetes Education Program (Centers for Disease Control and Prevention and the National Institutes of Health)
- National Health Council (a public education campaign on how individuals can better communicate with their providers)
- Health insurance carriers have consumer-focused websites that emphasize preventive care and disease management programs
- The National Committee for Quality Assurance (NCQA) annual HMO report card
- Maryland Health Care Commission HMO Consumer Guide, Hospital and Nursing Home Performance Evaluation Guides, and the Ambulatory Surgery Facility Consumer Guide.

Educating non-U.S. Citizens on the U.S. Health Care System

Almost 50 percent of Maryland's non-U.S. citizens are uninsured. Of the total uninsured population in Maryland, about 30 percent are non-U.S. citizens. They have higher rates of uninsurance regardless of income. Many of this group are low-income and either do not have access to health insurance through their employer and/or it is unaffordable. Those individuals who can afford health coverage may not be familiar with the U.S. health care system. The countries from which many of them immigrate have a more universal coverage system than the United States; therefore, it is not customary for these individuals to purchase health insurance on their own or through their employer. Other non-U.S. citizens come from countries that do not have a well-developed insurance system at all; instead they rely on more of a community-based health services model of health care delivery.

Several initiatives have been undertaken to assist the immigrant population to understand the U.S. health care system and to obtain care. Examples of health care educational activities geared to the immigrant population include:

- In Philadelphia, health literacy classes are offered to "senior immigrants with limited English language skills [on] how to communicate with health care providers more effectively and obtain medical services;"[318] and
- A U.S. and Mexico agreement that will promote health events and bilingual health education materials to help educate migrant workers about health care services available at community clinics in the U.S. The goal is to steer these patients from

[317] Ibid.
[318] Kaiser Daily Health Policy Report, "*Philadelphia Inquirer* Examines Health Literacy Classes Offered to Seniors with Limited English Skills", May 24, 2004 (Uhlman, *Philadelphia Inquirer*, May 24, 2004).

expensive hospital department treatment to the community clinics for preventive care.[319]

B. The Role of the Health Insurance Carrier and the Broker

The role of the employer health benefits representative, the broker, and the carrier are invaluable to educating individuals and groups on the basic tenets of health insurance. Most people are not aware of the differences between HMOs and PPOs, let alone the intricacies of the particular health plan. Educating the consumer on these issues is often left to the employer representative or a broker to assist the enrollee in understanding the details of the coverage.

In Maryland, health insurance carriers primarily produce and distribute information on their products to the health insurance brokers. Generally, the carriers educate the brokers on the plans offered by the carrier, and the benefits of each plan. In many instances, employers and individuals contact brokers for assistance in purchasing a health plan and rely heavily on the broker for assistance. In focus groups the MHCC conducted with small employers, we found that the broker plays an important advisory role in the purchasing process and in servicing health benefit plans.

C. Individual and Small Group Markets

The Maryland Insurance Administration (MIA) currently provides general information on individual health insurance carriers (non-group). This information could be featured more prominently on their website so that consumers would have ready access to the information. In addition, information to assist the consumer with contacting carriers and/or brokers and purchasing health insurance specific to the state of Maryland could be provided. There are websites that list plans and cost sharing arrangements depending on the consumer's location. At Ehealthinsurance.com, consumers can review individual or small group health insurance plans by zip code. Average monthly premiums, along with out-of-pocket costs, are featured for each plan.

Currently, the MHCC provides information on the Comprehensive Standard Health Benefit Plan (CSHBP) on its website. The CSHBP is the minimum level of benefits that may be sold to small employers (those with two to 50 employees) and the self-employed. The website, titled *A Guide to Purchasing Health Insurance for Small Employers*, provides information on the protections available to small employers under the Maryland Health Insurance Reform Act, those benefits that a carrier must include in the CSHBP, advantages to offering health insurance to small employees, as well as other information.

The California HealthCare Foundation also maintains a website to assist small employers with understanding health insurance, and guiding them on how to purchase insurance. The *HealthCoverage Guide.org* starts with a two-step process. Part One, titled "Getting Started," provides general information on health insurance, costs and benefits associated with various plans, how to evaluate plans, and alternatives to group coverage. Part Two, "Getting Coverage," lays out the different steps employers should take when

[319] Kaiser Daily Health Policy Report, "U.S., Mexico Health Officials Work to Educate Migrant Farm Workers on Health Care Options," October 13, 2004 (AP/Arizona Daily Start, October 12, 2004).

purchasing coverage. For example, an employer is encouraged to get organized, decide what he or she wants, find a broker, understand the marketplace, evaluate the options and close the deal.

D. Health Care Quality and Cost Information

The Maryland Health Care Commission maintains three separate websites on Maryland providers: The Hospital Performance Guide; The Nursing Home Performance Guide; and The Ambulatory Surgical Facility Consumer Guide. The Hospital Performance Guide enables consumers to review information on several facility characteristics, such as location of the hospital, number of beds, and accreditation status. Thirty-three high volume diagnosis-related groups (DRGs) are featured. For each hospital, consumers are able to compare the volume, risk adjusted length-of-stay, and risk adjusted readmission rate for each DRG. General information on patient rights and how hospitals are regulated in Maryland is also available in the Guide, as well as a checklist to help consumers select a hospital. Also included is guidance on what to expect in a hospital setting.

Quality of care information specific to the treatment and prevention of congestive heart failure and community acquired pneumonia, such as individual hospital rates, the state average, and the highest rate achieved by a hospital in Maryland for each of the measures is also presented. Data on Acute Myocardial Infarction (AMI) will soon be presented in the Guide. In addition, obstetrics information is available for those Maryland hospitals that have obstetrics programs.

The MHCC could consider adding cost data to the DRGs and the quality measures for each hospital. Since Maryland has an all-payor system, all consumers of the Guide, those who are insured, uninsured, or underinsured, pay the same amount for a particular procedure at a given hospital. The addition of cost data to the Hospital Performance Guide could provide consumers with an additional tool in selecting hospitals or speaking with their physician about the quality and cost effectiveness of care delivered at a hospital. In addition to the quality information, the cost data may be used to educate consumers on the cost of various procedures performed in a hospital setting.

XII. Preliminary Recommendations and Research for Final Report

In order to develop recommendations on ways to make private health insurance more affordable for Maryland residents, due to the Maryland General Assembly in January 2006, the MHCC will explore several issues over the next twelve months. Based on the MHCC's analysis of current literature, including legislation and activities undertaken by other states and health insurance carriers to stem the rising cost of medical care and health insurance, it is recommended that the Maryland General Assembly consider the following preliminary recommendations as attempts to control health care spending in Maryland:

- Transparency of full cost information to the consumer – Similar to the Florida legislation which requires the Agency for Health Care Administration (AHCA) to post pricing information on procedures performed in Florida hospitals, the Maryland Health Care Commission should consider adding cost data to its Maryland Hospital Performance Guide for each high volume medical procedure. Information describing the all-payer rate setting system as administered by the Health Services Cost Review Commission should be presented. Cost data may be presented in the Maryland Ambulatory Surgical Facility Consumer Guide as it is developed as well.

- Emergency Department Diversion Plans - Another part of the Florida legislation which Maryland could replicate is the encouragement of hospitals and health insurance carriers to have emergency department diversion plans, including an 'emergency hotline' whereby consumers may call to help determine if the emergency department is the appropriate setting for their medical condition. The legislation also encourages a hospital 'fast track' program which would refer non-emergency patients to an alternative site, and the increased on-call availability of health care providers to carriers' enrollees after hours. Maryland, as in other states, is seeing an increase in the number of patients seeking care in the emergency department setting, and many of these individuals have non-emergent medical conditions. To alleviate some of the burden faced by the hospitals in treating patients, it is worth educating patients on the appropriate setting for treating medical conditions.

- Financial Incentives to Providers - In order to encourage health care providers to provide cost-effective quality care, health insurance carriers should be encouraged to provide incentives to physicians. Blue Cross Blue Shield (BCBS) of Michigan recently paid $5 million in incentives to providers who directed patients to disease management programs in congestive heart failure, heart disease, asthma and diabetes. As the first BCBS organization to provide incentives to physicians in its traditional and preferred provider organization plans, ten physician groups with 2,900 physicians participated in the program, paying the physicians with money allocated towards increased physician fees. Through an education process with

nurses affiliated with the BCBS program, patients are taught ways to manage their chronic illness, which in turn reduces trips to the emergency room and hospital stays. Also, the HSCRC is currently developing a pay-for-performance program that will provide financial support and incentives to hospitals that meet or exceed established performance measures consistent with evidence-based health services research.

In addition to health insurance carriers, incentives should be explored through which hospitals, health systems, and private providers can be encouraged to improve chronic disease management.

- Redesign of the Small Employer Website - Similar to the California Healthcare Foundation's Health Coverage Guide, the MHCC should redesign their small employer website to include additional educational material that will assist small employers in understanding the intricacies of health insurance (especially the cost and options to reduce spending), and help them when purchasing coverage. In addition, information on individual insurance market products currently available on the Maryland Insurance Administration website should be more prominently featured to facilitate access by consumers. The MIA website should also include general information on health insurance to educate consumers on the costs associated with the plans, as well as basic information describing health insurance.

- Listing of Additional Prescription Drugs on Maryland OAG Website - Consumers may use the Maryland Office of the Attorney General website to locate the least expensive price for the drug they are taking according to their area of residence. It would be more beneficial, however, to include additional prescription drugs so that a greater share of the Maryland population would benefit from this cost comparison tool. On the Maryland Office of the Attorney General website,[320] prices for the 25 most commonly prescribed prescription drugs are available by county. A consumer can compare the prices for these drugs by county, by city, or zip code. The name and address of pharmacies are presented along with the 'usual and customary' price of the drugs.

In addition, the Maryland Health Care Commission will conduct a more detailed analysis of the cost drivers, including the issues related to health care status of Maryland residents (such as the prevalence of obesity and smoking in Maryland) and issues put forth in the legislation. MHCC staff will take into consideration the cost analysis undertaken by other states (e.g., Maine and Indiana). Staff will also explore the effectiveness of other state and carrier initiatives and programs, such as the use of evidence-based medicine, wellness programs coupled with health insurance premium rebates, provider pay-for-performance programs, and provider 'tiering' as possible methods to control health care spending and reduce health insurance premiums.

[320] http://www.oag.state.md.us/Drugprices/index.htm

Appendix A

Trends in Maryland Hospital Emergency Department Utilization: An Analysis of Issues and Recommended Strategies to Address Crowding

Report of the Joint Work Group on Emergency Department Utilization

Maryland Health Care Commission
Health Services Cost Review Commission

April 2002

Executive Summary

In Maryland, and across the United States, there have been substantial increases in the utilization of acute care hospital emergency department services over the past twelve years. In fiscal year 2001, there were 1.9 million visits to the emergency department services operated by Maryland's acute care hospitals. Between 1990 and 2001, the emergency department utilization increased by 454,000 visits or 30.6 percent. Over this same time period, Maryland's total population increased by about 11.6 percent.

Because emergency department services are a vital component of the health care system, the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) convened a Joint Work Group to examine the underlying causes of the recent increases in utilization, assess the impact of future trends on the provision of these services, and ensure that public policy is coordinated in developing effective strategies to address emergency department crowding. The findings and recommendations of the Joint Work Group are contained in *Trends in Maryland Hospital Emergency Department Utilization: An Analysis of Issues and Recommended Strategies to Address Crowding.*

STATE AND NATIONAL TRENDS IN EMERGENCY DEPARTMENT UTILIZATION

- Emergency department services accounted for 52 percent of the total patients served by Maryland acute care hospitals in 2000. In comparison, inpatient services represented about 16 percent of hospital caseloads.
- Fifteen of the 46 Maryland acute care hospitals with emergency departments had 50,000 or more visits during fiscal year 2001. Four (Johns Hopkins Hospital, Sinai Hospital of Baltimore, St. Agnes Hospital, and University of Maryland Hospital) of the 15 hospitals with 50,000 or more visits were located in Baltimore City; and three hospitals (Shady Grove Adventist Hospital, Prince George's Hospital Center, and Holy Cross Hospital) were located in the metropolitan Washington jurisdictions of Montgomery and Prince George's counties.
- Analyses of trend data on yellow and red alerts over the past several years shows substantial increases in the number of hours that hospital emergency departments are on ambulance diversion. In the metropolitan Baltimore region, there was a more than four fold increase in yellow alert hours between fiscal years 1996-2001. Yellow alert hours accounted for 16.4 percent of available emergency department hours and red alert for 14.2 percent of available hours in fiscal year 2001.
- The pattern of increasing emergency department utilization experienced in Maryland during recent years is consistent with national data. According to the American Hospital Association, the number of emergency room visits to U.S. hospitals increased by 19 percent between 1990 and 2000. Over this same time period, Maryland hospitals reported a 23 percent increase in emergency department use.
- More than one-half of all hospitalized patients are seen in the emergency department prior to admission. In 2000, 55.2 percent of all admissions for inpatient care came through the hospital emergency department. For the psychiatric service, almost three quarters (72.6 percent) of patients are admitted through the emergency department.
- Heart failure and shock, which accounted for slightly more than 5.3 percent of all admissions through the emergency department, were the primary reason for hospitalization. The second leading cause of hospitalization for patients admitted

through the emergency department was psychoses. Other leading conditions important to admission through the emergency department were pneumonia, chest pain, cerebrovascular disorders, chronic obstructive pulmonary disease, digestive disorders, and blood infections or septicemia.

FACTORS INFLUENCING EMERGENCY DEPARTMENT UTILIZATION

A large number of interrelated factors influence how hospital emergency department services are utilized and the frequency of diversions and crowding. These factors can be broadly categorized as follows: (1) increased demand for emergency department services; (2) changes in the management of emergency department patients; and, (3) the capacity of hospital and community health care system resources to address treatment and other needs following discharge from the emergency department.

Increased Demand for Emergency Department Services

- While HMOs sharply curtailed use of emergency department services in the early 1990's, this pattern has changed in response to consumer concerns about managed care combined with less rigid interpretations of what constitutes a medical emergency, particularly under recent prudent layperson laws. One consequence of this move away from strong utilization controls has been the increased use of emergency department services by managed care enrollees.
- Although managed care organizations may have eased restrictions on using emergency department services, the increase in managed care enrollment has at the same time increased use of primary care physicians and other clinicians. As a consequence, patients may be increasingly turning to the hospital emergency department when they need urgent care and cannot schedule a timely appointment with their own primary care physician. Busy primary care physicians also may be referring patients to the emergency department when appointments are not readily available.
- Many of the reasons that patients cite for using the emergency department for nonurgent care relate to access to care issues, both financial and non-financial, including lack of health insurance, clinic services not being available at night, not being able to leave work, not being able to get an appointment soon enough, and the convenience of emergency department care. While having a regular source of primary care may not entirely eliminate hospital emergency department use, available research suggests that it is associated with more appropriate utilization of the emergency department. Further analyses of the Maryland emergency department data set are required to more fully understand the reasons underlying the use of the emergency department for nonurgent conditions.
- Although only a small proportion of emergency department visits result in admission for inpatient care, more than one-half of all inpatient discharges from Maryland hospitals entered through the emergency department. As the major doorway to the hospital, the emergency department is a key service in maintaining a viable inpatient base. In an increasingly competitive health care market, this factor in and of itself may create conflicting incentives for hospitals.

Changes in the Management of Emergency Department Patients

- Recent efforts to more strictly enforce EMTALA requirements may contribute to crowding by increasing the length of time patients spend in the emergency department as well as encouraging physicians to refer and patients to self-refer to emergency department services.
- Problems with the availability of on-call specialists to provide a consultation is another factor that contributes to longer stays and crowding in the emergency department. Delays in specialists making themselves available for emergency department coverage stem from several factors, including lack of payment by uninsured patients, managed care policies, technological advances that have enabled more physicians to operate in their offices making them less reliant on hospital privileges, and EMTALA rules governing transfers of patients.
- Changes in the way health care services are delivered have also had an impact on the operation of the emergency department. Many of the conditions that once resulted in admission to the hospital now are treated and released following intensive therapy and observation in the emergency department.

Hospital and Community Health System Capacity

- Discussions with Maryland hospital staff suggest that delays in the ability to transfer patients from the emergency department to appropriate inpatient units within the hospital, particularly critical care units, is a significant factor contributing to congestion. When this occurs, patients must be held in the emergency department, thus occupying resources that otherwise would be available to treat incoming patients.
- The current nursing shortage may limit the number of licensed beds that hospitals are able to staff and operate. Factors responsible for constraining the supply of nurses, including decreased job satisfaction, expanded career opportunities, and a shrinking pool of new nurses to replace those retiring, are likely to persist and may worsen in the future. As a consequence, nursing staff shortages can be expected to have a continuing impact on hospital operations, including the ability to operate a full complement of licensed beds.
- Seasonal variation in hospital utilization patterns is another factor that increases pressure on available beds. For medical-surgical services, utilization predictably peaks during the winter months of January-February. On the peak census day in January 2000, statewide occupancy based on licensed beds was 93.3 percent. By comparison, the lowest patient census generally occurs during the summer months or December. In December, at the lowest point during 2000, occupancy was 60.0 percent based on licensed beds.
- The impact of the way beds are used on patient census at peak hours of operation is a third factor that may increase pressure on hospital system capacity. As length of stay has declined and outpatient services have increased it is not uncommon for patients to be admitted for up to 23 hour stays that occupy resources but may not necessarily be counted in the patient census. A related issue concerns how to count patients who experience extremely long lengths of stay in the emergency department and may eventually be discharged before being admitted.
- The capacity of the community health care system to provide needed services also has an impact on the ability of hospitals to discharge patients. Discussions with

hospital staff suggest that this problem particularly impacts vulnerable populations with serious and chronic illnesses, such as psychiatric patients.

HOSPITAL EMERGENCY DEPARTMENT CAPITAL PROJECTS

- The renovation and expansion of hospital emergency departments has been a significant trend in capital expenditure projects over the past several years in Maryland. Between 1997-2001, eight hospitals completed capital projects to expand or renovate emergency department services. Those eight projects cost $44,369,063. Seventeen Maryland hospitals have submitted plans for capital projects costing $81,891,679 to upgrade emergency department services between 2002-2004. An additional 10 hospitals have future plans to renovate or expand their emergency department services.
- Based on current plans, emergency department beds will increase by about 25 percent (from 1,303 to 1,627) between 1999 and 2004. Data reported to the Commission indicates that the size of emergency departments, as measured by square feet, will increase from 579,934 to 779, 721 (34.4 percent) over this same time period. Almost one-half of the projected growth in the emergency department will be in beds allocated to fast track and multi-purpose use (165 of the 324 additional beds).

RECOMMENDATIONS

RECOMMENDATION 1. The academic and research communities in Maryland, in collaboration with hospitals and state agencies, should seek funding from federal agencies and/or private foundations to support a research agenda designed to: (1) analyze the role of the emergency department in serving vulnerable populations; (2) evaluate options for organizing emergency department services to meet future community needs; and (3) identify best practices.

RECOMMENDATION 2. The Health Services Cost Review Commission's Hospital Ambulatory Care Data Set, which collects information on emergency department encounters from all Maryland acute care hospitals, should be used to monitor utilization patterns and guide policy formulation. In consultation with hospitals and relevant state agencies, HSCRC should develop comparative statistics and indicators and provide feedback to hospitals through preparation and dissemination of quarterly and annual reports on emergency department use.

RECOMMENDATION 3. The Yellow Alert Task Force, convened by the Maryland Institute for Emergency Medical Services Systems as a collaborative effort involving EMS providers, hospitals, and state agencies, should continue to serve as the forum for developing strategies to manage hospital emergency department diversions, including educating the public and health care providers about the appropriate use of emergency services.

RECOMMENDATION 4. The Maryland Health Care Commission, with the assistance of a Work Group composed of representatives from hospitals and relevant state agencies, should study the relationship between increased admissions through the emergency

department and other sources and inpatient bed capacity. This study should include an analysis of staffed versus licensed beds, options for measuring occupancy and licensed capacity, optimal occupancy thresholds, emergency department capacity, and other appropriate factors. The Commission should use results from this study in updating and revising the acute inpatient services component of the State Health Plan for Services and Facilities and Certificate of Need regulations, in recommending statutory changes where appropriate, and in other policy development efforts involving acute care hospitals.

RECOMMENDATION 5. The Health Services Cost Review Commission should consider innovative programs from hospitals that can be shown to be cost effective and improve the operation of the emergency department. The HSCRC should consider supplying hospitals with start-up funds to begin these programs if it can be clearly demonstrated that the public from the implementation of these programs will realize savings. This start-up money should only be supplied if there is a back-end guarantee by the hospitals that savings will be realized from the programs.

RECOMMENDATION 6. The Association of Maryland Hospitals and Health Systems should give priority in reviewing applications for the Hospital Bond Project Review Program to innovative projects designed to improve access to urgent and non-emergency care services for vulnerable populations.

RECOMMENDATION 7. The Maryland Health Care Commission, Office of Health Care Quality, Health Services Cost Review Commission, Maryland Institute for Emergency Medical Services Systems, and The Association of Maryland Hospitals and Health Systems should jointly study the access, quality of care, and reimbursement issues associated with hospital and nonhospital based urgent care centers, including freestanding emergency care centers.