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## State Legislative Testimony

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### MARYLAND'S HEALTH CARE MANDATE POLICY

Testimony on H.B. 939 before the Economic Matters Committee

Maryland House of Delegates

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Mr. Chairman and Members of the Committee:

My name is Robert E. Moffit. I am Director of Domestic Policy Studies at the Heritage Foundation. In that capacity, I oversee the Foundation's research work in the area of health care policy, including the financing and delivery of health care services in both government programs and in the private sector. It should be understood that the views I express here today are my own and do not necessarily reflect those of the Heritage Foundation.

It is an honor and a privilege to appear before the House Economic Matters Committee of the Maryland General Assembly to discuss House Bill 939 and the broader question of the impact and the policy issues surrounding the adoption of mandated benefits.

### **WHAT H.B. 939 DOES**

HB 939 provides that health insurers in the state of Maryland, whether profit or non-profit, may offer a "limited benefits" policy that excludes state mandated health benefits that currently apply to insurers in the Maryland health insurance market. The bill specifies that, for purposes of the legislation, that mandated benefits include particular health care services, benefits, coverage or reimbursement for providers as mandated by law. This appears to be a comprehensive definition of mandates, and would include legislative provisions requiring reimbursement for particular medical specialists and practitioners, and is thus in accord with what ordinary citizens would understand to be included as mandates.

The bill further specifies that limited benefits policies issued by any insurer or non-profit health plan may not exceed 10 percent of the total health benefit plans issued by insurers or non-profit organization. And it further requires any insurer or non-profit organization that issues such a limited benefits policy must disclose that the terms and conditions of the policy do not include the benefits or services mandated by law, including a list of the otherwise legally mandated benefits, and written acknowledgement that this information was provided to the policyholder. The bill further specifies that all other rules and regulations governing insurance would apply to the policy.

### **H.B. 939 AS PUBLIC POLICY**

H.B. 939 embodies sound public policy. While the bill does not repeal mandated benefits, it gives individuals and families the option of choosing alternatives. It enables them to make sensitive personal decisions in accord with their medical or financial condition. Thus, the chief benefit of the bill is that it would promote personal freedom of Maryland citizens. For those who hold personal freedom as a paramount value in public policy, this is a major improvement over current law.

H.B. 939 has the added benefit of introducing real market efficiencies into the purchasing of health care services. As a result of decades of federal and state level policies, the American health insurance market is profoundly distorted; it is plagued by perverse incentives on the part of providers and consumers; it is smothered in a regulatory system which is complex, cumbersome and confusing. Furthermore, largely because of the structure of the current health insurance market, patients are sometimes denied the services they need or forced to pay for services they either don't want or need. This adds to the cost, the waste, and the inefficiency and frustration with the system on the part of doctors and patients alike.

The strange distinction between customer and consumer is virtually unique to the health insurance market; it exists in no other sector of the American economy. There is a lack of transparency in this process. Too many employees erroneously think that the employer's contribution to the cost of their health insurance package is the employer's money, and not their own compensation, or they have not got a clue how much their employer's contribution to their benefits package actually is, let alone the cost of legal mandates on the package.

H.B. 939 represents a modest, but refreshing, break from this costly and counterproductive process. It would allow Maryland citizens to buy the level of coverage they think is best for them at a price they wish to pay. Maryland citizens should not be barred by the force of law from spending their own money to get the benefits package they want. They should be allowed to purchase the services that they, in consultation with their physicians, think is best for them. In that respect, the proposed bill would reduce the artificial barriers of rational purchasing and rational pricing that occurs in virtually every other sector of the American economy.

Finally, H.B. 939 would introduce a greater level of market competition into Maryland's private health insurance markets. There is clear evidence that the Maryland health insurance market, progressively regulated into greater uniformity through an accretion of complex legislative adjustments over the years- is becoming progressively less competitive. While this decline in the competitive character of the health insurance market, characterized by mergers and acquisitions, is a national phenomenon, Maryland can and should take serious steps to reverse this trend, and promote more, rather than fewer options, for individuals and families. By allowing citizens to purchase basic health insurance, the bill gives workers and families new opportunities to get coverage. Too many are priced out of the market, and have no coverage at all. A more robust and diverse health insurance market, with more and more individuals and families being mainstreamed into solid private health insurance, would improve the quality of life in Maryland.

**Some Improvements.** The bill imposes a 10 percent cap on an insurers sale of "limited benefit" policies. Why 10 percent? Or 20 percent? Or any percent? It is not at all clear why the legislation should put an arbitrary restriction on the ability of insurers to sell or the freedom of consumers to buy such a policy. This is a restriction on supply and demand and thus a deliberate distortion of the market. Besides being bad economic

policy, it is logically incompatible with the apparent purpose of the legislation in the first place, which is to promote personal freedom of choice. A better policy would be to eliminate any prior restraint on the sale of such policies and allow the consumers in the market to decide their popularity.

Secondly, it might be worthwhile to specify that a limited benefits package must meet requirements for catastrophic protection, as well as the inclusion of hospitalization and physician services as *categories* of benefits. As a consumer protection measure, this would not entail specifying treatments, procedures, levels of benefits- the subject of mandates, as commonly understood. An excellent statutory model for this approach is Chapter 89 of Title 5 of the United States Code, the law which governs the popular and successful Federal Employees Health Benefits program (FEHBP).

## **IMPROVING MARYLAND'S HEALTH CARE ECONOMY**

Maryland is in many respects a microcosm of America. It is a wealthy state with a diverse economy. Median family income in Maryland is considerably higher than the nation as a whole; and Maryland's level of poverty is lower than the nation as a whole.

Maryland is also a leader in the nation's health care industry. Health care spending in Maryland amounts to \$19.4 billion in year 2000 dollars.<sup>1</sup> Compared on a per capita basis, Maryland has more medical specialists, more physicians in residency, and a lower percentage of population under-served by primary care physicians than the nation as a whole.

There is a dynamic interaction between health care access, cost and quality. Keeping these components in some sort of equilibrium is the tough task of policy makers in the field of health care policy. In Maryland the overall picture is mixed. Based on Census Bureau reports, almost 10 percent of Maryland citizens were without health insurance coverage in 2000.<sup>2</sup> While this is considerably better than the national average of 14 percent, given the downturn in the economy, the loss of over a million jobs during the recession, the relationship between job status and insurance coverage, that raw number is likely to be very high both nationally and statewide.

There is a broad and well-established relationship between access and cost. Maryland is experiencing, like the nation at large, a significant increase in health care costs. Between 1999 and 2000, Maryland health care spending jumped from an increase of 4.6 percent to 8.4 percent.<sup>3</sup> When the statistics are finalized, they will doubtless show continued acceleration. The biggest growth in Maryland spending is attributable to Medicaid spending, which accounted for 19 percent of the spending increase in 2000.<sup>4</sup> The

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<sup>1</sup> Maryland Health Care Commission, *State Health Care Expenditures: Experience From 2000*, (Baltimore, 2001) p. v.

<sup>2</sup> Unites States Census Bureau, *Health Insurance Coverage 2000*, (September 2001), and p.11.

<sup>3</sup> Maryland Health Care Commission, *op. cit.*, p. v.

<sup>4</sup> *Ibid.*, p. vi.

disturbing news is that while Maryland Medicaid enrollment grew by 7.4 percent, enrollment in private sector plans grew by only 1 percent.<sup>5</sup>

Employees in large firms are more likely to get health insurance than employees in small firms; and employees in large firms are also more likely to be enrolled in self-insured plans covered under the provisions of the Employee Income Retirement Income Security Act of 1974, and thus exempt from the coverage and cost of state mandated benefits. While 55 percent of Maryland's small businesses (those with 50 or fewer employees) offer health insurance - a better rate than the nation as a whole- the cost of health insurance for employees in Maryland's small businesses is considerably higher than the nation as a whole. In 1999 dollars, Maryland small business employees pay 11.9 percent more in terms of average premiums for family coverage than similar businesses nationwide, a 10.3 more on average for single coverage than similarly situated persons nationwide.<sup>6</sup>

Just as troubling is the declining competitiveness of the Maryland's small group health insurance market. Between 1995 and 1999, the number of plans serving employees in this market declined from 37 to 23. While the trend in Maryland reflects national trends, it is disturbing. According to a study of the Maryland market by Health Management Associates, " ... between 1998 and 2000, the share of the largest two carriers jumped from 59 to 70 percent. Clearly, the number of health plans that can compete effectively across the state is not large, and the fact that just two firms control such a large market share diminishes competition."<sup>7</sup>

## **THE NATURE AND SCOPE OF MARYLAND HEALTH MANDATES**

According to a recent analysis by the Blue Cross/ Blue Shield Association, Maryland leads the nation with at least 52 mandates on private health insurance.<sup>8</sup> These include requirements that Maryland health plans cover specific benefits, medical conditions, medical services or medical providers (See Appendix for the Blue Cross and Blue Shield Association list). Only California, which has 43 mandates, comes close to Maryland.

Many states, recognizing that mandates have driven up health care costs for individuals and families, have enacted state mandated benefit evaluation laws. The record of these laws is spotty. In some states studies are conducted; in other states, they are not. In Maryland, the Maryland Health Care Commission has this responsibility. The Commission has recently examined 39 "required health insurance benefits for services" as specified under Maryland law, a more modest number, given the exclusion of provider mandates, which are included in the 2001 Blue Cross Blue Shield Association report.<sup>9</sup> According to the Commission's most recent report, conducted by William Mercer Inc., a

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<sup>5</sup> *Ibid.*

<sup>6</sup> Elliot Wicks, *Assessment of the Performance of Small Group Health Insurance Market Reforms in Maryland*, (Washington, D.C.: Health Management Associates, 2002), p. 18.

<sup>7</sup> Wicks, *op. cit.*, p. 26.

<sup>8</sup> Susan S. Laudicina et al., *State Legislative Health Care and Insurance Issues: 2001 Survey of Plans*, Washington, D.C., Blue Cross and Blue Shield Association, December 2001.

<sup>9</sup> The Maryland State Legislature may wish to examine the reasons for this discrepancy.

prominent consulting firm, on a “ full cost basis” the total cost of the Maryland mandates is about 14 percent of premium.<sup>10</sup> Under Maryland law, there is also an affordability cap of 2.2 percent of Maryland average annual wage. This means that if the full cost of mandates meets or exceeds this “ affordability cap” there is to be a moratorium on the enactment of new mandates and a comprehensive study of the impact of all exiting mandates. According the report, Maryland’s mandates, as a percentage of the average Maryland wage, amounts to 2.1 percent. As a matter of prudence, a tenth of a percentage point margin should not deter legislators from a serious evaluation of current policy.

Health benefits in the Maryland small group market are governed by the small group market laws. Under current law, these plans must offer a specified Comprehensive Standard Health Benefits Plan. Unlike most states laws, this is the only benefits package that is legally permitted to be offered to plans serving the small group market. Under Maryland law, an insurer serving the small group market can add benefits, but cannot subtract benefits, or offer a different combination of benefits. This is a remarkable restriction on the market’s ability to supply services. As described by the Health Management Associates, a Washington based consulting firm, the Maryland state legislature has used the Comprehensive Standard Health benefits Plan as a floor, while imposing a ceiling in the form of a cap: the average premium for the Standard Plan must not exceed 12 percent of the average annual Maryland wage, and only the Commission is empowered to make benefit changes to stay within that pre-ordained cap.<sup>11</sup> This “ceiling”, then, is also a remarkable restriction on the market’s ability to supply services.

## **THE RATIONALE FOR MANDATES**

Mandates are politically attractive. Based on the most recent survey of the blue cross blue shield association, the several states have imposed 1471 specific benefit mandates on private health insurance, requiring insurers to cover and patients to pay for a wide variety of specific conditions, services, providers or medical procedures.<sup>12</sup>

Patients sometimes complain that their medical conditions are insufficiently covered or not covered at all in employer-based insurance, and some physicians and other medical practitioners complain that their medical practices or services are insufficiently available through the employer-based third party payment system. They thus prevail upon the state legislatures to force private insurance companies to cover these conditions, services or medical procedures that they would not otherwise cover. It is not clear, without the benefit of a detailed legislative history, whether the adoption of any particular mandate is driven either by broad public demand, a desire to accommodate the latest findings of medical or biomedical research, an attempt to prevent the recurrence of a medically related tragedy, the belief that there is a genuine consumer demand for the mandated benefit or service, the belief that legal requirements are necessary for the opposite reason

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<sup>10</sup> Maryland Health Care Commission, Mandated Health Insurance Services Evaluation, a report conducted by William M. Mercer, Inc., December 20, 2001, p. 2.

<sup>11</sup> Wicks, *op. cit.* p. 11.

<sup>12</sup> Susan S. Laudicina *et al.*, *State Legislative Health Care and Insurance Issues: 2001 Survey of Plans*, Washington, D.C., Blue Cross and Blue Shield Association, December 2001.

(the virtual absence of consumer demand for the service or treatment), the personal experience or conviction of state legislators, or the political influence or visibility of a particular group of practitioners or medical specialists or patients. It should be noted, however, that the Institute of Medicine of the National Academy of Sciences conducted a workshop on the adoption of popular mandates for both breast cancer treatment and the 48 hour minimum hospital stay and concluded, “ A lesson from this policy case study is that science’s traditional methods of communication do not work well in influencing policy when public pressures politicize an issue.”<sup>13</sup>

Whether you count 39 or 52, Maryland legislators can always add more to that list. The problem, of course, is knowing when and where to stop. It is often undeniably true that any given mandate for any given provider or service can be justified by an appeal, often heartfelt and compelling, to the inherent benefit or efficacy of a service or a certain type of provider. If public policy were merely a matter of achieving an endless series of particular goods, world without end, then there would be no debate. If mandates are good, then, the more, the better.

Why not simply add to an ever-growing list ?. The possibilities are intriguing. America is currently on the cutting edge of a biomedical revolution with emerging technologies that will revolutionize the treatment of disease, adding new and more advanced technological weapons to the swelling arsenals of doctors and medical specialists to treat or cure or prevent illnesses: various laser treatments, digital implants for electrical stimulation to treat Parkinson’s disease and epilepsy, skin substitutes for burns and re-constructive surgery, new diagnostic technologies, new and ever more powerful drugs, new surgical systems. The 21<sup>st</sup> century will doubtless reap the rich fruits of the recent breakthroughs in the mapping of the human genome and the likely marriage of the silicon chip and the biological cell. Why should not every person, regardless of age, sex, income, class or medical condition be required by law to pay for these additional advances through every health plan or program on either shore of the Chesapeake Bay? These are, or shortly will be, tangible goods and services in the health care sector of the economy.

In fact, public policy is not driven by the achievement of particular goods. Public policy is broader and deeper than that, encompassing not merely the satisfaction of particular demands or the securing of particular goods or interests, but rather the necessity of balancing particular goods for the achievement of a common good or public interest. In that respect, the politics of mandates works directly against the superior policy of achieving a common good. As the editorialists in the December 4, 2001 edition of *The Washington Post*, commenting on *federal* proposals to mandate benefits in private insurance, noted: “ If Congress gets into the giddy business of conferring additional benefits without having to pay, or pay much attention to, the cumulative cost, the danger is that even more people will end up with no insurance at all.”

## **THE ECONOMIC IMPACT OF HEALTH MANDATES.**

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<sup>13</sup> Institute of Medicine, *Unintended Consequences of Health Policy Programs and Policies: A Workshop Summary* (Washington, D.C.: National Academy Press, 2001), p. 4

There is a positive relationship between increased health care costs, and an increase in the numbers of the uninsured nationwide. According to Congressional Budget Office, every 1 percent increase in health insurance costs causes roughly 200,000 Americans to lose coverage. Independent estimates put the figure even higher. According to the Lewin Group, a prominent private sector econometrics firm that measures the economic impact of health policy changes, every 1 percent increase in premiums causes roughly 300,000 Americans nationwide to lose coverage.

Mounting empirical evidence shows that increasing regulations drive up health care costs, including administrative and compliance costs, and increases the number of Americans who are forced to go without insurance. Because mandates mostly affect privately purchased health insurance through employer-sponsored health plans, where employees only pay a portion of the cost directly, they often appear to be free to employees. But, of course, this is not so; for, in point of fact, households actually pay close to 100 percent of all health care costs. Both independent economic analyses as well as government studies show that mandates on benefits force employers to pass their costs to employees in the form of lower wages or in reductions in other benefits covered—and possibly reductions in more desirable, or needed, benefits.

The professional literature in this area is rich and growing. For example, in 1999, Professor Gail Jensen of Wayne State University and Professor Michael Morrissey of the University of Alabama reported that mandates are responsible for higher levels of uninsured; they concluded that as many as one in four of Americans who are uninsured are uninsured as the result of state benefit mandates. “Mandates are not free. They are paid for by workers and their dependents, who receive lower wages or lose coverage altogether”.<sup>14</sup> Earlier, in 1998, researchers Frank A. Sloan and Christopher Conover, basing their findings on more than 100,000 observations, found that the probability of a person becoming uninsured increases with each government mandate.<sup>15</sup> In a landmark study of the issue, in 1996, analysts with the U.S. General Accounting Office (GAO) estimated that state mandated benefit laws accounted for 12 percent of the claims costs in Virginia, which then had 29 benefit and managed care mandates, and 22 percent in Maryland, which then had 36 mandates.<sup>16</sup> A similar study conducted by the actuarial firm of Milliman and Robertson for the National Center for Policy Analysis, a prominent public policy institute based in Texas, found that the 12 most common state-mandated benefits added as much as 30 percent to the cost of insurance.<sup>17</sup>

It should also be noted that it is not merely the cost of a particular service or provider in any given year, but rather the dynamics of the third party payment system, which fuels

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<sup>14</sup> Gail Jensen and Michael Morrissey, “Mandated Benefit Laws and Employer Sponsored Health Insurance”, a report for the Health Insurance Association of America, January 1999.

<sup>15</sup> Frank A. Sloan and Christopher J. Conover, “Effects of State Reforms on Health Insurance Coverage of Adults,” *Inquiry*, Vol. 35 (1998), pp. 280-293.

<sup>16</sup> United States General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*, GAO/HEHS-96-161, August 19, 1996.

<sup>17</sup> John Goodman and Merrill Matthews, ‘The Cost of Health Insurance mandates,’ National Center for Policy Analysis, *Brief Analysis* No.237, August 13, 1997.

incentives to higher utilization. This accelerating utilization, in turn, contributes to the rising cost of mandates.

Mandates can and do deliver tangible benefits to certain patients. But mandates also impose real costs and can and do have undesirable consequences. There are several:

**1. They aggravate the inequities in the tax treatment of health insurance at the expense of individuals and families.** Under current law, Americans can and do get unlimited tax relief for the purchase of health insurance on one and only one condition: they get health insurance coverage through their place of work. By law and regulation, then, health insurance is tied almost exclusively to the place of work. There is a direct and powerful relationship between job status, the kind of company that one works for, and one's access to affordable health care coverage. The professional literature shows that if one has a big income and works for a big company, one has access to a big health care benefits package, and one gets a big chunk of tax-free income. If one is poor, works for a small firm, and doesn't have a company based plan, one gets no tax break at all. This means practically speaking that one has to buy health insurance with after tax dollars, invariably on the individual insurance market, and this often makes health insurance prohibitively expensive, paying as much as 40 percent more in premiums for a package that would be available under a tax favored corporate plan. If one has to buy a package with a large number of mandated benefits, this makes such a package even more expensive and out of the reach of individuals and families in such a circumstance.

**2. Mandates impose the highest costs on those who can least afford it: low income workers and those without insurance.** The statistical relationship between the sheer number of mandates and the level of un-insurance is a weak one; the more important relationships are those between mandates and age, income, and employment levels. Mandates do not affect all workers in the same way. Workers with substantial incomes in large firms, or high wage workers in mid size or small firms, such as law firms, that operate under the small group insurance reforms, are obviously not affected by mandates in the same way as low wage workers and their families who work in small firms that offer health insurance, or firms that do not offer health insurance. Moreover, the impact is dramatically different for workers who must buy health insurance on their own in the individual market. According to the United States Census Bureau, persons who are uninsured are relatively young, heavily concentrated in the age bracket of 19 and 34. Approximately 80 percent of uninsured persons are in families where there is a full-time employee; they are low income generally (less than 200 percent of the official poverty level); they congregated in small businesses, particularly in the service industry; and they are disproportionately minority.<sup>18</sup> If these workers have access to health insurance at the place of work, the key question is whether or not the insurance is affordable to them. According to Lewin Group, it appears that approximately 25 percent of the uninsured have access to health insurance coverage at the place of work, but choose not to take advantage of it. The cost of coverage appears to be the main reason why workers don't get coverage.

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<sup>18</sup> U.S. Census Bureau, *op. cit.*

Of course, those workers who do not have access to health insurance at the place of work have little or no choice but to purchase health insurance on the individual market. In this instance, of course, the impact of benefit mandates can be substantial. While mandates are imposed for ostensibly humane reasons, there is nothing particularly humane about a public policy that hurts highly vulnerable citizens.

**3. Mandates have a disproportionate impact on the cost of individual insurance products.** Those who do not or cannot get coverage through employment based insurance, must cope with the higher administrative costs and the severe tax discrimination that affects the purchase of coverage on the individual market, but they must also cope with the additional cost of mandates. Maryland's current regulatory regime clearly has a disproportionate impact on the individual insurance market. According to the Mercer report, conducted on behalf of the Maryland Health Care Commission, while expressed simply as a percentage of premium, the cost is roughly the same as that of the group market, though in actual dollars the full cost of mandates for an individual policy is estimated to be \$1,058 per policy compared to a group policy, where the full cost is estimated to be \$814 annually per policy.<sup>19</sup>

**4. Mandates depress wages for workers and their families.** Health insurance benefits, like wages, are workers' compensation. They are not a free good that comes with a job; nor are they some simple addition to wages. Rather, there is invariably a trade off between benefits and wages. Generally speaking, an increase in health care benefits results in a corresponding decrease in wages and other compensation. Recent research indicates that the additional cost of health insurance, including the additional cost of mandates, is passed on to workers in the form of lower wages.<sup>20</sup>

**5. Mandates are imposed unevenly, with the unintended consequence of reducing the very size of the population targeted.** In Maryland and other states that impose benefit mandates, there are, of course, large classes of persons who are exempt from the state benefit mandates, including the enrollees in Medicare, Medicaid, and the Federal Employees Health Benefits Program (FEHBP). Moreover, many of those enrolled in employer based health insurance are enrolled in plans that self insure, and are thus under the federal regulatory regime established under the Employees Retirement Income Security Act of 1974.

In Maryland and other states, the imposition of health benefit mandates creates a strong incentive for firms to escape the state regulatory jurisdiction and come under the milder jurisdiction of ERISA. As Jensen and Morrissey note in their study of the economic impact of mandates, 43 percent of workers nationwide are enrolled in self insured plans: "In the presence of ERISA, a state mandate will not necessarily lead to substantially

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<sup>19</sup> William M Mercer Inc., *Mandated Health Insurance Services Evaluation*, a report for the Maryland Health Care Commission, December 20, 2001, p. 41.

<sup>20</sup> See Gail Jensen and Michael Morrissey, "Mandated Benefit Laws and Employer Sponsored Health Insurance", a report for the Health Insurance Association of America, January 1999, p. 14; see also Jonathan Gruber, "The Incidence of Mandated Maternity Benefit", *American Economic Review*, 84 (3), 1994, pp. 622-41.

more people with the covered benefit. Many will be excluded by virtue of coverage through self-insured plans, and others will move to self-insured firms.”<sup>21</sup> However, the avenues of escape from mandates are not, practically speaking, the same for all firms. Small firms and their employees, usually staffed with low income workers, are often unable to self-insure and secure ERISA protection from state mandated benefits and premium taxes, or more costly state insurance regulation, and thus “bear the brunt” of the higher costs that inevitably accompany state regulatory initiatives.<sup>22</sup> In short, mandates, of whatever variety, often disproportionately impact small business.

## **A BUILDING BLOCK OF HEALTH CARE REFORM**

HB 939 has only limited scope as a reform measure. It does not address the regulation of the insurance market; and it would make a limited contribution to the related problems of excessive cost and over-insurance.<sup>23</sup> But it represents genuine progress. Building on this small, but important step, Maryland legislators can take decisive actions to reduce costs for individuals and families, and make health insurance more accessible and affordable for the hundreds of thousands of Maryland citizens. This is a pressing problem, aggravated by the recession and the loss of coverage for thousands of persons who have also lost their job based health insurance coverage.

**Federal-State Cooperation.** In this connection, Maryland legislators should ponder ways to fashion health policies compatible with access proposals--particularly tax relief--being considered and debated at the national level. During the 2000 Presidential election, then Governor George Bush, Vice President Al Gore and former Senator Bill Bradley of New Jersey offered various tax credit proposals to address the problems of the uninsured and to expand health insurance coverage through the private sector with the unique benefits of an open and pluralistic patient-centered, patient-driven competitive market. Over the past two years, generous tax credit proposals have been advanced by national organizations ranging from the Progressive Policy Institute, the research arm of the Democratic Leadership Council, to the American Medical Association, the nation’s leading representative of organized medicine.

Currently, Congress is considering the President’s \$13 billion proposal to grant direct and immediate relief to unemployed workers who have lost their health insurance, using the administrative apparatus of the unemployment compensation system to secure immediate assistance. Legislation to accomplish this has been enacted in the House of Representatives twice, and is pending action in the Senate.

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<sup>21</sup> Jensen and Morrisey, *op. cit.*, p. 10.

<sup>22</sup> Tom Miller, Director of Health Policy Studies, The Cato Institute, “Improving Access to Health care Without Comprehensive Health Insurance Coverage”, February 7, 2002, p. 19. (unpublished manuscript).

<sup>23</sup> Says Dr. Jesse S. Hixon, Principal Economist of the American Medical Association, “The major design problem of our current health care system that people are over-insured. Correcting the incentive to over-insure will go a long way toward solving our health care expenditures” See Jesse S. Hixon Ph.D., *Six Questions Everyone Should Ask About Health System Reform: An Application of Basic Economics*, (Washington, D.C.: The Galen Institute, 2002), p. 3.

Moreover, the House has also recently enacted a \$100 million program for the states to establish high-risk pools that provide health insurance coverage for persons with pre-existing medical conditions. Today, 29 states have such risk pools, and such new funding could help Maryland provide crucial relief for many who are uninsured or otherwise uninsurable.

Finally, Maryland legislators should note that the President has unveiled a major \$100 billion proposal to expand coverage to all workers who are currently uninsured, including the creation of a new national system of health care tax credits or premium subsidies, while proposing innovative changes in both the SCHIP and Medicaid programs. This presents a rich opportunity for broad federal-state cooperation in dealing with the worsening problem of Americans who have lost or do not have access to health insurance coverage.

## **EXPANDING PATIENT CHOICE AND COVERAGE**

The major weakness of Maryland's health care system is not the absence of aggressive government regulation. By any standard, whether insurance regulation or rate regulation or the imposition of state mandated benefits, Maryland stands alone in the degree of its commitment to a regulatory health policy. If one is dissatisfied with the state of Maryland's health care system, certainly one's dissatisfaction can hardly be traceable to the state government's lack of regulatory enthusiasm.

As noted, health insurance markets are profoundly distorted by federal tax law; they are further distorted by detailed state rulemaking, which inhibits change, innovation, and flexibility. A sound market exists when firms can freely enter and freely exit that market, offering goods and services that they determine will appeal to the ever-changing wants and needs of a wide variety of individuals through a system of voluntary exchange. A deliberate political restriction of the availability of goods or services, or a practical prohibition on consumer choice, distorts the market. Distorted markets are inefficient; they fuel higher costs and ensure a waste of resources. It is one thing to struggle with a distorted and inefficient market that is a product of simple inertia; it is quite another to impose the additional costs in a market as a matter of deliberate policy, particularly on those who are least able to absorb these costs. The practical result, whether intended or not, is less real choice for patients, in choosing their doctors and specialists, and their health plans, benefits and services. It is a restriction on personal freedom.

The question is not whether Maryland can do better. The question is how Maryland can do better; how specifically to expand coverage, open up the markets, allow more genuine competition, how to promote more freedom of choice in the purchase of health insurance or health care services, and enable patients and their families to reap the benefits of a more flexible and cost effective system.

H.B. 939 only begins to accomplish that task. But it is a good start on the long and difficult road to health care reform.



Appendix: Maryland's State Mandated Benefits and Providers

Benefits

Alcoholism Treatment  
 Bone Density Screening  
 Breast Reconstruction  
 Cleft Palate  
 Clinical Trials  
 Colorectal Screening  
 Contraceptives  
 Dental Anesthesia  
 Diabetic Supplies/Edu  
 Drug Abuse Treatment  
 Emergency Services  
 Formula for PKU  
 Hair Prosthesis (Wigs)  
 Home Health Care  
 Hospice Care  
 In vitro Fertilization  
 Mammography Screening  
 Maternity  
 Mental Health (General)  
 Mental Health (Parity)  
 Minimum Mastectomy Stay  
 Minimum Maternity Stay  
 Off-Label Drug Use  
 Orthotics/Prosthetics  
 Prostate Cancer Screening  
 Rehabilitation Services  
 Second Med/Surg Opinion  
 Well-Child Care

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Total 28

Providers

Chiropractors  
 Dentists  
 Licensed Health Profs  
 Nurses Midwives  
 Nurse Anesthetists  
 Nurse Practitioners  
 Nurse, Psychiatric  
 Occupational Therapists  
 Optometrist  
 Osteopaths  
 Physical Therapists  
 Physician/Surg. Assistants  
 Podiatrists  
 Professional Counselors  
 Psychologists  
 Public and Other Facilities  
 Social Workers  
 Speech/Hearing Therapists

Patient Classes

Adopted Children  
 Continuation/Dependents  
 Continuation/Employees  
 Conversion to Non-Group  
 Handicapped Dependents

Newborns  


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 Total 24

Source: Blue Cross and Blue Shield Association, December 2001

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