

A Public-Private Partnership for Health Care For All Marylanders: Cost and Coverage Impacts Analysis

Final Report

prepared for:

Maryland Citizens' Health Initiative Education Fund, Inc

by:

The Lewin Group

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EXECUTIVE SUMMARY

In December of 2002, the Maryland Citizens' Health Initiative Education Fund Inc., released a plan to provide health insurance coverage to all Marylanders. The program requires all Maryland residents to obtain a minimum level of health insurance coverage for themselves and their children or pay a substantial tax penalty. To assist the low-income population, the program also provides subsidized coverage to adults living below 350 percent of the Federal Poverty Level (FPL), and children living below 400 percent of the FPL. In addition, the program requires that all insurers in the individual and small group market provide at least a minimum level of coverage with guaranteed issue, no pre-existing condition limitations, and with no variation in premiums by health status.

The program would be funded with increases in federal Medicaid matching funds, enrollee premiums and an employer payroll tax on employee wages. For firms with fewer than 10,000 workers in Maryland, the payroll tax rate would start at about 4.5 percent in the first year of the program and rise to about 5.98 percent over a five year as needed to fully fund the program. The tax rate for firms with over 10,000 workers in Maryland would be 8.0 percent. Employers would receive a tax credit for up to the amount of the payroll tax on spending for worker health benefits. The program is designed so that employers now spending more than the payroll tax amount (i.e., 4.5 percent of payroll) generally would not see an increase in costs, and would in fact see savings as provider uncompensated care charges are reduced.

In this study, we estimated the impact of the MdCare proposal on coverage and costs for the state government, employers and families in Maryland. We also developed a detailed analysis of the impacts that the program would have on employment in the state. Key findings include:

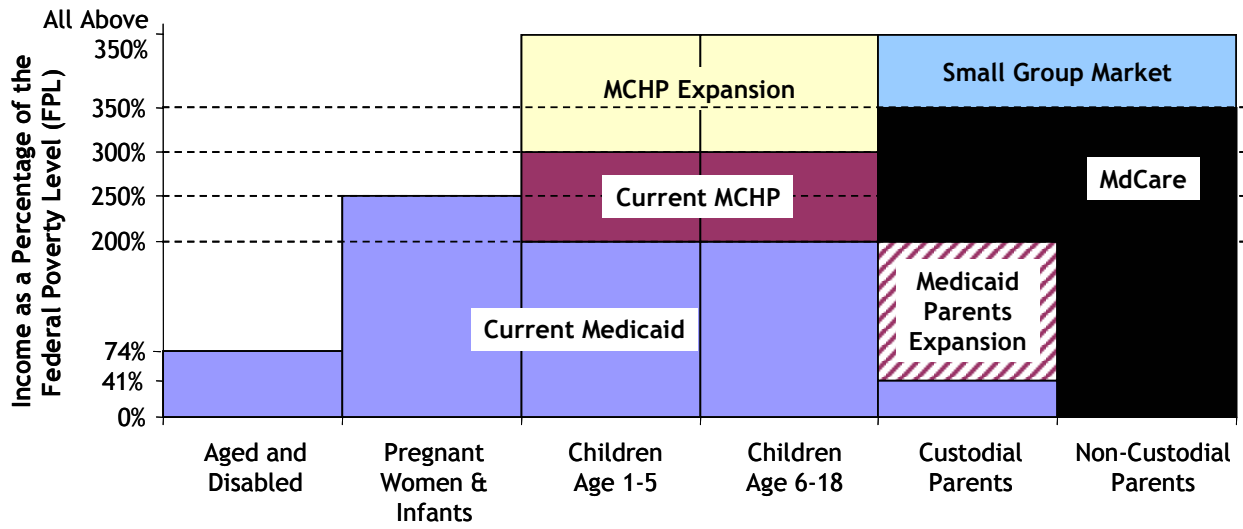
- The Program would provide coverage to about 589,200 of the 665,000 people in Maryland who are currently uninsured;
- The net cost of the program to the state (i.e., program costs less premiums and federal funding) would be about \$665.7 million, most of which would be raised through the payroll tax;
- The primary effect of the program would be a reduction in wage growth for workers who currently do not have access to "comprehensive and affordable" employer coverage; and
- There would be little net change in employment in Maryland under the program. Up to 10,000 minimum wage jobs would be lost in affected firms. This would be roughly offset by increased employment due to the influx of federal revenues to the state under the program.

Our results are summarized below:

PUBLIC COVERAGE PROGRAMS IN MARYLAND

The program would greatly expand the availability of subsidized health insurance coverage to low-income people in Maryland. The current Medicaid program covers aged and disabled people through 74 percent of the FPL (*Figure ES-1*). It also covers pregnant women through 250 percent of the FPL. Children living below through 200 percent of the FPL are eligible under Medicaid while all other children below 300 percent of the FPL are eligible for the Maryland Children's Health Program (MCHP). However, Medicaid covers parents living with children only if their incomes are less than about 41 percent of the FPL and does not cover adults without children at any income level (except aged and disabled).

**Figure ES-1
Expansions in Coverage Under the MdCare Program**



Source: The Henry J. Kaiser Family Foundation. State Health Facts Online, Available from eligibility links at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Maryland>.

The MdCare proposal would expand eligibility for Medicaid and MCHP to maximize the federal matching funds available for these programs. The MCHP program would be expanded to cover all children not otherwise covered under a parents’ employer health plan with a premium subsidy provided for children with incomes between 300 percent and 400 percent of the FPL. Eligibility for parents under Medicaid would be expanded to 200 percent of the FPL.

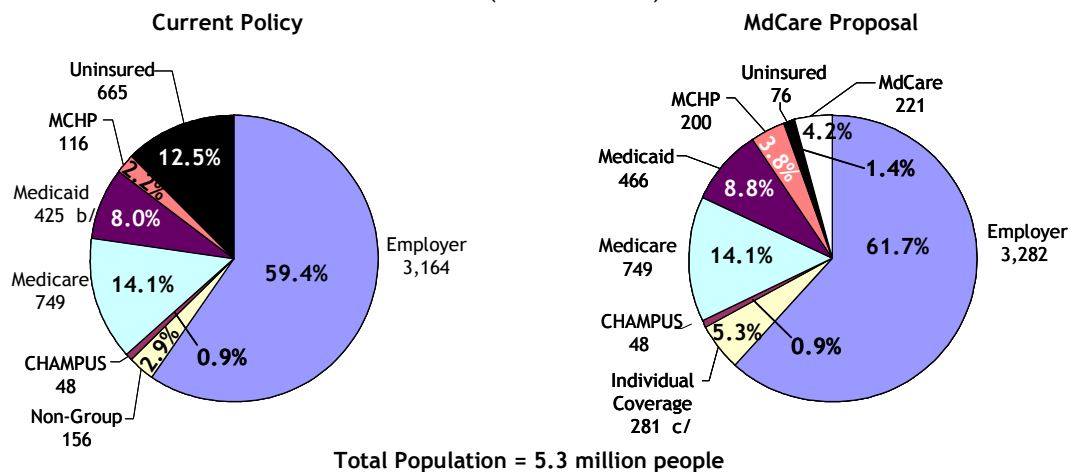
All other adults living below 350 percent of the FPL would be eligible for a newly established health benefits program called MdCare if they do not have access to “comprehensive” and “affordable” coverage through an employer. An employer’s Health plan is considered to be comprehensive and affordable if: 1) the plan provides at least the Maryland Comprehensive Standard Benefits Plan (CSHBP) benefits package as determined by the Maryland Health Care Commission MHCC; and the required worker premium contribution is less than 3.0 percent of income for individuals or 6.0 percent of income for families.

Adults living above 350 percent of the FPL would be eligible to purchase coverage in the newly redefined small group market, which would include all employers with under 100 workers (currently includes groups of 50 or less) and all individuals purchasing insurance on their own (i.e., the current non-group market).

CHANGES IN SOURCES OF COVERAGE

We estimate that there will be an average of about 665,600 people without insurance at any given point in time in 2003 (*Figure ES-2*). Under the MdCare program, about 589,200 people would become insured under either public or private health insurance, which is about 88 percent of those who are now uninsured. The key coverage impacts include:

Figure ES-2
Distribution of People by Primary Source of Coverage under Current Policy and the
MdCare Proposal in 2003^{a/}
 (in thousands)



a/ Coverage presented on an average monthly basis.
 b/ We estimate that

Medicaid/MCHP average monthly enrollment will reach 505,100 people in calendar year 2003, of whom about 80,200 are dually eligible for Medicaid and Medicare. The dual eligible population is counted as having Medicare as their primary source of coverage.

c/ Under the MdCare proposal, people without employer sponsored coverage who are living above 350 percent of the FPL would obtain coverage as an individual in the newly redefined small group market..

Source: Lewin Group estimates using the Health Benefits Simulation Model.

- The number of people with employer sponsored coverage would increase by about 118,800 people. These include: workers in firms that decide to offer insurance rather than pay the tax; and increased enrollment in existing employer health plans among eligible workers who currently decline the insurance available to them through their employer;
- The expansion in coverage to parents living below 200 percent of the FPL would increase Medicaid enrollment by about 40,600 people;
- MCHP enrollment would increase by about 84,000 children;
- The MdCare program for adults living below 350 percent of the FPL would cover about 220,700 people; and
- Uninsured adults with incomes above 350 percent of the FPL (125,100 people) would generally obtain coverage through the newly designated "small group" market to avoid paying the tax penalty.

An important result of the expansion in coverage would be a reduction in uncompensated care costs for hospitals of about \$228 million. These savings are automatically returned to payers through the Health Services Cost Review Commission (HSCRC) rate review process, resulting in substantial savings to employers now offering coverage to their workforce (discussed below).

Those who remain uninsured (76,800 people) generally would be difficult to reach populations with low incomes who would not have been required to pay a tax penalty for going without insurance (people below 200 percent of the FPL would not be subject to the tax penalty). These include about 22,100 children and about 54,600 adults.

PROGRAM COSTS AND REVENUES

Total benefits and administrative costs (before premium offsets) for the program would be about \$1.1 billion (*Figure ES-3*). This includes a net increase in provider payments under the current Medicaid program (\$177.0 million) and the cost of benefits provided under the expansions in Medicaid eligibility (\$128.5 million), the MCHP expansion (\$159.3 million), and the new MdCare program (\$617.5 million).

Figure ES-3
Sources and Uses of Funds Assuming Full Implementation in 2003
(in millions)^{a/}

Uses of Funds		Sources of Funds	
Current Medicaid Eligible	\$177.0	Premium Collections	\$184.2
Provider Payments	\$200.0	MCHP Premiums	\$120.2
Cost shift savings	(\$23.0)	MdCare Premiums	\$64.0
MCHP Expansion (84,000 Children)	\$159.3	Federal Match	\$172.4
Medicaid Expansion for Parents to 200% FPL (40,700 Parents)	\$128.5	Parents to 200% of FPL	\$64.3
MdCare: Adults under 350% FPL (220,700 Adults)	\$617.5	MCHP Kids to 400% of FPL	\$19.6
		Provider Payments	\$88.5
Total Program	\$1,082.3	Employer Assessment Revenue	\$565.7
		Tax Revenues (4.5%)	\$3,090.0
		Tax Credits	(\$2,524.3)
		Present MHIP Assessment	\$60.0
		Tobacco Tax Increase	\$100.0
Total Uses of Funds	\$1,082.3	Total Revenues/Offsets	\$1,082.3

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

There would be several offsets to these costs. Premium collections under MCHP and MdCare would be about \$184.2 million. There also would be about \$172.4 million in new federal matching funds for the expansion in Medicaid/MCHP coverage and improvements in provider reimbursement included in the MdCare proposal. Funding for the planned high-risk pool (i.e., hospital assessment revenues of \$60 million) would become available to fund the expansion. The program also includes a tobacco tax increase of about \$0.50 per pack, which would yield about \$100 million in revenues.

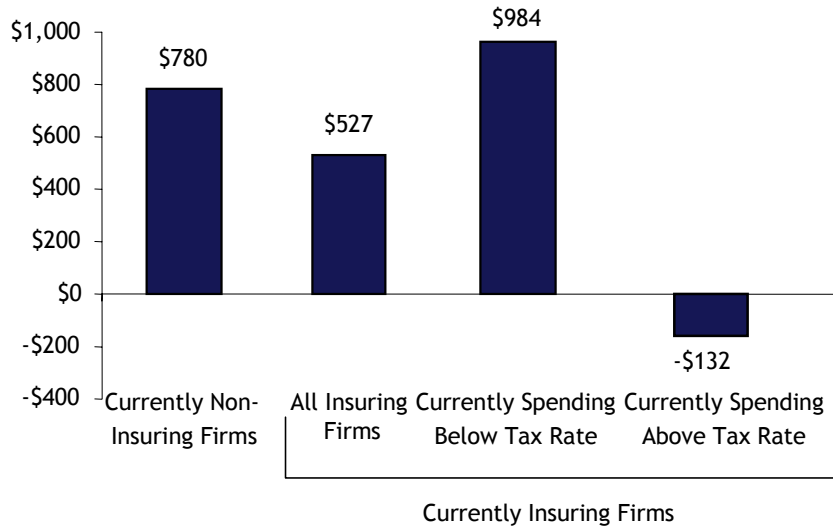
The payroll tax rate would be set at the level required to fully fund the remainder of the program, which we estimate to be about \$565.7 million in 2003. The tax rate required to raise this much in revenues would be about 4.5 percent. This results in tax collections of about \$3.1 billion, which are offset by about \$2.5 billion in credits for the cost of coverage provided by employers. The tax rate would increase to about 5.98 percent by the fifth year of the program, reflecting an expected growth in the number of eligible people over-time and the fact that health care costs are projected to grow faster than wages.

IMPACT ON PRIVATE EMPLOYERS

The program has the effect of requiring all Maryland private employers to contribute at least the payroll tax amount (i.e., 4.5 percent of payroll) for worker health benefits. Firms that now pay more than that amount would receive credits for the full amount of those health benefits up to the amount of the tax, resulting in no net increase in benefits costs to the employer. In fact, firms that currently spend more than the payroll tax amount on health benefits would see savings due to reduced uncompensated care costs for providers in the state. For firms spending less than the payroll tax amount on benefits, they would pay the difference between the payroll tax amount and the amount spent on health benefits.

About 41 percent of workers in insuring firms (i.e, firms that currently provide health benefits to at least some of their workers) are in firms that already spend more than the required percentage of payroll on health benefits. These firms will generally see savings due to reduced provider charges for uncompensated care averaging about \$132 per worker (*Figure ES-4*).

Figure ES-4
Change in Employer Spending Per Worker by Current Insuring Status and Spending Level as a Percentage of Payroll



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

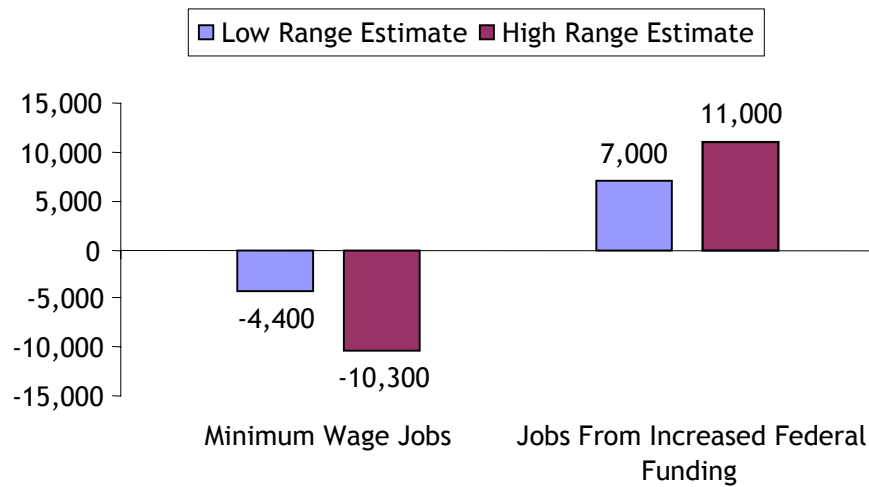
However, about 59 percent of workers in insuring firms are in a firm that currently spends less than the required percentage of payroll on health care. Health spending in these firms would increase by an average of about \$984 per worker. This would generally take the form of tax payments in excess of the tax credit for health spending, although many firms are expected to upgrade the coverage they offer rather than just paying the difference in taxes. The average increase in cost for firms that do not now provide coverage would be about \$780 per worker.

WAGE AND EMPLOYMENT EFFECTS

The economics literature indicates that most of the cost of increased health care spending has historically been passed-on to workers in the form of slowed wage growth. Employers are typically limited in what they can charge for their goods and services in the market place, which limits their ability of pass-on costs through higher prices. This necessitates changes in other compensation costs such as wages and other benefits. Employers experiencing an increase in costs under the proposal would generally pass-on the cost to their workers in the form of a reduction in the growth in wages over time. Conversely, wages in firms that experience savings under the program would be bid-up in the labor markets, resulting in increased wages for these workers.

However, losses of employment could occur among minimum wage workers because employers are prohibited from adjusting wages below that level. Based upon a review of the minimum wage literature, we estimate that between 4,400 and 10,300 minimum wage jobs could be lost as a result of the employer payroll tax requirement (*Figure ES-5*).

Figure ES-5
Changes in Employment in Maryland under MdCare Program by
Type of Employment Effect



Source: Lewin Group estimates using the Health Benefits Simulation Model.

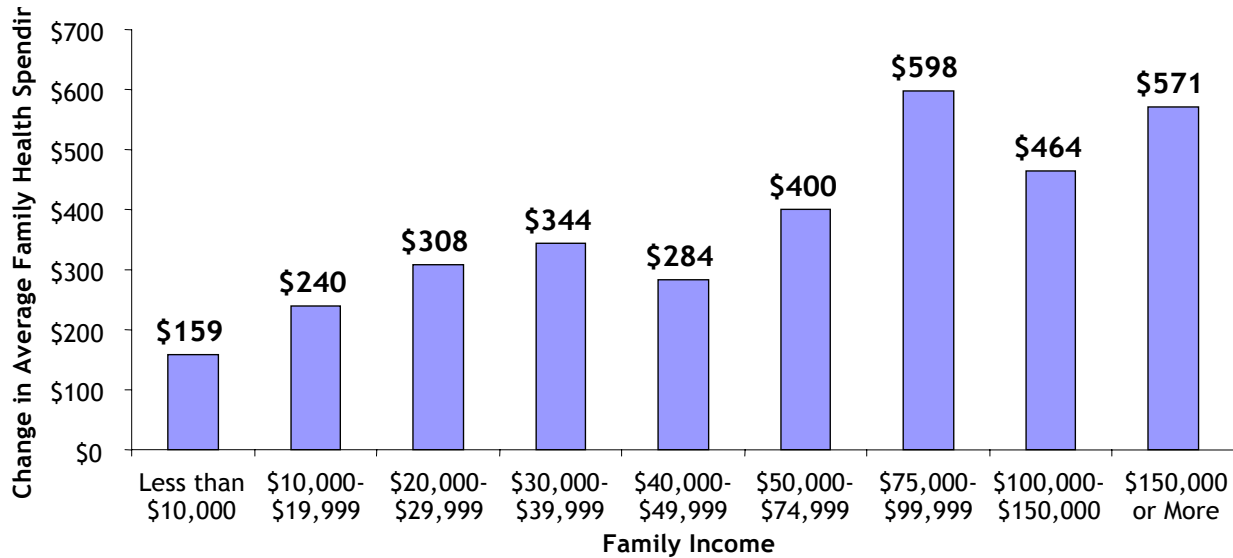
At the same time, employment in the state also would get a boost from an increase in federal spending for health care in the state of about \$462 million. This includes increased Medicaid funding and federal income and payroll tax reductions for people who see a reduction in wages under the proposal. At current average salary levels, these funds could result in a net increase in employment of between 7,000 and 11,000 people; which would more than offset the loss of employment among the minimum wage worker population. However, because most of this increase in employment would be in the health industry, few of these new jobs could be filled by the minimum wage workers who lose their jobs.

It is unlikely that the program would produce an exodus of employers to neighboring states. This is because about 65 percent of uninsured workers are employed in either the services or the retail trade industries such as restaurants, dry cleaners, gasoline stations, and stores. These businesses must locate near their markets or risk losing sales volume. For example, highly competitive services such as dry cleaners may find that moving their establishment just a mile or two into the District of Columbia could leave them vulnerable to competitors who are prepared to locate more conveniently to their customers. Moreover, the reductions in uncompensated care costs under the proposal could actually attract to the state some large employers in manufacturing and other higher wage industries that already provide health benefits in excess of the payroll tax percentage.

IMPACTS ON FAMILIES

Household health spending would be affected in several ways. Insurance premium payments by families would generally increase due to the increases in private coverage under the program. However, out-of-pocket spending would generally decline due to improvements in coverage. Also, as discussed above, after-tax wage income would on average decline to reflect the increase in employer costs associated with the MdCare program. These wage reductions are counted here as increased health care costs to families (*Figure ES-6*).

Figure ES-6
Change in Average Annual Health Spending Per Family by Family Income Under the MdCare Program in 2003: With Wage Effects



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Overall, we estimate that households would see health spending increase by an average of about \$391 per family when wage effects are included. The program would on average increase health spending for families at all income levels. Health spending would increase by an average of about \$159 for families with incomes below \$10,000. The average increase in spending would generally increase as income rises, reaching an average increase of about \$571 per family with incomes in excess of \$150,000.

These estimates mask the fact that some families would actually see savings under the program. For example, families with workers in firms that already spend more than the required percentage of payroll would on average see savings of about \$54 per year. These savings would be attributed to savings to their employer resulting from the reduction in uncompensated care costs for uninsured people. These savings to workers would take the form of an increase in wage growth in affected firms.

LEWIN GROUP EXPERIENCE

The Lewin Group has over 18 years experience in analyzing the impact of health reform initiatives on major stakeholder groups including employers, providers, governments and consumers. The Lewin analyses are based primarily upon a model of the U.S. healthcare system called the Health Benefits Simulation Model (HBSM), which first came to prominence in 1989 when it was used to estimate the cost of alternative universal coverage proposals for the Bipartisan Congressional Commission on Health Care. The model was again used by the Advisory Council on Social Security in 1991, and was used to analyze the impact of President Clinton's health reform proposal in 1993. We have since used the to model to simulate numerous health reforms at the state and federal levels ranging from expansions in the Medicaid program to single-payer models such as the proposal analyzed in this study.

This analysis was directed by Mr. John Sheils, a vice president with the Lewin Group, who is a nationally known expert on designing and evaluating health coverage expansion proposals. He joined Lewin in 1980 and has worked to establish the firm as one of the few independent sources of information on the financial impacts of major health reform initiatives. He has testified before various congressional committees and often works directly with members of Congress in evaluating and developing health reform initiatives. Mr. Sheils also authored the first independent analysis of President Clinton's health reform proposal in 1993, and provided analyses in support of recently enacted legislation in California that will expand employer coverage in the state. He also directed analyses of health reform proposals developed by eight major stakeholder groups for the "Coverage 2000 Initiative" sponsored by RWJF. He also provided analyses of the recent health reform proposal developed by the Commonwealth Fund and the health reform proposal developed for the Howard Dean presidential campaign.